| Heal th Financi  |  | DUKES MEMORIAL  |   |  | of Form CMS-2552-10   |
|--|--|---|---|--|---|
|  | s required by law (42 USC 1395g;   |   |   |  |   |
| payments made  | since the beginning of the cost  | reporting period being  | deemed overpayments (   | 42 USC 1395g).   | OMB NO. 0938-0050<br>EXPIRES 03-31-2022                                 |
| HOSPITAL AND<br>AND SETTLEMEN                                  | HOSPITAL HEALTH CARE COMPLEX COS<br>T SUMMARY  | T REPORT CERTIFICATION  | Provider CCN: 15-1318   | Period:<br>From 01/01/2019<br>To 12/31/2019  | Worksheet S<br>Parts I-III<br>Date/Time Prepared:<br>8/28/2020 10:36 am |
| PART I - COST  | REPORT STATUS  |   |   |  | 0/20/2020 10100 dim   |
| Provi der  | 1. [ X ] Electronically prepared   |   |   | Date: 8/28/202   | 20 Time: 10:36 am   |
| use only   | 2. [ ]Manually prepared cost   |   |   |  |   |
|  | 3. [ 0 ] If this is an amended r<br>4. [ F ] Medicare Utilization. E   | report enter the number<br>Enter "F" for full or "L   | of times the provider<br>" for low.   | resubmitted this co  | ost report  |
| Contractor<br>use only   | (1) As Submitted 7.<br>(2) Settled without Audit 8.  | Date Received:<br>Contractor No.<br>[ N ]Initial Report fo.<br>[ N ]Final Report for  | 11<br>or this Provider CCN 12   |  | r Code: 4<br>Iumn 1 is 4: Enter<br>es reopened = 0-9.                   |
| PART II - CER  | RTIFICATION  |   |   |  |   |
| ADMI NI STRATI V<br>PROVI DED OR P<br>ADMI NI STRATI V         | TION OR FALSIFICATION OF ANY INF<br>E ACTION, FINE AND/OR IMPRISONME<br>ROCURED THROUGH THE PAYMENT DIRE<br>E ACTION, FINES AND/OR IMPRISONM<br>FICATION BY CHIEF FINANCIAL OFFI   | NT UNDER FEDERAL LAW.<br>CTLY OR INDIRECTLY OF A<br>IENT MAY RESULT.  | FURTHERMORE, IF SERVIC<br>KICKBACK OR WERE OTHE   | ES IDENTIFIED IN TH  | IS REPORT WERE  |
| I HEF<br>el ect<br>Exper<br>endi r<br>compl<br>excep<br>heal t | REBY CERTIFY that I have read the<br>cronically filed or manually subm<br>ses prepared by DUKES MEMORIAL H<br>og 12/31/2019 and to the best of<br>ete and prepared from the books<br>of as noted. I further certify t<br>ch care services, and that the se<br>and regulations. | e above certification st<br>nitted cost report and t<br>HOSPITAL ( 15–1318 ) for<br>my knowledge and belief<br>and records of the prov<br>that I am familiar with | atement and that I hav<br>he Balance Sheet and S<br>the cost reporting pe<br>, this report and stat<br>ider in accordance wit<br>the laws and regulatic | Statement of Revenue<br>eriod beginning 01/C<br>cement are true, cor<br>ch applicable instru<br>ons regarding the pr | and<br>1/2019 and<br>rect,<br>ictions,<br>rovision of                   |
| [ ]  | I have read and agree with the a signature on this certification   |   |   |  |   |
|  |  | (Si gned)   |   | nistrator of Provide   | er(s)   |
|  |  |   | VP, REVENUE MANAG   | CEMENT   |   |
|  |  |   | Title   |  |   |
|  |  |   | Data  |  |   |
|  |  |   | Date  |  |   |

|        |                               |         | Title    | XVIII        |      |           |        |
|--------|-------------------------------|---------|----------|--------------|------|-----------|--------|
|        | Cost Center Description       | Title V | Part A   | Part B       | HIT  | Title XIX |        |
|        |                               | 1.00    | 2.00     | 3.00         | 4.00 | 5.00      |        |
|        | PART III - SETTLEMENT SUMMARY |         |          |              |      |           |        |
| 1.00   | Hospi tal                     | 0       | 249, 115 | -1, 004, 606 | 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       | 40, 637  | 0            |      | 0         | 5.00   |
| 6.00   | Swing Bed - NF                | 0       |          |              |      | 0         | 6.00   |
| 200.00 | Total                         | 0       | 289, 752 | -1, 004, 606 | 0    | 0         | 200.00 |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 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.

|          | Financial Systems<br>AL AND HOSPITAL HEALTH CARE COMPLEX                     |   | MEMORIAL             |             |          | 15-1318         | Period:<br>From 01/0    |                  | 1             | neet S-2             |       |
|----------|--|---|----------------------|-------------|----------|-----------------|-------------------------|------------------|---------------|----------------------|-------|
|          |  |   |                      |             |          |                 |                         | 1/2019           | Date/1        | Fime Pre<br>2020 10: |       |
|          | 1.00   | 2   | . 00                 |             | 3.00     |                 |                         | 4.00             | 0/20/2        | 2020 10.             |       |
| 0        | Hospital and Hospital Health Care Co<br>Street: 275 WEST 12TH STREET         | mplex Address:<br>P0 Box:                               |                      |             |          |                 |                         |                  |               |                      | 1     |
| 0        | City: PERU   | State:  | IN                   | Zip Code    | e: 46970 | ) Cour          | nty: MIAMI              |                  |               |                      | 1     |
| -        |  | Component N   | ame                  | CCN         | CBSA     | Provi de        | r Date                  |                  |               | tem (P,              |       |
|          |  |   |                      | Number      | Number   | r Type          | Certifie                |                  | <u>, 0, o</u> |                      | 4     |
|          |  | 1.00  |                      | 2.00        | 3.00     | 4.00            | 5.00                    | V 6. 00          | XVII<br>7.00  |                      | -     |
|          | Hospital and Hospital-Based Componen   |   | :                    | 2100        | 0100     |                 | 0.00                    | 1 01 00          |               |                      |       |
| 0        | Hospi tal  | DUKES MEMORIAL H  | IOSPI TAL            | 151318      | 99915    | 1               | 07/01/196               | 56 N             | 0             | P                    | 3     |
| 0<br>0   | Subprovider - IPF<br>Subprovider - IRF                                       |   |                      |             |          |                 |                         |                  |               |                      | 4     |
| 0        | Subprovider - (Other)  |   |                      |             |          |                 |                         |                  |               |                      | 6     |
| 0        | Swing Beds - SNF   | DUKES MEMORIAL H  | IOSPI TAL            | 15Z318      | 99915    |                 | 12/01/200               | 03 N             | 0             | N                    | 7     |
| 0        | Swing Beds - NF  | SB  |                      |             |          |                 |                         |                  |               |                      | 8     |
| 0        | Hospi tal -Based SNF   |   |                      |             |          |                 |                         |                  |               |                      | 9     |
| 00       | Hospital-Based NF  |   |                      |             |          |                 |                         |                  |               |                      | 10    |
| 00<br>00 | Hospi tal -Based OLTC<br>Hospi tal -Based HHA                                |   |                      |             |          |                 |                         |                  |               |                      | 11.   |
| 00       | Separately Certified ASC   |   |                      |             |          |                 |                         |                  |               |                      | 13    |
| 00       | Hospi tal -Based Hospi ce  |   |                      |             |          |                 |                         |                  |               |                      | 14.   |
| 00<br>00 | Hospital -Based Health Clinic - RHC  |   |                      |             |          |                 |                         |                  |               |                      | 15    |
| 00       | Hospital-Based Health Clinic - FQHC<br>Hospital-Based (CMHC) I               |   |                      |             |          |                 |                         |                  |               |                      | 17    |
| 00       | Renal Dialysis   |   |                      |             |          |                 |                         |                  |               |                      | 18    |
| 00       | Other  |   |                      |             |          |                 | Fro                     |                  | т             |                      | 19    |
|          |  |   |                      |             |          |                 | 1. (                    |                  |               | . 00                 | 1     |
|          | Cost Reporting Period (mm/dd/yyyy)   |   |                      |             |          |                 | 01/01,                  |                  | 12/3          | 1/2019               | 20    |
| 00       | Type of Control (see instructions)   |   |                      |             |          |                 | 4                       |                  |               |                      | 21    |
|          |  |   |                      |             |          | 1.00            | 2. (                    | 00               | 3.            | .00                  | 1     |
|          | Inpatient PPS Information  |   |                      |             |          |                 |                         |                  | 1             |                      |       |
| 00       | Does this facility qualify and is it<br>disproportionate share hospital adju | 2   | 0.5                  |             |          | Ν               |                         |                  |               |                      | 22.   |
|          | §412.106? In column 1, enter "Y" fo  |   |                      |             |          |                 |                         |                  |               |                      |       |
|          | facility subject to 42 CFR Section §   |   |                      | dment       |          |                 |                         |                  |               |                      |       |
| 01       | hospital?) In column 2, enter "Y" fo<br>Did this hospital receive interim un |   |                      | for this    | s        | N               | N                       |                  |               |                      | 22    |
| 01       | cost reporting period? Enter in colu   |   |                      |             |          |                 |                         |                  |               |                      | 22.   |
|          | the portion of the cost reporting pe   |   |                      |             |          |                 |                         |                  |               |                      |       |
|          | Enter in column 2, "Y" for yes or "N<br>reporting period occurring on or aft |   |                      |             | ost      |                 |                         |                  |               |                      |       |
| 02       | Is this a newly merged hospital that   | requires final  | uncompensa           | ated car    |          | Ν               | N                       |                  |               |                      | 22    |
|          | payments to be determined at cost re   |   |                      |             | s)       |                 |                         |                  |               |                      |       |
|          | Enter in column 1, "Y" for yes or "N<br>cost reporting period prior to Octob |   |                      |             | ves      |                 |                         |                  |               |                      |       |
|          | or "N" for no, for the portion of th   |   |                      |             |          |                 |                         |                  |               |                      |       |
| ٥s       | October 1.<br>Did this hospital receive a geograph                           | ic reclassificati                                       | ion from .           | urban to    |          | N               | N                       |                  |               | N                    | 22    |
| 00       | rural as a result of the OMB standar   | ds for delineati  | ng statist           | tical ar    |          | IN              |                         |                  |               |                      | 22.   |
|          | adopted by CMS in FY2015? Enter in c   | olumn 1, "Y" for  | yes or "N            | N" for n    | 0        |                 |                         |                  |               |                      |       |
|          | for the portion of the cost reportin<br>in column 2, "Y" for yes or "N" for  |   |                      |             | r        |                 |                         |                  |               |                      |       |
|          | reporting period occurring on or aft   | er October 1. (se                                       | ee instruc           | ctions)     |          |                 |                         |                  |               |                      |       |
|          | Does this hospital contain at least  |   |                      |             |          |                 |                         |                  |               |                      |       |
|          | counted in accordance with 42 CFR 41<br>yes or "N" for no.                   | 2. 105)? Enter IN                                       | corunn 3,            | , T TO      |          |                 |                         |                  |               |                      |       |
| 00       | Which method is used to determine Me   |   |                      |             |          |                 | 3 N                     |                  |               |                      | 23.   |
|          | below? In column 1, enter 1 if date<br>if date of discharge. Is the method   |   |                      | 2           |          |                 |                         |                  |               |                      |       |
|          | reporting period different from the  |   |                      |             | 031      |                 |                         |                  |               |                      |       |
|          | reporting period? In column 2, ente  | r "Y" for yes or  |                      |             | ato      | Out of          |                         | Modia            | hi d          | Othor                |       |
|          |  |   | In-State<br>Medicaid |             |          | Out-of<br>State | Out-of<br>State         | Medica<br>HMO da |               | Other<br>edi cai d   |       |
|          |  |   | paid days            | rs∣eligi    | ble N    | Medi cai d      | Medi cai d              |                  |               | days                 |       |
|          |  |   |                      | unpa<br>day | · · ·    | aid days        | el i gi bl e<br>unpai d |                  |               |                      |       |
|          |  |   | 1.00                 | 2.0         |          | 3.00            | 4. 00                   | 5.00             | )             | 6.00                 | -     |
|          |  |   |                      |             | -        |                 |                         | 0.00             |               |                      |       |
| 00       | If this provider is an IPPS hospital   |   | 1.00                 |             | 0        | 0               | 0                       |                  | 634           | ç                    | 9 24. |
| 00       | in-state Medicaid paid days in colum   | n 1, in-state   |                      |             | 0        | 0               | 0                       |                  | 634           | ç                    | 24    |
| 00       | in-state Medicaid paid days in colum<br>Medicaid eligible unpaid days in col | n 1, in-state<br>umn 2,                                 |                      |             | 0        | 0               | 0                       |                  | 634           | ç                    | 9 24  |
| 00       | in-state Medicaid paid days in colum   | n 1, in-state<br>umn 2,<br>olumn 3,<br>d days in column | 10                   |             | 0        | 0               | 0                       |                  | 634           | 5                    | 9 24. |

| )SPI T | Financial Systems DUKES<br>TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA   | ATA   | Provider CC   | CN: 15-1318                                 | Peri od:   |                    |           | eet S-2                     | 2          |
|--------|---|---|---|---|--|--------------------|-----------|-----------------------------|------------|
|        |   |   |   |   | From 01/0<br>To 12/3                                     | 1/2019             |           | ime Pre<br>020 10:          |            |
|        |   | In-State<br>Medicaid<br>paid days                       | In-State<br>Medicaid<br>eligible<br>unpaid<br>days  | Out-of<br>State<br>Medicaid<br>paid days    | Out-of<br>State<br>Medi cai d<br>el i gi bl e<br>unpai d | Medicai<br>HMO day | ys Me     | )ther<br>di cai d<br>days   |            |
|        |   | 1.00  | 2.00  | 3.00  | 4.00   | 5.00               | -         | 6.00                        | -          |
| . 00   | If this provider is an IRF, enter the in-state<br>Medicaid paid days in column 1, the in-state<br>Medicaid eligible unpaid days in column 2,<br>out-of-state Medicaid days in column 3, out-of-state<br>Medicaid eligible unpaid days in column 4, Medicaid<br>HMO paid and eligible but unpaid days in column 5. | C   |   |   | 0  | tural S            | 0         |                             | 25.        |
|        |   |   |   |   | 1. (   |                    |           | 00                          | -          |
| . 00   | Enter your standard geographic classification (not wa<br>cost reporting period. Enter "1" for urban or "2" for<br>Enter your standard geographic classification (not wa   | rural.  | -   |   |  | 2                  |           |                             | 26.<br>27. |
| . 00   | reporting period. Enter in column 1, "1" for urban denter the effective date of the geographic reclassifil f this is a sole community hospital (SCH), enter the   | ~"2" for r<br>cation in                                 | ural. If ap<br>column 2.                            | opl i cabl e,                               |  | 0                  |           |                             | 35         |
| . 00   | effect in the cost reporting period.  |   |   |   |  |                    |           |                             |            |
|        |   |   |   |   | Begi ni  |                    | Endi<br>2 | ng:<br>00                   | -          |
| 00     | Enter applicable beginning and ending dates of SCH st   |   | cript line  | 36 for numb                                 |  |                    | ۷.        | 50                          | 36         |
| 00     | of periods in excess of one and enter subsequent date<br>If this is a Medicare dependent hospital (MDH), enter<br>is in effect in the cost reporting period.  |   | r of period   | ds MDH statu                                | IS   | 0                  |           |                             | 37         |
| 01     | Is this hospital a former MDH that is eligible for th<br>accordance with FY 2016 OPPS final rule? Enter "Y" fo<br>instructions)   |   |   |   |  |                    |           |                             | 37         |
| 00     | If line 37 is 1, enter the beginning and ending dates<br>greater than 1, subscript this line for the number of<br>enter subsequent dates.   |   |   |   |  |                    |           |                             | 38         |
|        |   |   |   |   | Y/   |                    |           | /N                          |            |
| . 00   | Does this facility qualify for the inpatient hospital<br>hospitals in accordance with 42 CFR §412.101(b)(2)(i)<br>1 "Y" for yes or "N" for no. Does the facility meet<br>accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii<br>or "N" for no. (see instructions)   | ), (ii), or<br>the mileage                              | (iii)? Ent<br>requiremer                            | ter in colum<br>nts in                      | In   |                    |           | <u>00</u><br>N              | 39         |
| 00     | Is this hospital subject to the HAC program reduction<br>"N" for no in column 1, for discharges prior to Octob<br>no in column 2, for discharges on or after October 1.   | per 1. Ente   | r "Y" for y   |   |  | I                  | 1         | _                           | 40         |
|        |   |   |   |   |  | V<br>1.00          | 2.00      | XI X<br>3.00                | -          |
|        | Prospective Payment System (PPS)-Capital  |   |   |   |  | 1.00               | 2.00      | 3.00                        |            |
|        | Does this facility qualify and receive Capital paymer<br>with 42 CFR Section §412.320? (see instructions)   |   | ·   |   |  | N                  | N         | N                           | 45         |
| 00     | Is this facility eligible for additional payment exceptures pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.  |   |   |   |  | N                  | N         | N                           | 46         |
| 00     | Is this a new hospital under 42 CFR §412.300(b) PPS of<br>Is the facility electing full federal capital payment<br>Teaching Hospitals   | •   |   | 5   |  | N                  | N         | N<br>N                      | 47<br>48   |
| 00     | Is this a hospital involved in training residents in<br>"N" for no in column 1. If column 1 is "Y", are you i<br>GME payment reduction? Enter "Y" for yes or "N" for  | mpacted by  | CR 11642 (  |   |  |                    |           |                             | 56         |
| 00     | If line 56 is yes, is this the first cost reporting p<br>GME programs trained at this facility? Enter "Y" for<br>is "Y" did residents start training in the first mont<br>for yes or "N" for no in column 2. If column 2 is "Y<br>"N", complete Wkst. D, Parts III & IV and D-2, Pt. II                           | r yes or "N<br>th of this<br>Y", complet<br>∣, if appli | " for no ir<br>cost report<br>e Worksheet<br>cable. | n column 1.<br>ting period?<br>t E-4. lf co | If column '<br>'Enter "Y'<br>Numn 2 is                   | '                  |           |                             | 57         |
| 00     | If line 56 is yes, did this facility elect cost reimb<br>defined in CMS Pub. 15-1, chapter 21, §2148? If yes,   |   |   | ans' servi ce                               | es as  | N                  |           |                             | 58         |
| 00     | Are costs claimed on line 100 of Worksheet A? If yes  |   |   |   | _  | N                  |           |                             | 59         |
|        |   |   |   | NAHE 413.8<br>Y/N                           | 35 Worksh<br>Line  | e #                | Qualifi   | hrough<br>cation<br>on Code |            |
|        |   |   |   | 1.00  | 2.   | 00                 | 3         | 00                          | -          |
| . 00   | Are you claiming nursing and allied health education<br>any programs that meet the criteria under 42 CFR 413.<br>instructions) Enter "Y" for yes or "N" for no in col<br>is "Y", are you impacted by CR 11642 (or subsequent (  | 85? (see<br>umn 1. If                                   | column 1  | N   | 2.   |                    | 3.        | 00                          | 60         |

| OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA   | TA   | Provider CC   |   | eriod:<br>rom 01/01/2019<br>o 12/31/2019 |   | pared        |
|--|--|---|---|--|---|--------------|
|  | Y/N  | IME   | Direct GME                                | IME                                      | Direct GME                              |              |
|  | 1.00   | 2.00  | 3.00                                      | 4.00                                     | 5.00                                    |              |
| <ul> <li>Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)</li> </ul>  | N  |   |   | 0.00                                     | 0. OC                                   | 61.0         |
| I. 02 Enter the current year total unweighted primary care<br>FTE count (excluding OB/GYN, general surgery FTEs,<br>and primary care FTEs added under section 5503 of<br>ACA). (see instructions)  |  |   |   |  |   | 61. C        |
| I.03 Enter the base line FTE count for primary care<br>and/or general surgery residents, which is used for<br>determining compliance with the 75% test. (see<br>instructions)  |  |   |   |  |   | 61. C        |
| I. 04 Enter the number of unweighted primary care/or<br>surgery allopathic and/or osteopathic FTEs in the<br>current cost reporting period. (see instructions).  |  |   |   |  |   | 61. C        |
| I. 05 Enter the difference between the baseline primary<br>and/or general surgery FTEs and the current year's<br>primary care and/or general surgery FTE counts (line<br>61.04 minus line 61.03). (see instructions)   |  |   |   |  |   | 61. C        |
| I. 06 Enter the amount of ACA §5503 award that is being<br>used for cap relief and/or FTEs that are nonprimary<br>care or general surgery. (see instructions)  |  |   |   |  |   | 61.0         |
|  | Pro  | ogram Name  | Program Code                              | Unweighted IME<br>FTE Count              | Unweighted<br>Direct GME FTE<br>Count   | -            |
|  |  | 1.00  | 2.00                                      | 3.00                                     | 4.00                                    | 1            |
| <ul> <li>1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program name. Enter in column 2, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count.</li> </ul> |  |   |   | 0. oc<br>0. oc                           |   | 61. 1        |
|  |  |   |   |  | 1.00                                    | 1            |
| ACA Provisions Affecting the Health Resources and Ser  |  |   |   |  |   |              |
| <ol> <li>2.00 Enter the number of FTE residents that your hospital<br/>your hospital received HRSA PCRE funding (see instruc</li> <li>2.01 Enter the number of FTE residents that rotated from a<br/>during in this cost reporting period of HRSA THC program</li> </ol>   | tions)<br>Teachi<br>ram. (s  | ng Health Cent<br>see instructior   | ter (THC) into                            |  |   | 62.0<br>62.0 |
| Teaching Hospitals that Claim Residents in Nonprovide<br>8.00 Has your facility trained residents in nonprovider se<br>"Y" for yes or "N" for no in column 1. If yes, comple   | ttings   | during this co  | 67. (see instru                           | ictions)                                 | N                                       | 63.0         |
|  |  |   | Unweighted<br>FTEs<br>Nonprovider<br>Site | Unweighted<br>FTEs in<br>Hospital        | Ratio (col. 1/<br>(col. 1 + col.<br>2)) |              |
| Section 5504 of the ACA Base Year FTE Residents in No  | nnrovi   | der Settings  | 1.00<br>This base year                    | 2.00                                     | <u> </u>                                |              |
| <ul> <li>bectroin 3504 of the ACA base fear rise residents in No</li> <li>period that begins on or after July 1, 2009 and befor</li> <li>00 Enter in column 1, if line 63 is yes, or your facilit</li> <li>in the base year period, the number of unweighted non</li> <li>resident FTEs attributable to rotations occurring in</li> <li>settings. Enter in column 2 the number of unweighted</li> <li>resident FTEs that trained in your hospital. Enter in</li> <li>of (column 1 divided by (column 1 + column 2)). (see</li> </ul>   | <u>e June</u><br>y trair<br>-primar<br>all nor<br>non-pr<br>columr | 30, 2010.<br>med residents<br>ty care<br>provider<br>mary care<br>m 3 the ratio | 0.00                                      | -  |   | 64. (        |

| SPITAL AND HOSPITAL HEALTH CARE COMPL   | LEX IDENTIFICATION DA   | AIA Provider   | Fr   | eriod:<br>com 01/01/2019   | Worksheet S-2<br>Part I   |                |
|---|---|--|--|--|---|----------------|
|   |   |  | To   | 12/31/2019   | Date/Time Pre<br>8/28/2020 10:  | pared<br>36 am |
|   | Program Name  | Program Code   | Unwei ghted  | Unweighted   | Ratio (col. 3/  |                |
|   |   |  | FTEs   | FTEs in  | $(col \cdot 3 + col \cdot$  |                |
|   |   |  | Nonprovider<br>Site  | Hospi tal  | 4))   |                |
|   | 1.00  | 2.00   | 3.00   | 4.00   | 5.00  | 1              |
| 00 Enter in column 1, if line 63  |   |  | 0.00   | 0.00   |   | 65.            |
| is yes, or your facility<br>trained residents in the base<br>year period, the program name<br>associated with primary care<br>FTEs for each primary care<br>program in which you trained<br>residents. Enter in column 2,<br>the program code. Enter in<br>column 3, the number of<br>unweighted primary care FTE<br>residents attributable to<br>rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column<br>5, the ratio of (column 3   |   |  |  |  |   |                |
| divided by (column 3 + column<br>4)). (see instructions)  |   |  | Unweighted   | Unwei ghted  | Ratio (col. 1/  | ,              |
|   |   |  | FTEs   | FTEs in  | (col. 1 + col.  |                |
|   |   |  | Nonprovi der   | Hospi tal  | 2))   |                |
|   |   |  | Si te  |  |   |                |
| Contion FEOd of the AOA O   | Veen FTF Deet 1   | n Nonnessida O Litt  |  | 2.00   | 3.00  |                |
| Section 5504 of the ACA Current<br>beginning on or after July 1, 20   |   | n Nonprovider Settir   | igsErrective ro  | r cost reporti   | ing periods   |                |
| Enter in column 2 the number of   |   |  |  |  |   |                |
| Enter in column 2 the number of<br>FTEs that trained in your hospit<br>(column 1 divided by (column 1 +   | al. Enter in column   | ry care resident<br>3 the ratio of   | Unweighted<br>FTEs<br>Nonprovider<br>Site  | Unweighted<br>FTEs in<br>Hospital  | Ratio (col. 3/<br>(col. 3 + col.<br>4))   |                |
| FTEs that trained in your hospit<br>(column 1 divided by (column 1 +  | al. Enter in column<br>_column 2)). (see in   | ry care resident<br>3 the ratio of<br>structions)  | FTĔs<br>Nonprovi der<br>Si te<br>3.00  | FTES in<br>Hospital  | (col. 3 + col.<br>4))<br>5.00   | _              |
| <ul> <li>FTEs that trained in your hospit.<br/>(column 1 divided by (column 1 +<br/>divided by (column 1 +<br/>expected by (column 1)</li> <li>OO Enter in column 1, the program<br/>name associated with each of<br/>your primary care programs in<br/>which you trained residents.<br/>Enter in column 2, the program<br/>code. Enter in column 3, the<br/>number of unweighted primary<br/>care FTE residents attributable<br/>to rotations occurring in all<br/>non-provider settings. Enter in<br/>column 4, the number of<br/>unweighted primary care<br/>resident FTEs that trained in<br/>your hospital. Enter in column<br/>5, the ratio of (column 3)<br/>divided by (column 3 + column</li> </ul>  | al. Enter in column<br><u>column 2)). (see in</u><br>Program Name   | ry care resident<br>3 the ratio of<br>structions)<br>Program Code  | FTËs<br>Nonprovider<br>Site  | FTES in<br>Hospital  | (col. 3 + col.<br>4))<br>5.00   | _              |
| FTEs that trained in your hospit.<br>(column 1 divided by (column 1 +<br>00 Enter in column 1, the program<br>name associated with each of<br>your primary care programs in<br>which you trained residents.<br>Enter in column 2, the program<br>code. Enter in column 3, the<br>number of unweighted primary<br>care FTE residents attributable<br>to rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column<br>5, the ratio of (column 3  | al. Enter in column<br><u>column 2)). (see in</u><br>Program Name   | ry care resident<br>3 the ratio of<br>structions)<br>Program Code  | FTĔs<br>Nonprovi der<br>Si te<br>3.00  | FTES in<br>Hospital<br>4.00<br>0.00  | (col. 3 + col.<br>4))<br>5.00<br>0.000000   | _              |
| FTEs that trained in your hospit.<br>(column 1 divided by (column 1 +<br>column 1 divided by (column 1 +<br>00 Enter in column 1, the program<br>name associated with each of<br>your primary care programs in<br>which you trained residents.<br>Enter in column 2, the program<br>code. Enter in column 3, the<br>number of unweighted primary<br>care FTE residents attributable<br>to rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column<br>5, the ratio of (column 3<br>divided by (column 3 + column<br>4)). (see instructions)   | al. Enter in column<br><u>column 2)). (see in</u><br>Program Name<br><u>1.00</u>  | ry care resident<br>3 the ratio of<br>structions)<br>Program Code  | FTĔs<br>Nonprovi der<br>Si te<br>3.00  | FTES in<br>Hospital  | (col. 3 + col.<br>4))<br>5.00<br>0.000000   | _              |
| FTEs that trained in your hospit<br>(column 1 divided by (column 1 +<br>(column 1 divided by (column 1 +<br>name associated with each of<br>your primary care programs in<br>which you trained residents.<br>Enter in column 2, the program<br>code. Enter in column 3, the<br>number of unweighted primary<br>care FTE residents attributable<br>to rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column<br>5, the ratio of (column 3<br>divided by (column 3 + column<br>4)). (see instructions)  | al. Enter in column<br><u>column 2)). (see in</u><br>Program Name<br><u>1.00</u>  | ry care resident<br>3 the ratio of<br>structions)<br>Program Code<br>2.00  | FTĚs<br>Nonprovi der<br>Si te<br>3.00<br>0.00  | FTES in<br>Hospi tal<br>4.00<br>0.00<br>1.0  | (col . 3 + col .<br>4))<br>5.00<br>0.000000<br>0.0000000                          |                |
| FTEs that trained in your hospit.<br>(column 1 divided by (column 1 +<br>(column 1 divided by (column 1 +<br>00 Enter in column 1, the program<br>name associated with each of<br>your primary care programs in<br>which you trained residents.<br>Enter in column 2, the program<br>code. Enter in column 3, the<br>number of unweighted primary<br>care FTE residents attributable<br>to rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column<br>5, the ratio of (column 3<br>divided by (column 3 + column<br>4)). (see instructions)  | al. Enter in column<br><u>column 2)). (see in</u><br>Program Name<br><u>1.00</u><br><u>1.00</u>   | ry care resident<br>3 the ratio of<br>structions)<br>Program Code<br>2.00<br>1PF), or does it con  | FTĚs<br>Nonprovi der<br>Si te<br>3.00<br>0.00  | FTES in         Hospital         4.00         0.00         0.00         1.0         rovider? | (col . 3 + col .<br>4))<br>5.00<br>0.000000<br>0.0000000                          |                |
| FTEs that trained in your hospit.<br>(column 1 divided by (column 1 +<br>(column 1 divided by (column 1 +<br>)<br>00 Enter in column 1, the program<br>name associated with each of<br>your primary care programs in<br>which you trained residents.<br>Enter in column 2, the program<br>code. Enter in column 3, the<br>number of unweighted primary<br>care FTE residents attributable<br>to rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column<br>5, the ratio of (column 3<br>divided by (column 3 + column<br>4)). (see instructions) Inpatient Psychiatric Facility P<br>00 Is this facility an Inpatient Psy<br>Enter "Y" for yes or "N" for no<br>00 If line 70 is yes: Column 1: Did<br>recent cost report filed on or b<br>42 CFR 412.424(d)(1)(iii)(c)) Co<br>program in accordance with 42 CF<br>Column 3: If column 2 is Y, indi-<br>(see instructions) | al. Enter in column<br><u>column 2)). (see in</u><br>Program Name<br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u><br><u>1.00</u>   | ry care resident<br>3 the ratio of<br>structions)<br>Program Code<br>2.00<br>IPF), or does it con<br>n approved GME teach<br>004? Enter "Y" for<br>ility train resident<br>)(D)? Enter "Y" for                         | FTĚs<br>Nonprovi der<br>Si te<br>3.00<br>0.00<br>tain an IPF subp<br>ing program in t<br>yes or "N" for m<br>s in a new teach<br>yes or "N" for m    | FTES in<br>Hospital<br>4.00<br>0.00<br>1.0<br>rovider? N<br>he most<br>o. (see<br>ing<br>o.  | (col . 3 + col .<br>4))<br>5.00<br>0.000000<br>0.0000000                          | 70.            |
| FTEs that trained in your hospit.<br>(column 1 divided by (column 1 +<br>(column 1 divided by (column 1 +<br>)<br>00 Enter in column 1, the program<br>name associated with each of<br>your primary care programs in<br>which you trained residents.<br>Enter in column 2, the program<br>code. Enter in column 3, the<br>number of unweighted primary<br>care FTE residents attributable<br>to rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column<br>5, the ratio of (column 3<br>divided by (column 3 + column<br>4)). (see instructions)           Inpatient Psychiatric Facility P           00 Is this facility an Inpatient Ps<br>Enter "Y" for yes or "N" for no<br>00 If line 70 is yes: Column 1: Did<br>recent cost report filed on or b<br>42 CFR 412.424(d)(1)(iii)(c)) Co<br>program in accordance with 42 CF<br>Column 3: If column 2 is Y, indi-       | al. Enter in column<br><u>column 2)). (see in</u><br>Program Name<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1.00<br>1. | ry care resident<br>3 the ratio of<br>structions)<br>Program Code<br>2.00<br>IPF), or does it con<br>n approved GME teach<br>004? Enter "Y" for<br>ility train resident<br>)(D)? Enter "Y" for<br>ear began during thi | FTĚs<br>Nonprovi der<br>Si te<br>3.00<br>0.00<br>intain an IPF subp<br>sing program in t<br>yes or "N" for m<br>s in a new teach<br>yes or "N" for m | FTES in<br>Hospital<br>4.00<br>0.00<br>1.0<br>rovider? N<br>he most<br>o. (see<br>ing<br>o.  | (col . 3 + col .<br>4))<br>5.00<br>0.000000<br>0.0000000<br>0.0000000<br>0.000000 | _              |

| Health Financial Systems DUKES MEMORIA   | L HOSPI TAL          |                      | In Lie                                      | u of Form CMS-  | 2552-10          |
|--|----------------------|----------------------|---|---|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | Provider C           | 1                    | Period:<br>From 01/01/2019<br>Fo 12/31/2019 | Worksheet S-2<br>Part I<br>Date/Time Pre<br>8/28/2020 10: | pared:           |
|  |                      |                      |   | 1.00  |                  |
| Long Term Care Hospital PPS<br>80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes<br>81.00 Is this a LTCH co-located within another hospital for part of<br>"Y" for yes and "N" for no.   |                      |                      | period? Enter                               | N<br>N  | 80. 00<br>81. 00 |
| TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)86.00Did this facility establish a new Other subprovider (exclude)   |                      |                      |   | N   | 85.00<br>86.00   |
| \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.<br>87.00 [Is this hospital an extended neoplastic disease care hospital  |                      |                      |   | Ν   | 87.00            |
| 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.  |                      |                      | V   | XIX   |                  |
|  |                      |                      | 1.00  | 2.00  |                  |
| 70.00 Title V and XIX Services<br>90.00 Does this facility have title V and/or XIX inpatient hospita   | I services? E        | nter "Y" for         | N   | Y   | 90.00            |
| yes or "N" for no in the applicable column.<br>91.00 Is this hospital reimbursed for title V and/or XIX through t  |                      |                      | N   | Y   | 91.00            |
| full or in part? Enter "Y" for yes or "N" for no in the appl   | icable column        | l.                   | N IN  |   |                  |
| 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica  |                      | ion)? (see           |   | N   | 92.00            |
| 93.00 Does this facility operate an ICF/IID facility for purposes<br>"Y" for yes or "N" for no in the applicable column.   |                      | d XIX? Enter         | N   | Ν   | 93.00            |
| 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,  | and "N" for n        | o in the             | N   | Ν   | 94.00            |
| applicable column.<br>95.00  If line 94 is "Y", enter the reduction percentage in the app  |                      |                      | 0.00  | 0.00  | 95.00            |
| 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.  | or "N" for n         | o in the             | N   | Ν   | 96.00            |
| 97.00 If line 96 is "Y", enter the reduction percentage in the app<br>98.00 Does title V or XIX follow Medicare (title XVIII) for the in<br>stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f   | iterns and res       | idents post          | 0. 00<br>Y                                  | 0. 00<br>Y  | 97.00<br>98.00   |
| <ul> <li>column 1 for title V, and in column 2 for title XIX.</li> <li>98.01 Does title V or XIX follow Medicare (title XVIII) for the re<br/>C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti<br/>title XIX.</li> </ul>             |                      |                      | Y   | Y   | 98. 01           |
| 98.02 Does title V or XIX follow Medicare (title XVIII) for the ca<br>bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes c   |                      |                      | Y   | Y   | 98. 02           |
| <ul> <li>for title V, and in column 2 for title XIX.</li> <li>98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for years</li> </ul>                                      |                      |                      | Ν   | Ν   | 98. 03           |
| for title V, and in column 2 for title XIX.<br>98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH<br>outpatient services cost? Enter "Y" for yes or "N" for no in   |                      |                      | Ν   | Ν   | 98.04            |
| <pre>in column 2 for title XIX.<br/>98.05 Does title V or XIX follow Medicare (title XVIII) and add ba<br/>Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c</pre>  |                      |                      | Y   | Y   | 98. 05           |
| <ul> <li>column 2 for title XIX.</li> <li>98.06 Does title V or XIX follow Medicare (title XVIII) when cost<br/>Pts. I through IV? Enter "Y" for yes or "N" for no in column<br/>column 2 for title XIX.</li> </ul>                              |                      |                      | Y   | Y   | 98.06            |
| Rural Providers<br>105.00Does this hospital gualify as a CAH?  |                      |                      | Y   |   | 105.00           |
| 106.00 If this facility qualifies as a CAH, has it elected the all-  | inclusive met        | hod of payment       |   |   | 105.00           |
| for outpatient services? (see instructions)<br>107.00 Column 1: If line 105 is Y, is this facility eligible for co<br>training programs? Enter "Y" for yes or "N" for no in column<br>Column 2: If column 1 is Y and line 70 or line 75 is Y, do | 1. (see ins          | tructions)           | Ν   |   | 107.00           |
| approved medical education program in the CAH's excluded IP<br>Enter "Y" for yes or "N" for no in column 2. (see instructi   | F and/or IRF<br>ons) | uni t(s)?            | N   |   | 100.00           |
| 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.   |                      |                      | N   |   | 108.00           |
|  | Physi cal<br>1.00    | 0ccupational<br>2.00 | Speech<br>3.00                              | Respi ratory<br>4.00                                      | -                |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are<br>therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.  | Y                    | Y                    | Y   | N   | 109.00           |
|  |                      |                      |   | 1.00  | -                |
| 110.00 Did this hospital participate in the Rural Community Hospital<br>Demonstration) for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor<br>applicable.                             | Y" for yes or        | "N" for no. I        | f yes,                                      | N   | 110.00           |
|  |                      |                      |   |   | •                |

| Health Financial Systems DUKES MEMORIAL HOSPI   |   |         |                                | u of Form CMS  |  |
|---|---|---------|--------------------------------|--|--|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Prov  | ider CCN: 15-1318   |         | d:<br>01/01/2019<br>12/31/2019 | Worksheet S-<br>Part I<br>Date/Time Pr<br>8/28/2020 10 | epared:  |
|   |   |         | 1.00                           |  |  |
| 111.00 If this facility qualifies as a CAH, did it participate in the From<br>Health Integration Project (FCHIP) demonstration for this cost repo<br>"Y" for yes or "N" for no in column 1. If the response to column 1<br>integration prong of the FCHIP demo in which this CAH is participat<br>Enter all that apply: "A" for Ambulance services; "B" for additiona<br>for tele-health services.  | rting period? Ente<br>is Y, enter the<br>ing in column 2.                         |         | <u>1.00</u><br>N               | 2.00   | 111.00   |
|   | 1.00  |         | 2.00                           | 3.00   | -  |
| 112.00 Did this hospital participate in the Pennsylvania Rural Health Mode<br>demonstration for any portion of the current cost reporting period?<br>Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e<br>in column 2, the date the hospital began participating in the<br>demonstration. In column 3, enter the date the hospital ceased<br>participation in the demonstration, if applicable.<br>Miscellaneous Cost Reporting Information  |   |         |                                |  | 112.00   |
| 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for<br>in column 1. If column 1 is yes, enter the method used (A, B, or E<br>in column 2. If column 2 is "E", enter in column 3 either "93" perc<br>for short term hospital or "98" percent for long term care (include<br>psychiatric, rehabilitation and long term hospitals providers) base<br>the definition in CMS Pub. 15-1, chapter 22, §2208.1.   | only)<br>ent<br>s<br>d on   |         |                                |  | 0115.00  |
| 116.00 Is this facility classified as a referral center? Enter "Y" for yes<br>"N" for no.   | or N  |         |                                |  | 116.00   |
| 117.00 Is this facility legally-required to carry malpractice insurance? E<br>"Y" for yes or "N" for no.  | nter N  |         |                                |  | 117.00   |
| 118.00 Is the malpractice insurance a claims-made or occurrence policy? En<br>if the policy is claim-made. Enter 2 if the policy is occurrence.   | ter 1   | 1       |                                |  | 118.00   |
|   | Premi ums   | \$      | Losses<br>2.00                 | I nsurance   |  |
| 118.01List amounts of malpractice premiums and paid losses:   |   | 882     | 44, 130                        |  | 0 118. 01  |
|   |   |         | 1.00                           | 2.00   | -  |
| <ul> <li>118.02 Are malpractice premiums and paid losses reported in a cost center Administrative and General? If yes, submit supporting schedule lis and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmle §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies Hold Harmles Hold Harmles provision in ACA §3121 and applicable amendments? (see</li> </ul>  | ting cost centers<br>ss provision in A(<br>1, "Y" for yes of<br>for the Outpatier | -       | N                              | Ν  | 118. 02<br>119. 00<br>120. 00                            |
| Enter in column 2, "Y" for yes or "N" for no.<br>121.00Did this facility incur and report costs for high cost implantable   | devices charged to  |         | Y                              |  | 121.00   |
| patients? Enter "Y" for yes or "N" for no.<br>22.00 Does the cost report contain healthcare related taxes as defined in<br>Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y"<br>the Workbest A. Line purchase three taxes are included  |   |         | Ν                              |  | 122.00   |
| the Worksheet A line number where these taxes are included.<br>Transplant Center Information  |   |         | N                              |  |  |
| 25.00 Does this facility operate a transplant center? Enter "Y" for yes a yes, enter certification date(s) (mm/dd/yyyy) below. 4.001 f this is a Medicare certified kideou transplant center, enter the   |   |         | Ν                              |  | 125.00   |
| 126.00 If this is a Medicare certified kidney transplant center, enter the  |   |         |                                |  | 126.00   |
| in column 1 and termination date, if applicable, in column 2.   | certincation date   | *       |                                |  | 127.00   |
| 127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.   |   | 1       |                                |  | 128.00   |
| <ul> <li>27.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> </ul>  |   |         |                                |  |  |
| <ul> <li>27.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>29.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> </ul>  | ertification date   |         |                                |  |  |
| <ul> <li>27.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>29.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.</li> </ul>  | ertification date<br>he certification   | in      |                                |  | 130. 00  |
| <ul> <li>27.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>29.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>30.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.</li> </ul>  | ertification date<br>he certification   | in      |                                |  | 130. 00  |
| <ul> <li>127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.</li> <li>131.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in column 2.</li> <li>132.00 If this is a Medicare certified islet transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> </ul> | ertification date<br>he certification<br>the certification                        | in<br>1 |                                |  | 130. 00<br>131. 00<br>132. 00                            |
| <ul> <li>127.00 If this is a Medicare certified heart transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.</li> <li>131.00 If this is a Medicare certified intestinal transplant center, enter the date in column 1 and termination date, if applicable, in column 2.</li> <li>131.00 If this is a Medicare certified intestinal transplant center, enter that in column 1 and termination date, if applicable, in column 2.</li> <li>132.00 If this is a Medicare certified islet transplant center, enter the date in column 1 and termination date.</li> </ul>                      | ertification date<br>he certification<br>the certification<br>certification date  | in<br>1 |                                |  | 129.00<br>130.00<br>131.00<br>132.00<br>133.00<br>134.00 |

|  | X IDENTIFICATION DAT   | ΓA   | Provider CC  | N: 15-131  |   | od:<br>01/01/2019  | Worksheet S-<br>Part I                         | -2  |
|--|--|--|--|--|---|--|--|---|
|  |  |  |  |  | To  | 12/31/2019   |  |   |
| 1.00   |  | 2.00   |  |  |   | 3.00   | 10/20/2020 10                                  | <u>. 50 ai</u>                                  |
| If this facility is part of a cha  |  |  |  |  | ne name   | and address  | of the   |   |
| home office and enter the home of<br>1.00 Name: COMMUNITY HEALTH SYSTEMS,  |  |  | tractor numbe  |  | actor's   | Number: 5228   | 20   | 141.  |
| 2.00 Street: 4000 MERIDIAN BLVD  | PO Box:  | anie. w 5  |  |  | actor 3   | Number . 5220  | 10   | 142.  |
| 3.00 City: FRANKLIN  | State:   | TN   |  | Zip C  | ode:  | 3706   | 7  | 143.  |
|  |  |  |  |  |   |  | 1.00   | _   |
| 4.00 Are provider based physicians' co   | sts included in Works  | sheet A?   |  |  |   |  | 1.00<br>Y                                      | 144.  |
|  |  |  |  |  |   |  |  |   |
|  |  |  |  | 6  |   | 1.00   | 2.00   | 145   |
| 5.00 f costs for renal services are cl<br>inpatient services only? Enter "Y'   | ⊺aimed on wkst. A, Ii<br>' for ves or "N" for  | no in co   | are the costs<br>olumn 1 lf c  | olumn 1 i  | \$  |  |  | 145.  |
| no, does the dialysis facility in  | clude Medicare utiliz  |  |  |  |   |  |  |   |
| period? Enter "Y" for yes or "N"   |  |  |  | 10   |   |  |  |   |
| 6.00 Has the cost allocation methodolog<br>Enter "Y" for yes or "N" for no in  |  |  |  |  | lf  | N  |  | 146.  |
| yes, enter the approval date (mm/  |  |  | _,   |  |   |  |  |   |
|  |  |  |  |  |   |  | 1.00   | _   |
| 7.00Was there a change in the statisti   | cal basis? Enter "Y  | " for ver  | s or "N" for   | no.  |   |  | 1.00<br>N                                      | 147.  |
| 8.00 Was there a change in the order of  |  |  |  |  |   |  | N  | 148.  |
| 9.00Was there a change to the simplifi   | ed cost finding meth   | hod? Ente  |  |  |   |  | N  | 149.  |
|  |  |  | Part A<br>1.00   | <u>Part</u><br>2.00  |   | <u>Title V</u><br>3.00                                     | Title XIX<br>4.00                              | -   |
| Does this facility contain a prov  | ider that qualifies  | for an e   |  |  |   |  |  |   |
| or charges? Enter "Y" for yes or   |  |  |  |  |   |  | 3. 13)   |   |
| 5. 00 Hospi tal  |  |  | N  | N  |   | N  | N  | 155.  |
| 6.00 Subprovider – IPF<br>7.00 Subprovider – IRF   |  |  | N  | N<br>N   |   | N<br>N   | N<br>N   | 156.<br>157.                                    |
| 8. 00 SUBPROVI DER   |  |  |  |  |   |  |  | 158.  |
| 9. 00 SNF  |  |  | N  | N  |   | Ν  | N  | 159.  |
| 0.00HOME HEALTH AGENCY<br>1.00CMHC   |  |  | N  | N<br>N   |   | N<br>N   | N N  | 160.<br>161.                                    |
|  |  |  |  | 11   |   | IN   |  | 101.  |
|  |  |  |  |  |   |  | 1.00   |   |
| Multicampus<br>5.00 s this hospital part of a Multica  | amplic bochital that h   | hac one  |  | coc in di  | fforont   | CRSAc2   | N  | 165.  |
| Enter "Y" for yes or "N" for no.   | ampus nospitai that i  | las one o  | or more campu  | ses in ui  | rierent   | CDSAS?   | IN IN  | 105.  |
|  | Name   |  | County   | State  |   |  | FTE/Campus                                     |   |
|  |  |  | 1 00   |  |   |  |  |   |
| 6 00 lf line 145 is yes for each   | 0  | _  | 1.00   | 2.00   | 3.00  | 4.00   | 5.00   | 00144   |
|  | 0  |  | 1.00   | 2.00   | 3.00  | 4.00   |  | 00 166.   |
| campus enter the name in column<br>O, county in column 1, state in   | 0  |  | 1.00   | 2.00   | 3.00  | 4.00   |  | 00 166.   |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,  | 0  |  | 1.00   | 2.00   | 3.00  | 4.00   |  | 00 166.   |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in   | 0  |  | 1.00   | 2.00   | 3.00  | 4.00   |  | 00 166.   |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,  | 0  |  | 1.00   | 2.00   | 3.00  | 4.00   | 0. (   | 00 166.   |
| campus enter the name in column<br>O, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)  |  |  |  |  |   |  |  | 00 166.   |
| campus enter the name in column<br>O, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Health Information Technology (HI   | T) incentive in the .  |  | Recovery and   | I Rei nves   | tment Ac  |  | 0. (   | _   |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Heal th Information Technology (HI<br>7.00 Is this provider a meaningful user<br>3.00 If this provider is a CAH (line 10  | T) incentive in the a<br>r under §1886(n)? En<br>D5 is "Y") and is a n   | nter "Y"<br>meaningfu  | Recovery and<br>for yes or "<br>ul user (line  | I Reinves<br>N" for no   | tment Ac  | t  | 0. (   | 167.  |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Health Information Technology (HI<br>7.00 Is this provider a meaningful user<br>8.00 If this provider is a CAH (line 11<br>reasonable cost incurred for the I   | T) incentive in the<br>r under §1886(n)? Er<br>25 is "Y") and is a r<br>HIT assets (see instr  | nter "Y"<br>meaningfu<br>ructions)   | Recovery and<br>for yes or "<br>ul user (line<br>)   | I Reinves<br>N" for no<br>167 is '   | tment Ac<br>).<br>Y"), en                                   | ter the  | 0. (   | <br>167.<br>168.                                |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Health Information Technology (HI<br>7.00 Is this provider a meaningful use<br>8.00 If this provider is a CAH (line 10<br>reasonable cost incurred for the 1<br>8.01 If this provider is a CAH and is n   | T) incentive in the a<br>runder §1886(n)? Ei<br>D5 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user  | nter "Y"<br>meaningfu<br>ructions)<br>r, does t  | <u>Recovery and</u><br>for yes or "<br>ul user (line<br>)<br>this provider   | I Reinves<br>N" for no<br>167 is '<br>qualify  | t <u>ment Ac</u><br>).<br>Y"), en<br>for a h                | ter the  | 0. (   | <br>167.<br>168.                                |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Health Information Technology (HI<br>7.00 Is this provider a meaningful user<br>8.00 If this provider is a CAH (line 10<br>reasonable cost incurred for the I<br>8.01 If this provider is a CAH and isi<br>exception under §413.70(a)(6)(ii)<br>9.00 If this provider is a meaningful user  | T) incentive in the<br>r under §1886(n)? Er<br>D5 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user<br>? Enter "Y" for yes o<br>user (line 167 is "Y"   | nter "Y"<br>meaningfu<br>ructions)<br>r, does f<br>or "N" fo   | Recovery and<br>for yes or "<br>ul user (line<br>)<br>this provider<br>or no. (see i   | I Reinves<br>N" for no<br>167 is '<br>qualify<br>nstructio   | tment Ac<br>Y"), en<br>for a h<br>pns)                      | ter the ardshi p   | 0. (<br>1. 00<br>Y                             | 167.<br>168.<br>168.                            |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Health Information Technology (HI<br>7.00 Is this provider a meaningful user<br>8.00 If this provider is a CAH (line 10<br>reasonable cost incurred for the I<br>8.01 If this provider is a CAH and is i<br>exception under §413.70(a)(6)(ii)?  | T) incentive in the<br>r under §1886(n)? Er<br>D5 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user<br>? Enter "Y" for yes o<br>user (line 167 is "Y"   | nter "Y"<br>meaningfu<br>ructions)<br>r, does f<br>or "N" fo   | Recovery and<br>for yes or "<br>ul user (line<br>)<br>this provider<br>or no. (see i   | I Reinves<br>N" for no<br>167 is '<br>qualify<br>nstructio   | tment Ac<br>Y"), en<br>for a h<br>pns)                      | ter the<br>ardship<br>, enter the                          | 0. (<br>1. 00<br>Y<br>0. (                     | 166.<br>167.<br>168.<br>168.<br>168.<br>00 169. |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Health Information Technology (HI<br>7.00 Is this provider a meaningful user<br>8.00 If this provider is a CAH (line 10<br>reasonable cost incurred for the I<br>8.01 If this provider is a CAH and isi<br>exception under §413.70(a)(6)(ii)<br>9.00 If this provider is a meaningful user  | T) incentive in the<br>r under §1886(n)? Er<br>D5 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user<br>? Enter "Y" for yes o<br>user (line 167 is "Y"   | nter "Y"<br>meaningfu<br>ructions)<br>r, does f<br>or "N" fo   | Recovery and<br>for yes or "<br>ul user (line<br>)<br>this provider<br>or no. (see i   | I Reinves<br>N" for no<br>167 is '<br>qualify<br>nstructio   | tment Ac<br>Y"), en<br>for a h<br>pns)                      | ter the<br>ardship<br>, enter the<br>Beginning             | 0. (<br>1. 00<br>Y<br>0. (<br>Endi ng          | 167.<br>168.<br>168.                            |
| <pre>campus enter the name in column<br/>0, county in column 1, state in<br/>column 2, zip code in column 3,<br/>CBSA in column 4, FTE/Campus in<br/>column 5 (see instructions)<br/>Heal th Information Technology (HI<br/>7.00 Is this provider a meaningful user<br/>8.00 If this provider is a CAH (line 10<br/>reasonable cost incurred for the I<br/>8.01 If this provider is a CAH and is n<br/>exception under §413.70(a) (6) (ii)<br/>9.00 If this provider is a meaningful of<br/>transition factor. (see instruction)</pre>                     | T) incentive in the a<br>r under §1886(n)? Er<br>25 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user<br>? Enter "Y" for yes o<br>user (line 167 is "Y<br>ons)  | nter "Y"<br>meaningfu<br>ructions)<br>r, does f<br>or "N" fo<br>") and is  | Recovery and<br>for yes or "<br>ul user (line<br>)<br>this provider<br>or no. (see i<br>s not a CAH (  | I Reinves<br>N" for no<br>167 is '<br>qualify<br>nstructio<br>line 105                                   | tment Ac<br>Y"), en<br>for a h<br>pns)                      | ter the<br>ardship<br>, enter the                          | 0. (<br>1. 00<br>Y<br>0. (                     | 167.<br>168.<br>168.                            |
| campus enter the name in column<br>O, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Heal th Information Technology (HI<br>7.00 is this provider a meaningful user<br>8.00 If this provider is a CAH (line 10<br>reasonable cost incurred for the 1<br>8.01 If this provider is a CAH and is n<br>exception under §413.70(a) (6) (ii) (<br>17 this provider is a meaningful of<br>transition factor. (see instruction  | T) incentive in the a<br>r under §1886(n)? Er<br>25 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user<br>? Enter "Y" for yes o<br>user (line 167 is "Y<br>ons)  | nter "Y"<br>meaningfu<br>ructions)<br>r, does f<br>or "N" fo<br>") and is  | Recovery and<br>for yes or "<br>ul user (line<br>)<br>this provider<br>or no. (see i<br>s not a CAH (  | I Reinves<br>N" for no<br>167 is '<br>qualify<br>nstructio<br>line 105                                   | tment Ac<br>Y"), en<br>for a h<br>pns)                      | ter the<br>ardship<br>, enter the<br>Beginning             | 0. (<br>1. 00<br>Y<br>0. (<br>Endi ng          | 167.<br>168.<br>168.<br>00 169.                 |
| campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Heal th Information Technology (HI<br>7.00 Is this provider a meaningful use<br>8.00 If this provider is a CAH (line 10<br>reasonable cost incurred for the<br>8.01 If this provider is a CAH and is in<br>exception under §413.70(a) (6) (ii) /<br>9.00 If this provider is a meaningful use<br>transition factor. (see instruction<br>0.00 Enter in columns 1 and 2 the EHR I | T) incentive in the a<br>r under §1886(n)? Er<br>25 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user<br>? Enter "Y" for yes o<br>user (line 167 is "Y<br>ons)  | nter "Y"<br>meaningfu<br>ructions)<br>r, does f<br>or "N" fo<br>") and is  | Recovery and<br>for yes or "<br>ul user (line<br>)<br>this provider<br>or no. (see i<br>s not a CAH (  | I Reinves<br>N" for no<br>167 is '<br>qualify<br>nstructio<br>line 105                                   | tment Ac<br>Y"), en<br>for a h<br>pns)                      | ter the<br>ardshi p<br>, enter the<br>Begi nni ng<br>1. 00 | 0. (<br>1. 00<br>Y<br>0. (<br>Endi ng<br>2. 00 | 167.<br>168.<br>168.<br>000 169.                |
| 0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Heal th Information Technology (HI<br>7.00 Is this provider a meaningful user<br>8.00 If this provider is a CAH (line 10<br>reasonable cost incurred for the I<br>8.01 If this provider is a CAH and isn<br>exception under §413.70(a)(6)(ii)<br>9.00 If this provider is a meaningful u<br>transition factor. (see instruction<br>0.00 Enter in columns 1 and 2 the EHR I<br>period respectively (mm/dd/yyyy)     | T) incentive in the<br>r under §1886(n)? Er<br>D5 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user<br>? Enter "Y" for yes o<br>user (line 167 is "Y'<br>ons)<br>peginning date and er  | nter "Y"<br>meaningfu<br>ructions;<br>r, does f<br>or "N" fo<br>") and is<br>nding dat                           | Recovery and<br>for yes or "<br>ul user (line<br>)<br>this provider<br>or no. (see i<br>s not a CAH (<br>te for the re                                   | I Reinves<br>N" for no<br>167 is '<br>qualify<br>nstructio<br>line 105<br>porting                        | tment Ac<br>Y"), en<br>for a h<br>pns)                      | ter the<br>ardship<br>, enter the<br>Beginning             | 0. (<br>1. 00<br>Y<br>0. (<br>Endi ng          | 167.<br>168.<br>168.<br>00 169.                 |
| campus enter the name in column<br>O, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions)<br>Heal th Information Technology (HI<br>7.00 Is this provider a meaningful usee<br>8.00 If this provider is a CAH (line 10<br>reasonable cost incurred for the I<br>8.01 If this provider is a CAH and is n<br>exception under §413.70(a) (6) (ii) /<br>9.00 If this provider is a meaningful u<br>transition factor. (see instruction<br>0.00 Enter in columns 1 and 2 the EHR I | T) incentive in the a<br>r under §1886(n)? Ei<br>D5 is "Y") and is a r<br>HIT assets (see instr<br>not a meaningful user<br>? Enter "Y" for yes o<br>user (line 167 is "Y<br>ons)<br>Deginning date and er<br>vider have any days t<br>reported on Wkst. S-3 | nter "Y"<br>meaningfu<br>ructions;<br>r, does f<br>or "N" fo<br>") and is<br>nding dat<br>for indiv<br>3, Pt. I, | Recovery and<br>for yes or "<br>ul user (line<br>)<br>this provider<br>or no. (see i<br>s not a CAH (<br>te for the re<br>viduals enrol<br>, line 2, col | I Reinves<br>N" for no<br>167 is '<br>qualify<br>nstructio<br>line 105<br>porting<br>led in<br>. 6? Ente | tment Ac<br>).<br>Y"), en<br>for a h<br>ns)<br>i s "N")<br> | ter the<br>ardshi p<br>, enter the<br>Begi nni ng<br>1.00  | 0. (<br>1. 00<br>Y<br>0. (<br>Endi ng<br>2. 00 | 167.<br>168.<br>168.<br>00169.<br>170.          |

| IOSPI I        | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provider C                               | CN: 15-1318          | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet S-<br>Part II<br>Date/Time Pr<br>8/28/2020 10 | epared:          |
|----------------|--|--|----------------------|---|---|------------------|
|                |  |  |                      | Y/N<br>1.00                                 | <br>2.00  |                  |
|                | General Instruction: Enter Y for all YES responses. Enter N  | for all NO re                            | esponses. Ent        |   |   |                  |
|                | mm/dd/yyyy format.   |  |                      |   |   |                  |
|                | COMPLETED BY ALL HOSPITALS   |  |                      |   |   |                  |
|                | Provider Organization and Operation  |  |                      |   |   |                  |
| . 00           | Has the provider changed ownership immediately prior to the  |  |                      | N   |   | 1.00             |
|                | reporting period? If yes, enter the date of the change in c  | orumniz. (see                            | Y/N                  | Date  | V/I   |                  |
|                |  |  | 1.00                 | 2.00  | 3.00  | -                |
| 2.00           | Has the provider terminated participation in the Medicare P<br>yes, enter in column 2 the date of termination and in colum   |  | N                    | 2100  | 0.00  | 2.00             |
| 3. 00          | voluntary or "I" for involuntary.<br>Is the provider involved in business transactions, including<br>contracts, with individuals or entities (e.g., chain home of<br>or medical supply companies) that are related to the provid<br>officers, medical staff, management personnel, or members of<br>of directors through ownership, control, or family and othe<br>relationships? (see instructions) | ffices, drug<br>er or its<br>f the board | Y                    |   |   | 3. 00            |
|                |  |  | Y/N                  | Туре  | Date  |                  |
|                |  |  | 1.00                 | 2.00  | 3.00  |                  |
|                | Financial Data and Reports   |  | L                    |   |   |                  |
| 4. 00<br>5. 00 | Column 1: Were the financial statements prepared by a Cert<br>Accountant? Column 2: If yes, enter "A" for Audited, "C" f<br>or "R" for Reviewed. Submit complete copy or enter date ava<br>column 3. (see instructions) If no, see instructions.<br>Are the cost report total expenses and total revenues diffe  | or Compiled,<br>ilable in                | N                    |   |   | 4.00             |
|                | those on the filed financial statements? If yes, submit rec  |  |                      |   |   |                  |
|                |  |  |                      | Y/N   | Legal Oper.   |                  |
|                | Approved Educational Activitica  |  |                      | 1.00  | 2.00  | _                |
| b. 00          | Approved Educational Activities<br>Column 1: Are costs claimed for nursing school? Column 2:<br>the legal operator of the program?   | lfyes, is th                             | ne provider i        | s N   |   | 6.00             |
| . 00           | Are costs claimed for Allied Health Programs? If "Y" see in:   | structions.                              |                      | Ν   |   | 7.00             |
| 3. 00          | Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.  |  | during the           | N   |   | 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        | Ν   |   | 9.00             |
| 0.00           | Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.   |  | the current          | Ν   |   | 10.00            |
| 1.00           | Are GME cost directly assigned to cost centers other than I<br>Teaching Program on Worksheet A? If yes, see instructions.  | & R in an App                            | proved               | N   | Y/N   | 11.00            |
|                |  |  |                      |   | 1.00  | _                |
|                | Bad Debts  |  |                      |   | 1.00  |                  |
|                | Is the provider seeking reimbursement for bad debts? If yes<br>If line 12 is yes, did the provider's bad debt collection p   |  |                      | ost reporting                               | Y<br>N  | 12. 00<br>13. 00 |
| 4.00           | period? If yes, submit copy.<br>If line 12 is yes, were patient deductibles and/or co-payme  | nts waived? If                           | °yes, see in         | structions.                                 | N   | 14. 0            |
| 5.00           | Bed Complement<br>Did total beds available change from the prior cost reporti  | <u>v</u> i                               | yes, see ins<br>rt A | tructions.<br>Par                           | N<br>t B  | 15.0             |
|                |  | Y/N                                      | Date                 | Y/N   | Date  |                  |
|                |  | 1.00                                     | 2.00                 | 3.00  | 4.00  |                  |
| 6. 00          | PS&R Data<br>Was the cost report prepared using the PS&R Report only?<br>If either column 1 or 3 is yes, enter the paid-through  | Y  | 03/20/2020           | Y   | 03/20/2020  | 16. 0            |
| 17.00          | date of the PS&R Report used in columns 2 and 4 (see<br>instructions)<br>Was the cost report prepared using the PS&R Report for  | Ν  |                      | N   |   | 17.00            |
|                | totals and the provider's records for allocation? If<br>either column 1 or 3 is yes, enter the paid-through date<br>in columns 2 and 4. (see instructions)   |  |                      |   |   |                  |
| 18.00          | If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for additional claims that have been billed<br>but are not included on the PS&R Report used to file this<br>cost report?   | Ν  |                      | Ν   |   | 18.0             |
| 9.00           | cost report? If yes, see instructions.<br>If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for corrections of other PS&R Report   | Ν  |                      | Ν   |   | 19.0             |

|  | I AL HOSPI TAL               | N 15 4040    | D. 1                |                          | u of Form C                                    |         |
|--|------------------------------|--------------|---------------------|--------------------------|--|---------|
| OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   | Provider CC                  | N: 15-1318   | Peric<br>From<br>To | 01/01/2019<br>12/31/2019 | Worksheet<br>Part II<br>Date/Time<br>8/28/2020 | Prepare |
|  | Descri                       | ption        |                     | Y/N                      | Y/N  | 10.50 2 |
|  | 0                            |              |                     | 1.00                     | 3.00   |         |
| 0.00 If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for Other? Describe the other adjustments:  |                              |              |                     | N                        | Ν  | 20      |
| Report data for other: bescribe the other day stments.   | Y/N                          | Date         |                     | Y/N                      | Date   |         |
|  | 1.00                         | 2.00         |                     | 3.00                     | 4.00   |         |
| I.OO Was the cost report prepared only using the provider's records? If yes, see instructions.   | N                            |              |                     | N                        |  | 21      |
|  |                              |              |                     | -                        | 1.00   |         |
| COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC   | EPT CHILDRENS HO             | SPI TALS)    |                     |                          | 1.00   |         |
| Capital Related Cost   |                              |              |                     |                          |  |         |
| 2.00 Have assets been relifed for Medicare purposes? If yes, se  |                              |              |                     |                          | N  | 22      |
| Have changes occurred in the Medicare depreciation expense<br>reporting period? If yes, see instructions.  | Ν                            | 23           |                     |                          |  |         |
| 4.00 Were new leases and/or amendments to existing leases enter<br>If yes, see instructions  | red into during <sup>·</sup> | this cost re | eportir             | ng period?               | Ν  | 24      |
| 5.00 Have there been new capitalized leases entered into during  | g the cost repor             | ting period  | ?lfye               | es, see                  | Ν  | 25      |
| i nstructi ons.<br>5.00 Were assets subject to Sec. 2314 of DEFRA acquired during t  | the cost reportio            | ng period?   | lf yes,             | see                      | Ν  | 26      |
| instructions.<br>7.00  Has the provider's capitalization policy changed during th  | ne cost reporting            | g period? I  | f yes,              | submit                   | Ν  | 27      |
| copy.<br>Interest Expense  |                              |              |                     |                          |  |         |
| 3.00 Were new Loans, mortgage agreements or letters of credit e period? If yes, see instructions.  | entered into duri            | ing the cos  | t repor             | rti ng                   | Ν  | 28      |
| 0.00 Did the provider have a funded depreciation account and/or  |                              | ot Service I | Reserve             | e Fund)                  | Ν  | 29      |
| treated as a funded depreciation account? If yes, see inst<br>.00 Has existing debt been replaced prior to its scheduled mat                                   |                              | debt? If yes | s, see              |                          | Ν  | 30      |
| <pre>instructions. I.00 Has debt been recalled before scheduled maturity without i instructions.</pre>   | ssuance of new of            | debt? If ye  | s, see              |                          | Ν  | 31      |
| Purchased Services<br>2.00 Have changes or new agreements occurred in patient care se  | nyi cas furni sha            | d through c  | ontract             | ual l                    | N  | 32      |
| arrangements with suppliers of services? If yes, see instr<br>3.00   f line 32 is yes, were the requirements of Sec. 2135.2 ap                                 | ructions.                    | 0            |                     |                          | N  | 33      |
| no, see instructions.  | pried pertaining             | y to competi |                     | naarng? TT               | N  | 33      |
| Provi der-Based Physi ci ans   |                              | <u> </u>     |                     |                          |  |         |
| 4.00 Are services furnished at the provider facility under an a<br>If yes, see instructions.   | arrangement with             | provi der-ba | ased pr             | iysi ci ans?             | Y  | 34      |
| 5.00 If line 34 is yes, were there new agreements or amended ex<br>physicians during the cost reporting period? If yes, see i                                  |                              | ts with the  | provi c             | ler-based                | Y  | 35      |
| ,,,,,,,,,,,,,,,,,,   |                              |              |                     | Y/N                      | Date   |         |
| Home Office Costs  |                              |              |                     | 1.00                     | 2.00   |         |
| 0.00 Were home office costs claimed on the cost report?  |                              |              |                     | Y                        |  | 36      |
| .00 If line 36 is yes, has a home office cost statement been p<br>If yes, see instructions.  | prepared by the I            | nome office  | ?                   | Y                        |  | 37      |
| .00 If line 36 is yes, was the fiscal year end of the home of  |                              |              | f                   | N                        |  | 38      |
| the provider? If yes, enter in column 2 the fiscal year en<br>0.00 If line 36 is yes, did the provider render services to oth                                  |                              |              | s,                  | N                        |  | 39      |
| see instructions.<br>0.00   f ine_36 is yes, did the provider render services to the   | e home office?               | lfyes, see   |                     | N                        |  | 40      |
| i nstructi ons.  |                              |              |                     |                          |  |         |
| Cost Depart Droppers Contact Lafamatica  | 1. (                         | 00           |                     | 2.                       | 00   |         |
| Cost Report Preparer Contact Information<br>Enter the first name, last name and the title/position<br>held by the cost report preparer in columns 1, 2, and 3, | CALEB                        |              | TUBI                | 35                       |  | 41      |
| 2.00 Enter the employer/company name of the cost report preparer.  | COMMUNITY HEALT              | TH SYSTEMS,  |                     |                          |  | 42      |
| 3.00 Enter the telephone number and email address of the cost  | 615-465-7183                 |              |                     | EB_TUBBS@CHS             | NET.   | 43      |

| Heal th | Financial Systems DUKES M                              | EMORI | AL HOSPIT | AL       |            | In Lie                           | u of Form CMS- | 2552-10          |
|---------|--|-------|-----------|----------|------------|----------------------------------|----------------|------------------|
| H0SPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR | E     | Provi     | der CCN: |            | Period:                          | Worksheet S-2  | 2                |
|         |  |       |           |          |            | From 01/01/2019<br>To 12/31/2019 |                | epared:<br>36 am |
|         |  |       |           |          |            |                                  |                |                  |
|         |  |       |           | 3.00     |            |                                  |                |                  |
|         | Cost Report Preparer Contact Information               |       |           |          |            |                                  |                |                  |
| 41.00   | Enter the first name, last name and the title/position | n     | MANAGER,  | REVENUE  | MANAGEMENT |                                  |                | 41.00            |
|         | held by the cost report preparer in columns 1, 2, and  | 3,    |           |          |            |                                  |                |                  |
|         | respecti vel y.  |       |           |          |            |                                  |                |                  |
| 42.00   | Enter the employer/company name of the cost report     |       |           |          |            |                                  |                | 42.00            |
|         | preparer.  |       |           |          |            |                                  |                |                  |
| 43.00   | Enter the telephone number and email address of the co | ost   |           |          |            |                                  |                | 43.00            |
|         | report preparer in columns 1 and 2, respectively.      |       |           |          |            |                                  |                |                  |

|   | Financial Systems<br>TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC  | DUKES MEMORIAL             | <u>Provider CC</u> | N. 15 1010            | In Lie<br>Period:                | 2552-10   |  |
|---|--|----------------------------|--------------------|-----------------------|----------------------------------|---|--|
| HUSPII                                    | AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC  | AL DATA                    | Provider CC        | N: 15-1318            | From 01/01/2019<br>To 12/31/2019 | Worksheet S-3<br>Part I<br>Date/Time Pre<br>8/28/2020 10: | pared:   |
|   |  |                            |                    |                       |                                  | I/P Days / O/P<br>Visits / Trips                          |  |
|   | Component  | Worksheet A<br>Line Number | No. of Beds        | Bed Days<br>Available | CAH Hours                        | Title V   |  |
|   |  | 1.00                       | 2.00               | 3.00                  | 4.00                             | 5.00  |  |
| 1.00                                      | Hospital Adults & Peds. (columns 5, 6, 7 and<br>8 exclude Swing Bed, Observation Bed and<br>Hospice days)(see instructions for col. 2<br>for the portion of LDP room available beds) | 30. 00                     | 21                 | 7, 6                  | 65 64, 550. 00                   | 0   | 1.00   |
| 2.00<br>3.00<br>4.00                      | HMO and other (see instructions)<br>HMO IPF Subprovider<br>HMO IRF Subprovider   |                            |                    |                       |                                  |   | 2.00<br>3.00<br>4.00                               |
| 5.00<br>6.00                              | Hospital Adults & Peds. Swing Bed SNF<br>Hospital Adults & Peds. Swing Bed NF  |                            | 21                 | 7 (                   |                                  | 0   | 5.00<br>6.00                                       |
| 7.00                                      | Total Adults and Peds. (exclude observation beds) (see instructions)   |                            | 21                 | 7,6                   | 65 64, 550. 00                   | 0   | 7.00   |
| 8.00<br>9.00<br>10.00<br>11.00            | INTENSIVE CARE UNIT<br>CORONARY CARE UNIT<br>BURN INTENSIVE CARE UNIT<br>SURGICAL INTENSIVE CARE UNIT  | 31.00                      | 4                  | 1, 4                  | 60 9, 690. 00                    | 0   | 8.00<br>9.00<br>10.00<br>11.00                     |
| 12.00<br>13.00<br>14.00<br>15.00          | OTHER SPECIAL CARE (SPECIFY)<br>NURSERY<br>Total (see instructions)<br>CAH visits  | 43.00                      | 25                 | 9, 1                  | 25 74, 240. 00                   | 0<br>0<br>0   | 12.00<br>13.00<br>14.00<br>15.00                   |
| 16.00<br>17.00<br>18.00<br>19.00          | SUBPROVI DER – I PF<br>SUBPROVI DER – I RF<br>SUBPROVI DER<br>SKI LLED NURSI NG FACI LI TY   |                            |                    |                       |                                  |   | 16.00<br>17.00<br>18.00<br>19.00                   |
| 20.00<br>21.00<br>22.00                   | NURSING FACILITY<br>OTHER LONG TERM CARE<br>HOME HEALTH AGENCY   |                            |                    |                       |                                  |   | 20.00<br>21.00<br>22.00                            |
| 23.00<br>24.00<br>24.10<br>25.00          | AMBULATORY SURGICAL CENTER (D.P.)<br>HOSPICE<br>HOSPICE (non-distinct part)<br>CMHC - CMHC   | 30. 00                     |                    |                       |                                  |   | 23.00<br>24.00<br>24.10<br>25.00                   |
| 26.00<br>26.25<br>27.00                   | RURAL HEALTH CLINIC<br>FEDERALLY QUALIFIED HEALTH CENTER<br>Total (sum of lines 14-26)   | 89.00                      | 25                 |                       |                                  | 0   | 26.00<br>26.25<br>27.00                            |
| 28.00<br>29.00<br>30.00<br>31.00<br>32.00 | Observation Bed Days<br>Ambulance Trips<br>Employee discount days (see instruction)<br>Employee discount days - IRF<br>Labor & delivery days (see instructions)                      |                            | 0                  |                       | 0                                | 0   | 27.00<br>28.00<br>29.00<br>30.00<br>31.00<br>32.00 |
| <ul><li>32. 01</li><li>33. 00</li></ul>   | Total ancillary labor & delivery room<br>outpatient days (see instructions)<br>LTCH non-covered days<br>LTCH site neutral days and discharges  |                            | 0                  |                       |                                  |   | 32.00<br>32.01<br>33.00<br>33.01                   |

| HOSPI T  | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC  | AL DATA                 | Provider CC         |                       | Period:<br>From 01/01/2019<br>To 12/31/2019 |                         | pared:   |
|--|--|-------------------------|---------------------|-----------------------|---|-------------------------|--|
|  |  | I/P Days                | / O/P Visits        | / Trips               | Full Time                                   | Equi val ents           |  |
|  | Component  | Title XVIII             | Title XIX           | Total All<br>Patients | Total Interns<br>& Residents                | Employees On<br>Payroll |  |
|  |  | 6.00                    | 7.00                | 8.00                  | 9.00  | 10.00                   |  |
| 1.00<br>2.00<br>3.00<br>4.00   | Hospital Adults & Peds. (columns 5, 6, 7 and<br>8 exclude Swing Bed, Observation Bed and<br>Hospice days)(see instructions for col. 2<br>for the portion of LDP room available beds)<br>HMO and other (see instructions)<br>HMO IPF Subprovider<br>HMO IRF Subprovider   | 1, 383<br>442<br>0<br>0 | 53<br>643<br>0<br>0 | 2, 70                 | 9   |                         | 1.00<br>2.00<br>3.00<br>4.00   |
| 5.00<br>6.00   | Hospital Adults & Peds. Swing Bed SNF<br>Hospital Adults & Peds. Swing Bed NF  | 281                     | 0<br>0              | 29                    | 98<br>7                                     |                         | 5.00<br>6.00   |
| 7.00   | Total Adults and Peds. (exclude observation beds) (see instructions)   | 1, 664                  | 53                  | 3, 01                 | 4   |                         | 7.00   |
| 8.00<br>9.00<br>10.00<br>11.00<br>12.00  | INTENSIVE CARE UNIT<br>CORONARY CARE UNIT<br>BURN INTENSIVE CARE UNIT<br>SURGICAL INTENSIVE CARE UNIT<br>OTHER SPECIAL CARE (SPECIFY)  | 221                     | 11                  | 4C                    | 7   |                         | 8.00<br>9.00<br>10.00<br>11.00<br>12.00  |
| 13.00<br>14.00<br>15.00<br>16.00<br>17.00<br>18.00<br>19.00<br>20.00<br>21.00<br>22.00<br>23.00<br>24.00<br>24.10<br>25.00 | NURSERY<br>Total (see instructions)<br>CAH visits<br>SUBPROVIDER - IPF<br>SUBPROVIDER - IRF<br>SUBPROVIDER<br>SKILLED NURSING FACILITY<br>NURSING FACILITY<br>OTHER LONG TERM CARE<br>HOME HEALTH AGENCY<br>AMBULATORY SURGICAL CENTER (D.P.)<br>HOSPICE<br>HOSPICE (non-distinct part)<br>CMHC - CMHC                                   | 1, 885<br>0             | 37<br>101<br>0      | 33<br>3, 75           |   | 188. 72                 | 13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>20. 00<br>21. 00<br>22. 00<br>23. 00<br>24. 00<br>24. 10<br>25. 00 |
| 26. 00<br>26. 25<br>27. 00<br>28. 00<br>29. 00<br>30. 00<br>31. 00<br>32. 00<br>32. 01                                     | RURAL HEALTH CLINIC<br>FEDERALLY QUALIFIED HEALTH CENTER<br>Total (sum of lines 14-26)<br>Observation Bed Days<br>Ambulance Trips<br>Employee discount days (see instruction)<br>Employee discount days - IRF<br>Labor & delivery days (see instructions)<br>Total ancillary labor & delivery room<br>outpatient days (see instructions) | 0<br>0<br>0             | 0<br>0<br>0         | 1, OC                 |   |                         | 26.00<br>26.25   |
| 33. 00<br>33. 01   | LTCH non-covered days<br>LTCH si te neutral days and discharges  | 0<br>0                  |                     |                       |   |                         | 33. 00<br>33. 01   |

|                                  | Financial Systems<br>AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC   | DUKES MEMORIAL           | Provider C | CN: 15-1318 | Peri od:                         | u of Form CMS-2<br>Worksheet S-3          |                                  |
|----------------------------------|--|--------------------------|------------|-------------|----------------------------------|---|----------------------------------|
|                                  |  |                          |            |             | From 01/01/2019<br>To 12/31/2019 | Part I<br>Date/Time Pre<br>8/28/2020 10:3 |                                  |
|                                  |  | Full Time<br>Equivalents |            | Di s        | charges                          |   |                                  |
|                                  | Component  | Nonpai d<br>Workers      | Title V    | Title XVIII | Title XIX                        | Total All<br>Patients                     |                                  |
|                                  |  | 11.00                    | 12.00      | 13.00       | 14.00                            | 15.00                                     |                                  |
| 1.00                             | Hospital Adults & Peds. (columns 5, 6, 7 and<br>8 exclude Swing Bed, Observation Bed and<br>Hospice days)(see instructions for col. 2<br>for the portion of LDP room available beds) |                          | 0          | 4           | 27 281                           | 975                                       | 1.00                             |
| 2.00<br>3.00<br>4.00<br>5.00     | HMO and other (see instructions)<br>HMO IPF Subprovider<br>HMO IRF Subprovider<br>Hospital Adults & Peds. Swing Bed SNF  |                          |            |             | 06 0<br>0<br>0                   |   | 2.00<br>3.00<br>4.00<br>5.00     |
| 6.00<br>7.00                     | Hospital Adults & Peds. Swing Bed NF<br>Total Adults and Peds. (exclude observation<br>beds) (see instructions)  |                          |            |             |                                  |   | 6. 00<br>7. 00                   |
| 8.00<br>9.00<br>10.00            | INTENSIVE CARE UNIT<br>CORONARY CARE UNIT<br>BURN INTENSIVE CARE UNIT  |                          |            |             |                                  |   | 8.00<br>9.00<br>10.00            |
| 11. 00<br>12. 00<br>13. 00       | SURGI CAL INTENSI VE CARE UNI T<br>OTHER SPECI AL CARE (SPECI FY)<br>NURSERY   |                          |            |             |                                  |   | 11.00<br>12.00<br>13.00          |
| 14.00<br>15.00<br>16.00          | Total (see instructions)<br>CAH visits<br>SUBPROVIDER - IPF  | 0.00                     | 0          | 4           | 27 281                           | 975                                       | 14.00<br>15.00<br>16.00          |
| 17.00<br>18.00<br>19.00          | SUBPROVIDER - IRF<br>SUBPROVIDER<br>SKILLED NURSING FACILITY   |                          |            |             |                                  |   | 17.00<br>18.00<br>19.00          |
| 20.00<br>21.00<br>22.00          | NURSING FACILITY<br>OTHER LONG TERM CARE<br>HOME HEALTH AGENCY   |                          |            |             |                                  |   | 20.00<br>21.00<br>22.00          |
| 23.00<br>24.00<br>24.10<br>25.00 | AMBULATORY SURGICAL CENTER (D.P.)<br>HOSPICE<br>HOSPICE (non-distinct part)<br>CMHC - CMHC   |                          |            |             |                                  |   | 23.00<br>24.00<br>24.10<br>25.00 |
| 26.00<br>26.25<br>27.00          | RURAL HEALTH CLINIC<br>FEDERALLY QUALIFIED HEALTH CENTER<br>Total (sum of lines 14-26)   | 0. 00<br>0. 00           |            |             |                                  |   | 26.00<br>26.25<br>27.00          |
| 28.00<br>29.00<br>30.00          | Observation Bed Days<br>Ambulance Trips<br>Employee discount days (see instruction)  |                          |            |             |                                  |   | 28.00<br>29.00<br>30.00          |
| 31.00<br>32.00<br>32.01          | Employee discount days - IRF<br>Labor & delivery days (see instructions)<br>Total ancillary labor & delivery room  |                          |            |             |                                  |   | 31.00<br>32.00<br>32.01          |
| 33. 00                           | outpatient days (see instructions)<br>LTCH non-covered days<br>LTCH site neutral days and discharges   |                          |            |             | 0                                |   | 33. 00<br>33. 01                 |

| Heal th | Financial Systems  | DUKES MEMORIAL      | HOSPI TAL     |               | In Lie                                      | u of Form CMS-:    | 2552-10 |
|---------|--|---------------------|---------------|---------------|---|--------------------|---------|
| HOSPI T | AL WAGE RELATED COSTS                                      |                     | Provider C    | CN: 15-1318   | Period:<br>From 01/01/2019<br>To 12/31/2019 | Date/Time Pre      | pared:  |
|         |  |                     |               |               |   | 8/28/2020 10:      | 36 am   |
|         |  |                     |               |               |   | Amount<br>Reported |         |
|         |  |                     |               |               |   | 1.00               |         |
|         | PART IV - WAGE RELATED COSTS                               |                     |               |               |   | 1.00               |         |
|         | Part A - Core List   |                     |               |               |   |                    |         |
|         | RETIREMENT COST  |                     |               |               |   |                    | 1       |
| 1.00    | 401K Employer Contributions                                |                     |               |               |   | 204, 380           | 1.00    |
| 2.00    | Tax Sheltered Annuity (TSA) Employer Contri                | bution              |               |               |   | 0                  | 1       |
| 3.00    | Nonqualified Defined Benefit Plan Cost (see                |                     |               |               |   | 0                  | 3.00    |
| 4.00    | Qualified Defined Benefit Plan Cost (see in                |                     |               |               |   | 0                  | 4.00    |
|         | PLAN ADMINISTRATIVE COSTS (Paid to External                |                     |               |               |   |                    | 1       |
| 5.00    | 401K/TSA Plan Administration fees                          |                     |               |               |   | 0                  | 5.00    |
| 6.00    | Legal /Accounting/Management Fees-Pension Pl               | an                  |               |               |   | 0                  | 6.00    |
| 7.00    | Employee Managed Care Program Administration               | on Fees             |               |               |   | 0                  | 7.00    |
|         | HEALTH AND INSURANCE COST                                  |                     |               |               |   |                    | 1       |
| 8.00    | Health Insurance (Purchased or Self Funded)                | )                   |               |               |   | 0                  | 8.00    |
| 8.01    | Health Insurance (Self Funded without a Thi                | rd Party Administr  | ator)         |               |   | 0                  | 8.01    |
| 8.02    | Health Insurance (Self Funded with a Third                 | Party Administrato  | r)            |               |   | 973, 463           | 8. 02   |
| 8.03    | Health Insurance (Purchased)                               | -                   |               |               |   | 0                  | 8.03    |
| 9.00    | Prescription Drug Plan                                     |                     |               |               |   | 0                  | 9.00    |
| 10.00   | Dental, Hearing and Vision Plan                            |                     |               |               |   | 5, 702             | 10.00   |
| 11.00   | Life Insurance (If employee is owner or ber                | nefi ci ary)        |               |               |   | 9, 917             | 11.00   |
| 12.00   | Accident Insurance (If employee is owner or                |                     |               |               |   | 183                | 12.00   |
| 13.00   | Disability Insurance (If employee is owner                 | or beneficiary)     |               |               |   | 8, 681             | 13.00   |
| 14.00   | Long-Term Care Insurance (If employee is ow                | wner or beneficiary | ')            |               |   | 0                  | 14.00   |
| 15.00   | 'Workers' Compensation Insurance                           |                     |               |               |   | 113, 623           | 15.00   |
| 16.00   | Retirement Health Care Cost (Only current y                | year, not the extra | ordi nary aco | crual require | ed by FASB 106.                             | 0                  | 16.00   |
|         | Non cumulative portion)                                    |                     |               |               |   |                    |         |
|         | TAXES  |                     |               |               |   |                    |         |
|         | FICA-Employers Portion Only                                |                     |               |               |   | 674, 952           |         |
| 18.00   | Medicare Taxes - Employers Portion Only                    |                     |               |               |   | 157, 852           |         |
| 19.00   | Unemployment Insurance                                     |                     |               |               |   |                    | 19.00   |
| 20.00   | State or Federal Unemployment Taxes                        |                     |               |               |   | 27, 725            | 20.00   |
|         | OTHER  |                     |               |               |   |                    |         |
| 21.00   | Executive Deferred Compensation (Other Than instructions)) | n Retirement Cost R | eported on l  | ines 1 throu  | ugh 4 above. (see                           | 0                  | 21.00   |
| 22.00   | Day Care Cost and Allowances                               |                     |               |               |   | 0                  | 22.00   |
| 23.00   | Tuition Reimbursement                                      |                     |               |               |   | 0                  |         |
| 24.00   | Total Wage Related cost (Sum of lines 1 -23                | 3)                  |               |               |   | 2, 176, 478        | 24.00   |
|         | Part B - Other than Core Related Cost                      |                     |               |               |   |                    |         |
| 25.00   | OTHER WAGE RELATED COSTS (SPECIFY)                         |                     |               |               |   |                    | 25.00   |

| Heal th          | Financial Systems DUKES MEMORIAL HO  | SPI TAL        |              | In Lie                     | u of Form CMS-2             | 2552-10      |  |
|------------------|--|----------------|--------------|----------------------------|-----------------------------|--------------|--|
| HOSPI T          | AL UNCOMPENSATED AND INDIGENT CARE DATA  | Provider CCN:  |              | Peri od:                   | Worksheet S-1               | 0            |  |
|                  |  |                |              | From 01/01/2019            | Data /Tima Dra              | narad        |  |
|                  |  |                |              | To 12/31/2019              | Date/Time Pre 8/28/2020 10: |              |  |
|                  |  |                | I            |                            | 0,20,2020 101               |              |  |
|                  |  |                |              |                            | 1.00                        |              |  |
|                  | Uncompensated and indigent care cost computation   |                |              |                            |                             |              |  |
| 1.00             | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi   | ided by line   | 202 column   | 8)                         | 0. 182433                   | 1.00         |  |
|                  | Medicaid (see instructions for each line)  |                |              |                            |                             |              |  |
| 2.00             | Net revenue from Medicaid  |                |              |                            | 4, 427, 273                 |              |  |
| 3.00             | Did you receive DSH or supplemental payments from Medicaid?  | al novemanta f | From Modi oo | : 40                       |                             | 3.00         |  |
| 4.00<br>5.00     | If line 3 is yes, does line 2 include all DSH and/or supplementa<br>If line 4 is no, then enter DSH and/or supplemental payments fro |                | rom medica   | 10?                        | 0                           | 4.00<br>5.00 |  |
| 5.00<br>6.00     | Medicaid charges   |                |              |                            | 38, 610, 240                |              |  |
| 7.00             | Medicaid cost (line 1 times line 6)  |                |              |                            | 7, 043, 782                 |              |  |
| 8.00             | Difference between net revenue and costs for Medicaid program (  | line 7 minus   | sum of lin   | es 2 and 5 <sup>.</sup> if | 2, 616, 509                 |              |  |
| 0.00             | < zero then enter zero)  |                |              |                            | 2/010/00/                   |              |  |
|                  | Children's Health Insurance Program (CHIP) (see instructions for   | r each line)   |              |                            |                             | 1            |  |
| 9.00             | Net revenue from stand-alone CHIP  |                |              |                            | 0                           | 9.00         |  |
| 10.00            | Stand-alone CHIP charges   |                |              |                            | 0                           | 1            |  |
| 11.00            | Stand-alone CHIP cost (line 1 times line 10)   |                |              |                            | 0                           | 1            |  |
| 12.00            | Difference between net revenue and costs for stand-alone CHIP (  | line 11 minus  | ; line 9; i  | f < zero then              | 0                           | 12.00        |  |
|                  | enter zero)  |                |              |                            |                             |              |  |
| 13.00            | Other state or local government indigent care program (see inst<br>Net revenue from state or local indigent care program (Not incl   |                |              | )                          | 0                           | 13.00        |  |
| 14.00            | Charges for patients covered under state or local indigent care  |                |              |                            | 0                           |              |  |
| 14.00            | 10)  |                | The udeu     |                            | 0                           | 14.00        |  |
| 15.00            | State or local indigent care program cost (line 1 times line 14)   | )              |              |                            | 0                           | 15.00        |  |
| 16.00            | Difference between net revenue and costs for state or local ind  |                | ogram (lin   | e 15 minus line            | 0                           |              |  |
|                  | 13; if < zero then enter zero)   |                | <u> </u>     |                            |                             |              |  |
|                  | Grants, donations and total unreimbursed cost for Medicaid, CHIF   | P and state/I  | ocal indig   | ent care program           | ns (see                     |              |  |
| 47 00            | instructions for each line)  |                |              |                            |                             | 1 4 7 99     |  |
| 17.00            | Private grants, donations, or endowment income restricted to fur   |                |              |                            | 0                           |              |  |
| 18. 00<br>19. 00 | Government grants, appropriations or transfers for support of he<br>Total unreimbursed cost for Medicaid , CHIP and state and local  |                |              | (sum of lines              | 2, 616, 509                 | 1 .0.00      |  |
| 19.00            | 8, 12 and 16)  | rnurgent car   | e programs   | (Sum of Trifles            | 2,010,307                   | 19.00        |  |
|                  |  |                | Uni nsured   | Insured                    | Total (col. 1               |              |  |
|                  |  |                | patients     | pati ents                  | + col. 2)                   |              |  |
|                  |  |                | 1.00         | 2.00                       | 3.00                        |              |  |
| ~~ ~~            | Uncompensated Care (see instructions for each line)  |                |              |                            | 5 000 001                   |              |  |
| 20.00            | Charity care charges and uninsured discounts for the entire faci<br>(see instructions)   | ility          | 5, 002, 80   | 4 0                        | 5, 002, 804                 | 20.00        |  |
| 21.00            | Cost of patients approved for charity care and uninsured discou  | nte (soo       | 912, 67      | 7 0                        | 912, 677                    | 21.00        |  |
| 21.00            | instructions)  |                | 712,07       | / 0                        | 712,077                     | 21.00        |  |
| 22.00            | Payments received from patients for amounts previously written (   | off as         |              | 0 0                        | 0                           | 22.00        |  |
|                  | charity care   |                |              |                            |                             |              |  |
| 23.00            | Cost of charity care (line 21 minus line 22)   |                | 912, 67      | 7 0                        | 912, 677                    | 23.00        |  |
|                  |  |                |              |                            |                             |              |  |
|                  |  |                |              |                            | 1.00                        |              |  |
| 24.00            | Does the amount on line 20 column 2, include charges for patien  |                | l a length   | of stay limit              | N                           | 24.00        |  |
| 25.00            | imposed on patients covered by Medicaid or other indigent care   |                |              | la langth of               | 0                           | 25.00        |  |
| 25.00            | If line 24 is yes, enter the charges for patient days beyond the stav limit  | e indigent ca  | ire program  | s rength of                | 0                           | 25.00        |  |
| 26.00            | Total bad debt expense for the entire hospital complex (see ins  | tructions)     |              |                            | 2, 833, 445                 | 26.00        |  |
| 27.00            | Medicare reimbursable bad debts for the entire hospital complex (see this  |                | tions)       |                            | 783, 532                    |              |  |
| 27.01            | Medicare allowable bad debts for the entire hospital complex (se   |                |              |                            | 1, 205, 434                 |              |  |
| 28.00            |  |                |              |                            |                             |              |  |
| 29.00            | Cost of non-Medicare and non-reimbursable Medicare bad debt expe   | ense (see ins  | structions)  |                            | 718, 905                    |              |  |
| 30.00            | Cost of uncompensated care (line 23 column 3 plus line 29)   |                |              |                            | 1, 631, 582                 |              |  |
| 31.00            | Total unreimbursed and uncompensated care cost (line 19 plus li  | ne 30)         |              |                            | 4, 248, 091                 | 31.00        |  |

|                | Financial Systems   | DUKES MEMORIAL |               |             |                                  | u of Form CMS-2                | 2552-10        |
|----------------|---|----------------|---------------|-------------|----------------------------------|--------------------------------|----------------|
| RECLAS         | SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF                                    | EXPENSES       | Provider C    | CN: 15-1318 | Peri od:                         | Worksheet A                    |                |
|                |   |                |               |             | From 01/01/2019<br>To 12/31/2019 | Date/Time Pre<br>8/28/2020 10: |                |
|                | Cost Center Description   | Sal ari es     | Other         | Total (col. | 1 Reclassi ficati                | Recl assi fi ed                |                |
|                |   |                |               | + col. 2)   | ons (See A-6)                    | Trial Balance                  |                |
|                |   |                |               |             |                                  | (col. 3 +-                     |                |
|                |   | 1.00           | 2.00          | 3.00        | 4.00                             | col. 4)<br>5.00                |                |
|                | GENERAL SERVICE COST CENTERS  | 1.00           | 2.00          | 3.00        | 4.00                             | 5.00                           |                |
| 1.00           | 00100 CAP REL COSTS-BLDG & FIXT   |                | 969, 896      | 969, 89     | 96 487, 436                      | 1, 457, 332                    | 1.00           |
| 2.00           | 00200 CAP REL COSTS-MVBLE EQUIP   |                | 2, 262, 298   |             |                                  |                                | 2.00           |
| 4.00           | 00400 EMPLOYEE BENEFITS DEPARTMENT  | 128, 020       | 80, 025       |             |                                  |                                | •              |
| 5.01           | 00570 ADMI TTI NG   | 0              | 0             |             | 0 1, 196, 948                    |                                |                |
| 5.02           | 00590 ADMINISTRATIVE AND GENERAL  | 1, 677, 040    | 8, 489, 389   | 10, 166, 42 | -2, 909, 055                     | 7, 257, 374                    | 5.02           |
| 7.00           | 00700 OPERATION OF PLANT  | 288, 393       | 1, 561, 830   | 1, 850, 2   | 624, 969                         | 2, 475, 192                    | 7.00           |
| 8.00           | 00800 LAUNDRY & LINEN SERVICE   | 0              | 73, 037       | 73, 0       | 37 0                             | 73, 037                        | 8.00           |
| 9.00           | 00900 HOUSEKEEPI NG   | 354, 405       | 131, 793      | 486, 19     | -2, 062                          | 484, 136                       | 9.00           |
| 10.00          | 01000 DI ETARY  | 197, 849       | 158, 331      | 356, 18     | -208, 975                        | 147, 205                       | 10.00          |
| 11.00          | 01100 CAFETERI A  | 0              | 0             |             | 0 206, 285                       | 206, 285                       | 11.00          |
| 13.00          | 01300 NURSI NG ADMI NI STRATI ON  | 670, 125       | 90, 106       | 760, 23     |                                  |                                | 13.00          |
| 14.00          | 01400 CENTRAL SERVICES & SUPPLY   | 80, 789        | 187, 667      | 268, 4      | 56 -39, 752                      | 228, 704                       | 14.00          |
|                | 01500 PHARMACY  | 338, 082       | 1, 132, 987   |             |                                  | 497, 666                       | •              |
|                | 01600 MEDICAL RECORDS & LIBRARY   | 62, 659        | 210, 318      |             |                                  |                                | •              |
| 17.00          | 01700 SOCIAL SERVICE  | 0              | 0             |             | 0 209, 429                       | 209, 429                       | 17.00          |
|                | I NPATI ENT ROUTI NE SERVI CE COST CENTERS  | !              |               |             |                                  |                                |                |
| 30.00          | 03000 ADULTS & PEDIATRICS   | 2, 059, 373    | 1, 187, 628   |             |                                  |                                | 30.00          |
|                | 03100 I NTENSI VE CARE UNI T  | 401, 416       | 57, 098       |             |                                  |                                | •              |
| 43.00          | 04300 NURSERY   | 0              | 384           | 38          | 34 266, 230                      | 266, 614                       | 43.00          |
| F0 00          |   | 460.042        | 1 007 004     | 1 404 0     | 20 202 051                       | 1 014 070                      |                |
| 50.00          | 05000 OPERATING ROOM  | 468, 943       | 1,027,986     |             |                                  | 1, 214, 878                    | •              |
| 51.00          | 05100 RECOVERY ROOM   | 264, 429       | 37, 185       |             |                                  |                                | 1              |
| 52.00<br>53.00 | 05200 DELI VERY ROOM & LABOR ROOM<br>05300 ANESTHESI OLOGY                        | 0              | 0<br>115, 981 | 115, 9      | 0 0<br>31 0                      | 0<br>115, 981                  | 52.00<br>53.00 |
| 54.00          | 05400 RADI OLOGY-DI AGNOSTI C   | 400, 347       | 196, 455      |             |                                  | 1, 088, 139                    | 54.00          |
| 54.00<br>54.01 | 05400 KADI OLOGI - DI AGNOSTI C   | 98, 243        | 15, 612       |             |                                  | 1,000,139                      | 54.00          |
| 56.00          | 05600 RADI OI SOTOPE  | 84, 515        | 149, 354      |             |                                  |                                | 56.00          |
| 57.00          | 05700 CT SCAN   | 169, 876       | 150, 196      |             |                                  |                                | 57.00          |
| 58.00          | 05800 MRI   | 85, 447        | 94, 339       |             |                                  |                                | 58.00          |
| 60.00          | 06000 LABORATORY  | 759, 802       | 674, 955      |             |                                  | 1, 365, 933                    |                |
| 62.00          | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 0              | 81, 584       |             |                                  | 81, 584                        | 1              |
| 65.00          | 06500 RESPI RATORY THERAPY  | 479, 029       | 102, 824      |             |                                  |                                |                |
| 66.00          | 06600 PHYSI CAL THERAPY   | 486            | 421, 642      |             |                                  | 420, 361                       | 66.00          |
| 67.00          | 06700 OCCUPATI ONAL THERAPY   | 0              | 166, 200      |             |                                  | 166, 200                       | 67.00          |
| 68.00          | 06800 SPEECH PATHOLOGY  | 0              | 66, 133       | 66, 13      | 33 0                             | 66, 133                        | 68.00          |
| 69.00          | 06900 ELECTROCARDI OLOGY  | 192, 024       | 40, 429       | 232, 4      | 53 -5, 607                       | 226, 846                       | 69.00          |
| 71.00          | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT   | 0              | 0             |             | 0 31, 660                        | 31, 660                        | 71.00          |
| 72.00          | 07200 IMPL. DEV. CHARGED TO PATIENTS  | 0              | 0             |             | 0 215, 218                       |                                | 72.00          |
| 73.00          | 07300 DRUGS CHARGED TO PATIENTS   | 0              | 0             |             | 0 889, 906                       |                                | 73.00          |
| 76.00          | 03610 SLEEP LAB   | 0              | 0             |             | 0 0                              | 0                              | 76.00          |
|                | OUTPATIENT SERVICE COST CENTERS   |                |               |             |                                  |                                |                |
|                | 09000 CLINIC  | 110, 848       | 20, 410       |             |                                  |                                |                |
|                | 09100 EMERGENCY   | 3, 521, 646    | 673, 034      | 4, 194, 6   | 30 -7, 273                       | 4, 187, 407                    | 91.00          |
| 92.00          | 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART                                      |                |               |             |                                  |                                | 92.00          |
| 05 00          | OTHER REIMBURSABLE COST CENTERS   | 200 245        | 174 500       | 472.0       |                                  | 111 740                        | 05 00          |
| 95.00          | 09500 AMBULANCE SERVICES  | 299, 265       | 174, 593      | 473, 8      | 58 -27, 116                      | 446, 742                       | 95.00          |
| 110 00         | SPECIAL PURPOSE COST CENTERS<br>SUBTOTALS (SUM OF LINES 1 through 117)            | 12 102 054     | 20 001 600    | 22 004 7    |                                  | 22 004 750                     | 110 00         |
| 118.00         | NONREIMBURSABLE COST CENTERS  | 13, 193, 051   | 20, 801, 699  | 33, 994, 7  | 50 0                             | 33, 994, 750                   | 110.00         |
| 100 00         | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 0              | 0             |             | 0 0                              | 0                              | 190.00         |
|                | 19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN<br>19200 PHYSI CLANS' PRI VATE OFFI CES | 692            | 0<br>15, 144  |             |                                  |                                | 190.00         |
|                | TITE OF THE OFFICES   | 072            | 13, 144       |             |                                  |                                |                |
| 200.00         | TOTAL (SUM OF LINES 118 through 199)  | 13, 193, 743   | 20, 816, 843  | 34, 010, 5  | 36 0                             | 34, 010, 586                   | 200 00         |

| RECLASS | Financial Systems<br>SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF       | F EXPENSES   | Provider C                 | CN: 15-1318 | Peri od:                     | Worksheet    | A                        |
|---------|---|--------------|----------------------------|-------------|------------------------------|--------------|--------------------------|
|         |   |              |                            |             | From 01/01/20<br>To 12/31/20 | 19 Date/Time | e Preparec<br>) 10:36 an |
|         | Cost Center Description   | Adjustments  | Net Expenses               |             | <b>I</b> ,                   | 0/20/2020    | 10.30 all                |
|         |   |              | or Allocation              |             |                              |              |                          |
| D       |   | 6.00         | 7.00                       |             |                              |              |                          |
|         | GENERAL SERVICE COST CENTERS  | 790, 477     | 2 247 000                  |             |                              |              | 1                        |
|         |   |              | 2, 247, 809                |             |                              |              | 1.                       |
|         | 00200 CAP REL COSTS-MVBLE EQUIP   | 98, 833      | 2, 520, 073                |             |                              |              | 2.                       |
|         | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00570 ADMITTING                     | 0            | 1, 530, 719                |             |                              |              | 4.                       |
|         | 00570 ADMITTING<br>00590 ADMINISTRATIVE AND GENERAL                       | -355,000     | 1, 196, 948<br>6, 902, 374 |             |                              |              | 5.<br>5.                 |
|         | 00700 OPERATION OF PLANT  | -12, 387     | 2, 462, 805                |             |                              |              | 7.                       |
|         | 00800 LAUNDRY & LINEN SERVICE   | -12, 387     | 2, 402, 803                |             |                              |              | 8.                       |
|         | 00900 HOUSEKEEPING  | 0            | 484, 136                   |             |                              |              | 9.                       |
|         | 01000 DI ETARY  | 0            | 147, 205                   |             |                              |              | 10.                      |
|         | 01100 CAFETERI A  | -52, 549     | 153, 736                   |             |                              |              | 11.                      |
|         | 01300 NURSI NG ADMI NI STRATI ON  | -14, 155     | 343, 701                   |             |                              |              | 13.                      |
|         | 01400 CENTRAL SERVICES & SUPPLY   | 0            | 228, 704                   |             |                              |              | 14.                      |
|         | 01500 PHARMACY  | o            | 497, 666                   |             |                              |              | 15.                      |
|         | 01600 MEDICAL RECORDS & LIBRARY   | -1, 317      | 265, 017                   |             |                              |              | 16.                      |
| 1       | 01700 SOCI AL SERVI CE  | 0            | 209, 429                   | 1           |                              |              | 17.                      |
|         | INPATIENT ROUTINE SERVICE COST CENTERS                                    |              |                            |             |                              |              |                          |
|         | 03000 ADULTS & PEDIATRICS   | -774, 724    | 2, 185, 457                |             |                              |              | 30.                      |
|         | 03100 I NTENSI VE CARE UNI T  | 0            | 456, 670                   | 1           |                              |              | 31.                      |
| 3.00    | 04300 NURSERY   | 0            | 266, 614                   |             |                              |              | 43.                      |
|         | ANCILLARY SERVICE COST CENTERS  |              |                            |             |                              |              |                          |
|         | 05000 OPERATING ROOM  | -429, 902    | 784, 976                   |             |                              |              | 50.                      |
|         | 05100 RECOVERY ROOM   | 0            | 298, 129                   |             |                              |              | 51.                      |
| 1       | 05200 DELIVERY ROOM & LABOR ROOM  | 0            | 0                          |             |                              |              | 52.                      |
|         | 05300 ANESTHESI OLOGY   | -115, 981    | 0                          |             |                              |              | 53.                      |
|         | 05400 RADI OLOGY-DI AGNOSTI C   | 0            | 1, 088, 139                |             |                              |              | 54.                      |
|         | 05401 ULTRASOUND  | 0            | 0                          |             |                              |              | 54.                      |
|         | 05600 RADI OI SOTOPE  | 0            | 0                          |             |                              |              | 56.                      |
|         | 05700 CT SCAN   | 0            | 0                          |             |                              |              | 57.                      |
|         |   | 0            | 0                          |             |                              |              | 58.                      |
| 1       |   | 0            | 1, 365, 933                |             |                              |              | 60.                      |
|         | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                                | 0            | 81, 584                    |             |                              |              | 62.                      |
|         | 06500 RESPI RATORY THERAPY<br>06600 PHYSI CAL THERAPY                     | 0            | 560, 688                   |             |                              |              | 65.                      |
|         | 06000 PHYSICAL THERAPY<br>06700 OCCUPATIONAL THERAPY                      | 0            | 420, 361<br>166, 200       |             |                              |              | 66.<br>67.               |
|         | 06800 SPEECH PATHOLOGY  | 0            |                            |             |                              |              | 68.                      |
|         | 06900 ELECTROCARDI OLOGY  | -1, 507      | 66, 133<br>225, 339        |             |                              |              | 69.                      |
|         | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                 | -1, 507      | 31, 660                    | 1           |                              |              | 71.                      |
|         | 07200 IMPL. DEV. CHARGED TO PATIENTS                                      | 0            | 215, 218                   | 1           |                              |              | 71.                      |
|         | 07300 DRUGS CHARGED TO PATIENTS   | 0            | 889, 906                   | 1           |                              |              | 73.                      |
|         | 03610 SLEEP LAB   | o            | 007,700                    | 1           |                              |              | 76.                      |
|         | DUTPATIENT SERVICE COST CENTERS   |              |                            |             |                              |              |                          |
|         | 09000 CLINIC  | 0            | 126, 023                   |             |                              |              | 90.                      |
|         | 09100 EMERGENCY   | -331, 833    | 3, 855, 574                |             |                              |              | 91.                      |
|         | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                 |              |                            |             |                              |              | 92.                      |
|         | OTHER REIMBURSABLE COST CENTERS   |              |                            |             |                              |              |                          |
|         | 09500 AMBULANCE SERVI CES   | 0            | 446, 742                   |             |                              |              | 95.                      |
| -       | SPECIAL PURPOSE COST CENTERS  |              |                            |             |                              |              |                          |
| 18. 00  | SUBTOTALS (SUM OF LINES 1 through 117)                                    | -1, 200, 045 | 32, 794, 705               |             |                              |              | 118.                     |
|         | NONREI MBURSABLE COST CENTERS   |              |                            |             |                              |              |                          |
|         | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                 | 0            | 0                          |             |                              |              | 190.                     |
|         | 19200 PHYSICIANS' PRIVATE OFFICES<br>TOTAL (SUM OF LINES 118 through 199) | 0            | 15, 836                    |             |                              |              | 192.<br>200.             |
| 00.00   |   | -1, 200, 045 | 32, 810, 541               | 1           |                              |              | 1200                     |

|   | Financial Systems<br>SIFICATIONS  |  | DUKES MEMORIA                                  | L HOSPITAL<br>Provider CO   | From 01/01/2019<br>To 12/31/2019 Date/Tim | t A-6<br>e Prepared:  |
|---|---|--|--|---|---|---|
|   |   | Increases  |  |   | 8/28/202                                  | <u>0 10:'36 am</u>  |
|   | Cost Center<br>2.00   | Line #<br>3.00   | Salary<br>4.00                                 | 0ther<br>5.00   |   |   |
| 1.00  | A - EMPLOYEE BENEFITS<br>EMPLOYEE BENEFITS DEPARTMENT<br>O                        | 4.00   | 0  | <u>1, 325, 901</u><br>1, 325, 901   |   | 1.00  |
| 1.00  | B - RENT AND LEASES<br>CAP REL COSTS-BLDG & FIXT                                  | 1.00   | 0  | 58, 472   |   | 1.00  |
| 2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00<br>10.00   | CAP REL COSTS-MVBLE EQUIP   | 2.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00 |  | 131, 198<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   |   | 2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00<br>10.00   |
| 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>20. 00  |   | 0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.0  |  |   |   | 11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>20. 00  |
| 21.00   |   | 0.00   | 0  | 00000000  |   | 21.00   |
| 1.00<br>2.00  | C - OTHER CAPITAL COSTS<br>CAP REL COSTS-BLDG & FIXT<br>CAP REL COSTS-BLDG & FIXT | 1.00<br>1.00   | 0  | 80, 703<br>348, 261   |   | 1.00  |
| 3.00  | CAP REL COSTS-MVBLE EQUIP   | 2.00   | <u>o</u>                                       | <u> </u>  |   | 3.00  |
|   | D - CNO COSTS   |  | 0  | 450, 708  |   |   |
| 1.00  | NURSING ADMINISTRATION  | <u> </u>   | <u>122, 4</u> 23<br>122, 423                   | <u>0</u>  |   | 1.00  |
| 1.00  | E - MEDI CAL SUPPLI ES<br>MEDI CAL SUPPLI ES CHARGED TO                           | 71.00  | 0  | 31, 660   |   | 1.00  |
| 2.00  | PATIENT<br>I MPL. DEV. CHARGED TO<br>PATIENTS                                     | 72.00  | 0  | 215, 218  |   | 2.00  |
|   | 0   |  | 0  | 246, 878  |   |   |
| 1.00  | DRUGS_CHARGED_TO_PATIENTS   | 73.00  | <u>0</u> 0                                     | <u> </u>  |   | 1.00  |
| 1.00  | G - NURSERY<br>NURSERY  | 43.00  | <u>234, 238</u> 234, 238                       | <u>32, 376</u><br>32, 376   |   | 1.00  |
|   | I - MISC DEPARTMENTS  |  |  |   |   |   |
| 1.00  | ADMI TTI NG<br>O<br>J - OTHER RADI OLOGY  | 5.01   | <u> </u>                                       | <u>667, 287</u><br>667, 287   |   | 1.00  |
| 1.00<br>2.00<br>3.00<br>4.00  | RADI OLOGY-DI AGNOSTI C   | 54.00<br>0.00<br>0.00<br>0.00                                | 438, 081<br>0<br>0<br>0<br>438, 081            | 182, 268<br>0<br>0<br>0<br>182, 268   |   | 1.00<br>2.00<br>3.00<br>4.00  |
| 1.00  | K - DI ETARY COSTS TO CAFETERIA   | <u>11.00</u>   | <u>107, 595</u>                                | <u> </u>  |   | 1.00  |
|   | M - REPAIRS AND MAINTENANCE   |  |  |   |   |   |
| $\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$ | OPERATION OF PLANT  | 7.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00<br>0.00 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 638, 359<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 |   | $\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$ |
| 13.00<br>14.00<br>15.00   |   | 0.00<br>0.00<br>0.00   | 0<br>0<br>0                                    | 0<br>0<br>0   |   | 13. 00<br>14. 00<br>15. 00  |

## Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 RECLASSI FI CATI ONS Provider CCN: 15-1318 Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 8/28/2020 10:36 am Increases Cost Center Line # Sal ary 0ther 4.00 5.00 2.00 3.00 16.00 0.00 16.00 0 0 17.00 0.00 0 0 0 0 0 0 0 0 0 0 0 0 17.00 0 0 0 0 18.00 0.00 18.00 19.00 0.00 19.00 20.00 0.00 20.00 21.00 0.00 0 0 0 21.00 22.00 0.00 22.00 23.00 0.00 23.00 24.00 0.00 0 24.00 25.00 0.00 0 25.00 0 0 638, 359 26.00 0.00 26.00 N - CASE MANAGEMENT 1.00 ADMI NI STRATI VE AND GENERAL 5.02 280, 046 30, 636 1.00 2.00 SOCIAL SERVICE 17.00 19<u>0, 2</u>55 1<u>9, 1</u>74 2.00

470, 301

1, 902, 299

49,810

500.00

4, 777, 853

500.00 Grand Total: Increases

|                  |   | Decreases      | <u> </u>                     | 0.11                         |                |                |
|------------------|---|----------------|------------------------------|------------------------------|----------------|----------------|
|                  | Cost Center   | Line #         | Salary                       |                              | Wkst. A-7 Ref. |                |
|                  | 6.00<br>A - EMPLOYEE BENEFITS                       | 7.00           | 8.00                         | 9.00                         | 10.00          |                |
| 1.00             | A - EMPLOTEE BENEFITS<br>ADMINISTRATIVE AND GENERAL | 5.02           | 0                            | 1, 325, 901                  | 0              | 1.00           |
| 1.00             |   |                | — — — <del>o</del>           | 1, 325, 901                  | <u> </u>       | 1.00           |
|                  | B - RENT AND LEASES                                 | I              |                              | 110201701                    |                |                |
| 1.00             | EMPLOYEE BENEFITS DEPARTMENT                        | 4.00           | 0                            | 1, 850                       | 10             | 1.00           |
| 2.00             | ADMINI STRATI VE AND GENERAL                        | 5.02           | 0                            | 15, 815                      | 10             | 2.00           |
| 3.00             | OPERATION OF PLANT                                  | 7.00           | 0                            | 13, 390                      | 0              | 3.00           |
| 4.00             | DI ETARY  | 10.00          | 0                            | 1, 853                       | 0              | 4.00           |
| 5.00             | NURSING ADMINISTRATION                              | 13.00          | 0                            | 2, 860                       | 0              | 5.00           |
| 6.00             | CENTRAL SERVICES & SUPPLY                           | 14.00          | 0                            | 20, 769                      | 0              | 6.00           |
| 7.00<br>8.00     | PHARMACY<br>MEDI CAL RECORDS & LI BRARY             | 15.00<br>16.00 | 0                            | 59, 466<br>5, 012            | 0              | 7.00<br>8.00   |
| 9.00             | ADULTS & PEDIATRICS                                 | 30.00          | 0                            | 5,012                        | 0              | 9.00           |
| 10.00            | INTENSIVE CARE UNIT                                 | 31.00          | o                            | 1,008                        | 0              | 10.00          |
| 11.00            | OPERATING ROOM                                      | 50.00          | 0                            | 28, 242                      | 0              | 11.00          |
| 12.00            | RECOVERY ROOM                                       | 51.00          | 0                            | 1, 999                       | 0              | 12.00          |
| 13.00            | RADI OLOGY-DI AGNOSTI C                             | 54.00          | 0                            | 8, 303                       | 0              | 13.00          |
| 14.00            | MRI   | 58.00          | 0                            | 1, 792                       | 0              | 14.00          |
| 15.00            | LABORATORY  | 60.00          | 0                            | 1,008                        | 0              | 15.00          |
| 16.00            | RESPI RATORY THERAPY                                | 65.00          | 0                            | 6, 071                       | 0              | 16.00          |
| 17.00            | PHYSICAL THERAPY                                    | 66.00          | 0                            | 1,008                        | 0              | 17.00          |
| 18. 00<br>19. 00 | ELECTROCARDI OLOGY<br>CLI NI C                      | 69.00<br>90.00 | 0                            | 2,838                        | 0              | 18.00<br>19.00 |
| 20.00            | EMERGENCY   | 90.00<br>91.00 | 0                            | 3, 846<br>2, 783             | 0              | 20.00          |
| 20.00            | AMBULANCE SERVICES                                  | 95.00          | 0                            | 4, 508                       |                | 21.00          |
| 21.00            | 0   |                | — — — <del>o</del>           | 189, 670                     |                | 21.00          |
|                  | C - OTHER CAPITAL COSTS                             |                |                              | ,                            |                |                |
| 1.00             | ADMINI STRATI VE AND GENERAL                        | 5.02           | 0                            | 456, 708                     | 12             | 1.00           |
| 2.00             |   | 0.00           | 0                            | 0                            | 13             | 2.00           |
| 3.00             | <u> </u>  |                | 0                            | 0                            | 12             | 3.00           |
|                  | 0   |                | 0                            | 456, 708                     |                |                |
| 1 00             | D - CNO COSTS<br>ADMINISTRATIVE AND GENERAL         | 5.02           | 100 400                      | 0                            | 0              | 1 00           |
| 1.00             | ADMINISTRATIVE AND GENERAL                          | <u>5.02</u>    | <u>122, 423</u><br>122, 423  | <u>0</u>                     | 0              | 1.00           |
|                  | E - MEDICAL SUPPLIES                                |                | 122, 423                     | 0                            |                |                |
| 1.00             | CENTRAL SERVICES & SUPPLY                           | 14.00          | 0                            | 9, 496                       | 0              | 1.00           |
| 2.00             | OPERATING ROOM                                      | 50.00          | 0                            | 237, 382                     | 0              | 2.00           |
|                  | 0   |                | 0                            | 246, 878                     |                |                |
|                  | F - COST OF DRUGS/IV SOLUTION                       |                |                              |                              |                | -              |
| 1.00             | PHARMACY  | <u>15.</u> 00  | •                            | 889,906                      | 0              | 1.00           |
|                  |   |                | 0                            | 889, 906                     |                |                |
| 1.00             | G - NURSERY<br>ADULTS & PEDIATRICS                  | 30.00          | 234, 238                     | 32, 376                      | 0              | 1.00           |
| 1.00             |   |                | 234, 238                     |                              |                | 1.00           |
|                  | I - MISC DEPARTMENTS                                |                | 201,200                      | 02,070                       |                |                |
| 1.00             | ADMINI STRATI VE AND GENERAL                        | 5.02           | 529, 661                     | 667, 287                     | 0              | 1.00           |
|                  | 0   |                | 529, 661                     | 667, 287                     |                |                |
|                  | J - OTHER RADIOLOGY                                 |                |                              |                              |                |                |
| 1.00             | ULTRASOUND  | 54.01          | 98, 243                      | 9, 314                       |                | 1.00           |
| 2.00             | RADI OI SOTOPE                                      | 56.00          | 84, 515                      | 121, 434                     |                | 2.00           |
| 3.00             | CT SCAN   | 57.00          | 169, 876                     | 41, 414                      | 0              | 3.00           |
| 4.00             | MRI   | <u>58.</u> 00  | 8 <u>5, 4</u> 47<br>438, 081 | 1 <u>0, 1</u> 06<br>182, 268 |                | 4.00           |
|                  | K - DIETARY COSTS TO CAFETERI                       | A              | 430,001                      | 102, 200                     |                | -              |
| 1.00             | DI ETARY  | 10.00          | 107, 595                     | 98, 690                      | 0              | 1.00           |
|                  | 0 — — — — — — —                                     |                | 107, 595                     | 98, 690                      |                |                |
|                  | M - REPAIRS AND MAINTENANCE                         | *              |                              |                              |                |                |
| 1.00             | EMPLOYEE BENEFITS DEPARTMENT                        | 4.00           | 0                            | 1, 377                       | 0              | 1.00           |
| 2.00             | ADMINISTRATIVE AND GENERAL                          | 5.02           | 0                            | 101, 942                     | 0              | 2.00           |
| 3.00             | HOUSEKEEPING  | 9.00           | 0                            | 2,062                        | 0              | 3.00           |
| 4.00             |   | 10.00          | 0                            | 837                          | 0              | 4.00           |
| 5.00<br>6.00     | NURSING ADMINISTRATION<br>CENTRAL SERVICES & SUPPLY | 13.00<br>14.00 | 0                            | 1, 827<br>9, 487             | 0              | 5.00<br>6.00   |
| 7.00             | PHARMACY  | 15.00          | 0                            | 24, 031                      | 0              | 7.00           |
| 8.00             | MEDI CAL RECORDS & LI BRARY                         | 16.00          | o                            | 1, 631                       | o              | 8.00           |
| 9.00             | ADULTS & PEDIATRICS                                 | 30.00          | o                            | 14, 957                      | Ō              | 9.00           |
| 10.00            | INTENSIVE CARE UNIT                                 | 31.00          | o                            | 836                          | o              | 10.00          |
| 11.00            | NURSERY   | 43.00          | О                            | 384                          | 0              | 11.00          |
| 12.00            | OPERATING ROOM                                      | 50.00          | 0                            | 16, 427                      | 0              | 12.00          |
| 13.00            | RECOVERY ROOM                                       | 51.00          | 0                            | 1, 486                       | 0              | 13.00          |
| 14.00            | RADI OLOGY-DI AGNOSTI C                             | 54.00          | 0                            | 120, 709                     | 0              | 14.00          |
| 15.00            |   | 54.01          | 0                            | 6, 298                       |                | 15.00          |
| 16. 00<br>17. 00 | RADI OI SOTOPE<br>CT SCAN                           | 56.00<br>57.00 | 0                            | 27, 920<br>108, 782          |                | 16.00<br>17.00 |
| 17.00            |   | 57.00          | U                            | 100, 702                     | U              | 17.00          |

## Health Financial Systems RECLASSIFICATIONS

## DUKES MEMORIAL HOSPITAL

Decreases

In Lieu of Form CMS-2552-10 Worksheet A-6

Provider CCN: 15-1318

Period: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 8/28/2020 10:36 am

| Health Financial Systems |                        |           | DUKES MEMORIA | L HOSPI TAL |               | In Lieu of Form CMS-2552-        |                                |                  |
|--------------------------|------------------------|-----------|---------------|-------------|---------------|----------------------------------|--------------------------------|------------------|
| RECLAS                   | SIFICATIONS            |           |               | Provider (  | CCN: 15-1318  | Period:                          | Worksheet A-                   | 6                |
|                          |                        |           |               |             |               | From 01/01/2019<br>To 12/31/2019 | Date/Time Pro<br>8/28/2020 10: | epared:<br>36 am |
|                          |                        | Decreases |               |             |               |                                  |                                |                  |
|                          | Cost Center            | Line #    | Sal ary       | Other       | Wkst. A-7 Ref | <u>.</u>                         |                                |                  |
|                          | 6. 00                  | 7.00      | 8.00          | 9.00        | 10.00         |                                  |                                |                  |
| 18.00                    | MRI                    | 58.00     | 0             | 82, 441     |               | 0                                |                                | 18.00            |
| 19.00                    | LABORATORY             | 60.00     | 0             | 67, 816     |               | 0                                |                                | 19.00            |
| 20.00                    | RESPI RATORY THERAPY   | 65.00     | 0             | 15, 094     |               | 0                                |                                | 20.00            |
| 21.00                    | PHYSICAL THERAPY       | 66.00     | 0             | 759         |               | 0                                |                                | 21.00            |
| 22.00                    | ELECTROCARDI OLOGY     | 69.00     | 0             | 2, 769      |               | 0                                |                                | 22.00            |
| 23.00                    | CLINIC                 | 90.00     | 0             | 1, 389      |               | 0                                |                                | 23.00            |
| 24.00                    | EMERGENCY              | 91.00     | 0             | 4, 490      |               | 0                                |                                | 24.00            |
| 25.00                    | AMBULANCE SERVICES     | 95.00     | 0             | 22, 608     |               | 0                                |                                | 25.00            |
| 26.00                    | AMBULANCE SERVICES     |           |               |             |               | 0                                |                                | 26.00            |
|                          | 0                      |           | 0             | 638, 359    |               | 7                                |                                |                  |
|                          | N - CASE MANAGEMENT    |           |               |             |               |                                  |                                | ]                |
| 1.00                     | NURSING ADMINISTRATION | 13.00     | 470, 301      | 49, 810     |               | 0                                |                                | 1.00             |
| 2.00                     |                        | 0.00      | 0             | 0           |               | 0                                |                                | 2.00             |
|                          | 0                      |           | 470, 301      | 49, 810     |               | 7                                |                                |                  |
| 500.00                   | Grand Total: Decreases |           | 1, 902, 299   | 4, 777, 853 |               |                                  |                                | 500.00           |

|              | nancial Systems                             | DUKES MEMORIA    | L HOSPI TAL |                | _ | In Lie                         | u of Form CMS-2 | 2552-10 |
|--------------|---|------------------|-------------|----------------|---|--------------------------------|-----------------|---------|
| RECONCI LI A | ATION OF CAPITAL COSTS CENTERS              |                  | Provider CC | CN: 15-1318    |   | 1:<br>01/01/2019<br>12/31/2019 |                 | pared:  |
|              |   |                  |             | Acqui si ti on | s |                                |                 |         |
|              |   | Begi nni ng      | Purchases   | Donati on      |   | Total                          | Disposals and   |         |
|              |   | Bal ances        |             |                |   |                                | Retirements     |         |
|              |   | 1.00             | 2.00        | 3.00           |   | 4.00                           | 5.00            |         |
| PAR          | RT I - ANALYSIS OF CHANGES IN CAPITAL ASSET | BALANCES         |             |                |   |                                |                 |         |
| 1.00 Lar     | nd  | 193, 225         | 0           |                | 0 | 0                              | 0               | 1.00    |
| 2.00 Lar     | nd Improvements                             | 1, 015, 684      | 0           |                | 0 | 0                              | 0               | 2.00    |
| 3.00 Bui     | ildings and Fixtures                        | 28, 299, 654     | 0           |                | 0 | 0                              | 0               | 3.00    |
| 4.00 Bui     | ilding Improvements                         | 33, 380, 013     | 0           |                | 0 | 0                              | 0               | 4.00    |
| 5.00 Fix     | xed Equipment                               | 0                | 0           |                | 0 | 0                              | 0               | 5.00    |
| 6.00 Mov     | vable Equipment                             | 0                | 0           |                | 0 | 0                              | 0               | 6.00    |
| 7.00 HIT     | T designated Assets                         | 4, 602, 668      | 0           |                | 0 | 0                              | 0               | 7.00    |
| 8.00 Sub     | btotal (sum of lines 1-7)                   | 67, 491, 244     | 0           |                | 0 | 0                              | 0               | 8.00    |
| 9.00 Rec     | conciling Items                             | 0                | 0           |                | 0 | 0                              | 0               | 9.00    |
| 10.00 Tot    | tal (line 8 minus line 9)                   | 67, 491, 244     | 0           |                | 0 | 0                              | 0               | 10.00   |
|              |   | Endi ng Bal ance | Fully       |                |   |                                |                 |         |
|              |   | ů l              | Depreciated |                |   |                                |                 |         |
|              |   |                  | Assets      |                |   |                                |                 |         |
|              |   | 6.00             | 7.00        |                |   |                                |                 |         |
|              | RT I - ANALYSIS OF CHANGES IN CAPITAL ASSET |                  |             |                |   |                                |                 |         |
| 1.00 Lar     |   | 193, 225         | 0           |                |   |                                |                 | 1.00    |
| 2.00 Lar     | nd Improvements                             | 1, 015, 684      | 0           |                |   |                                |                 | 2.00    |
|              | ildings and Fixtures                        | 28, 299, 654     | 0           |                |   |                                |                 | 3.00    |
| 4.00 Bui     | ilding Improvements                         | 33, 380, 013     | 0           |                |   |                                |                 | 4.00    |
| 5.00 Fix     | xed Equipment                               | 0                | 0           |                |   |                                |                 | 5.00    |
| 6.00 Mov     | vable Equipment                             | 0                | 0           |                |   |                                |                 | 6.00    |
| 7.00 HIT     | T designated Assets                         | 4, 602, 668      | 0           |                |   |                                |                 | 7.00    |
| 8.00 Sub     | btotal (sum of lines 1-7)                   | 67, 491, 244     | 0           |                |   |                                |                 | 8.00    |
| 9.00 Rec     | conciling Items                             | 0                | 0           |                |   |                                |                 | 9.00    |
| 10.00 Tot    | tal (line 8 minus line 9)                   | 67, 491, 244     | 0           |                |   |                                |                 | 10.00   |

| Heal th | Financial Systems                             | DUKES MEMORIA     | AL HOSPITAL    |               | In Lie                           | u of Form CMS-2 | 2552-10 |
|---------|---|-------------------|----------------|---------------|----------------------------------|-----------------|---------|
| RECONO  | CILIATION OF CAPITAL COSTS CENTERS            |                   | Provider CO    | CN: 15-1318   | Peri od:                         | Worksheet A-7   |         |
|         |   |                   |                |               | From 01/01/2019<br>To 12/31/2019 |                 | pared:  |
|         |   |                   |                |               |                                  | 8/28/2020 10:   |         |
|         |   |                   | SL             | JMMARY OF CAP | I TAL                            |                 |         |
|         | Cost Center Description                       | Depreciation      | Lease          | Interest      | Insurance (see                   |                 |         |
|         |   |                   |                |               |                                  | instructions)   |         |
|         |   | 9.00              | 10.00          | 11.00         | 12.00                            | 13.00           |         |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WORK |                   |                | nd 2          | -                                |                 |         |
| 1.00    | CAP REL COSTS-BLDG & FIXT                     | 969, 896          |                |               | 0 0                              | 0               | 1.00    |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                     | 2, 262, 298       |                |               | 0 0                              | 0               | 2.00    |
| 3.00    | Total (sum of lines 1-2)                      | 3, 232, 194       |                |               | 0 0                              | 0               | 3.00    |
|         |   | SUMMARY O         | F CAPITAL      |               |                                  |                 |         |
|         | Cost Center Description                       | Other             | Total (1) (sum |               |                                  |                 |         |
|         |   | Capi tal -Rel ate | of cols. 9     |               |                                  |                 |         |
|         |   | d Costs (see      | through 14)    |               |                                  |                 |         |
|         |   | instructions)     | -              |               |                                  |                 |         |
|         |   | 14.00             | 15.00          |               |                                  |                 |         |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WORE | SHEET A, COLUM    | N 2, LINES 1 a | nd 2          |                                  |                 |         |
| 1.00    | CAP REL COSTS-BLDG & FIXT                     | 0                 | 969, 896       |               |                                  |                 | 1.00    |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                     | 0                 | 2, 262, 298    |               |                                  |                 | 2.00    |
| 3.00    | Total (sum of lines 1-2)                      | 0                 | 3, 232, 194    |               |                                  |                 | 3.00    |

| Health Financial Systems  | DUKES MEMORIA                                  | AL HOSPITAL       |                                   | In Lie                                      | u of Form CMS-2     | 552-10       |
|---|--|-------------------|-----------------------------------|---|---------------------|--------------|
| RECONCILIATION OF CAPITAL COSTS CENTERS                         |  | Provider C        |                                   | Period:<br>From 01/01/2019<br>Fo 12/31/2019 |                     |              |
|   | COM  | PUTATION OF RAT   | [10S                              | ALLOCATION OF                               | OTHER CAPITAL       |              |
| Cost Center Description   | Gross Assets                                   | Capi tal i zed    | Gross Assets                      | Ratio (see                                  | Insurance           |              |
|   |  | Leases            | for Ratio<br>(col. 1 - col.<br>2) | instructions)                               |                     |              |
|   | 1.00   | 2.00              | 3.00                              | 4.00  | 5.00                |              |
| PART III - RECONCILIATION OF CAPITAL COSTS CE                   | NTERS  |                   |                                   |   |                     |              |
| 1.00 CAP REL COSTS-BLDG & FIXT                                  | 0  | 0                 | (                                 | 1. 000000                                   | 0                   | 1.00         |
| 2.00 CAP REL COSTS-MVBLE EQUIP                                  | 0  | 0                 |                                   | 0. 000000                                   |                     | 2.00         |
| 3.00 Total (sum of lines 1-2)                                   | 0  | 0                 |                                   | 1.000000                                    | 0                   | 3.00         |
|   | ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL |                   |                                   |   |                     |              |
| Cost Center Description   | Taxes  | 0ther             | Total (sum of                     | Depreciation                                | Lease               |              |
|   |  | Capi tal -Rel ate |                                   |   |                     |              |
|   |  | d Costs           | through 7)                        |   |                     |              |
|   | 6.00   | 7.00              | 8.00                              | 9.00  | 10.00               |              |
| PART III - RECONCILIATION OF CAPITAL COSTS CE                   | INTERS 0                                       | 0                 |                                   | 1 710 501                                   | 93, 473             | 1.00         |
| 2.00 CAP REL COSTS-BEDG & FIXT                                  | 0  | Ű                 |                                   | 1, 718, 591<br>2, 322, 581                  | 93, 473<br>168, 907 | 2.00         |
| 3.00 Total (sum of lines 1-2)                                   | 0  | -                 |                                   | 4, 041, 172                                 |                     | 2.00<br>3.00 |
|   | 0  | °                 | I<br>JMMARY OF CAPI               |   | 202, 300            | 3.00         |
|   |  | 50                |                                   |   |                     |              |
| Cost Center Description   | Interest                                       | Insurance (see    | Taxes (see                        | Other                                       | Total (2) (sum      |              |
|   |  | instructions)     | instructions)                     | Capi tal -Rel ate                           | of cols. 9          |              |
|   |  |                   |                                   | d Costs (see                                | through 14)         |              |
|   |  |                   |                                   | instructions)                               |                     |              |
|   | 11.00  | 12.00             | 13.00                             | 14.00                                       | 15.00               |              |
| PART III - RECONCILIATION OF CAPITAL COSTS CE                   |  | 00.700            | 0.40.04                           |   | 0.047.000           | 1 00         |
| 1.00 CAP REL COSTS-BLDG & FIXT                                  | 6, 781   |                   |                                   |   | 2, 247, 809         | 1.00         |
| 2.00 CAP REL COSTS-MVBLE EQUIP<br>3.00 Total (sum of lines 1-2) | 841  |                   |                                   |   | 2, 520, 073         | 2.00<br>3.00 |
| 3.00  Total (sum of lines 1-2)                                  | 7,622  | 108, 447          | 348, 26                           | ij U  | 4, 767, 882         | 3.00         |

| Health Financial Systems | DUKES MEMORIAL HOSPITAL | In Li |
|--------------------------|-------------------------|-------|
|                          |                         |       |

| Health Financial Systems  |                      | DUKES MEMORIAL    | HOSPI TAL  | In Lie                                      | u of Form CMS-2                                 | 2552-10          |
|---|----------------------|-------------------|--|---|---|------------------|
| ADJUSTMENTS TO EXPENSES   |                      |                   | Provider CCN: 15-1318                                  | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet A-8<br>Date/Time Pre<br>8/28/2020 10: | pared:           |
|   |                      | т                 | Expense Classification o<br>o/From Which the Amount is |   |   |                  |
| Cost Center Descri  | ption Basis/Code (2) | Amount            | Cost Center  | Line #                                      | Wkst. A-7 Ref.                                  |                  |
|   | 1.00                 | 2.00              | 3.00   | 4.00  | 5.00  | 1.00             |
| 1.00 Investment income - CAP<br>COSTS-BLDG & FIXT (chapt  |                      | 00.               | AP REL COSTS-BLDG & FIXT                               | 1.00  | 0   | 1.00             |
| 2.00 Investment income - CAP<br>COSTS-MVBLE EQUIP (chapt  |                      | oc                | AP REL COSTS-MVBLE EQUIP                               | 2.00  | 0   | 2.00             |
| 3.00 Investment income - othe   |                      | 0                 |  | 0.00  | 0   | 3.00             |
| (chapter 2)<br>4.00 Trade, quantity, and tim  | ne                   | 0                 |  | 0.00  | 0   | 4.00             |
| discounts (chapter 8)   |                      |                   |  |   |   |                  |
| 5.00 Refunds and rebates of expenses (chapter 8)  |                      | 0                 |  | 0.00  | 0   | 5.00             |
| 6.00 Rental of provider space suppliers (chapter 8)   | e by                 | 0                 |  | 0.00  | 0   | 6.00             |
| 7.00 Telephone services (pay stations excluded) (chap   | A                    | -21, 963 Al       | DMINISTRATIVE AND GENERAL                              | 5.02  | 0   | 7.00             |
| 8.00 21)<br>Tel evi si on and radio ser<br>(chapter 21)   |                      | -12, 3870         | PERATION OF PLANT                                      | 7.00  | 0   | 8.00             |
| 9.00 Parking Lot (chapter 21)<br>10.00 Provider-based physician<br>adjustment   |                      | 0<br>-1, 649, 217 |  | 0.00  | 0   | 9.00<br>10.00    |
| 11.00 Sale of scrap, waste, et  | C.                   | 0                 |  | 0.00  | 0   | 11.00            |
| <ul> <li>(chapter 23)</li> <li>12.00 Related organization<br/>transactions (chapter 10)</li> </ul>  |                      | -175, 158         |  |   | 0   | 12.00            |
| <ul><li>13.00 Laundry and linen servic</li><li>14.00 Cafeteria-employees and</li></ul>  |                      | 0<br>-52, 549C    | AFFTERIA   | 0.00  |   |                  |
| 15.00 Rental of quarters to en  |                      | 0                 |  | 0.00  |   |                  |
| and others<br>16.00 Sale of medical and surg<br>supplies to other than  | ji cal               | 0                 |  | 0.00  | 0   | 16.00            |
| patients<br>17.00 Sale of drugs to other t<br>patients  | han                  | О                 |  | 0.00  | 0   | 17.00            |
| 18.00 Sale of medical records abstracts   | and B                | -1, 317M          | EDICAL RECORDS & LIBRARY                               | 16.00                                       | 0   | 18.00            |
| 19.00 Nursing and allied healt education (tuition, fees   |                      | O                 |  | 0.00  | 0   | 19. 00           |
| <ul> <li>books, etc.)</li> <li>20.00 Vending machines</li> <li>21.00 Income from imposition or<br/>interest, finance or per<br/>charges (chapter 21)</li> </ul> |                      | -3, 585 Al<br>0   | DMI NI STRATI VE AND GENERAL                           | 5. 02<br>0. 00                              | 0<br>0  | 20. 00<br>21. 00 |
| 22.00 Interest expense on Medi<br>overpayments and borrowi  | ngs to               | Ο                 |  | 0.00  | 0   | 22.00            |
| 23.00 Adjustment for respirato<br>therapy costs in excess<br>limitation (chapter 14)  | ory A-8-3            | OR                | ESPI RATORY THERAPY                                    | 65.00                                       |   | 23. 00           |
| 24.00 Adjustment for physical therapy costs in excess   | A-8-3                | OP                | HYSICAL THERAPY  | 66.00                                       |   | 24.00            |
| 25.00 limitation (chapter 14)<br>utilization review -<br>physicians' compensation   | 1                    | 0 *               | ** Cost Center Deleted ***                             | 114.00                                      |   | 25.00            |
| (chapter 21)<br>26.00 Depreciation - CAP REL<br>COSTS-BLDG & FLXT   | А                    | 362, 205 C        | AP REL COSTS-BLDG & FIXT                               | 1.00  | 9   | 26.00            |
| 27.00 Depreciation - CAP REL<br>COSTS-MVBLE EQUIP   | A                    | 43, 589 C         | AP REL COSTS-MVBLE EQUIP                               | 2.00  | 9   | 27.00            |
| 28.00 Non-physician Anesthetis  | st                   | 0 *               | ** Cost Center Deleted ***                             |   |   | 28.00            |
| <ul> <li>29.00 Physicians' assistant</li> <li>30.00 Adjustment for occupation</li> <li>therapy costs in excess</li> </ul>                                       |                      | 000               | CCUPATI ONAL THERAPY                                   | 0.00<br>67.00                               |   | 29.00<br>30.00   |
| 30.99 Hospice (non-distinct) (<br>instructions)   | see A                | -4, 730A          | DULTS & PEDIATRICS                                     | 30.00                                       |   | 30. 99           |
| 31.00 Adjustment for speech pathology costs in exces  | A-8-3                | OS                | PEECH PATHOLOGY  | 68.00                                       |   | 31.00            |
| 32.00 I imitation (chapter 14)<br>CAH HIT Adjustment for<br>Depreciation and Interes  | t                    | 0                 |  | 0.00  |   | 32.00            |
| 33.00 TRAINING REVENUE  | В                    | -14, 155 N        | URSING ADMINISTRATION                                  | 13.00                                       | 0   | 33.00            |

| Health Financial Systems             | DUKES MEMORIA   | AL HOSPI TAL | In Lie                      | eu of Form CMS-2 | 2552-10                          |                 |
|--------------------------------------|-----------------|--------------|-----------------------------|------------------|----------------------------------|-----------------|
| ADJUSTMENTS TO EXPENSES              |                 |              | Peri od:                    | Worksheet A-8    |                                  |                 |
|                                      |                 |              |                             | From 01/01/2019  |                                  |                 |
|                                      |                 |              |                             | To 12/31/2019    | Date/Time Prep<br>8/28/2020 10:3 | pared:<br>36 am |
|                                      |                 |              | Expense Classification or   | Worksheet A      | 0/20/2020 10.                    |                 |
|                                      |                 |              | To/From Which the Amount is |                  |                                  |                 |
|                                      |                 |              |                             |                  |                                  |                 |
|                                      |                 |              |                             |                  |                                  |                 |
|                                      |                 |              |                             |                  |                                  |                 |
|                                      |                 |              |                             |                  |                                  |                 |
| Cost Center Description              | Basi s/Code (2) | Amount       | Cost Center                 | Line #           | Wkst. A-7 Ref.                   |                 |
|                                      | 1.00            | 2.00         | 3.00                        | 4.00             | 5.00                             |                 |
| 33.01 FI TNESS REVENUE               | В               | -1, 825      | ADMINISTRATIVE AND GENERAL  | 5.02             | 0                                | 33.01           |
| 33. 02 MI SCELLANEOUS I NCOME        | В               | -57, 321     | ADMINISTRATIVE AND GENERAL  | 5. 02            | 0                                | 33.02           |
| 33.03 PATIENT PHONE DEPRECIATION     | A               | -2, 628      | CAP REL COSTS-MVBLE EQUIP   | 2.00             | 9                                | 33.03           |
| 33. 04 CHARI TABLE CONTRI BUTI ONS   | A               | -3, 899      | ADMINISTRATIVE AND GENERAL  | 5.02             | 0                                | 33.04           |
| 33.05 EMPLOYEE SELF INS DISCOUNTS    | В               |              | ADMINISTRATIVE AND GENERAL  | 5.02             |                                  | 33.05           |
| 33.07 POB CAPITAL RELATED EXPENSE    | A               |              | CAP REL COSTS-BLDG & FIXT   | 1.00             |                                  | 33.07           |
| 33.08 POB CAPITAL RELATED EXPENSE    | A               |              | CAP REL COSTS-MVBLE EQUIP   | 2.00             |                                  | 33.08           |
| 35.00 MARKETING EXPENSE              | A               |              | ADMINISTRATIVE AND GENERAL  | 5. 02            |                                  | 35.00           |
| 36.00 PENALTIES                      | A               | -            | ADMINISTRATIVE AND GENERAL  | 5.02             |                                  | 36.00           |
| 37.00 LOBBYING EXPENSE IN            | A               | -2, 573      | ADMINISTRATIVE AND GENERAL  | 5.02             | 0                                | 37.00           |
| ASSOCIATION DUES                     |                 |              |                             |                  |                                  |                 |
| 38.00 COUNTRY CLUB / SOCIAL DUES     | A               |              | ADMINISTRATIVE AND GENERAL  | 5.02             |                                  | 38.00           |
| 40.00 PHYSICIAN RECRUITING           | A               |              | ADMINISTRATIVE AND GENERAL  | 5.02             | 0                                | 40.00           |
| 50.00 TOTAL (sum of lines 1 thru 49) |                 | -1, 200, 045 |                             |                  |                                  | 50.00           |
| (Transfer to Worksheet A,            |                 |              |                             |                  |                                  |                 |
| column 6, line 200.)                 |                 |              |                             |                  |                                  |                 |

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

| Heal th      | Financial Systems             | DUKES MEMORI   | AL HOSPI TAL   | In Lie                           | u of Form CMS-2 | 2552-10      |
|--------------|-------------------------------|--|--|----------------------------------|-----------------|--------------|
|              | ENT OF COSTS OF SERVICES FROM | RELATED ORGANIZATIONS AND HOM                          |  | Period:                          | Worksheet A-8   | -1           |
| OFFICE       | COSTS                         |  |  | From 01/01/2019<br>To 12/31/2019 | Date/Time Pre   | nared        |
|              |                               |  |  |                                  | 8/28/2020 10:   |              |
|              | Line No.                      | Cost Center  | Expense Items  | Amount of                        | Amount          |              |
|              |                               |  |  | Allowable Cost                   |                 |              |
|              |                               |  |  |                                  | Wks. A, column  |              |
|              | 1.00                          | 2.00   | 3, 00  | 4.00                             | 5<br>5. 00      |              |
|              | A. COSTS INCURRED AND ADJUST  |  |  |                                  |                 |              |
|              | HOME OFFICE COSTS:            |  |  |                                  |                 |              |
| 1.00         | 0.00                          |  | PASI CAPITAL COSTS - BLDG &                                  | 0                                | 0               | 1.00         |
| 2.00         | 0.00                          |  | PASI CAPITAL COSTS - MOVEABL                                 | 0                                | 0               | 2.00         |
| 3.00         | 0.00                          |  | PASI OPERATING COSTS   | 0                                | 0               | 3.00         |
| 3.02         | 0.00                          |  | SHARED SERVICE CENTER ALLOCA                                 |                                  | 0               | 3.02         |
| 3.04         | 0.00                          |  | NEW CAPITAL - BUILDING AND F                                 |                                  | 0               | 3.04         |
| 4.00         |                               | CAP REL COSTS-BLDG & FIXT                              | PASI Capital Costs - Bldg &                                  | 6, 781                           | 0               | 4.00         |
| 4.01         |                               | CAP REL COSTS-MVBLE EQUIP                              | PASI Capital Costs - Moveabl                                 | 841                              | 0               | 4.01         |
| 4.02         |                               | ADMINI STRATI VE AND GENERAL                           | PASI Operating Costs   | 190, 672                         | 180, 635        | 4.02         |
| 4.03<br>4.04 |                               | ADMINISTRATIVE AND GENERAL                             | Shared Service Center Alloca                                 |                                  | 561, 729        | 4.03         |
| 4.04<br>4.05 |                               | CAP REL COSTS-BLDG & FIXT<br>CAP REL COSTS-MVBLE EQUIP | New Capital - Building & Fix<br>New Capital - Movable Equipm |                                  | 0               | 4.04<br>4.05 |
| 4.05         |                               | ADMINISTRATIVE AND GENERAL                             | Non-Capital Home Office Cost                                 |                                  | 0               | 4.05         |
| 4.00         |                               | ADMINI STRATI VE AND GENERAL                           | Malpractice Costs  | 56, 012                          | 392, 336        | 4.00         |
| 4.08         |                               | ADMI NI STRATI VE AND GENERAL                          | Management Fees  | 00,012                           | 443,032         | 4.08         |
| 4.09         |                               | ADMINISTRATIVE AND GENERAL                             | 401K Fees  | 0                                | 5, 558          | 4.09         |
| 4.10         | 5. 02                         | ADMINISTRATIVE AND GENERAL                             | Audit Fees   | 0                                | 22, 544         | 4.10         |
| 4.11         | 5.02                          | ADMINISTRATIVE AND GENERAL                             | Corporate Overhead Allocatio                                 | 0                                | 475, 594        | 4.11         |
| 4.12         | 5.02                          | ADMINISTRATIVE AND GENERAL                             | HIIM Allocation  | 0                                | 147, 157        | 4.12         |
| 4.13         | 5. 02                         | ADMINISTRATIVE AND GENERAL                             | PASI Lien Unit Collection Fe                                 | 0                                | 4, 977          | 4.13         |
| 5.00         | TOTALS (sum of lines 1-4).    |  |  | 2, 058, 404                      | 2, 233, 562     | 5.00         |
|              | Transfer column 6, line 5 to  |  |  |                                  |                 |              |
|              | Worksheet A-8, column 2,      |  |  |                                  |                 |              |
|              | line 12.                      |  | <u> </u>   |                                  |                 |              |

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

| 1103 110 | t been posted to worksheet A,                                       | corumns ranu/or z, the amoun | it allowable si | ouru be murcateu micorumin 4 | or this part.  |  |  |  |
|----------|---|------------------------------|-----------------|------------------------------|----------------|--|--|--|
|          |   |                              |                 | Related Organization(s) and/ | or Home Office |  |  |  |
|          |   |                              |                 |                              |                |  |  |  |
|          |   |                              |                 |                              |                |  |  |  |
|          | Symbol (1)  | Name                         | Percentage of   | Name                         | Percentage of  |  |  |  |
|          | Symbol (1)  | Name                         |                 | Name                         |                |  |  |  |
|          |   |                              | Ownership       |                              | Ownershi p     |  |  |  |
|          | 1.00  | 2.00                         | 3.00            | 4.00                         | 5.00           |  |  |  |
|          | B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: |                              |                 |                              |                |  |  |  |

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

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

| rerinbur |                         |  |        |
|----------|-------------------------|--|--------|
| 6.00     | В                       | 0. 00 COMMUNI TY HEALTH SYTEMS 100. 00 | 6.00   |
| 7.00     | В                       | 0.00 PASI 100.00                       | 7.00   |
| 8.00     | В                       | 0.00 HOSPI TAL LAUNDRY SERVICE 100.00  | 8.00   |
| 9.00     |                         | 0.00 0.00                              | 9.00   |
| 10.00    |                         | 0.00 0.00                              | 10.00  |
| 100.00   | G. Other (financial or  |  | 100.00 |
|          | non-financial) specify: |  |        |

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 provider.

| Health Financial Systems                       | DUKES MEMORIAL I                    | HOSPI TAL             | In Lieu         | u of Form CMS-2552-10 |
|--|-------------------------------------|-----------------------|-----------------|-----------------------|
| STATEMENT OF COSTS OF SERVICES<br>OFFICE COSTS | FROM RELATED ORGANIZATIONS AND HOME | Provider CCN: 15-1318 | From 01/01/2019 |                       |
|  |                                     |                       | To 12/31/2019   | Date/Time Prepared:   |

|       |                |                  |                                       |                           | 8/28/2020 10                 |       |
|-------|----------------|------------------|---------------------------------------|---------------------------|------------------------------|-------|
|       | Net            | Wkst. A-7 Ref.   |                                       |                           |                              |       |
|       | Adjustments    |                  |                                       |                           |                              |       |
|       | (col. 4 minus  |                  |                                       |                           |                              |       |
|       | col. 5)*       |                  |                                       |                           |                              |       |
|       | 6.00           | 7.00             | · · · · · · · · · · · · · · · · · · · |                           |                              |       |
|       |                |                  | ENTS REQUIRED AS A RESULT OF TH       | ANSACTIONS WITH RELATED O | ORGANIZATIONS OR CLAIMED     |       |
|       | HOME OFFICE CO |                  |                                       |                           |                              |       |
| 1.00  | 0              | 0                |                                       |                           |                              | 1.00  |
| 2.00  | 0              | 0                |                                       |                           |                              | 2.00  |
| 3.00  | 0              | 0                |                                       |                           |                              | 3.00  |
| 3.02  | 0              | 0                |                                       |                           |                              | 3. 02 |
| 3.04  | 0              | 0                |                                       |                           |                              | 3.04  |
| 4.00  | 6, 781         |                  |                                       |                           |                              | 4.00  |
| 4.01  | 841            |                  |                                       |                           |                              | 4.01  |
| 4.02  | 10, 037        |                  |                                       |                           |                              | 4.02  |
| 4.03  | 103, 436       |                  |                                       |                           |                              | 4.03  |
| 4.04  | 35, 001        |                  |                                       |                           |                              | 4.04  |
| 4.05  | 37, 709        |                  |                                       |                           |                              | 4.05  |
| 4.06  | 1, 066, 223    |                  |                                       |                           |                              | 4.06  |
| 4.07  | -336, 324      |                  |                                       |                           |                              | 4.07  |
| 4.08  | -443, 032      |                  |                                       |                           |                              | 4.08  |
| 4.09  | -5, 558        |                  |                                       |                           |                              | 4.09  |
| 4.10  | -22, 544       |                  |                                       |                           |                              | 4.10  |
| 4.11  | -475, 594      |                  |                                       |                           |                              | 4.11  |
| 4.12  | -147, 157      |                  |                                       |                           |                              | 4.12  |
| 4.13  | -4, 977        |                  |                                       |                           |                              | 4.13  |
| 5.00  | -175, 158      |                  |                                       |                           |                              | 5.00  |
| * The | amounts on lin | es 1-4 (and subs | cripts as appropriate) are tra        | nsferred in detail to Wor | ksheet A, column 6, lines as |       |

riate) are transferred in 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

| nus n | Deen posted to norkaneet A,  | cordinas i and/or 2, the amount arrowable should be mareated in cordinary or this part. |  |
|-------|------------------------------|---|--|
|       | Rel ated Organization(s)     |   |  |
|       | and/or Home Office           |   |  |
|       |                              |   |  |
|       |                              |   |  |
|       | Type of Business             |   |  |
|       |                              |   |  |
|       | 6.00                         |   |  |
|       | B. INTERRELATIONSHIP TO RELA | TED ORGANIZATION(S) AND/OR HOME OFFICE:   |  |
|       |                              |   |  |

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

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

| 6.00   | HOSPITAL MANAGEMENT | 6.00   |
|--------|---------------------|--------|
| 7.00   | DEBT COLLECTION     | 7.00   |
| 8.00   | LAUNDRY SERVICE     | 8.00   |
| 9.00   |                     | 9.00   |
| 10.00  |                     | 10.00  |
| 100.00 |                     | 100.00 |

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.

 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.

| Heal th      | Financial Syste | ems                                   | DUKES MEMORI   | AL HOSPI TAL |              |               | In Lie          | eu of Form CMS-                | 2552-10      |
|--------------|-----------------|---------------------------------------|----------------|--------------|--------------|---------------|-----------------|--------------------------------|--------------|
| PROVI DE     | R BASED PHYSIC  | I AN ADJUSTMENT                       |                | Provi de     | er CCN: 15-1 |               | Period:         | Worksheet A-8                  | 3-2          |
|              |                 |                                       |                |              |              |               | From 01/01/2019 |                                |              |
|              |                 |                                       |                |              |              |               | To 12/31/2019   | Date/Time Pre<br>8/28/2020 10: |              |
|              | Wkst. A Line #  | Cost Center/Physician                 | Total          | Professi on  | al Provi     | der           | RCE Amount      | Physi ci an/Prov               |              |
|              |                 | I denti fi er                         | Remuneration   | Component    | Compo        | nent          |                 | ider Component                 |              |
|              |                 |                                       |                |              |              |               |                 | Hours                          |              |
|              | 1.00            | 2.00                                  | 3.00           | 4.00         | 5. (         | 00            | 6.00            | 7.00                           |              |
| 1.00         |                 | ADULTS & PEDIATRICS                   | 769, 994       | 769.         | 994          | C             | 0 0             | 0                              | 1.00         |
| 2.00         | 50.00           | OPERATING ROOM                        | 429, 902       | 429,         | 902          | C             | 0               | 0                              | 2.00         |
| 3.00         |                 | ANESTHESI OLOGY                       | 115, 981       | 115,         |              | C             |                 | 0                              | 3.00         |
| 4.00         |                 | ELECTROCARDI OLOGY                    | 1, 507         |              | 507          | Ċ             | 0               | 0                              | 4.00         |
| 5.00         |                 | EMERGENCY                             | 2, 076, 800    | 331,         |              | 744, 967      | -               | 0                              | 5.00         |
| 6.00         | 0.00            |                                       | 2,070,000      | 551,         | 0 1, 1       | יסי, דרי<br>ר |                 | 0                              | 6.00         |
| 7.00         | 0.00            |                                       | 0              |              | 0            | C             |                 | 0                              | 7.00         |
| 8.00         | 0.00            |                                       | 0              |              | 0            |               |                 | 0                              | 8.00         |
|              | 0.00            |                                       | 0              |              | 0            |               |                 | 0                              |              |
| 9.00         |                 |                                       | 0              |              | 0            | C             | 0               | 0                              | 9.00         |
| 10.00        | 0.00            |                                       | 0              |              | 0            |               | 0               | 0                              | 10.00        |
| 200.00       |                 |                                       | 3, 394, 184    | 1, 649,      |              | 744, 967      |                 | 0                              | 200.00       |
|              | Wkst. A Line #  | , , , , , , , , , , , , , , , , , , , | Unadjusted RCE |              |              |               | Provi der       | Physician Cost                 |              |
|              |                 | I denti fi er                         | Limit          | Unadj usted  |              |               |                 | of Malpractice                 |              |
|              |                 |                                       |                | Limit        | Conti r      | 5             | Share of col.   | Insurance                      |              |
| -            |                 |                                       |                |              | Educa        |               | 12              |                                |              |
|              | 1.00            | 2.00                                  | 8.00           | 9.00         | 12.          |               | 13.00           | 14.00                          |              |
| 1.00         |                 | ADULTS & PEDIATRICS                   | 0              |              | 0            | C             |                 |                                | 1.00         |
| 2.00         |                 | OPERATING ROOM                        | 0              |              | 0            | C             |                 | -                              | 2.00         |
| 3.00         |                 | ANESTHESI OLOGY                       | 0              |              | 0            | C             |                 | 0                              | 3.00         |
| 4.00         | 69.00           | ELECTROCARDI OLOGY                    | 0              |              | 0            | C             | 0               | 0                              | 4.00         |
| 5.00         | 91.00           | EMERGENCY                             | 0              |              | 0            | C             | 0               | 0                              | 5.00         |
| 6.00         | 0.00            |                                       | 0              |              | 0            | C             | 0               | 0                              | 6.00         |
| 7.00         | 0.00            |                                       | 0              |              | 0            | C             | 0               | 0                              | 7.00         |
| 8.00         | 0.00            |                                       | 0              |              | 0            | C             | 0 0             | 0                              | 8.00         |
| 9.00         | 0.00            |                                       | 0              |              | 0            | C             | ol o            | 0                              | 9.00         |
| 10.00        | 0.00            |                                       | 0              |              | 0            | C             | 0               | 0                              | 10.00        |
| 200.00       |                 |                                       | 0              |              | 0            | C             | 0               | 0                              |              |
|              | Wkst. A Line #  | Cost Center/Physician                 | Provi der      | Adjusted R   | CE RC        | F             | Adjustment      | -                              |              |
|              |                 | I denti fi er                         | Component      | Limit        | Disallo      |               |                 |                                |              |
|              |                 |                                       | Share of col.  | 2            | Diodirio     | Jindinoo      |                 |                                |              |
|              |                 |                                       | 14             |              |              |               |                 |                                |              |
|              | 1.00            | 2.00                                  | 15.00          | 16.00        | 17.          | 00            | 18.00           |                                |              |
| 1.00         | 30.00           | ADULTS & PEDIATRICS                   | 0              |              | 0            | C             | 769, 994        |                                | 1.00         |
| 2.00         |                 | OPERATING ROOM                        | 0              |              | 0            | C             | 429,902         |                                | 2.00         |
| 3.00         |                 | ANESTHESI OLOGY                       | 0              |              | 0            | C             |                 |                                | 3.00         |
| 4.00         |                 | ELECTROCARDI OLOGY                    | 0              |              | 0            | C             |                 |                                | 4.00         |
| 5.00         |                 | EMERGENCY                             | 0              |              | 0            | C             |                 |                                | 5.00         |
| 6.00         | 0.00            |                                       | 0              |              | 0            | C             |                 |                                | 6.00         |
| 7.00         | 0.00            |                                       |                |              | 0            | C             | ~               |                                | 7.00         |
| 7.00<br>8.00 | 0.00            |                                       |                |              | 0            | 0             |                 |                                | 8.00         |
| 8.00<br>9.00 | 0.00            |                                       |                |              | 0            | C             | -               |                                | 8.00<br>9.00 |
|              |                 | 4                                     | 0              |              | 0            |               |                 |                                |              |
| 10.00        | 0.00            |                                       | 0              |              | -            | C             |                 |                                | 10.00        |
| 200.00       | I               | I                                     | 0              | l            | 0            | C             | 1, 649, 217     |                                | 200.00       |
|              |                 |                                       |                |              |              |               |                 |                                |              |

| JTSIE                            | Financial Systems DUKES ME<br>IABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED<br>DE SUPPLIERS  | BY Prov  | ider CCN: 15-13                              | 18 Period:<br>From 01/01/201<br>To 12/31/201 |                       | epared:        |
|----------------------------------|--|--|--|--|-----------------------|----------------|
|                                  |  |  |  | Physical Thera                               |                       |                |
|                                  |  |  |  |  | 1.00                  |                |
|                                  | PART I – GENERAL INFORMATION   |  |  |  | 1.00                  |                |
| 00                               | Total number of weeks worked (excluding aides) (see in   | structions)  |  |  | 52                    |                |
| 00                               | Line 1 multiplied by 15 hours per week   |  |  | / · · · · ·                                  | 780                   |                |
| 00                               | Number of unduplicated days in which supervisor or the<br>Number of unduplicated days in which therapy assistant   |  |  |  | 0                     |                |
| 00                               | nor therapist was on provider site (see instructions)  |  | del Site but in                              | er ther Supervisor                           | 0                     | 4.00           |
| 00                               | Number of unduplicated offsite visits - supervisors or   |  |  |  | 0                     |                |
| 00                               | Number of unduplicated offsite visits - therapy assist   |  |  |  | 0                     | 6.00           |
|                                  | assistant and on which supervisor and/or therapist was instructions)   | not present  | during the vis                               | rt(s)) (see                                  |                       |                |
| 00                               | Standard travel expense rate   |  |  |  | 0.00                  | 7.00           |
| 00                               | Optional travel expense rate per mile  |  |  |  | 5. 19                 | 8.00           |
|                                  | Supervis<br>1.00   |  |  |  | Trai nees<br>5. 00    |                |
| 00                               |  |  |  | 496.48 2,936.9                               |                       | 9.00           |
| . 00                             | AHSEA (see instructions)   | 0.00   | 81.04  | 50. 50 17. 5                                 | 50 0.00               | 10.00          |
| . 00                             |  | 40. 52   | 40. 52                                       | 25.25  |                       | 11.00          |
|                                  | one-half of column 2, line 10; column 3,<br>one-half of column 3, line 10)   |  |  |  |                       |                |
| . 00                             | Number of travel hours (provider site)   | 0  | o  | 0  |                       | 12.00          |
| 01                               | Number of travel hours (offsite)   | ō  | o  | 0  |                       | 12.0           |
| 00                               | Number of miles driven (provider site)   | 0  | 0  | 0  |                       | 13.0           |
| 01                               | Number of miles driven (offsite)   | 0  | 0  | 0  |                       | 13.0           |
|                                  |  |  |  |  | 1.00                  |                |
|                                  | Part II - SALARY EQUIVALENCY COMPUTATION   |  |  |  |                       |                |
| 00                               | Supervisors (column 1, line 9 times column 1, line 10)   |  |  |  | 0                     |                |
| 00                               | Therapists (column 2, line 9 times column 2, line 10)  |  |  |  | 270, 122              |                |
| 00<br>00                         | Assistants (column 3, line 9 times column 3, line10)<br>Subtotal allowance amount (sum of lines 14 and 15 for 1  | respiratory *  | therany or line                              | s 14-16 for all                              | 126, 072<br>396, 194  |                |
| 00                               | others)  | respiratory  | inerapy or time.                             | 3 14-10 101 811                              | 370, 174              | 17.0           |
| 00                               | Aides (column 4, line 9 times column 4, line 10)   |  |  |  | 51, 397               | 18. C          |
| 00                               | Trainees (column 5, line 9 times column 5, line 10)  |  | 1. 47  |  | 0                     | 19.0           |
| . 00                             | Total allowance amount (sum of lines 17-19 for respira<br>If the sum of columns 1 and 2 for respiratory therapy of   |  |  |  |                       | 20.0           |
|                                  | occupational therapy, line 9, is greater than line 2, r  |  |  |  |                       |                |
|                                  | the amount from line 20. Otherwise complete lines 21-2   |  |  |  |                       |                |
| . 00                             | Weighted average rate excluding aides and trainees (III  |  |  | umns 1 and 2, line                           | 9 0.00                | 21.0           |
| . 00                             | for respiratory therapy or columns 1 thru 3, line 9 for<br>Weighted allowance excluding aides and trainees (line 3   | 0  | 22.0   |  |                       |                |
| . 00                             | Total salary equivalency (see instructions)  |  | ,  |  | 447, 591              |                |
|                                  | PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND  | TRAVEL EXPENS  | E COMPUTATION                                | - PROVIDER SITE                              |                       | -              |
| 00                               | Standard Travel Allowance<br>Therapists (line 3 times column 2, line 11)   |  |  |  | 0                     | 24.0           |
| . 00                             | Assistants (line 4 times column 3, line 11)  |  |  |  | 0                     |                |
| 00                               | Subtotal (line 24 for respiratory therapy or sum of lin  | nes 24 and 25  | o for all other                              | s)   | 0                     |                |
| 00                               | Standard travel expense (line 7 times line 3 for respin  | ratory therap  | by or sum of li                              | nes 3 and 4 for all                          | 0                     | 27.0           |
| 00                               | others)<br>Total standard travel allowance and standard travel exp   | nonco at tho   | providor cito                                | (sum of lines 26 an                          | d O                   | 28.0           |
| 00                               |  | pense at the   | provider site                                | (Sum of Trifes 20 an                         |                       | 20.0           |
|                                  | Optional Travel Allowance and Optional Travel Expense  |  |  |  |                       |                |
| 00                               | Therapists (column 2, line 10 times the sum of columns   |  | 1e 12 )                                      |  | 0                     |                |
| 00                               | Assistants (column 3, line 10 times column 3, line 12)<br>Subtotal (line 29 for respiratory therapy or sum of line   |  | ) for all other                              | e)   | 0                     |                |
| 00                               | Optional travel expense (line 8 times columns 1 and 2,   |  |  | ,  | 0                     |                |
|                                  | columns 1-3, line 13 for all others)   |  | 5  |  |                       |                |
| 00                               | Standard travel allowance and standard travel expense  | • •  |  |  | 0                     |                |
| 00<br>00                         | Optional travel allowance and standard travel expense<br>Optional travel allowance and optional travel expense   | •  |  |  | 0                     |                |
| 00                               | Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TH  |  |  | SERVICES OUTSIDE P                           |                       | 35.0           |
|                                  | Standard Travel Expense  |  |  |  |                       |                |
|                                  | Therapists (line 5 times column 2, line 11)  |  |  |  | 0                     |                |
|                                  | Assistants (line 6 times column 3, line 11)  |  |  |  | 0                     |                |
| 00                               | Subtotal (sum of lines 36 and 37)  | 5 and 6)   |  |  | 0                     |                |
| 00<br>00                         | Standard travel expense (line 7 times the sum of lines   | 5 and 0)   |  |  | 0                     | 1 3 /. 0       |
| 00<br>00                         | Standard travel expense (line 7 times the sum of lines<br>Optional Travel Allowance and Optional Travel Expense  |  | 10)  |  | 0                     | 40.0           |
| 00<br>00<br>00                   | Optional Travel Allowance and Optional Travel Expense<br>Therapists (sum of columns 1 and 2, line 12.01 times co   |  | e 10)  |  |                       | 41.0           |
| 00<br>00<br>00                   | Optional Travel Allowance and Optional Travel Expense<br>Therapists (sum of columns 1 and 2, line 12.01 times co<br>Assistants (column 3, line 12.01 times column 3, line  |  | e 10)  |  | 0                     |                |
| 00<br>00<br>00<br>00<br>00<br>00 | Optional Travel Allowance and Optional Travel Expense<br>Therapists (sum of columns 1 and 2, line 12.01 times co<br>Assistants (column 3, line 12.01 times column 3, line<br>Subtotal (sum of lines 40 and 41)   | 10)  |  |  | 0                     | 42.0           |
| 00<br>00<br>00                   | Optional Travel Allowance and Optional Travel Expense<br>Therapists (sum of columns 1 and 2, line 12.01 times co<br>Assistants (column 3, line 12.01 times column 3, line<br>Subtotal (sum of lines 40 and 41)<br>Optional travel expense (line 8 times the sum of column  | 10)<br><u>ns 1-3, line</u>                             | 13.01)                                       | following three Li                           | 0                     | 42.0           |
| 00<br>00<br>00<br>00<br>00       | Optional Travel Allowance and Optional Travel Expense<br>Therapists (sum of columns 1 and 2, line 12.01 times co<br>Assistants (column 3, line 12.01 times column 3, line<br>Subtotal (sum of lines 40 and 41)<br>Optional travel expense (line 8 times the sum of column<br>Total Travel Allowance and Travel Expense - Offsite Ser<br>or 46, as appropriate. | 10)<br><u>nns 1-3, line</u><br>rvices; Compl           | 13.01)<br>ete one of the                     |  | 0<br>0<br>nes 44, 45, | 42. C<br>43. C |
|                                  | Optional Travel Allowance and Optional Travel Expense<br>Therapists (sum of columns 1 and 2, line 12.01 times co<br>Assistants (column 3, line 12.01 times column 3, line 5<br>Subtotal (sum of lines 40 and 41)<br>Optional travel expense (line 8 times the sum of column<br>Total Travel Allowance and Travel Expense - Offsite Ser                         | 10)<br>nns 1-3, line<br>rvices; Compl<br>(sum of lines | 13.01)<br>ete one of the<br>s 38 and 39 - se | ee instructions)                             | 0<br>0<br>nes 44, 45, | 42.0           |

| REASONABLE COST DETERMINATION FOR THERAPY SERVICES F<br>OUTSIDE SUPPLIERS                  |                      |                                     |                               | Period: Worksheet //<br>From 01/01/2019 Parts I-VI<br>To 12/31/2019 Date/Time I<br>8/28/2020 |                   | Prepared:            |              |
|--|----------------------|-------------------------------------|-------------------------------|--|-------------------|----------------------|--------------|
|  |                      |                                     |                               | []   | Physical Therapy  | Cost                 |              |
|  |                      |                                     |                               |  |                   | 1.00                 |              |
| 6.00 Optional travel allowance   | and optional travel  | expense (sum o                      |                               |  |                   |                      | 46.0         |
|  | -                    | Therapists<br>1.00                  | Assi stants<br>2.00           | Ai des<br>3.00   | Trai nees<br>4.00 | <u>Total</u><br>5.00 |              |
| PART V - OVERTIME COMPUTAT   | 1 ON                 | 1.00                                | 2.00                          | 3.00   | 4.00              | 5.00                 |              |
| 7.00 Overtime hours worked duri  |                      | 0.00                                | 0.00                          | 0.0  | 0.00              | 0.00                 | 47.0         |
| period (if column 5, line  |                      |                                     |                               |  |                   |                      |              |
| equal to or greater than 2   |                      |                                     |                               |  |                   |                      |              |
| complete lines 48-55 and e<br>column of line 56)   | enter zero in each   |                                     |                               |  |                   |                      |              |
| 8.00 Overtime rate (see instruc  | rtions)              | 0.00                                | 0.00                          | 0.0  | 0.00              |                      | 48.0         |
| 9.00 Total overtime (including   |                      | 0.00                                | 0.00                          |  |                   |                      | 49.0         |
| allowance) (multiply line  |                      | 0.00                                | 0.00                          | 0.0  | 0.00              |                      | 17.0         |
| CALCULATION OF LIMIT   |                      |                                     |                               |  |                   |                      | 1            |
| 0.00 Percentage of overtime hou  | urs by category      | 0.00                                | 0.00                          | 0.0  | 0.00              | 0.00                 | 50.0         |
| (divide the hours in each  |                      |                                     |                               |  |                   |                      |              |
| by the total overtime work   | ked – column 5,      |                                     |                               |  |                   |                      |              |
| line 47)   | tondord work yoor    | 0.00                                | 0.00                          | 0.0  | 0.00              | 0.00                 | E1 0         |
| 1.00 Allocation of provider's s<br>for one full-time employee                              |                      | 0.00                                | 0.00                          | 0.0  | 0.00              | 0.00                 | 51. C        |
| percentages on line 50) (s   |                      |                                     |                               |  |                   |                      |              |
| DETERMINATION OF OVERTIME  |                      | I                                   |                               |  |                   |                      |              |
| 2.00 Adjusted hourly salary equ  |                      | 81.04                               | 50.50                         | 17.5   | 0 0.00            |                      | 52.0         |
| (see instructions)   | 5                    |                                     |                               |  |                   |                      |              |
| 3.00 Overtime cost limitation (  | (line 51 times line  | 0                                   | 0                             |  | 0 0               |                      | 53.0         |
| 52)  |                      |                                     |                               |  |                   |                      |              |
| 4.00 Maximum overtime cost (ent  | ter the lesser of    | 0                                   | 0                             |  | 0 0               |                      | 54.0         |
| line 49 or line 53)<br>5.00 Portion of overtime alread                                     | ty included in       | 0                                   | 0                             |  | 0 0               |                      | 55.0         |
| hourly computation at the  |                      | 0                                   | 0                             |  | 0 0               |                      | 35.0         |
| line 47 times line 52)   | raiozir (mar crpr j  |                                     |                               |  |                   |                      |              |
| 6.00 Overtime allowance (line 5  | 54 minus line 55 -   | 0                                   | 0                             |  | 0 0               | 0                    | 56.0         |
| if negative enter zero) (  |                      |                                     |                               |  |                   |                      |              |
| the sum of columns 1, 3, a   |                      |                                     |                               |  |                   |                      |              |
| respiratory therapy and co   | olumns 1 through 3   |                                     |                               |  |                   |                      |              |
| for all others.)   |                      |                                     |                               |  |                   |                      |              |
|  |                      |                                     |                               |  |                   | 1.00                 |              |
| Part VI - COMPUTATION OF T   | HERAPY LIMITATION A  | ND EXCESS COST A                    | ADJUSTMENT                    |  |                   |                      |              |
| 7.00 Salary equivalency amount   | (from line 23)       |                                     |                               |  |                   | 447, 591             | 57.(         |
| 8.00 Travel allowance and exper  |                      |                                     |                               |  |                   | 0                    |              |
| 9.00 Travel allowance and exper  |                      | es (from lines ·                    | 44, 45, or 46                 | )  |                   | 0                    |              |
| 0.00 Overtime allowance (from o  |                      |                                     |                               |  |                   | 0                    |              |
| 1.00 Equipment cost (see instru  |                      |                                     |                               |  |                   | 0                    |              |
| 2.00 Supplies (see instructions<br>3.00 Total allowance (sum of li                         |                      |                                     |                               |  |                   | 0<br>447, 591        |              |
| 4.00 Total cost of outside supp  |                      | vour records)                       |                               |  |                   | 447, 591             |              |
| 5.00 Excess over limitation (li  |                      |                                     | enter zero)                   |  |                   |                      | 65.          |
| LINE 33 CALCULATION  |                      | in negative,                        | 2010)                         |  |                   |                      | 00.          |
| 00.00 Line 26 = line 24 for resp   | oiratory therapy or  | sum of lines 24                     | and 25 for a                  | II others  |                   | 0                    | 100. (       |
| 00.01 Line 27 = line 7 times lir   | ne 3 for respiratory | therapy or sum                      | of lines 3 a                  | nd 4 for all   | others            | 0                    | 100. (       |
| 00.02  | Flines 26 and 27     |                                     |                               |  |                   | 0                    | 100. (       |
| LINE 34 CALCULATION  |                      |                                     |                               |  |                   |                      |              |
| 01.00 Line 27 = line 7 times lir   |                      |                                     |                               |  | others            | -                    | 101. (       |
|  | 3 13                 | sum of lines 29                     | and 30 for a                  | II others  |                   |                      | 101. (       |
| 01.01 Line 31 = line 29 for resp   |                      |                                     |                               |  |                   | 0                    | 101. (       |
| 01.02 Line 34 = sum of lines 27  | and 31               |                                     |                               |  |                   |                      |              |
| D1.02 Line 34 = sum of lines 27<br>LINE 35 CALCULATION                                     |                      | cum of lines 20                     | and 20 fam -                  | II others  |                   |                      | 102 4        |
| 01.02 Line 34 = sum of lines 27<br>LINE 35 CALCULATION<br>02.00 Line 31 = line 29 for resp | piratory therapy or  | sum of lines 29                     | and 30 for a                  | ll others  | mps 1_3 line      |                      | 102.         |
| D1.02 Line 34 = sum of lines 27<br>LINE 35 CALCULATION                                     | piratory therapy or  | sum of lines 29<br>13 for respirate | and 30 for a<br>ory therapy o | ll others<br>r sum of colu   | mns 1-3, line     |                      | 102.<br>102. |

| REASON                           | Financial Systems<br>IABLE COST DETERMINATION FOR THERAPY SERVICES<br>DE SUPPLIERS  | DUKES MEMORI A<br>FURNI SHED BY                     | AL HOSPITAL<br>Provider CC | F                    | In Lie<br>eriod:<br>rom 01/01/2019<br>o 12/31/2019<br>Occupational<br>Therapy | u of Form CMS-2<br>Worksheet A-8<br>Parts I-VI<br>Date/Time Prep<br>8/28/2020 10:<br>Cost | -3<br>pared:     |  |
|----------------------------------|---|---|----------------------------|----------------------|---|---|------------------|--|
|                                  |   |   |                            |                      | -   | 1.00  |                  |  |
| 1.00                             | PART I - GENERAL INFORMATION<br>Total number of weeks worked (excluding aides   | s) (see instruc                                     | tions)                     |                      |   | 52  | 1.00             |  |
| 2.00                             | Line 1 multiplied by 15 hours per week  |   | (1013)                     |                      |   | 780   |                  |  |
| 3.00<br>4.00                     | Number of unduplicated days in which supervisions of unduplicated days in which therapy   |   |                            |                      |   | 0   | 3.00<br>4.00     |  |
| 5.00                             | nor therapist was on provider site (see inst<br>Number of unduplicated offsite visits - supe  | ructions)   |                            |                      |   | 0   | 5.00             |  |
| 6.00                             | Number of unduplicated offsite visits - thera<br>assistant and on which supervisor and/or the<br>instructions)                      | apy assistants                                      | (include only v            | isits made by        |   | 0   |                  |  |
| 7.00<br>8.00                     | Standard travel expense rate<br>Optional travel expense rate per mile   |   |                            |                      |   | 0. 00<br>5. 19  |                  |  |
| 0100                             |   | Supervi sors  | Therapi sts                | Assi stants          | Ai des  | Trai nees   |                  |  |
| 9.00                             | Total hours worked  | 1.00<br>0.00  | 2.00<br>2,269.90           | <u>3.00</u><br>53.05 | 4.00  | 5.00  | 9.00             |  |
| 10. 00<br>11. 00                 | AHSEA (see instructions)<br>Standard travel allowance (columns 1 and 2,<br>one-half of column 2, line 10; column 3,                 | 0. 00<br>38. 41                                     | 76.82<br>38.41             | 50. 50<br>25. 25     |   | 0.00  | 10. 00<br>11. 00 |  |
| 12.00                            | one-half of column 3, line 10)<br>Number of travel hours (provider site)  | 0   | о                          | 0                    |   |   | 12.00            |  |
| 12. 01<br>13. 00                 | Number of travel hours (offsite)<br>Number of miles driven (provider site)  | 0   | 0                          | 0                    |   |   | 12.01<br>13.00   |  |
| 13.00                            | Number of miles driven (provider site)  | 0   | 0                          | 0                    |   |   | 13.00            |  |
|                                  |   |   |                            |                      | F   | 1.00  |                  |  |
| 14.00                            | Part II - SALARY EQUIVALENCY COMPUTATION  | Line 10)  |                            |                      |   | 0   | 14.00            |  |
| 14.00<br>15.00                   | Supervisors (column 1, line 9 times column 1,<br>Therapists (column 2, line 9 times column 2,                                       |   |                            |                      |   | 0<br>174, 374   | 14.00<br>15.00   |  |
| 16. 00<br>17. 00                 | Assistants (column 3, line 9 times column 3,<br>Subtotal allowance amount (sum of lines 14 au                                       |   | ratory thorapy             | or Lines 14 1        | 4 for all   | 2, 679<br>177, 053  | •                |  |
| 17.00                            | others)   | nu is ioi respi                                     | ratory therapy             | of times 14-1        |   | 177,055   | 17.00            |  |
| 18.00<br>19.00                   | Aides (column 4, line 9 times column 4, line<br>Trainees (column 5, line 9 times column 5, l  |   | 0                          |                      |   |   |                  |  |
| 20.00                            |   |   |                            |                      |   |   |                  |  |
|                                  | occupational therapy, line 9, is greater than   | n line 2, make i                                    |                            |                      |   |   |                  |  |
| 21.00                            | the amount from line 20. Otherwise complete<br>Weighted average rate excluding aides and tra  |   | divided by sur             | n of columns 1       | and 2 line 9  | 0.00  | 21.00            |  |
|                                  | for respiratory therapy or columns 1 thru 3,  |   |                            |                      |   |   |                  |  |
| 22. 00<br>23. 00                 | Weighted allowance excluding aides and train<br>Total salary equivalency (see instructions)   |   |                            |                      |   | 0<br>177, 053   |                  |  |
|                                  | PART III - STANDARD AND OPTIONAL TRAVEL ALLOW<br>Standard Travel Allowance  | VANCE AND TRAVE                                     | L EXPENSE COMPL            | JTATION - PROV       | I DER SI TE   |   |                  |  |
| 24.00                            | Therapists (line 3 times column 2, line 11)   |   |                            |                      |   | 0   | 24.00            |  |
| 25. 00<br>26. 00                 | Assistants (line 4 times column 3, line 11)<br>Subtotal (line 24 for respiratory therapy or   | sum of lines 2                                      | 4 and 25 for al            | L others)            |   | 0   |                  |  |
| 27.00                            | Standard travel expense (line 7 times line 3  |   |                            |                      | and 4 for all   | 0   |                  |  |
| 28.00                            | others)<br>Total standard travel allowance and standard<br>27)  | travel expense                                      | at the provide             | er site (sum o       | flines 26 and   | 0   | 28.00            |  |
| 20.00                            | Optional Travel Allowance and Optional Travel   |   |                            |                      |   |   | 20.00            |  |
| 29.00<br>30.00                   | Therapists (column 2, line 10 times the sum a<br>Assistants (column 3, line 10 times column 3                                       |   | a 2, line 12)              |                      |   | 0   |                  |  |
| 31.00                            | Subtotal (line 29 for respiratory therapy or  |   |                            |                      | c   | 0   | 31.00            |  |
| 32.00                            | Optional travel expense (line 8 times columns<br>columns 1-3, line 13 for all others)   | s I and 2, IIne                                     | 13 TOP respira             | atory therapy        | or sum or   | 0   | 32.00            |  |
| 33.00                            | Standard travel allowance and standard trave  |   |                            | 4 21)                |   | 0   | 33.00<br>34.00   |  |
| 34.00<br>35.00                   | Optional travel allowance and standard trave<br>Optional travel allowance and optional trave  |   |                            |                      |   | 0<br>0  | 34.00            |  |
|                                  | Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/<br>Standard Travel Expense  | ANCE AND TRAVEL                                     | EXPENSE COMPUT             | ATION - SERVI        | CES OUTSIDE PRO   | VIDER SITE  |                  |  |
| 36.00                            | Therapists (line 5 times column 2, line 11)   |   |                            |                      |   | 0   |                  |  |
| 37.00<br>38.00                   | Assistants (line 6 times column 3, line 11)<br>Subtotal (sum of lines 36 and 37)  |   |                            |                      |   | 0   |                  |  |
|                                  | Standard travel expense (line 7 times the sur   |   | d 6)                       |                      |   | 0   |                  |  |
| 38.00<br>39.00                   |   | Evnansa   |                            |                      |   |   | 40.00            |  |
| 39. 00                           | Optional Travel Allowance and Optional Travel<br>Therapists (sum of columns 1 and 2. line 12.                                       |   | 2, [jne 10)                |                      | 1   | 01  |                  |  |
| 39.00<br>40.00<br>41.00          | Therapists (sum of columns 1 and 2, line 12.0<br>Assistants (column 3, line 12.01 times column                                      | 01 times column                                     | 2, line 10)                |                      |   | 0<br>0  | 41.00            |  |
| 39. 00<br>40. 00                 | Therapists (sum of columns 1 and 2, line 12.0<br>Assistants (column 3, line 12.01 times column<br>Subtotal (sum of lines 40 and 41) | 01 times column<br>n 3, line 10)                    |                            |                      |   |   | 41.00<br>42.00   |  |
| 39.00<br>40.00<br>41.00<br>42.00 | Therapists (sum of columns 1 and 2, line 12.0<br>Assistants (column 3, line 12.01 times column                                      | D1 times column<br>n 3, line 10)<br>m of columns 1- | 3, line 13.01)             | e of the follo       | wing three line   | 0<br>0<br>0   | 41.00<br>42.00   |  |

| UTSI D                       | ABLE COST DETERMINATION FOR THERAPY SERVICES F<br>E SUPPLIERS   | FURNI SHED BY      | Provider C         | CN: 15-1318    | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet A-8<br>Parts I-VI<br>Date/Time Pre<br>8/28/2020 10: | pared:                     |
|------------------------------|---|--------------------|--------------------|----------------|---|---|----------------------------|
|                              |   |                    |                    |                | Occupati onal<br>Therapy                    | Cost  |                            |
|                              |   |                    |                    |                |   | 1.00  |                            |
|                              | Optional travel allowance and standard travel   |                    |                    |                |   | 0   |                            |
| 6.00                         | Optional travel allowance and optional travel   |                    |                    |                |   | 0   | 46.0                       |
|                              |   | Therapists<br>1.00 | Assistants<br>2.00 | Ai des<br>3.00 | Trai nees<br>4.00                           | <u> </u>  |                            |
|                              | PART V - OVERTIME COMPUTATION   | 1.00               | 2.00               | 3.00           | 4.00  | 5.00  |                            |
| 7.00                         | Overtime hours worked during reporting<br>period (if column 5, line 47, is zero or<br>equal to or greater than 2,080, do not<br>complete lines 48-55 and enter zero in each<br>column of line 56) | 0. 00              | 0.00               | 0. 0           | 0.00  | 0.00  | 47.C                       |
| 3. 00                        | Overtime rate (see instructions)  | 0. 00              | 0.00               |                |   |   | 48.0                       |
| 9. 00                        | Total overtime (including base and overtime<br>allowance) (multiply line 47 times line 48)<br>CALCULATION OF LIMIT  | 0. 00              | 0.00               | 0.0            | 0.00  |   | 49.0                       |
| 0. 00                        | Percentage of overtime hours by category<br>(divide the hours in each column on line 47<br>by the total overtime worked - column 5,<br>line 47)   | 0.00               | 0.00               | 0.0            | 0.00  | 0.00  | 50.0                       |
| 1. 00                        | Allocation of provider's standard work year<br>for one full-time employee times the<br>percentages on line 50) (see instructions)   | 0. 00              | 0.00               | 0.0            | 0.00  | 0.00  | 51.0                       |
| 2. 00                        | DETERMINATION OF OVERTIME ALLOWANCE<br>Adjusted hourly salary equivalency amount  | 76. 82             | 50.50              | 0.0            | 0.00  |   | 52.0                       |
|                              | (see instructions)  |                    |                    |                |   |   |                            |
| 3.00                         | Overtime cost limitation (line 51 times line 52)  | 0                  | 0                  |                | 0 0   |   | 53.0                       |
| 4.00                         | Maximum overtime cost (enter the lesser of<br>line 49 or line 53)   | 0                  | 0                  |                | 0 0   |   | 54.0                       |
| 5.00                         | Portion of overtime already included in<br>hourly computation at the AHSEA (multiply<br>line 47 times line 52)  | 0                  | 0                  |                | 0 0   |   | 55.0                       |
| 6. 00                        | Overtime allowance (line 54 minus line 55 -<br>if negative enter zero) ( Enter in column 5<br>the sum of columns 1, 3, and 4 for  | O                  | 0                  |                | 0 0   | 0   | 56.0                       |
|                              | respiratory therapy and columns 1 through 3 for all others.)  |                    |                    |                |   |   |                            |
|                              |   |                    |                    |                |   | 1.00  |                            |
|                              | Part VI - COMPUTATION OF THERAPY LIMITATION A   | ND EXCESS COST     | ADJUSTMENT         |                |   |   |                            |
| 7.00<br>3.00<br>9.00<br>0.00 | Salary equivalency amount (from line 23)<br>Travel allowance and expense - provider site<br>Travel allowance and expense - Offsite servic<br>Overtime allowance (from column 5, line 56)          |                    |                    | )              |   | 177, 053<br>0<br>0<br>0                                       | 58. 0<br>59. 0             |
|                              | Equipment cost (see instructions)<br>Supplies (see instructions)  |                    |                    |                |   | 0<br>0  |                            |
| 8.00                         | Total allowance (sum of lines 57-62)  |                    |                    |                |   | 177, 053  |                            |
| . 00<br>. 00                 | Total cost of outside supplier services (from<br>Excess over limitation (line 64 minus line 63  |                    | enter zero)        |                |   | 165, 072<br>0   |                            |
| 0 00                         | LINE 33 CALCULATION<br>Line 26 = line 24 for respiratory therapy or   | sum of lines 2     | 1 and 25 for a     | 11 others      |   | 0   | 100.                       |
| 0. 01                        | Line 27 = line 7 times line 3 for respiratory<br>Line 33 = line 28 = sum of lines 26 and 27   |                    |                    |                | others                                      | 0   | 100. (<br>100. (<br>100. ( |
|                              | LINE 34 CALCULATION<br>Line 27 = line 7 times line 3 for respiratory<br>Line 31 = line 29 for respiratory therapy or  |                    |                    |                | others                                      | 0   | 101. (<br>101. (           |
|                              | Line 34 = sum of lines 27 and 31  | Sull OF TITLES ZY  |                    |                |   |   | 101.0                      |
| JT. UZ                       | ILINE 35 CALCULATION  |                    |                    |                |   |   |                            |
| 2.00                         | LINE 35 CALCULATION<br>Line 31 = line 29 for respiratory therapy or<br>Line 32 = line 8 times columns 1 and 2, line   |                    |                    |                | Imps 1_3 Lino                               |   | 102.                       |

|                | IABLE COST DETERMINATION FOR THERAPY SERVICES<br>DE SUPPLIERS                                   | FURNI SHED BY     | Provider CCN: 1   | 1            | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet A-8-<br>Parts I-VI<br>Date/Time Prep<br>8/28/2020 10:3 | pared:         |
|----------------|---|-------------------|-------------------|--------------|---|--|----------------|
|                |   |                   |                   | 5            | Speech Pathology                            | Cost   |                |
|                |   |                   |                   |              |   | 1.00   |                |
| 1 00           | PART I - GENERAL INFORMATION  | -) (              | :>                |              |   |  | 1 1 00         |
| 1.00<br>2.00   | Total number of weeks worked (excluding aides<br>Line 1 multiplied by 15 hours per week         | s) (see Instruct  | ions)             |              |   | 52<br>780  | •              |
| 3.00           | Number of unduplicated days in which supervis   | sor or therapist  | was on provider   | site (see    | instructions)                               | 0  |                |
| 4.00           | Number of unduplicated days in which therapy  |                   | n provider site b | out neither  | r supervi sor                               | 0  | 4.00           |
| 5.00           | nor therapist was on provider site (see inst  |                   | niata (ana inatru | (ationa)     |   | 0  | 5.00           |
| 6.00           | Number of unduplicated offsite visits - super<br>Number of unduplicated offsite visits - thera  |                   |                   |              | v therapy                                   | 0  | 6.00           |
|                | assistant and on which supervisor and/or the  |                   |                   |              |   |  |                |
| 7 00           | instructions)   |                   |                   |              |   | 0.00   | 1 7 00         |
| 7.00<br>8.00   | Standard travel expense rate<br>Optional travel expense rate per mile                           |                   |                   |              |   | 0. 00<br>5. 19   | 7.00           |
| 0.00           |   | Supervi sors      | Therapists As     | ssistants    | Ai des                                      | Trai nees  | 0.00           |
|                |   | 1.00              | 2.00              | 3.00         | 4.00  | 5.00   |                |
| 9.00<br>10.00  | Total hours worked<br>AHSEA (see instructions)  | 0. 00<br>0. 00    | 914.76<br>73.84   | 0.00<br>0.00 |   | 0. 00<br>0. 00   | •              |
| 11.00          | Standard travel allowance (columns 1 and 2,   | 36. 92            | 36. 92            | 0.0          |   | 0.00   | 11.00          |
|                | one-half of column 2, line 10; column 3,  |                   |                   |              |   |  |                |
| 10.00          | one-half of column 3, line 10)  |                   |                   |              | 0   |  | 10.00          |
| 12.00<br>12.01 | Number of travel hours (provider site)<br>Number of travel hours (offsite)                      | 0                 | 0                 |              | 0   |  | 12.00          |
| 13.00          | Number of miles driven (provider site)  | 0                 | 0                 |              | 0   |  | 13.00          |
| 13.01          | Number of miles driven (offsite)  | 0                 | 0                 | (            | 0   |  | 13.0           |
|                |   |                   |                   |              | -   | 1.00   |                |
|                | Part II - SALARY EQUIVALENCY COMPUTATION  |                   |                   |              | I   | 1.00   |                |
| 14.00          | Supervisors (column 1, line 9 times column 1,   |                   |                   |              |   | 0  |                |
| 15.00          | Therapists (column 2, line 9 times column 2,  |                   |                   |              |   | 67, 546  |                |
| 16.00<br>17.00 | Assistants (column 3, line 9 times column 3,<br>Subtotal allowance amount (sum of lines 14 an   |                   | atory therapy or  | lines 14-    | 16 for all                                  | 0<br>67, 546   | 16.00          |
| 17.00          | others)   | id 15 for respire | atory therapy of  | 111163 14-   |   | 07, 340  | 17.00          |
| 18.00          | Aides (column 4, line 9 times column 4, line  |                   |                   |              |   | 0  | 18.00          |
| 19.00          | Trainees (column 5, line 9 times column 5, li   | for all atheres   | 0                 |              |   |  |                |
| 20. 00         | Total allowance amount (sum of lines 17-19 for<br>If the sum of columns 1 and 2 for respiratory |                   |                   |              |   | 67, 546<br>10 0ay or   | 20.00          |
|                | occupational therapy, line 9, is greater than   |                   |                   |              |   |  |                |
| 01 00          | the amount from line 20. Otherwise complete   |                   |                   | 2            | 1   | 0.00   |                |
| 21.00          | Weighted average rate excluding aides and tra<br>for respiratory therapy or columns 1 thru 3,   |                   | 2                 | COLUMNS      | I and 2, IIne 9                             | 0.00   | 21.00          |
| 22.00          | Weighted allowance excluding aides and trained  |                   |                   |              |   | 0  | 22.00          |
| 23.00          | Total salary equivalency (see instructions)   | ·····             |                   |              |   | 67, 546  | 23.00          |
|                | PART III - STANDARD AND OPTIONAL TRAVEL ALLOW<br>Standard Travel Allowance                      | VANCE AND TRAVEL  | EXPENSE COMPUTAT  | ION - PROV   | /IDER SITE                                  |  | -              |
| 24.00          | Therapists (line 3 times column 2, line 11)   |                   |                   |              |   | 0  | 24.00          |
| 25.00          | Assistants (line 4 times column 3, line 11)   |                   |                   |              |   | 0  | 25.00          |
| 26.00          | Subtotal (line 24 for respiratory therapy or  |                   |                   |              |   | 0  | 1              |
| 27.00          | Standard travel expense (line 7 times line 3 others)  | for respiratory   | therapy or sum c  | or lines 3   | and 4 for all                               | 0  | 27.00          |
| 28.00          | Total standard travel allowance and standard  | travel expense    | at the provider s | site (sum o  | of lines 26 and                             | 0  | 28.00          |
|                | 27)   | -                 |                   |              |   |  | 1              |
| 29.00          | Optional Travel Allowance and Optional Travel<br>Therapists (column 2, line 10 times the sum of |                   | 2 line 12 )       |              |   | 0  | 29.00          |
| 30.00          | Assistants (column 3, line 10 times column 3,   |                   | 2, 1110 12 )      |              |   | 0  | •              |
| 31.00          | Subtotal (line 29 for respiratory therapy or  |                   |                   | ,            |   | 0  | •              |
| 32.00          | Optional travel expense (line 8 times columns   | s 1 and 2, line   | 13 for respirator | ry therapy   | or sum of                                   | 0  | 32.00          |
| 33.00          | columns 1-3, line 13 for all others)<br>Standard travel allowance and standard travel           | expense (line     | 28)               |              |   | 0  | 33.00          |
| 34.00          | Optional travel allowance and standard travel   |                   |                   | )            |   | 0  |                |
| 35.00          | Optional travel allowance and optional travel   |                   |                   |              |   | 0  | 35.00          |
|                | Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA<br>Standard Travel Expense                        | ANCE AND TRAVEL   | EXPENSE COMPUTATI | ON - SERVI   | CES OUTSIDE PRO                             | VIDER SITE   | -              |
| 36.00          | Therapists (line 5 times column 2, line 11)   |                   |                   |              |   | 0  | 36.00          |
| 37.00          | Assistants (line 6 times column 3, line 11)   |                   |                   |              |   | 0  | 37.00          |
| 38.00          | Subtotal (sum of lines 36 and 37)   | n of Linco F - '  | 4)                |              |   | 0  | 38.00          |
| 39.00          | Standard travel expense (line 7 times the sur<br>Optional Travel Allowance and Optional Travel  |                   | 0)                |              |   | 0  | 39.00          |
| 40.00          | Therapists (sum of columns 1 and 2, line 12.0   |                   | 2, line 10)       |              |   | 0  | 40.00          |
| 41.00          | Assistants (column 3, line 12.01 times column   |                   | <i>,</i>          |              |   | 0  | 41.00          |
| 10 00          | Subtotal (sum of lines 40 and 41)   |                   |                   |              |   | 0  | •              |
| 42.00          | Optional travel expense (line 8 times the sur   |                   |                   | the foll     | wing three line                             | 0  | 43.00          |
| 42.00<br>43.00 |   |                   |                   |              | www.tht.tht.ee.line                         | 3 44 40  | 1              |
|                | Total Travel Allowance and Travel Expense - (   | orrsite services  | comprete one or   | the form     | swing three time                            |  |                |
|                |   | expense (sum o    | flines 38 and 39  | 9 - see ins  | structions)                                 | 0  | 44. 0<br>45. 0 |

| REASONABLE COST DETERMINATION FOR THERAPY SERVICES F<br>OUTSIDE SUPPLIERS |   | I ERS From       |               | Period:<br>From 01/01/2019 |                  | -3<br>pared: |                  |
|---|---|------------------|---------------|----------------------------|------------------|--------------|------------------|
|   |   |                  |               |                            | Speech Pathology | Cost         |                  |
|   |   |                  |               |                            |                  | 1.00         |                  |
| 46.00   | Optional travel allowance and optional travel   | expense (sum o   | flines 42 an  | d 43 - see i               | nstructions)     |              | 46.00            |
|   |   | Therapi sts      | Assi stants   | Ai des                     | Trai nees        | Total        |                  |
|   |   | 1.00             | 2.00          | 3.00                       | 4.00             | 5.00         |                  |
|   | PART V - OVERTIME COMPUTATION   | I                |               | 1                          | - 1              |              |                  |
| 47.00   | Overtime hours worked during reporting  | 0.00             | 0.00          | 0.                         | 00 0.00          | 0.00         | 47.00            |
|   | 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)  |                  |               |                            |                  |              |                  |
| 48.00   | Overtime rate (see instructions)  | 0.00             | 0.00          | 0.                         | 0.00             |              | 48.00            |
| 49.00   | Total overtime (including base and overtime   | 0. 00            | 0.00          | 0.                         | 00 0.00          |              | 49.00            |
|   | allowance) (multiply line 47 times line 48)   |                  |               |                            |                  |              |                  |
|   | CALCULATION OF LIMIT  |                  |               |                            |                  |              |                  |
| 50.00   | Percentage of overtime hours by category  | 0. 00            | 0.00          | 0.                         | 0.00             | 0.00         | 50.00            |
|   | (divide the hours in each column on line 47<br>by the total overtime worked - column 5,     |                  |               |                            |                  |              |                  |
|   | line 47)  |                  |               |                            |                  |              |                  |
| 51.00   | Allocation of provider's standard work year   | 0.00             | 0.00          | 0.                         | 0.00             | 0.00         | 51.00            |
|   | for one full-time employee times the  |                  |               |                            |                  |              |                  |
|   | percentages on line 50) (see instructions)  |                  |               |                            |                  |              |                  |
|   | DETERMINATION OF OVERTIME ALLOWANCE   |                  |               | -                          |                  |              |                  |
| 52.00   | Adjusted hourly salary equivalency amount   | 73.84            | 0.00          | 0.                         | 0.00             |              | 52.00            |
| 53.00   | (see instructions)<br>Overtime cost limitation (line 51 times line                          | 0                | 0             |                            | 0 0              |              | 53.0             |
| 53.00   | 52)   | 0                | 0             |                            | 0 0              |              | 55.00            |
| 54.00   | Maximum overtime cost (enter the lesser of  | o                | 0             |                            | 0 0              |              | 54.00            |
|   | line 49 or line 53)   | -                | -             |                            | -                |              |                  |
| 55.00   | Portion of overtime already included in   | 0                | 0             |                            | 0 0              |              | 55.00            |
|   | hourly computation at the AHSEA (multiply   |                  |               |                            |                  |              |                  |
|   | line 47 times line 52)<br>Overtime allowance (line 54 minus line 55                         |                  | 0             |                            | 0                | 0            |                  |
| 56.00   | Overtime allowance (line 54 minus line 55 -<br>if negative enter zero) (Enter in column 5   | 0                | 0             |                            | 0 0              | 0            | 56.00            |
|   | the sum of columns 1, 3, and 4 for  |                  |               |                            |                  |              |                  |
|   | respiratory therapy and columns 1 through 3   |                  |               |                            |                  |              |                  |
|   | for all others.)  |                  |               |                            |                  |              |                  |
|   |   |                  |               |                            |                  |              |                  |
|   |   |                  |               |                            |                  | 1.00         |                  |
|   | Part VI - COMPUTATION OF THERAPY LIMITATION A   | ND EXCESS COST A | ADJUSIMENI    |                            |                  | (7 54/       | <b>F7</b> 0      |
|   | Salary equivalency amount (from line 23)<br>Travel allowance and expense - provider site    | (from lines 22   | 24 or $25))$  |                            |                  | 67, 546<br>0 |                  |
|   | Travel allowance and expense - offsite service  |                  |               | )                          |                  | 0            |                  |
|   | Overtime allowance (from column 5, line 56)   |                  | 11, 10, 01 10 | /                          |                  | 0            |                  |
|   | Equipment cost (see instructions)   |                  |               |                            |                  | 0            |                  |
|   | Supplies (see instructions)   |                  |               |                            |                  | 0            | 62.0             |
| 3.00  | Total allowance (sum of lines 57-62)  |                  |               |                            |                  | 67, 546      | 63.0             |
|   | Total cost of outside supplier services (from   | ,                |               |                            |                  | 66, 133      |                  |
|   | Excess over limitation (line 64 minus line 63   | 3 - if negative, | enter zero)   |                            |                  | 0            | 65.0             |
|   | LINE 33 CALCULATION   | <u> </u>         | 1.05.0        |                            |                  |              | 100 0            |
|   | Line 26 = line 24 for respiratory therapy or  |                  |               |                            | athana           |              | 100.0            |
|   | Line 27 = line 7 times line 3 for respiratory<br>Line 33 = line 28 = sum of lines 26 and 27 | the apy of sum   | of times 3 a  |                            | others           |              | 100. 0<br>100. 0 |
|   | LINE 34 CALCULATION   |                  |               |                            |                  | 0            | 100. 02          |
|   | Line 27 = line 7 times line 3 for respiratory   | / therapy or sum | of lines 3 a  | nd 4 for all               | others           | 0            | 101.00           |
|   | Line 31 = line 29 for respiratory therapy or  |                  |               |                            |                  |              | 101.0            |
|   | Line 34 = sum of lines 27 and 31  |                  |               |                            |                  | 0            | 101.02           |
| l   | LINE 35 CALCULATION   |                  |               |                            |                  |              |                  |
|   | Line 31 = line 29 for respiratory therapy or  |                  |               |                            |                  |              | 102. 0           |
| 02.01   | Line 32 = line 8 times columns 1 and 2, line  | 13 for respirat  | ory therapy o | r sum of col               | umns 1-3, line   | 0            | 102. 0           |
|   | 13 for all others   |                  |               |                            |                  |              |                  |
| ~ ~   | Line 35 = sum of lines 31 and 32  |                  |               |                            | 1                | ^            | 102.0            |

| Health Fi        | inancial Systems   | DUKES MEMORIA   | AL HOSPITAL         |                   | In Lie                                      | u of Form CMS-  | 2552-10          |
|------------------|--|---|---------------------|-------------------|---|---|------------------|
| COST ALL         | OCATION - GENERAL SERVICE COSTS  |   | Provider CO         |                   | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet B<br>Part I<br>Date/Time Pre<br>8/28/2020 10: |                  |
|                  |  |   | CAPI TAL REL        | ATED COSTS        |   |   |                  |
|                  | Cost Center Description  | Net Expenses<br>for Cost<br>Allocation<br>(from Wkst A<br>col. 7) | BLDG & FIXT         | MVBLE EQUIP       | EMPLOYEE<br>BENEFI TS<br>DEPARTMENT         | ADMI TTI NG   |                  |
|                  |  | 0   | 1.00                | 2.00              | 4.00  | 5. 01   |                  |
|                  | ENERAL SERVICE COST CENTERS  | 2, 247, 809   | 2, 247, 809         | [                 |   |   | 1.00             |
|                  | D200 CAP REL COSTS-MVBLE EQUIP   | 2, 520, 073   | 2,217,007           | 2, 520, 07        | 73  |   | 2.00             |
|                  | 0400 EMPLOYEE BENEFITS DEPARTMENT                                      | 1, 530, 719   | 10, 254             | 11, 49            | 97 1, 552, 470                              |   | 4.00             |
|                  | 0570 ADMI TTI NG   | 1, 196, 948   | 16, 521             | 18, 52            |   | 1, 294, 925   |                  |
|                  | 0590 ADMINISTRATIVE AND GENERAL  | 6, 902, 374   | 138, 982            | 155, 81           |   | 0   | 1                |
|                  | D700 OPERATION OF PLANT<br>D800 LAUNDRY & LINEN SERVICE                | 2, 462, 805<br>73, 037  | 609, 408<br>26, 555 | 683, 22<br>29, 77 |   | 0   |                  |
|                  | D900 HOUSEKEEPING  | 484, 136  | 25, 636             | 28, 74            |   | 0   |                  |
|                  | 1000 DI ETARY  | 147, 205  | 32, 961             | 36, 95            |   | 0   |                  |
|                  | 1100 CAFETERI A  | 153, 736  | 29, 601             | 33, 18            |   | 0   |                  |
|                  | 1300 NURSING ADMINISTRATION  | 343, 701  | 8, 138              |                   |   | 0   |                  |
|                  | 1400 CENTRAL SERVICES & SUPPLY<br>1500 PHARMACY                        | 228, 704  | 41, 343             | 46, 35            |   | 0   |                  |
|                  | 1600 MEDICAL RECORDS & LIBRARY   | 497, 666<br>265, 017  | 23, 881<br>38, 646  | 26, 77<br>43, 32  |   | 0   |                  |
|                  | 1700 SOCIAL SERVICE  | 209, 429  | 10, 045             | 11, 26            |   | 0   |                  |
|                  | NPATIENT ROUTINE SERVICE COST CENTERS                                  |   |                     |                   |   |   |                  |
|                  | 3000 ADULTS & PEDIATRICS   | 2, 185, 457   | 318, 726            |                   |   |   |                  |
|                  | 3100 I NTENSI VE CARE UNI T  | 456, 670  | 40, 088             |                   |   |   |                  |
|                  | 4300 NURSERY<br>ICI LLARY SERVI CE COST CENTERS                        | 266, 614  | 8, 708              | 9, 76             | 27,832                                      | 2, 053  | 43.00            |
|                  | 5000 OPERATING ROOM  | 784, 976  | 150, 945            | 169, 22           | 28 55, 720                                  | 115, 412  | 50.00            |
|                  | 5100 RECOVERY ROOM   | 298, 129  | 11, 882             | 13, 32            |   | 22, 722   |                  |
|                  | 5200 DELIVERY ROOM & LABOR ROOM  | 0   | 0                   |                   | 0 0   | 0   |                  |
|                  | 5300 ANESTHESI OLOGY   | 0   | 0                   | 110 (1            | 0 0   | 0   |                  |
|                  | 5400 RADI OLOGY-DI AGNOSTI C<br>5401 ULTRASOUND                        | 1, 088, 139   | 127, 204            | 142, 61           | 12 99, 622<br>0 0                           | 310, 266<br>0   | 1                |
|                  | 5600 RADI OI SOTOPE  | 0   | 0                   |                   | 0 0   | 0   | 1                |
|                  | 5700 CT SCAN   | 0   | 0                   |                   | 0 0   | 0   |                  |
|                  | 5800 MRI   | 0   | 0                   |                   | 0 0   | 0   | 58.00            |
|                  | 5000 LABORATORY  | 1, 365, 933   | 35, 705             | 40, 02            |   | 175, 092  |                  |
|                  | 5200 WHOLE BLOOD & PACKED RED BLOOD CELLS<br>5500 RESPI RATORY THERAPY | 81, 584<br>560, 688   | 1, 372              | 1, 53             |   | 3, 690  |                  |
|                  | 6600 PHYSI CAL THERAPY   | 420, 361  | 36, 077<br>102, 940 | 40, 44<br>115, 40 |   | 31, 838<br>20, 154                                      |                  |
|                  | 5700 OCCUPATI ONAL THERAPY   | 166, 200  | 2, 802              | 3, 14             |   | 9, 058  |                  |
|                  | 5800 SPEECH PATHOLOGY  | 66, 133   | 0                   |                   | 0 0   | 1, 513  |                  |
|                  | 5900 ELECTROCARDI OLOGY  | 225, 339  | 47, 261             | 52, 98            |   | 49, 984   |                  |
|                  | 7100 MEDICAL SUPPLIES CHARGED TO PATIENT                               | 31, 660   | 0                   |                   | 0 0   | 32, 311   |                  |
|                  | 7200 IMPL. DEV. CHARGED TO PATIENTS<br>7300 DRUGS CHARGED TO PATIENTS  | 215, 218<br>889, 906  | 0                   |                   | 0 0   |   | 72.00            |
|                  | 3610 SLEEP LAB   | 007,700   | 0                   |                   | 0 0   | 0   |                  |
|                  | JTPATIENT SERVICE COST CENTERS   |   |                     |                   | -1  |   |                  |
|                  | 2000 CLINIC  | 126, 023  | 31, 600             |                   |   | 732   |                  |
|                  | P100 EMERGENCY   | 3, 855, 574   | 85, 675             | 96, 05            | 52 418, 445                                 | 176, 350  |                  |
|                  | 0200 OBSERVATION BEDS (NON-DISTINCT PART                               |   |                     |                   |   |   | 92.00            |
|                  | 2500 AMBULANCE SERVICES  | 446, 742  | 29, 729             | 33, 33            | 30 35, 559                                  | 59, 040   | 95.00            |
|                  | PECIAL PURPOSE COST CENTERS  | 440,742   | 27,127              |                   | 55, 55, 55,                                 | 37, 040   | /0.00            |
| 118.00<br>NC     | SUBTOTALS (SUM OF LINES 1 through 117)<br>DNREIMBURSABLE COST CENTERS  | 32, 794, 705  | 2, 042, 685         |                   |   |   |                  |
|                  | 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                               | 0   | 9, 138              |                   |   |   | 190.00           |
|                  | 9200 PHYSICIANS' PRIVATE OFFICES                                       | 15, 836   | 195, 986            | 219, 72           | 24 82                                       | 0   | 192.00           |
| 200.00<br>201.00 | Cross Foot Adjustments<br>Negative Cost Centers                        |   | 0                   |                   | 0 0   | 0   | 200.00<br>201.00 |
| 201.00           | TOTAL (sum lines 118 through 201)                                      | 32, 810, 541  |                     | 2, 520, 07        |   |   |                  |

| Health Financial Systems  | DUKES MEMORI         | AL HOSPITAL                             |                       | In Lie                         | u of Form CMS-2         | 2552-10        |
|---|----------------------|---|-----------------------|--------------------------------|-------------------------|----------------|
| COST ALLOCATION - GENERAL SERVICE COSTS   |                      | Provider C                              | CN: 15-1318 P         | eri od:                        | Worksheet B             |                |
|   |                      |   | F<br> T               | rom 01/01/2019<br>o 12/31/2019 | Part I<br>Date/Time Pre | pared:         |
|   |                      |   |                       |                                | 8/28/2020 10:           | 36 am          |
| Cost Center Description   | Subtotal             | ADMI NI STRATI VE<br>AND GENERAL        | OPERATION OF<br>PLANT | LAUNDRY &<br>LINEN SERVICE     | HOUSEKEEPI NG           |                |
|   | 5A. 01               | 5. 02                                   | 7.00                  | 8.00                           | 9.00                    |                |
| GENERAL SERVICE COST CENTERS  |                      |   |                       |                                |                         |                |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT  |                      |   |                       |                                |                         | 1.00           |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP  |                      |   |                       |                                |                         | 2.00           |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT<br>5. 01 00570 ADMITTING                             |                      |   |                       |                                |                         | 4.00<br>5.01   |
| 5. 02 00590 ADMINI STRATI VE AND GENERAL  | 7, 352, 232          | 7, 352, 232                             |                       |                                |                         | 5.01           |
| 7.00 00700 OPERATION OF PLANT   | 3, 789, 705          |   |                       |                                |                         | 7.00           |
| 8.00 00800 LAUNDRY & LINEN SERVICE  | 129, 363             |   |                       | 268, 313                       |                         | 8.00           |
| 9. 00 00900 HOUSEKEEPI NG   | 580, 623             | 167, 681                                | 98, 077               | 0                              | 846, 381                | 9.00           |
| 10. 00 01000 DI ETARY   | 227, 843             |   |                       | 0                              | 23, 350                 |                |
|   | 229, 307             |   |                       | 0                              | 20, 970                 |                |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON<br>14. 00 01400 CENTRAL SERVI CES & SUPPLY            | 399, 252<br>325, 997 |   | 31, 136<br>158, 169   | 0                              | 5, 765<br>29, 289       |                |
| 15. 00 01500 PHARMACY   | 588, 491             |   |                       | 0                              | 16, 918                 |                |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY  | 354, 435             |   |                       | 0                              | 27, 378                 |                |
| 17. 00 01700 SOCIAL SERVICE   | 253, 342             |   |                       | 0                              | 7, 116                  |                |
| INPATIENT ROUTINE SERVICE COST CENTERS  |                      |   |                       |                                |                         |                |
| 30. 00 03000 ADULTS & PEDI ATRI CS  | 3, 146, 608          |   |                       |                                | 225, 792                | 30.00          |
| 31. 00 03100 I NTENSI VE CARE UNI T   | 598, 317             |   | 153, 365              | 31, 662                        | 28, 399                 |                |
| 43.00 04300 NURSERY   | 314, 970             | 90, 962                                 | 33, 315               | 25, 906                        | 6, 169                  | 43.00          |
| ANCI LLARY SERVI CE COST CENTERS  | 1, 276, 281          | 368, 584                                | 577, 476              | 0                              | 106, 933                | 50.00          |
| 51. 00 05100 RECOVERY ROOM  | 377, 473             |   | 45, 458               | 0                              | 8, 418                  |                |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM  | 0                    | 0                                       |                       | 0                              | 0, 110                  | 52.00          |
| 53. 00 05300 ANESTHESI OLOGY  | 0                    | 0                                       | 0                     | 0                              | 0                       | 53.00          |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C   | 1, 767, 843          | 510, 544                                | 486, 649              | 0                              | 90, 114                 | 54.00          |
| 54. 01 05401 ULTRASOUND   | 0                    | 0                                       | 0                     | 0                              | 0                       | 54.01          |
| 56. 00 05600 RADI OI SOTOPE   | 0                    | 0                                       | 0                     | 0                              | 0                       | 56.00          |
| 57. 00 05700 CT SCAN<br>58. 00 05800 MRI  |                      | 0                                       |                       | 0                              | 0                       | 57.00<br>58.00 |
| 60. 00 06000 LABORATORY   | 1, 707, 039          | 492, 984                                | 136, 596              | 0                              | 25, 294                 | 60.00          |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 88, 184              |   | 5, 249                | 0                              | 972                     | 62.00          |
| 65.00 06500 RESPI RATORY THERAPY  | 725, 967             |   |                       | 0                              | 25, 558                 |                |
| 66. 00 06600 PHYSI CAL THERAPY  | 658, 921             | 190, 293                                | 393, 821              | 0                              | 72, 925                 | 66.00          |
| 67.00 06700 OCCUPATI ONAL THERAPY   | 181, 201             |   |                       | 0                              | 1, 985                  |                |
| 68.00 06800 SPEECH PATHOLOGY  | 67, 646              |   |                       | 0                              | 0                       | 68.00          |
| 69. 00 06900 ELECTROCARDI OLOGY   | 398, 386             |   | 180, 809              | 0                              | 33, 481                 | 69.00          |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT<br>72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 63, 971<br>228, 209  |   |                       | 0                              | 0                       | 71.00<br>72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  | 1, 084, 474          |   |                       | 0                              | 0                       | 73.00          |
| 76. 00 03610 SLEEP LAB  | 0                    |   | 0                     | 0                              | 0                       | 76.00          |
| OUTPATIENT SERVICE COST CENTERS   |                      |   |                       | · · · · ·                      | -                       |                |
| 90. 00 09000 CLI NI C   | 206, 954             |   |                       | 0                              | 22, 387                 | 90.00          |
| 91. 00 09100 EMERGENCY  | 4, 632, 096          | 1, 337, 724                             | 327, 769              | 0                              | 60, 694                 |                |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART   | 0                    |   |                       |                                |                         | 92.00          |
|   | (04.400              | 174 540                                 | 110 704               |                                | 0                       |                |
| 95. 00 09500 AMBULANCE SERVICES<br>SPECIAL PURPOSE COST CENTERS                               | 604, 400             | 174, 548                                | 113, 734              | 0                              | 0                       | 95.00          |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 32, 359, 530         | 7, 221, 982                             | 4, 849, 192           | 268, 313                       | 839, 907                | 118 00         |
| NONREI MBURSABLE COST CENTERS   | 02,007,000           | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 1,017,172             | 200,010                        | 0077707                 |                |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 19, 383              | 5, 598                                  | 34, 961               | 0                              | 6, 474                  | 190. 00        |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES   | 431, 628             | 124, 652                                | 0                     | 0                              |                         | 192.00         |
| 200.00 Cross Foot Adjustments   | 0                    |   |                       |                                |                         | 200.00         |
| 201.00 Negative Cost Centers  |                      |   | 0                     | 0                              | 0<br>846, 381           | 201.00         |
| 202.00   TOTAL (sum lines 118 through 201)  | 32, 810, 541         | 7, 352, 232                             | 4, 884, 153           | 268, 313                       | 840, 381                | 202.00         |

| Heal th        | Financial Systems   | DUKES MEMORIA | L HOSPI TAL      |                              | In Lie                     | u of Form CMS-                 | 2552-10 |
|----------------|---|---------------|------------------|------------------------------|----------------------------|--------------------------------|---------|
| COST A         | LLOCATION - GENERAL SERVICE COSTS                           |               | Provi der C      | CN: 15-1318                  | Period:<br>From 01/01/2019 | Worksheet B<br>Part I          |         |
|                |   |               |                  |                              | To 12/31/2019              | Date/Time Pre<br>8/28/2020 10: |         |
|                | Cost Center Description                                     | DI ETARY      | CAFETERI A       | NURSI NG<br>ADMI NI STRATI ( |                            | PHARMACY                       |         |
|                |   | 10.00         | 11.00            | 13.00                        | SUPPLY<br>14.00            | 15.00                          |         |
|                | GENERAL SERVICE COST CENTERS                                | 10.00         | 11.00            | 10.00                        | 14.00                      | 13.00                          |         |
| 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                          |               |                  |                              |                            |                                | 4.00    |
| 5.01           | 00570 ADMI TTI NG   |               |                  |                              |                            |                                | 5.01    |
| 5.02           | 00590 ADMINISTRATIVE AND GENERAL                            |               |                  |                              |                            |                                | 5. 02   |
| 7.00           | 00700 OPERATION OF PLANT                                    |               |                  |                              |                            |                                | 7.00    |
| 8.00           | 00800 LAUNDRY & LINEN SERVICE                               |               |                  |                              |                            |                                | 8.00    |
| 9.00           | 00900 HOUSEKEEPI NG   |               |                  |                              |                            |                                | 9.00    |
| 10.00          | 01000 DI ETARY  | 443, 092      |                  |                              |                            |                                | 10.00   |
| 11.00          |   | 0             | 429, 745         |                              | -                          |                                | 11.00   |
| 13.00          | 01300 NURSING ADMINISTRATION                                | 0             | 9, 292           |                              |                            |                                | 13.00   |
| 14.00          | 01400 CENTRAL SERVICES & SUPPLY<br>01500 PHARMACY           | 0             | 7, 238           |                              | 0 614, 839                 | 00/ 101                        | 14.00   |
| 15.00          |   | 0             | 13, 527          |                              | 0 15, 881                  | 896, 131                       | 15.00   |
| 16.00<br>17.00 | 01600 MEDI CAL RECORDS & LI BRARY<br>01700 SOCI AL SERVI CE | 0             | 6, 448<br>7, 396 |                              | 0 296<br>38 0              | 0                              | 1       |
| 17.00          | INPATIENT ROUTINE SERVICE COST CENTERS                      | 0             | 7, 390           | אן דו, זכ                    |                            | 0                              | 17.00   |
| 30.00          | 03000 ADULTS & PEDIATRICS                                   | 390, 500      | 88, 781          | 279, 67                      | 75 33,077                  | 0                              | 30.00   |
| 31.00          | 03100 I NTENSI VE CARE UNI T                                | 52, 592       | 14, 760          |                              |                            | 0                              |         |
| 43.00          | 04300 NURSERY   | 0             | 9, 071           |                              | 0 0                        | 0                              | 1       |
| 45.00          | ANCI LLARY SERVI CE COST CENTERS                            | 0             | 7,071            | 1                            | <u> </u>                   | 0                              | +5.00   |
| 50.00          | 05000 OPERATING ROOM  | 0             | 21, 176          | 25, 98                       | 84, 441                    | 0                              | 50.00   |
| 51.00          | 05100 RECOVERY ROOM   | 0             | 9, 987           |                              |                            | 0                              |         |
| 52.00          | 05200 DELIVERY ROOM & LABOR ROOM                            | 0             | C                |                              | 0 0                        | 0                              | 1       |
| 53.00          | 05300 ANESTHESI OLOGY                                       | 0             | C                | þ                            | 0 0                        | 0                              | 53.00   |
| 54.00          | 05400 RADI OLOGY-DI AGNOSTI C                               | 0             | 44, 375          | 5                            | 0 44, 759                  | 0                              | 54.00   |
| 54.01          | 05401 ULTRASOUND  | 0             | C                |                              | 0 0                        | 0                              | 54.01   |
| 56.00          | 05600 RADI OI SOTOPE  | 0             | C                |                              | 0 0                        | 0                              | 56.00   |
| 57.00          | 05700 CT SCAN   | 0             | C                | )                            | 0 0                        | 0                              | 57.00   |
| 58.00          | 05800 MRI   | 0             | C                |                              | 0 0                        | 0                              | 58.00   |
| 60.00          | 06000 LABORATORY  | 0             | 51, 612          | 2                            | 0 990                      | 0                              | 60.00   |
| 62.00          | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                  | 0             | C                |                              | 0 24, 581                  | 0                              | 62.00   |
| 65.00          | 06500 RESPI RATORY THERAPY                                  | 0             | 21, 397          | 1                            | 0 13, 417                  | 0                              | 65.00   |
| 66.00          | 06600 PHYSI CAL THERAPY                                     | 0             | 32               | 1                            | 0 1, 683                   | 0                              | 66.00   |
| 67.00          | 06700 OCCUPATIONAL THERAPY                                  | 0             | C                |                              | 0 0                        | 0                              |         |
| 68.00          | 06800 SPEECH PATHOLOGY                                      | 0             | C                |                              | 0 0                        | 0                              | 68.00   |
| 69.00          | 06900 ELECTROCARDI OLOGY                                    | 0             | 8, 692           | 2                            | 0 1, 302                   | 0                              | 69.00   |
| 71.00          | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT                | 0             | C                |                              | 0 9, 187                   | 0                              | 71.00   |
| 72.00          | 07200 I MPL. DEV. CHARGED TO PATIENTS                       | 0             | C                |                              | 0 65, 197                  | 0                              |         |
| 73.00<br>76.00 | 07300 DRUGS CHARGED TO PATIENTS<br>03610 SLEEP LAB          | 0             | C C              |                              | 0 268, 131<br>0 0          | 896, 131                       | 1       |
| 76.00          | OUTPATIENT SERVICE COST CENTERS                             | 0             | Ĺ                | /                            | 0 0                        | 0                              | 76.00   |
| 00 00          | 09000 CLINIC  | 0             | 5, 626           | 12, 16                       | 2, 033                     | 0                              | 90.00   |
|                | 09100 EMERGENCY   | 0             | 92, 541          |                              |                            |                                | 91.00   |
| 91.00          | 09200 OBSERVATION BEDS (NON-DISTINCT PART                   | 0             | 72, 341          | 137,71                       | 21,204                     | 0                              | 92.00   |
| 92.00          | OTHER REIMBURSABLE COST CENTERS                             | <u> </u>      |                  | 1                            |                            |                                | 92.00   |
| 95 00          | 09500 AMBULANCE SERVICES                                    | 0             | 17, 762          |                              | 0 21, 594                  | 0                              | 95.00   |
| 75.00          | SPECIAL PURPOSE COST CENTERS                                | 9             | 17,702           | -                            | 21, 374                    | 0                              | 75.00   |
| 118.00         |   | 443, 092      | 429, 713         | 560, 74                      | 614, 839                   | 896, 131                       | 1118 00 |
| 110.00         | NONREI MBURSABLE COST CENTERS                               | 443, 072      | 427,710          | J <u> </u>                   | 014,007                    | 070, 131                       | 110.00  |
| 190.00         | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                   | 0             | C                |                              | 0 0                        | 0                              | 190.00  |
|                | 19200 PHYSI CLANS' PRI VATE OFFICES                         | o             | 32               |                              | 0 0                        |                                | 192.00  |
| 200.00         |   |               | 02               | 1                            |                            | 0                              | 200.00  |
| 201.00         | 5   | 0             | C                | þ                            | 0 0                        | 0                              | 201.00  |
| 202.00         |   | 443, 092      | 429, 745         | 5 560, 74                    | 614, 839                   | 896, 131                       |         |
|                |   |               |                  |                              |                            |                                |         |

| Health Financial Systems  | DUKES MEMORI          | AL HOSPI TAL     |                   | In Lie                     | u of Form CMS-                 | 2552-10          |
|---|-----------------------|------------------|-------------------|----------------------------|--------------------------------|------------------|
| COST ALLOCATION - GENERAL SERVICE COSTS   |                       | Provider CCN     | l: 15-1318        | Period:<br>From 01/01/2019 | Worksheet B<br>Part I          |                  |
|   |                       |                  |                   | To 12/31/2019              | Date/Time Pre<br>8/28/2020 10: | pared:<br>36 am  |
| Cost Center Description   | MEDI CAL<br>RECORDS & | SOCI AL SERVI CE | Subtotal          | Intern &<br>Residents Cost | Total                          |                  |
|   | LIBRARY               |                  |                   | & Post                     |                                |                  |
|   |                       |                  |                   | Stepdown                   |                                |                  |
|   | 16.00                 | 17.00            | 24.00             | Adjustments<br>25.00       | 26.00                          |                  |
| GENERAL SERVICE COST CENTERS  | 10.00                 | 17.00            | 24.00             | 23.00                      | 20.00                          |                  |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT  |                       |                  |                   |                            |                                | 1.00             |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP<br>4.00 00400 EMPLOYEE BENEFITS DEPARTMENT                     |                       |                  |                   |                            |                                | 2.00             |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT<br>5. 01 00570 ADMITTING                                   |                       |                  |                   |                            |                                | 4.00<br>5.01     |
| 5. 02 00590 ADMINISTRATIVE AND GENERAL  |                       |                  |                   |                            |                                | 5. 02            |
| 7.00 00700 OPERATION OF PLANT   |                       |                  |                   |                            |                                | 7.00             |
| 8.00 00800 LAUNDRY & LINEN SERVICE  |                       |                  |                   |                            |                                | 8.00             |
| 9. 00 00900 HOUSEKEEPI NG<br>10. 00 01000 DI ETARY  |                       |                  |                   |                            |                                | 9.00<br>10.00    |
| 11. 00 01100 CAFETERIA  |                       |                  |                   |                            |                                | 11.00            |
| 13.00 01300 NURSING ADMINISTRATION  |                       |                  |                   |                            |                                | 13.00            |
| 14.00 01400 CENTRAL SERVICES & SUPPLY   |                       |                  |                   |                            |                                | 14.00            |
| 15. 00 01500 PHARMACY<br>16. 00 01600 MEDI CAL RECORDS & LI BRARY                                   | 420 744               |                  |                   |                            |                                | 15.00<br>16.00   |
| 17. 00 01700 SOCIAL SERVICE   | 638, 766<br>0         |                  |                   |                            |                                | 17.00            |
| INPATIENT ROUTINE SERVICE COST CENTERS  |                       | 571,230          |                   |                            |                                | 17.00            |
| 30. 00 03000 ADULTS & PEDI ATRI CS  | 203, 114              | 307, 294         | 7, 013, 66        |                            | 7, 013, 669                    | 30.00            |
| 31. 00 03100 INTENSIVE CARE UNIT  | 113                   |                  | 1, 156, 50        |                            | 1, 156, 507                    |                  |
| 43. 00 04300 NURSERY<br>ANCI LLARY SERVI CE COST CENTERS  | 7, 092                | 37, 774          | 525, 25           | 59 0                       | 525, 259                       | 43.00            |
| 50. 00 05000 OPERATING ROOM   | 147,032               | 0                | 2, 607, 90        | 04 0                       | 2, 607, 904                    | 50.00            |
| 51.00 05100 RECOVERY ROOM   | 113                   | 0                | 592, 55           |                            | 592, 557                       |                  |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM   | 0                     |                  |                   | 0 0                        | 0                              |                  |
| 53. 00 05300 ANESTHESI OLOGY<br>54. 00 05400 RADI OLOGY-DI AGNOSTI C                                | 0<br>76, 813          |                  | 3, 021, 09        | 0 0<br>97 0                | 0<br>3, 021, 097               |                  |
| 54. 01 05401 ULTRASOUND   | 70,013                | 1                | 5, 021, 05        | 0 0                        | 3, 021, 097                    | 1                |
| 56. 00 05600 RADI 0I SOTOPE   | 0                     | 0                |                   | 0 0                        | 0                              | 56.00            |
| 57. 00 05700 CT SCAN  | 0                     | -                |                   | 0 0                        | 0                              |                  |
| 58. 00 05800 MRI<br>60. 00 06000 LABORATORY   | 0<br>3, 402           | -                | 2, 417, 91        | 0 0<br>17 0                | 0<br>2, 417, 917               |                  |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 3, 402                | -                | 2, 417, 91        |                            | 2, 417, 917<br>144, 525        |                  |
| 65. 00 06500 RESPI RATORY THERAPY   | 113                   |                  | 1, 134, 12        |                            | 1, 134, 128                    |                  |
| 66. 00 06600 PHYSI CAL THERAPY  | 78, 306               | 1                | 1, 395, 98        |                            | 1, 395, 981                    |                  |
| 67. 00 06700 OCCUPATI ONAL THERAPY<br>68. 00 06800 SPEECH PATHOLOGY                                 | 113                   |                  | 246, 34           |                            | 246, 349                       |                  |
| 68. 00 06800 SPEECH PATHOLOGY<br>69. 00 06900 ELECTROCARDI OLOGY                                    | 113<br>1, 000         |                  | 87, 29<br>738, 72 |                            | 87, 295<br>738, 722            |                  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT   | 0                     | 1                | 91, 63            |                            | 91, 633                        |                  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS  | 0                     |                  | 359, 31           |                            | 359, 312                       |                  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | 0                     | -                | 2, 561, 92        |                            | 2, 561, 927                    |                  |
| 76. 00 03610 SLEEP LAB<br>OUTPATI ENT SERVICE COST CENTERS  | 0                     | 0                |                   | 0 0                        | 0                              | 76.00            |
| 90. 00 09000 CLINIC   | 2, 518                | 0                | 432, 34           | 13 0                       | 432, 343                       | 90.00            |
| 91. 00 09100 EMERGENCY  | 98, 689               | 1 1              | 6, 708, 48        | 37 0                       | 6, 708, 487                    |                  |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART  |                       |                  |                   | 0                          |                                | 92.00            |
| 0THER REI MBURSABLE COST CENTERS<br>95. 00 09500 AMBULANCE SERVI CES                                | 20, 163               | 0                | 952, 20           | 01 0                       | 952, 201                       | 05 00            |
| SPECIAL PURPOSE COST CENTERS  | 20, 103               |                  | 932, 20           |                            | 932, 201                       | 95.00            |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 638, 766              | 391, 236         | 32, 187, 81       | 13 0                       | 32, 187, 813                   | 118.00           |
| NONREI MBURSABLE COST CENTERS   | 0                     |                  |                   |                            | // 41/                         | 100.00           |
| 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN<br>192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES | 0                     | 1 1              | 66, 41<br>556, 31 |                            | 66, 416<br>556, 312            | 190.00<br>192.00 |
| 200.00 Cross Foot Adjustments   |                       |                  | 000, 0            | 0 0                        |                                | 200.00           |
| 201.00 Negative Cost Centers  | 0                     | 0                |                   | 0 0                        | 0                              | 201.00           |
| 202.00  TOTAL (sum lines 118 through 201)   | 638, 766              | 391, 236         | 32, 810, 54       | 41 0                       | 32, 810, 541                   | 202. 00          |
|   |                       |                  |                   |                            |                                |                  |

| Heal th          | Financial Systems  | DUKES MEMORIA            | AL HOSPI TAL       |   | In Lie                     | u of Form CMS-2        | 2552-10            |
|------------------|--|--------------------------|--------------------|---|----------------------------|------------------------|--------------------|
|                  | TION OF CAPITAL RELATED COSTS  |                          | Provider CO        | CN: 15-1318                             | Period:<br>From 01/01/2019 | Worksheet B<br>Part II |                    |
|                  |  |                          |                    |   | To 12/31/2019              | Date/Time Pre          | pared:             |
|                  |  |                          | CAPI TAL REL       | ATED COSTS                              |                            | 8/28/2020 10:          | <u>36 am</u>       |
|                  |  |                          |                    |   |                            |                        |                    |
|                  | Cost Center Description  | Directly<br>Assigned New | BLDG & FIXT        | MVBLE EQUIP                             | Subtotal                   | EMPLOYEE<br>BENEFI TS  |                    |
|                  |  | Capi tal                 |                    |   |                            | DEPARTMENT             |                    |
|                  |  | Related Costs            |                    |   |                            |                        |                    |
|                  | GENERAL SERVICE COST CENTERS   | 0                        | 1.00               | 2.00                                    | 2A                         | 4.00                   |                    |
| 1.00             | 00100 CAP REL COSTS-BLDG & FIXT  |                          |                    |   |                            |                        | 1.00               |
| 2.00             | 00200 CAP REL COSTS-MVBLE EQUIP  |                          | 40.054             |   |                            |                        | 2.00               |
| 4.00<br>5.01     | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00570 ADMITTING                    | 0                        | 10, 254<br>16, 521 | 11, 49<br>18, 52                        |                            | 21, 751<br>882         | 4.00<br>5.01       |
| 5.02             | 00590 ADMINISTRATIVE AND GENERAL   | 0                        | 138, 982           | 155, 81                                 |                            | 2, 173                 | 1                  |
| 7.00             | 00700 OPERATION OF PLANT   | 0                        | 609, 408           | 683, 22                                 | 1, 292, 633                | 480                    |                    |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE  | 0                        | 26, 555            | 29, 77                                  |                            | 0                      |                    |
| 9. 00<br>10. 00  | 00900 HOUSEKEEPI NG<br>01000 DI ETARY                                    | 0                        | 25, 636<br>32, 961 | 28, 74<br>36, 95                        |                            | 590<br>150             |                    |
| 11.00            | 01100 CAFETERI A   | 0                        | 29, 601            | 33, 18                                  |                            | 179                    |                    |
| 13.00            | 01300 NURSI NG ADMI NI STRATI ON   | 0                        | 8, 138             | 9, 12                                   |                            | 537                    |                    |
| 14.00            | 01400 CENTRAL SERVICES & SUPPLY  | 0                        | 41, 343            |   |                            | 135                    |                    |
| 15.00            |  | 0                        | 23, 881            | 26, 77                                  |                            | 563                    |                    |
| 16. 00<br>17. 00 | 01600 MEDICAL RECORDS & LIBRARY<br>01700 SOCIAL SERVICE                  | 0                        | 38, 646<br>10, 045 | 43, 32<br>11, 26                        |                            | 104<br>317             |                    |
| 17.00            | INPATIENT ROUTINE SERVICE COST CENTERS                                   | 0                        | 10, 045            | 11, 20                                  | 21, 307                    | 517                    | 17.00              |
| 30.00            | 03000 ADULTS & PEDIATRICS  | 0                        | 318, 726           | 357, 33                                 | 676, 057                   | 3, 039                 | 30.00              |
| 31.00            | 03100 I NTENSI VE CARE UNI T   | 0                        | 40, 088            | 44, 94                                  |                            | 668                    |                    |
| 43.00            | 04300 NURSERY<br>ANCI LLARY SERVI CE COST CENTERS                        | 0                        | 8, 708             | 9, 76                                   | 18, 471                    | 390                    | 43.00              |
| 50.00            | 05000 OPERATING ROOM   | 0                        | 150, 945           | 169, 22                                 | 28 320, 173                | 781                    | 50.00              |
| 51.00            | 05100 RECOVERY ROOM  | 0                        | 11, 882            | 13, 32                                  |                            | 440                    |                    |
| 52.00            | 05200 DELIVERY ROOM & LABOR ROOM   | 0                        | 0                  |   | 0 0                        | 0                      | 52.00              |
| 53.00            | 05300 ANESTHESI OLOGY  | 0                        | 0                  | 110 (1                                  | 0 0                        | 0                      |                    |
| 54.00<br>54.01   | 05400 RADI OLOGY-DI AGNOSTI C<br>05401 ULTRASOUND                        | 0                        | 127, 204           | 142, 61                                 | 2 269, 816<br>0 0          | 1, 396<br>0            |                    |
| 56.00            | 05600 RADI OI SOTOPE   | 0                        | 0                  |   | 0 0                        | 0                      |                    |
| 57.00            | 05700 CT SCAN  | 0                        | 0                  |   | 0 0                        | 0                      | 57.00              |
| 58.00            | 05800 MRI  | 0                        | 0                  |   | 0 0                        | 0                      |                    |
| 60.00<br>62.00   | 06000 LABORATORY<br>06200 WHOLE BLOOD & PACKED RED BLOOD CELLS           | 0                        | 35, 705            |   |                            | 1, 265                 |                    |
| 65.00            | 06500 RESPIRATORY THERAPY  | 0                        | 1, 372<br>36, 077  | 1, 53<br>40, 44                         |                            | 0<br>798               |                    |
| 66.00            | 06600 PHYSI CAL THERAPY  | 0                        | 102, 940           | 115, 40                                 |                            | 1                      | 66.00              |
| 67.00            | 06700 OCCUPATI ONAL THERAPY  | 0                        | 2, 802             | 3, 14                                   | 1 5, 943                   | 0                      | 67.00              |
| 68.00            | 06800 SPEECH PATHOLOGY   | 0                        | 0                  | 50.00                                   | 0 0                        | 0                      |                    |
| 69.00<br>71.00   | 06900 ELECTROCARDI OLOGY<br>07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT | 0                        | 47, 261<br>0       | 52, 98                                  | 36 100, 247<br>0 0         | 320<br>0               |                    |
|                  | 07200 I MPL. DEV. CHARGED TO PATIENTS                                    | 0                        | 0                  |   | 0 0                        | 0                      |                    |
| 73.00            | 07300 DRUGS CHARGED TO PATIENTS  | 0                        | 0                  |   | 0 0                        | 0                      |                    |
|                  | 03610 SLEEP LAB  | 0                        | 0                  |   | 0 0                        | 0                      | 76.00              |
| 90, 00           | OUTPATIENT SERVICE COST CENTERS  |                          | 21 400             | 35, 42                                  | 67 020                     | 185                    | 90.00              |
| 90.00<br>91.00   | 09100 EMERGENCY  | 0                        | 31, 600<br>85, 675 |   |                            |                        | 90.00              |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                |                          | 00,070             | , | 0                          | 0,00,                  | 92.00              |
|                  | OTHER REIMBURSABLE COST CENTERS  |                          |                    |   |                            |                        |                    |
| 95.00            | 09500 AMBULANCE SERVICES   | 0                        | 29, 729            | 33, 33                                  | 63, 059                    | 498                    | 95.00              |
| 118.00           | SPECIAL PURPOSE COST CENTERS<br>SUBTOTALS (SUM OF LINES 1 through 117)   | 0                        | 2, 042, 685        | 2, 290, 10                              | 4, 332, 789                | 21, 750                | 118 00             |
| 110.00           | NONREI MBURSABLE COST CENTERS  | 0                        | 2,042,003          | 2,270,10                                | 4, 332, 767                | 21,750                 | 110.00             |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                | 0                        | 9, 138             |   |                            |                        | 190. 00            |
|                  | 19200 PHYSI CI ANS' PRI VATE OFFI CES                                    | 0                        | 195, 986           | 219, 72                                 |                            | 1                      | 192.00             |
| 200.00<br>201.00 |  |                          | 0                  |   | 0 0                        | 0                      | 200. 00<br>201. 00 |
| 201.00           |  | 0                        | 2, 247, 809        | 2, 520, 07                              | -                          | 21, 751                |                    |
| 50               |  | · · · ·                  | , , 507            | ,, .,                                   | , , 502                    | ,.01                   |                    |

| Health Financial Systems  | DUKES MEMORI  | AL HOSPI TAL      |            | In Lie                     | eu of Form CMS-2               | 2552-10        |
|---|---------------|-------------------|------------|----------------------------|--------------------------------|----------------|
| ALLOCATION OF CAPITAL RELATED COSTS   |               | Provider C        |            | Period:<br>From 01/01/2019 | Worksheet B                    |                |
|   |               |                   |            | To 12/31/2019              | Date/Time Pre                  |                |
| Cost Contor Description   | ADMI TTI NG   | ADMI NI STRATI VE |            | LAUNDRY &                  | 8/28/2020 10:<br>HOUSEKEEPI NG | 36 am          |
| Cost Center Description   | ADMITTING     | AND GENERAL       | PLANT      | LINEN SERVICE              | HOUSEKEEPING                   |                |
|   | 5.01          | 5.02              | 7.00       | 8.00                       | 9.00                           |                |
| GENERAL SERVICE COST CENTERS  | 1             | 1                 | 1          |                            |                                |                |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT  |               |                   |            |                            |                                | 1.00           |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP<br>4.00 00400 EMPLOYEE BENEFITS DEPARTMENT                         |               |                   |            |                            |                                | 2.00<br>4.00   |
| 5. 01 00570 ADMITTING   | 35, 925       |                   |            |                            |                                | 5.01           |
| 5. 02 00590 ADMINI STRATI VE AND GENERAL  | 33, 723       |                   |            |                            |                                | 5.02           |
| 7.00 00700 OPERATION OF PLANT   | 0             |                   |            | 0                          |                                | 7.00           |
| 8.00 00800 LAUNDRY & LINEN SERVICE  | 0             |                   |            |                            |                                | 8.00           |
| 9.00 00900 HOUSEKEEPI NG  | 0             |                   |            |                            | 88, 594                        | 9.00           |
| 10. 00 01000 DI ETARY   | 0             | 2, 658            | 34, 52     | 7 0                        | 2, 444                         | 10.00          |
| 11. 00 01100 CAFETERI A   | 0             | 2, 675            | 31, 00     | 7 0                        | 2, 195                         | 11.00          |
| 13.00 01300 NURSING ADMINISTRATION  | 0             | 4, 657            |            | 5 0                        | 603                            | 13.00          |
| 14.00 01400 CENTRAL SERVICES & SUPPLY   | 0             | 3, 803            |            |                            | 3, 066                         |                |
| 15.00 01500 PHARMACY  | 0             | -,                |            |                            | 1, 771                         | 15.00          |
| 16.00 01600 MEDICAL RECORDS & LIBRARY   | 0             |                   |            |                            | 2,866                          |                |
| 17.00 01700 SOCIAL SERVICE  | 0             | 2,955             | 10, 52     | 3 0                        | 745                            | 17.00          |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         O3000         ADULTS & PEDI ATRI CS | 1, 897        | 36, 705           | 333, 87    | 0 67, 274                  | 23, 633                        | 30.00          |
| 31. 00 03100 I NTENSI VE CARE UNI T   | 248           |                   |            |                            | 23, 033                        | 31.00          |
| 43. 00  04300  NURSERY  | 57            |                   |            |                            | 646                            |                |
| ANCI LLARY SERVICE COST CENTERS   | 57            | 5,074             | 7,12       | 2 0,270                    | 040                            | 45.00          |
| 50. 00 05000 OPERATING ROOM   | 3, 208        | 14, 888           | 158, 11    | 8 0                        | 11, 193                        | 50.00          |
| 51.00 05100 RECOVERY ROOM   | 632           |                   |            |                            | 881                            | 51.00          |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM  | 0             | 0 0               |            | 0 0                        | 0                              | 52.00          |
| 53. 00 05300 ANESTHESI OLOGY  | 0             | 0                 |            | 0 0                        | 0                              | 53.00          |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C   | 8, 555        | 20, 622           | 133, 24    | 9 0                        | 9, 433                         |                |
| 54.01 05401 ULTRASOUND  | 0             | -                 |            | 0 0                        | 0                              | 54.01          |
| 56. 00 05600 RADI OI SOTOPE   | 0             | -                 |            | 0 0                        | 0                              | 56.00          |
| 57. 00 05700 CT SCAN  | 0             | -                 |            | 0 0                        | 0                              | 57.00          |
| 58. 00 05800 MRI  | 0             | -                 |            | 0 0<br>1 0                 | 0                              | 58.00          |
| 60.00 06000 LABORATORY<br>62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                              | 4, 867<br>103 |                   |            |                            | 2,648                          | 60.00<br>62.00 |
| 65. 00 06500 RESPI RATORY THERAPY   | 885           |                   |            | -                          | 2, 675                         |                |
| 66. 00 06600 PHYSI CAL THERAPY  | 560           |                   |            |                            | 7,633                          |                |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 252           |                   |            |                            | 208                            | 67.00          |
| 68.00 06800 SPEECH PATHOLOGY  | 42            |                   |            | 0 0                        | 0                              | 68.00          |
| 69.00 06900 ELECTROCARDI OLOGY  | 1, 389        |                   |            | 7 0                        | 3, 505                         | 69.00          |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT   | 898           | 746               |            | 0 0                        | 0                              | 71.00          |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS  | 361           | 2, 662            |            | 0 0                        | 0                              | 72.00          |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | 5, 408        |                   |            | 0 0                        | 0                              | 73.00          |
| 76.00 03610 SLEEP LAB   | 0             | 0 0               |            | 0 0                        | 0                              | 76.00          |
| OUTPATIENT SERVICE COST CENTERS   |               |                   |            |                            |                                |                |
| 90. 00 09000 CLINIC   | 20            |                   |            |                            |                                |                |
| 91.00 09100 EMERGENCY   | 4, 902        | 2 54, 035         | 89, 74     | 6 0                        | 6, 353                         | 91.00          |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART  |               |                   |            |                            |                                | 92.00          |
| OTHER REIMBURSABLE COST CENTERS<br>95. 00 09500 AMBULANCE SERVICES                                      | 1, 641        | 7, 050            | 31, 14     | 1 0                        | 0                              | 95.00          |
| SPECIAL PURPOSE COST CENTERS  | 1, 041        | 7,030             | 51, 14     | 1 0                        | 0                              | 95.00          |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 35, 925       | 291, 710          | 1, 327, 74 | 7 85, 651                  | 87 916                         | 118.00         |
| NONREI MBURSABLE COST CENTERS   | 00,720        | 2,1,,10           | 1,027,71   | , 00,001                   | 07,710                         | 110.00         |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 0             | 226               | 9, 57      | 3 0                        | 678                            | 190.00         |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES   | 0             |                   |            | 0 0                        |                                | 192.00         |
| 200.00 Cross Foot Adjustments   |               |                   |            |                            |                                | 200.00         |
| 201.00 Negative Cost Centers  | 0             | 0                 |            | 0 0                        |                                | 201.00         |
| 202.00 TOTAL (sum lines 118 through 201)  | 35, 925       | 296, 971          | 1, 337, 32 | 0 85, 651                  | 88, 594                        | 202.00         |
|   |               |                   |            |                            |                                |                |

| Cost Center Description         DIETARY         CAFETERIA<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATURE<br>AMMINISTRATU |        | Financial Systems<br>TION OF CAPITAL RELATED COSTS | DUKES MEMORIAL |            | CN: 15-1318 | Period:          | u of Form CMS-:<br>Worksheet B | 2002-10  |
|---|--------|--|----------------|------------|-------------|------------------|--------------------------------|----------|
| Display         Display         CAFETERIA<br>ADMIN STRATIO<br>200100         AURESING<br>SUPPLY         CENTERL<br>SUPPLY         PHARMACY           1:00         00100         CAP REL COSTS-BLIDG & FIXT<br>200         10:00         11:00         13:00         14:00         10:00           1:00         00100         CAP REL COSTS-BLIDG & FIXT<br>200         200         200         CAP REL COSTS-BURGE FIXT<br>200            | ALLOUP | TION OF CALLIAL RELATED COSTS                      |                | Trovider c |             | From 01/01/2019  | Part II<br>Date/Time Pre       |          |
| CENERAL SERVICE COST CENTERS         10.00         11.00         13.00         14.00         15.00           1.00         00100 (AP ReL COST SHUGE 6 IXT         1  |        | Cost Center Description                            | DI ETARY       | CAFETERI A |             | N SERVICES &     |                                |          |
| 1.00         00100 (AP REL COSTS-BLOG & FIXT         1           2.00         00200 (AP REL COSTS-BLOG & FIXT         4           4.00         00400 (AP REL COSTS-BLOG & FIXT         4           5.00         00570 (AM) HISTRATIVE AND GENERAL         7           7.00         0700 (DFRATION OF PLANT         5           5.02         00590 (AM) HISTRATIVE AND GENERAL         7           7.00         0700 (DFRATION OF PLANT         6           8.00         00800 (AM) HISTRATIVE AND GENERAL         7           7.00         0700 (DFRATION OF PLANT         6           8.00         00800 (AM) HISTNATIVE AND GENERAL         7           7.00         0700 (DFRATION OF PLANT         0           8.00         01000 (CAFETERIA A         0         96, 843           11.00         01400 (ENTRAN AND INSTRATIVE AND HISTNATION         0         7, 11           14.00         01400 (ENTRAN AND HISTNATIVE SERVICE COST CENTERS         0         1, 701         709         0         11           15.00         01500 (HARMACY         0         1, 701         709         0         15           16.00         01600 (HEICAL RECORDS & LIBRAY         0         1, 701         20         2, 264         0         0   |        |  | 10.00          | 11.00      | 13.00       |                  | 15.00                          |          |
| 2.00 00200 CAP REL COSTS-JAVBLE FOULP COSTS-JAVBLE FOULP COSTS JAVBLE TO USE AND ADD TT ING COSTO ADDIT TI NG COSTO ADDIT STATU OL AND CENERAL COSTS JAVBLE STATUS ADDIT STATU OL AND CENERAL COSTS JAVBLE STATUS ADDIT STATU OL AND CENERAL COSTS JAVBLE STATUS ADDIT STATU OL ADDIT S  |        |  |                |            | 1           |                  |                                |          |
| 4.00         00400         EMPLOYCE BENEFITS DEPARTMENT         4.00         5.01         00570         ADM ITTIN         5.02         00570         ADM ITTINE AND CENERAL         5.02         00590         ADM ITTINE AND CENERAL         5.02         00590         ADM ITTINE AND CENERAL         7.7           0.00         00000         DERATION OF PLANT         0         9.0         0990         MOSKEEPIN OF ALMIN STRATION         0         2.137         33.721         1.11           11.00         01000         DETRAL SERVICES A SUPPLY         0         2.137         33.721         1.11           11.00         01000         CHTRAL SERVICES A SUPPLY         0         1.483         0         3.608         91.587           11.00         01000         MURSING COST AL SERVICE         0         1.701         709         6         0         0         10           11.00         01000         MURSING COST AL SERVICE         0         1.701         709         6         0         0         10         11           12.00         MURSING COST AL SERVICE         0         1.701         709         6         0         0         0         0         0         0         0         0         0         0   |        |  |                |            |             |                  |                                | 1.00     |
| 5.01         00570 ADM ITTING         5.02         5.02         00570 ADM ITTING         5.02         5.02         00570 ADM ITTING         5.02         <  |        |  |                |            |             |                  |                                | 2.00     |
| 5.02         00590 ADM IN STRATIVE AND CENERAL         5.02         00590 ADM INSTRATIVE AND CENERAL         7           8.00         00600 LAUNDRY & LINEN SERVICE         9         9           9.00         00600 ADM INSTRATIVE AND SERVICE         9           9.00         00600 ADMESSEEFIN AND SERVICE         9           10.00         01000 ADTESTARY         109, 693         11           13.00         01000 ADTESTARY         0         2,137         33,721           14         01300 AUNESIN COM SAMENIN STRATION         0         2,137         33,721         13           15.00         01500 PMARMACY         0         3,111         0         3,608         91,597         14           15.00         01500 PMARMACY         0         1,701         700         0         0         17           10.00         03000 ADMLTS & FENUCE COST CENTERS         96,673         20,420         16,820         7,514         0         3           30.00         03000 ADMLTS & FENUCE COST CENTERS         9         17         16         17         17         17         17         17         17         17         17         16         17         17         17         16         16         16  |        |  |                |            |             |                  |                                | 5.01     |
| 7.00         00700 (DeFEATION OF PLANT         7.00         00700 (DeFEATION OF PLANT         7.00           9.00         008000 (LNURRY & LINER STRVICE         9.00         00000 (INUSKERPING         9.00           11.00         01100 (CAFETERIA         0         9.88,843         11           13.00         01000 (CAFETERIA         0         28,843         33,721         13           14.00         01400 (CENTRAL SERVICES & SUPPLY         0         1,665         0         139,671         13           16.00         01600 (MEDICAL RECORDS & LIBRARY         0         1,483         0         67         0         17           IMPATIENT ROUTINE SERVICE COST CENTERS         0         1,483         0         67         0         0         17           IMPATIENT ROUTINE SERVICE COST CENTERS         0         1,701         709         0         0         17           10.00         03000 (MUTS A PEDIATING ROOM         0         2,977         2,276         964         0         5           10.00         0500 (DEVERY ROOM         0         2,977         2,276         964         0         5           10.00         0500 (DEVERY ROOM         0         0         0         0         0   |        |  |                |            |             |                  |                                | 5. 02    |
| 8.00         00600 LAUNDRY & LINEN SERVICE         8.00         9.00   |        |  |                |            |             |                  |                                | 7.00     |
| 9 00 00900 HOUSEKEPPING 0100 (HOUSEKEPPING 0109, 693 01100 (AFETERIA 00 996, 843 01100 (AFETERIA 00 996, 843 01100 (AFETERIA 100 0 20, 8137 033, 721 0100 (AFETERIA 100 0 20, 8137 033, 721 0100 (AFETERIA 100 0) (AFETERIA 100 0) (AFETERIA 100 0, 1400 (AFETERIA 100 (AFET  |        |  |                |            |             |                  |                                | 8.00     |
| 11 0.0       01100 CAFETERIA       0       99, 843       11         11 0.0       01300 (NRSIN 6A AMIN STRATION       0       2, 137       33, 721       13         14 0.0       01400 (ENTRAL SERVICES SUPPLY       0       1, 665       0       139, 671       14         15 0.0       01500 (MEDI CAL, RECORDS & LI BRARY       0       1, 613       0       560       159, 71       14         16 0.0       01600 (MEDI CAL, RECORDS & LI BRARY       0       1, 483       0       67       0       16         0.0       03000 AULTS & FENICE COST CENTERS       0       1, 483       0       63       31       00       0300 (NTESTRY AMIN T       13, 020       3, 965       3, 442       628       0       31       00       0300 (NTESTRY FWICE COST CENTERS       0   |        |  |                |            |             |                  |                                | 9.00     |
| 13:00       01300 NURSING ADMINISTRATION       0       2, 137       33, 721       13         14:00       01400 (ENTRAL SERVICES & SUPPLY       0       1, 665       0       13, 00, 671       14         15:00       01500 (PHARMACY)       0       3, 111       0       3, 008       91, 587       15         16:00       01600 (PHARMACY)       0       1, 483       0       67       0       16         10:00       SOCIAL SERVICE       0       1, 701       709       0       0       17         10:00       01000 ADULTS & PEDIATRIC COST CENTERS       96, 673       20, 420       16, 820       7, 514       0       0       30         10:00       01300 DITENTEN VEC COST CENTERS       0       2, 086       3, 342       628       0       3         10:00       05000 DEFLORTING ROOM       0       4, 871       1, 562       0       50       50       00       50000 DEFLORTING ROOM       0       2, 297       2, 276       964       55       52       00       5000 DEFLORTING ROOM       0       0       0       0       55       50       0       50       0       50       50       50       50       50       50       50  | 10.00  | 01000 DI ETARY                                     | 109, 693       |            |             |                  |                                | 10.00    |
| 14.00       01400       CENTRAL SERVICES & SUPPLY       0       1,665       0       139,671       14         16.00       01600       MEDICAL RECORDS & LIBRARY       0       1,701       709       0       0         10.00       01500       MEDICAL RECORDS & LIBRARY       0       1,433       0       6,67       0       1,652       0       1,652       0       3       3,95       3,342       6,28       0       0       0       3       3       0 </td <td>11.00</td> <td>01100 CAFETERI A</td> <td>0</td> <td>98, 843</td> <td></td> <td></td> <td></td> <td>11.00</td>  | 11.00  | 01100 CAFETERI A                                   | 0              | 98, 843    |             |                  |                                | 11.00    |
| 15:00       01500 PHARMACY       0       3,111       0       3,608       91,587       15         17:00       000 MEDICAL SERVICE       0       1,701       709       0       0       17         INPART INT. POULTINE SERVICE COST CENTERS   |        |  | 0              |            |             |                  |                                | 13.00    |
| 16.00       01000       MEDICAL, RECORDS & LIBRARY       0       1,433       0       67       01       10         10.00       1700       1701       709       0       0       16       00       1701       709       0       0       1701       709       0       0       1701       709       0       0       1701       709       0       0       1701       709       0       0       1701       709       0       0       1701       709       0       0       1701       709       0       0       1701       709       0       0       1701       709       0       0       1701       1709       0 <td< td=""><td></td><td></td><td>°,</td><td></td><td></td><td></td><td></td><td>14.00</td></td<>  |        |  | °,             |            |             |                  |                                | 14.00    |
| 17.00     O1700     SOCIAL SERVICE     0     1,701     709     0     0     17       10     03000     AULT ENT ROTITENT ROTITES SERVICE COST CENTERS     96,673     20,420     16,820     7,514     0     31       31.00     03000     INTERS VICE CARE UNIT     13,020     3,395     3,342     628     0     31       31.00     04300     INTERS VICE CARE UNIT     13,020     3,395     3,342     628     0     31       31.00     04300     INTERS VICE CARE UNIT     13,020     3,395     3,342     628     0     31       31.00     04300     INTERS VICE CARE UNIT     13,020     3,395     3,342     628     0     31       31.00     00     00     0     0     0     0     0     0     0       31.00     00     0     0     0     0     0     0     0     0       31.00     05100     PERATING ROM     0 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td></td<>  |        |  | -              |            |             |                  |                                |          |
| INPATIENT ROUTINE SERVICE COST CENTERS         0  |        |  | -              |            |             | -                |                                |          |
| 30:00       03000 ADULTS & PEDIATRICS       96, 673       20, 420       16, 820       7, 514       0       30         43:00       04300 NURSERY       0       2,086       0       0       43         43:00       04300 NURSERY       0       2,086       0       0       43         AMCILLARY SERVICE COST CENTERS       0       2,086       0       0       43         AMCILLARY SERVICE COST CENTERS       0       4,871       1,562       19,182       55         50:00       05000 PELIVERY NOOM       0       4,871       1,562       19,182       55         51:00       0500 REDUCVERY NOOM       0       0       0       0       0       53         51:00       0500 RADUCLORY DIAGNOSTIC       0       10,206       10,168       54         56:00       05600 RADUCLORY DIAGNOSTIC       0       0       0       0       55         56:00       05600 LABORATORY       0       0       0       0       55       58       0       66         66:00       06200 MEADULES LOOD & PACKED RED BLODD CELLS       0       0       0       0       58       66       66       66       66       66       66       66 </td <td>17.00</td> <td></td> <td>0</td> <td>1, 701</td> <td>/0</td> <td>9 0</td> <td>0</td> <td>17.00</td>   | 17.00  |  | 0              | 1, 701     | /0          | 9 0              | 0                              | 17.00    |
| 31.00       03100       INTENSIVE CARE UNIT       13,020       3,395       3,342       628       0       31         43.00       04300       NURSERV       0       2,086       0       0       43         50.00       05000       OPERATING ROOM       0       4,871       1,562       19,182       0       50         51.00       05100       RECOVERY ROOM       0       2,287       9,644       51         52.00       05200       DELIVERY ROOM & LABOR ROOM       0       0       0       52       0       0,00       0       0       53         53.00       05300       ANESTHESI LOCY       0       0       0       0       0       54       0       54.00       0.00       0       0       0       55       54.00       0.00 OKON RABINESI LOCY       0       0       0       0       0       55       56.00       0.00 OKON CT SCAN       0       0       0       0       56       56.00       0.00 OKON CT SCAN       0       0       0       55       66.00       66.00       0.6000       RABORATORY       0       0       0       56       66.00       66.00       66.00       66.00       66.00 <td< td=""><td>20.00</td><td></td><td>04 472</td><td>20 420</td><td>14 02</td><td>0 7 514</td><td>0</td><td>30.00</td></td<>   | 20.00  |  | 04 472         | 20 420     | 14 02       | 0 7 514          | 0                              | 30.00    |
| 43.00         04300         NURSERY         0         2.066         0         0         43.33           ANCLLARY SERVICE COST CENTERS         50.00         05000         OPERATING ROM         0         4.871         1.562         19,182         50.50         50.00         50.00         05100         RECOVERY ROM         0         0         0         0         0         0         0         0         0         0         0         0         0         53.00         05300         RAUSTHESI OLOGY         0         0         0         0         0         0         0         54.01         0.500         RAUSTORY         0         0         0         0         0         0         0         55.00         0.00         0         0         0         0         0         0         0         0         0         0         0         0         0         55.60         0.00            |        |  |                |            |             |                  |                                |          |
| ANCI LLARY SERVICE COST CENTERS         Image: Control of Operant ING ROOM         O         4, 871         1, 562         19, 182         O         50           51.00         05000         OPERATI NG ROOM         0         2, 277         2, 276         944         0         51           52.00         05200         DELIVERY ROOM & LABOR ROOM         0   |        |  |                |            |             |                  |                                |          |
| 50.00       05000       0FERATING ROOM       0       4,871       1,562       19,182       0       50         51.00       05100       05000       REOVERY ROOM       0       2,277       2,276       964       0       51         52.00       05300       ALESTHESI 0LOGY       0       0       0       0       0       0       52         53.00       05300       ALESTHESI 0LOGY       0       0       0       0       0       0       54         54.01       05400       RADOR RADI 0LOSOTOFE       0   | 43.00  |  | U              | 2,000      | 7           | <u> </u>         | 0                              | 43.00    |
| 51.00       OS100       RECOVERY ROOM       0       2,297       2,276       964       0       51         52.00       OS200       DELIVERY ROOM & LABOR ROOM       0       0       0       0       52         53.00       DS300       ANESTHESI OLDGY       0       0       0       0       0       53         54.00       DS400       RANDIOLDGY-DIAKNOSTIC       0       10,206       0       10,168       54         54.00       DS400       RADIOLDGY-DIAKNOSTIC       0       0       0       0       0       53         54.00       DS400       RADIOLDGY-DIAKNOSTIC       0       0       0       0       0       0       0       55         56.00       DS600       RADIOLDGY-DIAKNOSTOPE       0       0       0       0       0       0       0       0       0       0       0       584       66       66       66000       AGOO PHYSICAL THERAPY       0       11,871       0       225       0       60       66       66       6600       6600       9400 PHYSICAL THERAPY       0       0       0       0       66       67.00       0       0       0       0       0       0   | 50 00  |  | 0              | 4 871      | 1 56        | 2 19 182         | 0                              | 50.00    |
| 52.00         OS200         DELIVERY ROM & LABOR ROOM         0        <  |        |  |                |            |             |                  |                                |          |
| 53.00       NESTHESI OLOCY       0       0       0       0       0       0       53         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       10, 206       0       10, 168       0       54         54.00       05401       ULTRASOUND       0       0       0       0       54         57.00       05700       CT SCAN       0       0       0       0       57         80.0       05800       MRI       0       0       0       0       0       55         80.0       05800       MRI       0       11, 871       0       225       0       60         90.0       05500       RESPI RATORY THERAPY       0       7       0       382       0       66         60.00       06900       RESPI PATORY THERAPY       0       7       0       382       0       66         <  | 52.00  |  | 0              |            |             |                  | 0                              | 52.00    |
| 54.01       05401       ULTRASOUND       0  | 53.00  | 05300 ANESTHESI OLOGY                              | 0              | C          |             | 0 0              | 0                              | 53.00    |
| 56.00       05600       RADI 0I SOTOPE       0 <td>54.00</td> <td>05400 RADI OLOGY-DI AGNOSTI C</td> <td>0</td> <td>10, 206</td> <td></td> <td>0 10, 168</td> <td>0</td> <td>54.00</td>   | 54.00  | 05400 RADI OLOGY-DI AGNOSTI C                      | 0              | 10, 206    |             | 0 10, 168        | 0                              | 54.00    |
| 57.00       05700       CT SCAN       0       0       0       0       57.50         58.00       05800       MRI       0       0       0       0       58.60         60.00       06000       LABORATORY       0       11.871       0       225       0         62.00       06200       WHOLE BLODD & PACKED RED BLOOD CELLS       0       0       0       5,584       0       62         65.00       06500       RESPI RATORY THERAPY       0       4,921       0       3,048       0       65         66.00       06600       PHYSI CAL THERAPY       0       7       0       382       0       66         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       0       67         68.00       06800       SPECH PATHOLOGY       0       1,999       0       2,087       0       71         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0       0       0       0       2,087       0       71         72.00       07300       DRUS CALARGED TO PATI ENTS       0       0       0       0       0       0       0       0       70 <td>54.01</td> <td>05401 ULTRASOUND</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>54.01</td>   | 54.01  | 05401 ULTRASOUND                                   | 0              | C          |             | 0 0              | 0                              | 54.01    |
| 58.00       05800       MRI       0       0       0       0       58         60.00       06000       LABORATORY       0       11,871       0       225       0       60         62.00       06200       HOLE BLOOD & PACKED RED BLOOD CELLS       0       0       5,584       0       62         65.00       06500       RESPI RATORY THERAPY       0       4,921       0       3,048       65         66.00       06600       PHYSI CAL THERAPY       0       7       0       382       0       66         67.00       06700       0CCUPATI ONAL THERAPY       0       7       0       382       0       68         69.00       06800       SPEECH PATHOLOGY       0       0       0       0       68       66       69       69       0       0       0       0       68       66       69       69       0       0       0       0       0       68       66       69       69       0       0       0       0       0       0       0       0       72       73       73       73       73       73       73       73       73       73       73       73   | 56.00  |  | 0              | C          |             | 0 0              | 0                              | 56.00    |
| 60.00         06000         LABORATORY         0         11, 871         0         225         0         60           62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0         5,584         0         62           65.00         06500         RESPI RATORY THERAPY         0         4,921         0         3,048         0         65           66.00         06600         PHYSI CAL THERAPY         0         7         0         382         0         66           67.00         0CCUPATI ONAL THERAPY         0         7         0         382         0         67           68.00         06600         PLYSI CAL THERAPY         0         0         0         0         0         67         0         0         0         0         67         68         0         06900         ECETROCARDI OLOGY         0         0         0         67         67         67         67         67         0         0         67         67         67         67         67         67         67         67         67         67         67         67         67         67         67         67         67         67         67<   | 57.00  |  | 0              | C          |             | 0 0              | 0                              | 57.00    |
| 62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0         5,584         0         62           65.00         06500         RESPI RATORY THERAPY         0         4,921         0         3,048         65           66.00         06600         PHSI CAL THERAPY         0         7         0         382         0         66           67.00         06700         0CCUPATI ONAL THERAPY         0         0         0         0         67         0         382         0         68         67         0         67         0         382         0         68         0         600         0         0         0         0         0         0         0         67         67         0         382         0         68         67         0         0         0         0         0         67         67         67         67         67         67         67         67         67         67         69         69         69         69         69         69         69         69         69         69         69         69         69         69         69         69         69         69         69   |        |  | 0              | 0          |             | -                |                                |          |
| 65:00       06500       RESPI RATORY THERAPY       0       4,921       0       3,048       0       65         66:00       06600       PHYSI CAL THERAPY       0       7       0       382       0       66         67:00       0CCUPATI ONAL THERAPY       0       0       0       0       0       66         67:00       0CCUPATI ONAL THERAPY       0       0       0       0       66         68:00       06800       SPECH PATHOLOGY       0       0       0       0       66         69:00       06900       ELECTROCARDI OLOGY       0       1,999       0       2,087       0       71         72:00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       14,811       0       72         73:00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       0       0       73         76:00       03610       SLEEP LAB       0       0       1,294       731       462       0       90         90:00       DEMERGENCY       0       1,294       731       462       0       91       92       92       92       92 <t< td=""><td></td><td></td><td>0</td><td>11, 871</td><td></td><td></td><td>-</td><td>60.00</td></t<>  |        |  | 0              | 11, 871    |             |                  | -                              | 60.00    |
| 66.00         06600         PHYSI CAL THERAPY         0         7         0         382         0         66           67.00         06700         0CCUPATI ONAL THERAPY         0         0         0         0         67           68.00         06800         SPEECH PATHOLOGY         0         0         0         0         67         0         0         0         0         67         0         0         0         0         67         0         0         0         0         0         67         0         0         0         0         67         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         66         69         0         0         0         0         0         0         66         69         0         0         0         0         0         0         0         0         0         0         0         0         11         0         72         0         13         14         0         0         0         0         0         0         0         0         0         0         0   |        |  | 0              | С          |             |                  |                                | 62.00    |
| 67.00         06700         0CUPATIONAL THERAPY         0         0         0         0         67           68.00         06800         SPEECH PATHOLOGY         0         0         0         0         68           69.00         06900         ELECTROCARDIOLOGY         0         1,999         0         296         68           71.00         OTOO         MEDI CAL SUPPLIES CHARGED TO PATIENT         0         0         2,087         0         71           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         0         14,811         0         72           73.00         03010         DRUGS CHARGED TO PATIENTS         0         0         0         0         0         0         91,587         73           76.00         03610         SLEEP LAB         0         0         0         0         0         90         90         91         0         92.0         09100         EMERGENCY         92         92         92         0         92.00         DSECVATION BEDS (NON-DI STINCT PART         92         92         92         92.00         DSEVATION BEDS (NON-DI STINCT PART         92         93         94         93         95         95  |        |  | 0              |            |             |                  |                                |          |
| 68.00         06800         SPECH         PATHOLOGY         0         0         0         0         68           69.00         06900         ELECTROCARDIOLOGY         0         1,999         0         296         0         69           71.00         O7100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         2,087         0         71           72.00         O7200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         0         14,811         0         72           73.00         O7300         DRUGS CHARGED TO PATI ENTS         0         0         0         0         60,910         91,587         73           76.00         03610         SLEEP LAB         0         0         0         0         0         0         76           0100         DP100         ENREGENCY         0         1,294         731         462         0         90         91         92         92         9200         085RVATI ON BEDS (NON-DI ST I NCT PART         92         92         0         92.00         94,085         0         4,905         0         92         92         92         95         5         5         5   |        |  | 0              |            |             |                  |                                |          |
| 69.00         06900         ELECTROCARDI OLOGY         0         1,999         0         296         0         69           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENT         0         0         0         2,087         0         71           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         0         14,811         0         72           73.00         07300         PRUGS CHARGED TO PATI ENTS         0         0         0         0         0         73           73.00         07300         PRUGS CHARGED TO PATI ENTS         0         0         0         0         0         73           00         03610         SLEEP LAB         0         0         0         0         0         76           01PATI ENT SERVICE COST CENTERS         0         1,294         731         462         0         90         91         92.00         09500         AL830         0         91         92         92.00         09500         AL8430         0         92         92.00         09500         AL801         AL830         0         92         92.00         09500         AL8430         0         92         92.01 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td> <td>1</td>   |        |  | 0              |            |             | -                |                                | 1        |
| 71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       2,087       0       71         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       14,811       0       72         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       60,910       91,587       73         76.00       03610       SLEEP LAB       0   |        |  | 0              |            |             |                  | -                              | 1        |
| 72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       14,811       0       72         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       60,910       91,587       73         76.00       03610       SLEEP LAB       0       0       0       0       0       76         0UTPATIENT SERVICE COST CENTERS       0       1,294       731       462       0       90         90.00       09000       CLINIC       0       1,294       731       462       90       91         91.00       09100       EMERGENCY       0       21,287       8,281       4,830       91       92         92.00       OBSERVATION BEDS (NON-DISTINCT PART       0       4,085       0       4,905       95       95         95.00       09500       AMBULANCE SERVICES       0       4,085       0       4,905       95         95.00       09500       AMBULANCE SERVICES       0       4,085       0       4,905       95         91.00       190000       SUBTOTALS (SUM OF LINES 1 through 117)       109,693       98,836       33,721       139,671       91,587       118         91.00  |        |  | 0              |            |             |                  |                                | 1        |
| 73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       60,910       91,587       73         76.00       03610       SLEEP LAB       0       0       0       0       0       76         00.00       09000       CLINIC       0       1,294       731       462       0       90       91       90       00       0       91       90       91       92       91.00       EMERGENCY       0       21,287       8,281       4,830       91       92       92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       92       92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       92       92.00       09200       AMBULANCE SERVICES       0       4,085       0       4,905       0       92         95.00       09500       AMBULANCE SERVICES       0       4,085       0       4,905       0       95       95       95       95       95       95       95.00       SUBTOTALS (SUM OF LINES 1 through 117)       109,693       98,836       33,721       139,671       91,587       118         190.00       190000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190       190  |        |  | 0              | C          |             |                  |                                | 1        |
| 76.00         03610         SLEEP LAB         0         0         0         0         76           OUTPATIENT SERVICE COST CENTERS         0         1,294         731         462         0         91.00         ERGENCY         90         91.00         21,287         8,281         4,830         90         91         92         90         90200         OBSERVATI ON BEDS (NON-DI STI NCT PART         92.00         99200         MBURSABLE COST CENTERS         92.00         94.085         0         4,905         0         95         95         95.00         MBURSABLE COST CENTERS         95         95.00         SUBTOTALS (SUM OF LI NES 1 through 117)         109,693         98,836         33,721         139,671         91,587         118           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0   |        |  | 0              | C          |             |                  |                                | 1        |
| 90.00       09000       CLINIC       0       1,294       731       462       0       90         91.00       09100       EMERGENCY       0       21,287       8,281       4,830       0       91         92.00       09200       DBSERVATI ON BEDS (NON-DI STINCT PART       0       21,287       8,281       4,830       0       91         92.00       09500       ABBULANCE SERVI CES       0       4,085       0       4,905       0       92         07500       AMBULANCE SERVI CES       0       4,085       0       4,905       0       95         95.00       OP500 CAL PURPOSE COST CENTERS       0       4,085       0       4,905       0       95         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       109,693       98,836       33,721       139,671       91,587       118         190.00       190000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       19200         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       7       0       0       19200         200.00       Cross Foot Adjustments       0       0       0       0       200       200       0 <td>76.00</td> <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td></td>   | 76.00  |  | 0              | C          |             |                  |                                |          |
| 91.00       09100       EMERGENCY       0       21,287       8,281       4,830       0       91         92.00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART       92       92       92       92         0THER       REI MBURSABLE COST CENTERS       0       4,085       0       4,905       95         SPECIAL       PURPOSE COST CENTERS       0       4,085       33,721       139,671       91,587       118         118.00       SUBTOTALS (SUM OF LI NES 1 through 117)       109,693       98,836       33,721       139,671       91,587       118         190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       1900         190.00       FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       192         200.00       Cross Foot Adjustments       0       0       0       0       200         201.00       Negative Cost Centers       0       0       0       0       200   |        |  |                |            |             |                  |                                |          |
| 92.00         OBSERVATION BEDS (NON-DISTINCT PART         92           OTHER         REIMBURSABLE COST CENTERS         0         4,085         0         4,905         95           95.00         OP500 AMBULANCE SERVICES         0         4,085         0         4,905         0         95           SPECIAL PURPOSE COST CENTERS           TH8.00         SUBTOTALS (SUM OF LINES 1 through 117)         109,693         98,836         33,721         139,671         91,587           NONREI MBURSABLE COST CENTERS           190.00         19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         19000         19000         0         0         0         19000         19000         19000         19000         0         0         19000         19000         19000         0         0         19000         19000         19000         19000         0         0         19000         19000         0         0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>1 462</td> <td>0</td> <td>1 201 00</td>  |        |  | 0              |            |             | 1 462            | 0                              | 1 201 00 |
| OTHER         REI MBURSABLE         COST CENTERS           95.00         09500         AMBULANCE         SERVI CES         0         4,085         0         4,905         0         95           SPECI AL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         109,693         98,836         33,721         139,671         91,587         118           NONREI MBURSABLE COST CENTERS           190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         1900         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         7         0         0         19200         19200         Cross Foot Adjustments         200         0         0         0         200         201.00         Negative Cost Centers         0         0         0         0         0         0         201   | 91.00  |  | 0              | 21, 287    | 8, 28       | 1 4, 830         | 0                              | 91.00    |
| 95.00         09500         AMBULANCE         SERVICES         0         4,085         0         4,905         0         95           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         109,693         98,836         33,721         139,671         91,587         118           NONREI MBURSABLE COST CENTERS           190.00         190000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         1900         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         7         0         0         19200         19200         200.00         Cross Foot Adjustments         200         201.00         Negative Cost Centers         0         0         0         0         0         201         0         0         0         0         0         0         0         0         0         0         0         0         0         0         201         0   | 92.00  |  |                |            |             |                  |                                | 92.00    |
| SPECIAL PURPOSE COST CENTERS           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         109, 693         98, 836         33, 721         139, 671         91, 587         118           NONREI MBURSABLE COST CENTERS         0         0         0         0         190.00         1900.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         1902.00         19200         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         7         0         0         19200           192.00         19200         Cross Foot Adjustments         0         0         0         200         200         201.00         Negative Cost Centers         0         0         0         0         0         201  |        |  |                |            |             |                  |                                |          |
| 118.00         SUBTOTALS (SUM OF LINES 1 through 117)         109,693         98,836         33,721         139,671         91,587         118           NONREI MBURSABLE COST CENTERS         190.00         190000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         1900         19200         19200         91,587         118         190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         1900         0         1900         0         1900         0         1900         1900         0         1900         1900         200  | 95.00  |  | 0              | 4, 085     |             | 0 4, 905         | 0                              | 95.00    |
| NONREI MBURSABLE COST CENTERS           190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         7         0         0         0         192           200.00         Cross Foot Adjustments         0         0         0         0         0         200           201.00         Negative Cost Centers         0         0         0         0         0         0         0         201   | 446 6  |  | 400 45-        |            |             | 4 400 ()         |                                | 440.05   |
| 190.00         19000         GI FT,         FLOWER,         COFFEE SHOP & CANTEEN         0         0         0         0         190           192.00         19200         PHYSI CI ANS'         PRI VATE OFFI CES         0         7         0         0         192           200.00         Cross Foot Adjustments         0         0         0         0         200           201.00         Negative Cost Centers         0   | 118.00 |  | 109, 693       | 98, 836    | 33, 72      | 139, 671         | 91, 587                        | 1118.00  |
| 192.00         192.00         PHYSI CLANS' PRI VATE OFFICES         0         7         0         0         192           200.00         Cross Foot Adjustments         0         0         0         200   | 100 00 |  |                |            | J           |                  | -                              | 100.00   |
| 200.00         Cross Foot Adjustments         200           201.00         Negative Cost Centers         0  |        |  |                | C          |             |                  |                                | 190.00   |
| 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201  |        |  | 0              | /          |             | 0                | 0                              |          |
|   |        |  | ~              | ~          |             |                  | ^                              | 200.00   |
| 202.00 TOTAL (sum Lines 118 through 201) 109,693 98,843 33,721 139,671 91,587 202   |        |  | 109, 693       | 98, 843    |             | 0 U<br>1 120 471 |                                |          |

| Heal th  | Financial Systems  | DUKES MEMORIA                     | AL HOSPI TAL     |                                 | In Lie  | u of Form CMS-:  | 2552-10  |
|--|--|-----------------------------------|------------------|---------------------------------|---|--|--|
| ALLOCA   | TION OF CAPITAL RELATED COSTS  |                                   | Provi der CCI    |                                 | Period:<br>From 01/01/2019<br>To 12/31/2019                     | Worksheet B<br>Part II<br>Date/Time Pre<br>8/28/2020 10: | pared:   |
|  | Cost Center Description  | MEDI CAL<br>RECORDS &<br>LI BRARY | SOCI AL SERVI CE | Subtotal                        | Intern &<br>Residents Cost<br>& Post<br>Stepdown<br>Adjustments | Total  |  |
|  |  | 16.00                             | 17.00            | 24.00                           | 25.00   | 26.00  |  |
|  | GENERAL SERVICE COST CENTERS   |                                   | <u>г</u>         |                                 |   |  | 1  |
| 1.00<br>2.00<br>4.00<br>5.01<br>5.02<br>7.00<br>8.00<br>9.00 | 00100 CAP REL COSTS-BLDG & FIXT<br>00200 CAP REL COSTS-MVBLE EQUI P<br>00400 EMPLOYEE BENEFITS DEPARTMENT<br>00570 ADMITING<br>00590 ADMINISTRATIVE AND GENERAL<br>00700 OPERATION OF PLANT<br>00800 LAUNDRY & LINEN SERVICE<br>00900 HOUSEKEEPING |                                   |                  |                                 |   |  | 1.00<br>2.00<br>4.00<br>5.01<br>5.02<br>7.00<br>8.00<br>9.00 |
| 10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00     | 01000 DI ETARY<br>01100 CAFETERI A<br>01300 NURSI NG ADMI NI STRATI ON<br>01400 CENTRAL SERVI CES & SUPPLY<br>01500 PHARMACY<br>01600 MEDI CAL RECORDS & LI BRARY  | 131, 109                          |                  |                                 |   |  | 10.00<br>11.00<br>13.00<br>14.00<br>15.00<br>16.00           |
| 17.00  | 01700 SOCIAL SERVICE<br>INPATIENT ROUTINE SERVICE COST CENTERS   | 0                                 | 38, 257          |                                 |   |  | 17.00  |
| 31.00  | 03000 ADULTS & PEDIATRICS<br>03100 INTENSIVE CARE UNIT<br>04300 NURSERY  | 41, 690<br>23<br>1, 456           | 4, 515           | 1, 355, 64<br>172, 92<br>47, 86 | 2 0   | 1, 355, 640<br>172, 922<br>47, 866                       | 31.00  |
|  | ANCI LLARY SERVI CE COST CENTERS   |                                   |                  |                                 | 1   |  | 1  |
| 51. 00<br>52. 00   | 05000 OPERATING ROOM<br>05100 RECOVERY ROOM<br>05200 DELIVERY ROOM & LABOR ROOM  | 30, 179<br>23<br>0                | 0                | 564, 15<br>49, 56               |   | 564, 155<br>49, 566<br>0                                 | 51.00<br>52.00   |
| 54. 00<br>54. 01   | 05300 ANESTHESI OLOGY<br>05400 RADI OLOGY-DI AGNOSTI C<br>05401 ULTRASOUND<br>05600 RADI OI SOTOPE   | 0<br>15, 766<br>0<br>0            | 0                |                                 | 0 0<br>1 0<br>0 0<br>0 0  | 0<br>479, 211<br>0<br>0                                  |  |
| 57. 00<br>58. 00   | 05700 CT SCAN<br>05800 MRI<br>06000 LABORATORY   | 0<br>0<br>0<br>698                |                  | 154, 62                         | 0 0<br>0 0  | 0<br>0<br>154, 622                                       | 57.00<br>58.00   |
| 62. 00<br>65. 00   | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS<br>06500 RESPI RATORY THERAPY<br>06600 PHYSI CAL THERAPY  | 15<br>23<br>16, 073               | 0<br>0           | 11, 18<br>135, 13<br>358, 52    | 0 0<br>2 0  | 11, 180<br>135, 132<br>358, 521                          | 62.00<br>65.00   |
| 69.00  | 06700 OCCUPATI ONAL THERAPY<br>06800 SPEECH PATHOLOGY<br>06900 ELECTROCARDI OLOGY  | 23<br>23<br>205                   | 0                | 11, 47<br>85<br>162, 11         | 4 0   | 11, 475<br>854<br>162, 115                               | 68.00  |
| 72. 00<br>73. 00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT<br>07200 IMPL. DEV. CHARGED TO PATIENTS<br>07300 DRUGS CHARGED TO PATIENTS   | 0<br>0<br>0                       | 0                | 3, 73<br>17, 83<br>170, 55      | 4 0<br>5 0  | 3, 731<br>17, 834<br>170, 555                            | 72.00<br>73.00   |
| 76.00  | 03610 SLEEP LAB<br>OUTPATI ENT SERVICE COST CENTERS  | 0                                 | 0                |                                 | 0 0   | 0  | 76.00  |
| 91.00  | 09000 CLINIC<br>09100 EMERGENCY  | 517<br>20, 256                    |                  | 108, 09<br>397, 27              |   | 108, 096<br>397, 276                                     | 91.00  |
|  | 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART<br>OTHER REI MBURSABLE COST CENTERS   |                                   |                  |                                 | 0   |  | 92.00  |
|  | 09500 AMBULANCE SERVICES<br>SPECIAL PURPOSE COST CENTERS   | 4, 139                            | 0                | 116, 51                         | 8 0   | 116, 518   | 95.00  |
| 118.00   | SUBTOTALS (SUM OF LINES 1 through 117)<br>NONREIMBURSABLE COST CENTERS   | 131, 109                          | · · ·            | 4, 317, 26                      |   | 4, 317, 269  |  |
| 192. 00<br>200. 00   |  | 0<br>0                            |                  | 29, 86<br>420, 75               | 3 0<br>0 0  | 420, 753<br>0  | 200. 00  |
| 201.00<br>202.00   |  | 0<br>131, 109                     | 0<br>38, 257     | 4, 767, 88                      | 0 0<br>2 0  | 0<br>4, 767, 882   | 201. 00<br>202. 00   |

|                  | Financial Systems<br>LLOCATION - STATISTICAL BASIS                             | DUKES MEMORIA                | AL HOSPITAL<br>Provider CC   | N: 15-1318            | In Lie<br>Period:                | worksheet B-1  |                    |
|------------------|--|------------------------------|------------------------------|-----------------------|----------------------------------|----------------|--------------------|
|                  |  |                              |                              |                       | From 01/01/2019<br>To 12/31/2019 |                |                    |
|                  |  | CAPI TAL REI                 | LATED COSTS                  |                       |                                  | 8/28/2020 10:  | 36 am              |
|                  |  |                              |                              |                       |                                  |                |                    |
|                  | Cost Center Description  | BLDG & FIXT<br>(SQUARE FEET) | MVBLE EQUIP<br>(SQUARE FEET) | EMPLOYEE<br>BENEFI TS | ADMI TTI NG<br>(GROSS            | Reconciliation |                    |
|                  |  | (000,                        | (000)                        | DEPARTMENT            | CHARGES)                         |                |                    |
|                  |  |                              |                              | (GROSS                |                                  |                |                    |
|                  |  | 1.00                         | 2.00                         | SALARI ES)<br>4.00    | 5. 01                            | 5A. 02         |                    |
|                  | GENERAL SERVICE COST CENTERS   |                              |                              |                       |                                  |                |                    |
|                  | 00100 CAP REL COSTS-BLDG & FIXT  | 193, 337                     |                              |                       |                                  |                | 1.00               |
| 2.00<br>4.00     | 00200 CAP REL COSTS-MVBLE EQUIP<br>00400 EMPLOYEE BENEFITS DEPARTMENT          | 882                          | 193, 337<br>882              | 13, 065, 723          | 3                                |                | 2.00<br>4.00       |
| 5.01             | 00570 ADMI TTI NG  | 1, 421                       |                              | 529, 66               |                                  |                | 5.01               |
| 5.02             | 00590 ADMINISTRATIVE AND GENERAL   | 11, 954                      |                              | 1, 305, 00            |                                  | -7, 352, 232   | 5.02               |
| 7.00<br>8.00     | 00700 OPERATION OF PLANT<br>00800 LAUNDRY & LINEN SERVICE                      | 52, 416<br>2, 284            |                              | 288, 39               | 3 O<br>D O                       | 0              | 7.00<br>8.00       |
| 9.00             | 00900 HOUSEKEEPING   | 2, 204                       |                              | 354, 40               | -                                | 0              |                    |
|                  | 01000 DI ETARY   | 2, 835                       |                              | 90, 25                | 4 O                              | 0              | 10.00              |
|                  |  | 2, 546                       |                              | 107, 59               |                                  | 0              |                    |
|                  | 01300 NURSI NG ADMI NI STRATI ON<br>01400 CENTRAL SERVI CES & SUPPLY           | 700<br>3, 556                |                              | 322, 24<br>80, 78     |                                  | 0              | 13.00<br>14.00     |
|                  | 01500 PHARMACY   | 2, 054                       |                              | 338, 08               |                                  | 0              | 15.00              |
|                  | 01600 MEDI CAL RECORDS & LI BRARY  | 3, 324                       |                              | 62, 65                |                                  | 0              | 16.00              |
| 17.00            | 01700 SOCIAL SERVICE<br>INPATIENT ROUTINE SERVICE COST CENTERS                 | 864                          | 864                          | 190, 25               | 5 0                              | 0              | 17.00              |
| 30.00            | 03000 ADULTS & PEDI ATRI CS  | 27, 414                      | 27, 414                      | 1, 825, 13            | 5 9, 297, 091                    | 0              | 30.00              |
|                  | 03100 I NTENSI VE CARE UNI T   | 3, 448                       |                              | 401, 41               |                                  |                |                    |
| 43.00            | 04300 NURSERY<br>ANCI LLARY SERVI CE COST CENTERS                              | 749                          | 749                          | 234, 23               | 8 279, 672                       | 0              | 43.00              |
| 50.00            | 05000 OPERATI NG ROOM  | 12, 983                      | 12, 983                      | 468, 943              | 3 15, 725, 867                   | 0              | 50.00              |
|                  | 05100 RECOVERY ROOM  | 1, 022                       |                              | 264, 42               |                                  | 0              | 51.00              |
|                  | 05200 DELIVERY ROOM & LABOR ROOM   | 0                            | 0                            |                       | 0 0                              | 0              |                    |
| 53.00<br>54.00   | 05300 ANESTHESI OLOGY<br>05400 RADI OLOGY-DI AGNOSTI C                         | 10, 941                      | 10, 941                      | 838, 42               | 0<br>8 42, 268, 189              | 0              | 53.00<br>54.00     |
| 54.01            | 05401 ULTRASOUND   | 0                            | 0                            |                       | 0 0                              | 0              | 54.01              |
| 56.00            | 05600 RADI OI SOTOPE   | 0                            | 0                            |                       | o c                              | 0              | 56.00              |
|                  | 05700 CT SCAN<br>05800 MRI   | 0                            | 0                            |                       |                                  | 0              | 57.00              |
|                  | 06000 LABORATORY   | 3, 071                       | -                            | 759, 80               | 0                                | 0              | 58.00<br>60.00     |
| 62.00            | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                                     | 118                          |                              |                       | 502, 735                         | 0              | 62.00              |
|                  | 06500 RESPIRATORY THERAPY  | 3, 103                       |                              | 479, 02               |                                  |                | 65.00              |
| 66. 00<br>67. 00 | 06600 PHYSI CAL THERAPY<br>06700 OCCUPATI ONAL THERAPY                         | 8, 854<br>241                | 8, 854<br>241                | 48                    | 6 2, 746, 184<br>0 1, 234, 183   | 0              | 66.00<br>67.00     |
|                  | 06800 SPEECH PATHOLOGY   | 0                            |                              |                       | 206, 144                         | 0              | 68.00              |
|                  | 06900 ELECTROCARDI OLOGY   | 4, 065                       |                              | 192, 02               |                                  | 0              | 69.00              |
|                  | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT                                   | 0                            |                              |                       | 0 4, 402, 640<br>0 1, 770, 180   |                |                    |
|                  | 07200 IMPL. DEV. CHARGED TO PATIENTS<br>07300 DRUGS CHARGED TO PATIENTS        | 0                            |                              |                       | 0 1, 770, 180<br>0 26, 511, 543  |                |                    |
|                  | 03610 SLEEP LAB  | 0                            |                              |                       | 0 0                              | 0              | 1                  |
|                  | OUTPATIENT SERVICE COST CENTERS  | 0.740                        | 0.740                        | 110.04                | 00.704                           |                |                    |
|                  | 09000 CLINIC<br>09100 EMERGENCY  | 2, 718<br>7, 369             |                              |                       |                                  |                | 1                  |
|                  | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                      | ,,,                          | 1,007                        | 0,021,01              | 21,027,172                       |                | 92.00              |
|                  | OTHER REIMBURSABLE COST CENTERS  | 0.557                        | 0.557                        | 200.04                |                                  |                | 05.00              |
|                  | 09500 AMBULANCE SERVICES<br>SPECIAL PURPOSE COST CENTERS                       | 2, 557                       | 2, 557                       | 299, 26               | 5 8, 044, 648                    | 0              | 95.00              |
| 118.00           |  | 175, 694                     | 175, 694                     | 13, 065, 03           | 1 176, 436, 192                  | -7, 352, 232   | 118.00             |
| 100.00           | NONREI MBURSABLE COST CENTERS  | 70/                          |                              |                       |                                  |                |                    |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN<br>19200 PHYSICIANS' PRIVATE OFFICES | 786<br>16, 857               |                              | 693                   | 0<br>2 0                         |                | 190. 00<br>192. 00 |
| 200.00           | Cross Foot Adjustments   | 10,007                       | 10,007                       | 07.                   |                                  |                | 200.00             |
| 201.00           | Negative Cost Centers  |                              |                              |                       |                                  |                | 201.00             |
| 202.00           | Cost to be allocated (per Wkst. B,<br>Part I)                                  | 2, 247, 809                  | 2, 520, 073                  | 1, 552, 470           | 0 1, 294, 925                    |                | 202.00             |
| 203.00           | Unit cost multiplier (Wkst. B, Part I)   | 11. 626378                   | 13. 034613                   | 0. 118820             | 0. 007339                        |                | 203.00             |
| 204.00           | Cost to be allocated (per Wkst. B,   |                              |                              | 21, 75                |                                  |                | 204.00             |
| 20E 00           | Part II)   |                              |                              | 0.001///              | 0,000004                         |                | 205 00             |
| 205.00           | Unit cost multiplier (Wkst. B, Part<br>II)                                     |                              |                              | 0.00166               | 5 0. 000204                      |                | 205.00             |
| 206.00           | NAHE adjustment amount to be allocated   |                              |                              |                       |                                  |                | 206. 00            |
| 207 00           | (per Wkst. B-2)  |                              |                              |                       |                                  |                | 207 00             |
| 207.00           | NAHE unit cost multiplier (Wkst. D,<br>Parts III and IV)                       |                              |                              |                       |                                  |                | 207.00             |
|                  |  | 1                            | , I                          |                       | ,                                | 1              | •                  |

|                | Financial Systems   | DUKES MEMORI            |                  |                         |                          | u of Form CMS-2             |                |
|----------------|---|-------------------------|------------------|-------------------------|--------------------------|-----------------------------|----------------|
| COST A         | LLOCATION - STATISTICAL BASIS   |                         | Provider C       |                         | eriod:<br>rom 01/01/2019 | Worksheet B-1               |                |
|                |   |                         |                  | То                      |                          | Date/Time Pre 8/28/2020 10: |                |
|                | Cost Center Description   | ADMI NI STRATI VE       | OPERATION OF     | LAUNDRY &               | HOUSEKEEPI NG            | DI ETARY                    |                |
|                |   | AND GENERAL             |                  | LINEN SERVICE           | (SQUARE FEET)            | (PATIENT DAYS)              |                |
|                |   | (ACCUMULATED<br>COST)   | (SQUARE FEET)    | (TOTAL PATIENT<br>DAYS) |                          |                             |                |
|                |   | 5. 02                   | 7.00             | 8.00                    | 9.00                     | 10.00                       |                |
|                | GENERAL SERVICE COST CENTERS  | I                       | I                | 1                       |                          |                             |                |
| 1.00<br>2.00   | 00100 CAP REL COSTS-BLDG & FIXT<br>00200 CAP REL COSTS-MVBLE EQUIP                |                         |                  |                         |                          |                             | 1.00<br>2.00   |
| 2.00<br>4.00   | 00400 EMPLOYEE BENEFITS DEPARTMENT  |                         |                  |                         |                          |                             | 4.00           |
| 5.01           | 00570 ADMI TTI NG   |                         |                  |                         |                          |                             | 5.01           |
| 5.02           | 00590 ADMINISTRATIVE AND GENERAL  | 25, 458, 309            |                  |                         |                          |                             | 5.02           |
| 7.00           | 00700 OPERATION OF PLANT  | 3, 789, 705             | 109, 807         | 2.440                   |                          |                             | 7.00           |
| 8.00<br>9.00   | 00800 LAUNDRY & LI NEN SERVI CE<br>00900 HOUSEKEEPI NG                            | 129, 363<br>580, 623    | 2, 284<br>2, 205 | 3, 449<br>0             | 102, 761                 |                             | 8.00<br>9.00   |
|                | 01000 DI ETARY  | 227, 843                | 2, 203           | 0                       | 2, 835                   | 3, 429                      |                |
|                | 01100 CAFETERI A  | 229, 307                | 2, 546           | 0                       | 2, 546                   | 0                           |                |
| 13.00          | 01300 NURSING ADMINISTRATION  | 399, 252                | 700              | 0                       | 700                      | 0                           | 13.00          |
|                | 01400 CENTRAL SERVICES & SUPPLY   | 325, 997                | 3, 556           | 0                       | 3, 556                   | 0                           | 14.00          |
|                | 01500 PHARMACY<br>01600 MEDICAL RECORDS & LIBRARY                                 | 588, 491<br>354, 435    | 2, 054<br>3, 324 | 0                       | 2, 054<br>3, 324         | 0                           | 15.00<br>16.00 |
|                | 01700 SOCIAL SERVICE  | 253, 342                | 864              | 0                       | 3, 324<br>864            | 0                           | 17.00          |
|                | INPATIENT ROUTINE SERVICE COST CENTERS  | 2007012                 |                  |                         |                          |                             |                |
|                | 03000 ADULTS & PEDI ATRI CS   | 3, 146, 608             | 27, 414          | 2, 709                  | 27, 414                  | 3, 022                      |                |
|                | 03100 I NTENSI VE CARE UNI T  | 598, 317                | 3, 448           | 407                     | 3, 448                   | 407                         | 31.00          |
| 43.00          | 04300 NURSERY<br>ANCI LLARY SERVI CE COST CENTERS                                 | 314, 970                | 749              | 333                     | 749                      | 0                           | 43.00          |
| 50.00          | 05000 OPERATI NG ROOM   | 1, 276, 281             | 12, 983          | 0                       | 12, 983                  | 0                           | 50.00          |
| 51.00          | 05100 RECOVERY ROOM   | 377, 473                | 1, 022           | 0                       | 1, 022                   | 0                           | 51.00          |
| 52.00          | 05200 DELIVERY ROOM & LABOR ROOM  | 0                       | 0                | 0                       | 0                        | 0                           | 52.00          |
| 53.00          | 05300 ANESTHESI OLOGY   | 0                       | 0                | 0                       | 0                        | 0                           | 53.00          |
|                | 05400 RADI OLOGY-DI AGNOSTI C<br>05401 ULTRASOUND                                 | 1, 767, 843             | 10, 941          | 0                       | 10, 941                  | 0                           | 54.00          |
|                | 05600 RADI OI SOTOPE  | 0                       |                  | 0                       | 0                        | 0                           | 54.01<br>56.00 |
|                | 05700 CT SCAN   | 0                       | 0                | 0                       | 0                        | 0                           | 57.00          |
| 58.00          | 05800 MRI   | 0                       | 0                | 0                       | 0                        | 0                           | 58.00          |
|                | 06000 LABORATORY  | 1, 707, 039             | 3, 071           | 0                       | 3, 071                   | 0                           | 60.00          |
| 62.00          | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 88, 184                 | 118              | 0                       | 118                      | 0                           | 62.00          |
| 65.00<br>66.00 | 06500 RESPI RATORY THERAPY<br>06600 PHYSI CAL THERAPY                             | 725, 967<br>658, 921    | 3, 103<br>8, 854 | 0                       | 3, 103<br>8, 854         | 0                           | 65.00<br>66.00 |
|                | 06700 OCCUPATI ONAL THERAPY   | 181, 201                | 241              | 0                       | 241                      | 0                           | 67.00          |
| 68.00          | 06800 SPEECH PATHOLOGY  | 67, 646                 | 0                | 0                       | 0                        | 0                           | 68.00          |
| 69.00          | 06900 ELECTROCARDI OLOGY  | 398, 386                | 4, 065           | 0                       | 4, 065                   | 0                           | 69.00          |
|                | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT<br>07200 IMPL. DEV. CHARGED TO PATIENTS | 63, 971                 | 0                | 0                       | 0                        | 0                           | 71.00          |
| 72.00<br>73.00 | 07300 DRUGS CHARGED TO PATIENTS   | 228, 209<br>1, 084, 474 |                  | 0                       | 0                        | 0                           | 72.00<br>73.00 |
|                | 03610 SLEEP LAB   | 0                       | 0                | 0                       | 0                        | 0                           |                |
|                | OUTPATIENT SERVICE COST CENTERS   |                         |                  |                         |                          |                             |                |
|                | 09000 CLINIC  | 206, 954                |                  |                         | 2, 718                   | 0                           |                |
|                | 09100 EMERGENCY<br>09200 OBSERVATION BEDS (NON-DISTINCT PART                      | 4, 632, 096             | 7, 369           | 0                       | 7, 369                   | 0                           | 91.00<br>92.00 |
| 92.00          | OTHER REIMBURSABLE COST CENTERS   |                         |                  |                         |                          |                             | 92.00          |
| 95.00          | 09500 AMBULANCE SERVICES  | 604, 400                | 2, 557           | 0                       | 0                        | 0                           | 95.00          |
|                | SPECIAL PURPOSE COST CENTERS  |                         |                  |                         |                          |                             |                |
| 118.00         | SUBTOTALS (SUM OF LINES 1 through 117)<br>NONREIMBURSABLE COST CENTERS            | 25, 007, 298            | 109, 021         | 3, 449                  | 101, 975                 | 3, 429                      | 118.00         |
| 190.00         | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 19, 383                 | 786              | 0                       | 786                      | 0                           | 190.00         |
|                | 19200 PHYSICIANS' PRIVATE OFFICES   | 431, 628                | 0                | 0                       | 0                        | 0                           | 192.00         |
| 200.00         |   |                         |                  |                         |                          |                             | 200.00         |
| 201.00         |   | 7 252 222               | 4 004 152        | 240 212                 | 044 201                  | 442 002                     | 201.00         |
| 202.00         | Cost to be allocated (per Wkst. B,<br>Part I)                                     | 7, 352, 232             | 4, 884, 153      | 268, 313                | 846, 381                 | 443, 092                    | 202.00         |
| 203.00         | Unit cost multiplier (Wkst. B, Part I)  | 0. 288795               | 44. 479432       | 77. 794433              | 8. 236403                | 129. 219014                 | 203.00         |
| 204.00         | Cost to be allocated (per Wkst. B,  | 296, 971                | 1, 337, 320      |                         | 88, 594                  | 109, 693                    | 204.00         |
| 0.05           | Part II)  |                         |                  |                         |                          |                             | 005 5-         |
| 205.00         | Unit cost multiplier (Wkst. B, Part   | 0. 011665               | 12. 178823       | 24. 833575              | 0. 862136                | 31. 989793                  | 205.00         |
| 206.00         | NAHE adjustment amount to be allocated (per Wkst. B-2)                            |                         |                  |                         |                          |                             | 206. 00        |
| 207.00         |   |                         |                  |                         |                          |                             | 207.00         |
|                | Parts III and IV)   |                         |                  |                         |                          |                             |                |

| Health Financial Systems  | DUKES MEMORI | AL HOSPI TAL      |                        | In Lie                   | u of Form CMS-            | 2552-10        |
|---|--------------|-------------------|------------------------|--------------------------|---------------------------|----------------|
| COST ALLOCATION - STATISTICAL BASIS   |              | Provider C        |                        | eriod:<br>rom 01/01/2019 | Worksheet B-1             |                |
|   |              |                   | T                      |                          | Date/Time Pre             |                |
| Cost Center Description   | CAFETERI A   | NURSI NG          | CENTRAL                | PHARMACY                 | 8/28/2020 10:<br>MEDI CAL | <u>36 am</u>   |
|   | (FTES)       | ADMI NI STRATI ON | SERVICES &             | (COSTED REQ)             | RECORDS &                 |                |
|   |              | (NURSI NG         | SUPPLY<br>(COSTED REQ) |                          | LIBRARY<br>(TIME SPENT)   |                |
|   |              | SALARI ES)        | (COSTED REQ)           |                          | (TIME SPENT)              |                |
|   | 11.00        | 13.00             | 14.00                  | 15.00                    | 16.00                     |                |
| GENERAL SERVICE COST CENTERS           1.00         00100         CAP REL COSTS-BLDG & FIXT |              |                   | 1                      |                          |                           | 1 1 00         |
| 1. 00  00100  CAP_REL_COSTS-BLDG_&_FLXT<br>2. 00  00200  CAP_REL_COSTS-MVBLE_EQUIP          |              |                   |                        |                          |                           | 1.00           |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT   |              |                   |                        |                          |                           | 4.00           |
| 5. 01 00570 ADMI TTI NG   |              |                   |                        |                          |                           | 5.01           |
| 5. 02  00590  ADMINI STRATI VE AND GENERAL<br>7. 00  00700  OPERATI ON OF PLANT             |              |                   |                        |                          |                           | 5.02<br>7.00   |
| 8.00 00800 LAUNDRY & LINEN SERVICE  |              |                   |                        |                          |                           | 8.00           |
| 9.00 00900 HOUSEKEEPI NG  |              |                   |                        |                          |                           | 9.00           |
| 10. 00 01000 DI ETARY   | 10.50        |                   |                        |                          |                           | 10.00          |
| 11. 00 01100 CAFETERIA<br>13. 00 01300 NURSING ADMINISTRATION                               | 13, 597      |                   |                        |                          |                           | 11.00<br>13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY   | 292          |                   | 2, 040, 614            |                          |                           | 14.00          |
| 15. 00 01500 PHARMACY   | 428          |                   | 52, 709                |                          |                           | 15.00          |
| 16.00 01600 MEDICAL RECORDS & LIBRARY   | 204          |                   | 982                    |                          | 1, 468, 665               | 1              |
| 17.00 01700 SOCIAL SERVICE  | 234          | 4 81, 873         | 0                      | 0                        | 0                         | 17.00          |
| 30. 00 03000 ADULTS & PEDIATRICS  | 2,809        | 1, 942, 474       | 109, 781               | 0                        | 467,007                   | 30.00          |
| 31. 00 03100 I NTENSI VE CARE UNI T   | 467          |                   |                        |                          | 260                       | 1              |
| 43. 00 04300 NURSERY  | 287          | 7 0               | 0                      | 0                        | 16, 306                   | 43.00          |
| ANCI LLARY SERVI CE COST CENTERS<br>50. 00 05000 OPERATI NG ROOM                            | 670          | 180, 448          | 280, 254               | 0                        | 338, 058                  | 50.00          |
| 51. 00 05100 RECOVERY ROOM  | 316          |                   |                        |                          | 260                       | 1              |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM  | (            |                   | 0                      |                          | 0                         |                |
| 53. 00 05300 ANESTHESI OLOGY  | (            | -                 | 0                      | 0                        | 0                         |                |
| 54. 00  05400  RADI OLOGY-DI AGNOSTI C<br>54. 01  05401  ULTRASOUND                         | 1,404        |                   | 148, 551<br>0          | 0                        | 176, 609<br>0             | 1              |
| 56. 00 05600 RADI 0I SOTOPE   |              |                   | 0                      | 0                        | 0                         |                |
| 57. 00 05700 CT SCAN  | 0            | 0 0               | 0                      | 0                        | 0                         |                |
| 58. 00 05800 MRI  | (            | -                 | 0                      | 0                        | 0                         | 1              |
| 60.00 06000 LABORATORY<br>62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                  | 1, 633       |                   | 3, 286                 | 0                        | 7, 823                    | 1              |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS<br>65. 00 06500 RESPI RATORY THERAPY      | 677          |                   | 81, 584<br>44, 531     | 0                        | 165<br>260                | 1              |
| 66. 00 06600 PHYSI CAL THERAPY  |              |                   | 5, 585                 | 0                        | 180, 043                  | 1              |
| 67.00 06700 OCCUPATI ONAL THERAPY   | (            |                   | 0                      | 0                        | 260                       | 1              |
| 68. 00 06800 SPEECH PATHOLOGY<br>69. 00 06900 ELECTROCARDI OLOGY                            | (            |                   | 0                      | 0                        | 260<br>2, 299             | 1              |
| 69. 00 06900 ELECTROCARDI OLOGY<br>71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT      | 275          |                   | 4, 322<br>30, 492      |                          | 2, 299                    | 1              |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS  |              |                   | 216, 386               |                          | 0                         | 1              |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | (            |                   |                        |                          | 0                         |                |
| 76.00 03610 SLEEP LAB   | (            | 0 0               | 0                      | 0                        | 0                         | 76.00          |
| OUTPATI ENT_SERVICE_COST_CENTERS           90.00         O9000         CLINIC               | 178          | 84, 476           | 6, 749                 | 0                        | 5, 789                    | 90.00          |
| 91.00 09100 EMERGENCY   | 2, 928       |                   |                        |                          | 226, 907                  |                |
| 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART   |              |                   |                        |                          |                           | 92.00          |
| 0THER REI MBURSABLE COST CENTERS<br>95.00 09500 AMBULANCE SERVI CES                         | 562          | 2 0               | 71, 668                | 0                        | 46, 359                   | 95.00          |
| SPECIAL PURPOSE COST CENTERS  | 502          |                   | /1,008                 | 0                        | 40, 339                   | 95.00          |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 13, 596      | 3, 894, 644       | 2, 040, 614            | 942, 615                 | 1, 468, 665               | 118.00         |
| NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN             |              |                   | 0                      | 0                        | 0                         | 190.00         |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES  |              |                   | 0                      | 0                        |                           | 192.00         |
| 200.00 Cross Foot Adjustments   |              |                   |                        |                          |                           | 200. 00        |
| 201.00 Negative Cost Centers  | 100 7.0      |                   |                        |                          | (00.7//                   | 201.00         |
| 202.00 Cost to be allocated (per Wkst. B,<br>Part I)  | 429, 745     | 5 560, 747        | 614, 839               | 896, 131                 | 638, 766                  | 202.00         |
| 203.00 Unit cost multiplier (Wkst. B, Part I)   | 31. 605869   | 0. 143979         | 0. 301301              | 0. 950686                | 0. 434930                 | 203.00         |
| 204.00 Cost to be allocated (per Wkst. B,   | 98, 843      |                   |                        | 91, 587                  | 131, 109                  | 1              |
| Part II)  | 7 0/0/7      |                   | 0.00044                | 0.0074/0                 | 0 000074                  | 205 00         |
| 205.00 Unit cost multiplier (Wkst. B, Part  | 7. 269471    | 0. 008658         | 0.068446               | 0. 097163                | 0.089271                  | 205.00         |
| 206.00 NAHE adjustment amount to be allocated   |              |                   |                        |                          |                           | 206. 00        |
| (per Wkst. B-2)   |              |                   |                        |                          |                           | 207 00         |
| 207.00 NAHE unit cost multiplier (Wkst. D,<br>Parts III and IV)                             |              |                   |                        |                          |                           | 207.00         |
| ,   | I            | 1                 | 1                      | ı I                      |                           | 1              |

|                | Financial Systems<br>LLOCATION - STATISTICAL BASIS                        | DUKES MEMORIAL         | Provi der CCN: 15-1318 | Peri od:        | <u>of Form CMS-2552-1</u><br>Worksheet B-1 |
|----------------|---|------------------------|------------------------|-----------------|--|
|                |   |                        |                        | From 01/01/2019 | Date/Time Prepared                         |
|                |   |                        |                        | 10 12/31/2019   | 8/28/2020 10: 36 am                        |
|                | Cost Center Description   | SOCI AL SERVI CE       |                        |                 |  |
|                |   | (TOTAL PATIENT         |                        |                 |  |
|                |   | DAYS)                  |                        |                 |  |
|                | GENERAL SERVICE COST CENTERS  | 17.00                  |                        |                 |  |
| 1.00           | 00100 CAP REL COSTS-BLDG & FIXT   |                        |                        |                 | 1.0  |
| 2.00           | 00200 CAP REL COSTS-MVBLE EQUIP   |                        |                        |                 | 2.0  |
| 4.00           | 00400 EMPLOYEE BENEFITS DEPARTMENT  |                        |                        |                 | 4. C                                       |
| 5.01           | 00570 ADMI TTI NG   |                        |                        |                 | 5.0  |
| 5.02<br>7.00   | 00590 ADMINISTRATIVE AND GENERAL<br>00700 OPERATION OF PLANT              |                        |                        |                 | 5.0  |
| 7.00<br>3.00   | 00800 LAUNDRY & LINEN SERVICE   |                        |                        |                 | 8.0  |
| 9.00           | 00900 HOUSEKEEPING  |                        |                        |                 | 9.0  |
| 10.00          | 01000 DI ETARY  |                        |                        |                 | 10.0                                       |
|                | 01100 CAFETERI A  |                        |                        |                 | 11.0                                       |
|                | 01300 NURSING ADMINISTRATION  |                        |                        |                 | 13.0                                       |
|                | 01400 CENTRAL SERVICES & SUPPLY   |                        |                        |                 | 14.0                                       |
|                | 01500 PHARMACY<br>01600 MEDI CAL RECORDS & LI BRARY                       |                        |                        |                 | 15.0                                       |
|                | 01700 SOCIAL SERVICE  | 3, 449                 |                        |                 | 17.0                                       |
|                | INPATIENT ROUTINE SERVICE COST CENTERS                                    |                        |                        |                 |  |
|                | 03000 ADULTS & PEDIATRICS   | 2, 709                 |                        |                 | 30. C                                      |
|                | 03100 I NTENSI VE CARE UNI T  | 407                    |                        |                 | 31.0                                       |
| 13.00          |   | 333                    |                        |                 | 43.0                                       |
| 50.00          | ANCI LLARY SERVI CE COST CENTERS  | 0                      |                        |                 | 50.0                                       |
|                | 05100 RECOVERY ROOM   | 0                      |                        |                 | 51.0                                       |
|                | 05200 DELIVERY ROOM & LABOR ROOM  | 0                      |                        |                 | 52.0                                       |
|                | 05300 ANESTHESI OLOGY   | 0                      |                        |                 | 53. C                                      |
|                | 05400 RADI OLOGY-DI AGNOSTI C   | 0                      |                        |                 | 54. C                                      |
|                | 05401 ULTRASOUND  | 0                      |                        |                 | 54.0                                       |
|                | 05600 RADI OI SOTOPE  | 0                      |                        |                 | 56. C<br>57. C                             |
| 58.00          | 05700 CT SCAN<br>05800 MRI  | 0                      |                        |                 | 57.0                                       |
|                | 06000 LABORATORY  | 0                      |                        |                 | 60.0                                       |
| 52.00          | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                                | 0                      |                        |                 | 62.0                                       |
| 65.00          | 06500 RESPI RATORY THERAPY  | 0                      |                        |                 | 65. C                                      |
|                | 06600 PHYSI CAL THERAPY   | 0                      |                        |                 | 66.0                                       |
|                | 06700 OCCUPATI ONAL THERAPY<br>06800 SPEECH PATHOLOGY                     | 0                      |                        |                 | 67.0                                       |
|                | 06900 ELECTROCARDI OLOGY  | 0                      |                        |                 | 68. 0<br>69. 0                             |
|                | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                 | 0                      |                        |                 | 71.0                                       |
|                | 07200 IMPL. DEV. CHARGED TO PATIENTS                                      | 0                      |                        |                 | 72.0                                       |
|                | 07300 DRUGS CHARGED TO PATIENTS   | 0                      |                        |                 | 73.0                                       |
| 76.00          | 03610 SLEEP LAB   | 0                      |                        |                 | 76.0                                       |
| 00 00          |   |                        |                        |                 |  |
|                | 09000 CLINIC<br>09100 EMERGENCY   | 0                      |                        |                 | 90. 0<br>91. 0                             |
|                | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                 | 0                      |                        |                 | 92.0                                       |
|                | OTHER REIMBURSABLE COST CENTERS   | I I                    |                        |                 |  |
| 95.00          | 09500 AMBULANCE SERVI CES   | 0                      |                        |                 | 95. C                                      |
|                | SPECIAL PURPOSE COST CENTERS  |                        |                        |                 |  |
| 118.00         |   | 3, 449                 |                        |                 | 118. 0                                     |
| 190 00         | NONREIMBURSABLE COST CENTERS<br>19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0                      |                        |                 | 190. 0                                     |
|                | 19200 PHYSI CLANS' PRI VATE OFFI CES                                      | 0                      |                        |                 | 190.0                                      |
| 00.00          |   |                        |                        |                 | 200. 0                                     |
| 201.00         |   |                        |                        |                 | 201. C                                     |
| 02.00          |   | 391, 236               |                        |                 | 202. 0                                     |
| 02 00          | Part I)   | 112 121610             |                        |                 | 202 0                                      |
| 03.00<br>04.00 |   | 113. 434619<br>38, 257 |                        |                 | 203. 0<br>204. 0                           |
| .57.00         | Part II)  | 50,207                 |                        |                 | 204.0                                      |
| 205.00         |   | 11. 092201             |                        |                 | 205. C                                     |
|                | 11)   |                        |                        |                 |  |
| 206.00         |   |                        |                        |                 | 206. 0                                     |
| 207.00         | (per Wkst. B-2)<br>NAHE unit cost multiplier (Wkst. D,                    |                        |                        |                 | 507 0                                      |
|                | INAME UNIT COST MULTIPLIER (WKSL. D,                                      |                        |                        |                 | 207.0                                      |

| COMPUTATION OF RATIO OF COSTS TO CHARGES |  | Th Financial Systems DUKES MEMORIAL H |               | CN: 15-1318 | In Lieu of Form CMS-25<br>Period: Worksheet C |               | 2552-10 |
|--|--|---------------------------------------|---------------|-------------|---|---------------|---------|
| COMPUT                                   | ATTON OF RATIO OF COSTS TO CHARGES         |                                       | Provider Co   | UN: 15-1318 | From 01/01/2019                               | Part I        |         |
|  |  |                                       |               |             | To 12/31/2019                                 | Date/Time Pre | pared:  |
|  |  |                                       |               |             |   | 8/28/2020 10: | 36 am   |
|  |  |                                       | Title         | XVIII       | Hospi tal                                     | Cost          |         |
|  |  |                                       |               |             | Costs   |               |         |
|  | Cost Center Description                    | Total Cost                            | Therapy Limit | Total Costs |   | Total Costs   |         |
|  |  | (from Wkst. B,                        | Adj .         |             | Di sal I owance                               |               |         |
|  |  | Part I, col.                          |               |             |   |               |         |
|  |  | 26)                                   | 2.00          | 2.00        | 4.00  | F 00          |         |
|  | INPATIENT ROUTINE SERVICE COST CENTERS     | 1.00                                  | 2.00          | 3.00        | 4.00  | 5.00          |         |
|  | 03000 ADULTS & PEDIATRICS                  | 7,013,669                             |               | 7,013,6     | 59 0  | 0             | 30.00   |
|  |  |                                       |               |             |   | 0             |         |
|  | 03100 I NTENSI VE CARE UNI T               | 1, 156, 507                           |               | 1, 156, 5   |   | -             |         |
| 43.00                                    |  | 525, 259                              |               | 525, 2      | 59 0  | 0             | 43.00   |
|  | ANCI LLARY SERVI CE COST CENTERS           | 2 (07 004                             |               | 2 (07 0     | 04 0  | 0             | 50.00   |
|  |  | 2, 607, 904                           |               | 2,607,9     |   |               |         |
|  | 05100 RECOVERY ROOM                        | 592, 557                              |               | 592, 5      | 57 0  | 0             |         |
|  | 05200 DELIVERY ROOM & LABOR ROOM           | 0                                     |               |             | 0 0   | 0             |         |
|  | 05300 ANESTHESI OLOGY                      | 0                                     |               |             | 0 0   | 0             |         |
|  | 05400 RADI OLOGY-DI AGNOSTI C              | 3, 021, 097                           |               | 3, 021, 0   | 97 0  | 0             |         |
|  | 05401 ULTRASOUND                           | 0                                     |               |             | 0 0   | 0             |         |
|  | 05600 RADI OI SOTOPE                       | 0                                     |               |             | 0 0   | 0             |         |
|  | 05700 CT SCAN                              | 0                                     |               |             | 0 0   | 0             |         |
|  | 05800 MRI                                  | 0                                     |               |             | 0 0   | 0             |         |
|  | 06000 LABORATORY                           | 2, 417, 917                           |               | 2, 417, 9   |   | 0             | 00.00   |
|  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 144, 525                              |               | 144, 5      |   | 0             |         |
|  | 06500 RESPI RATORY THERAPY                 | 1, 134, 128                           | 0             | .,          |   | 0             |         |
|  | 06600 PHYSI CAL THERAPY                    | 1, 395, 981                           | 0             | 1, 395, 9   |   | 0             | 00.00   |
|  | 06700 OCCUPATI ONAL THERAPY                | 246, 349                              |               | 246, 3      |   | 0             |         |
|  | 06800 SPEECH PATHOLOGY                     | 87, 295                               | 0             | 87, 2       | 95 0  | 0             | 68.00   |
|  | 06900 ELECTROCARDI OLOGY                   | 738, 722                              |               | 738, 7      | 22 0  | 0             | 69.00   |
| 71.00                                    | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 91, 633                               |               | 91, 6       | 33 0  | 0             | 71.00   |
|  | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 359, 312                              |               | 359, 3      | 12 0  | 0             | 72.00   |
| 73.00                                    | 07300 DRUGS CHARGED TO PATIENTS            | 2, 561, 927                           |               | 2, 561, 9   | 27 0  | 0             | 73.00   |
| 76.00                                    | 03610 SLEEP LAB                            | 0                                     |               |             | 0 0   | 0             | 76.00   |
|  | OUTPATIENT SERVICE COST CENTERS            |                                       |               |             |   |               |         |
|  | 09000 CLI NI C                             | 432, 343                              |               | 432, 3      | 43 0  | 0             | 90.00   |
|  | 09100 EMERGENCY                            | 6, 708, 487                           |               | 6, 708, 4   | 37 0  | 0             |         |
| 92.00                                    | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 1, 750, 350                           |               | 1, 750, 3   | 50  | 0             | 92.00   |
|  | OTHER REIMBURSABLE COST CENTERS            |                                       |               | 1           |   |               |         |
|  | 09500 AMBULANCE SERVI CES                  | 952, 201                              |               | 952, 2      |   | -             |         |
| 200.00                                   |  | 33, 938, 163                          |               |             |   |               | 200.00  |
| 201.00                                   |  | 1, 750, 350                           |               | 1, 750, 3   |   |               | 201.00  |
| 202.00                                   | Total (see instructions)                   | 32, 187, 813                          | 0             | 32, 187, 8  | 13 0  | 0             | 202.00  |

| Health Financial Systems                         | DUKES MEMORIA | L HOSPI TAL   |                          | In Lie                                      | u of Form CMS-  | 2552-10 |
|--|---------------|---------------|--------------------------|---|---|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES         |               | Provider C    |                          | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet C<br>Part I<br>Date/Time Pre<br>8/28/2020 10: |         |
|  |               |               | XVIII                    | Hospi tal                                   | Cost  |         |
|  |               | Charges       |                          |   |   |         |
| Cost Center Description                          | Inpati ent    | Outpati ent   | Total (col.<br>+ col. 7) | 6 Cost or Other<br>Ratio                    | TEFRA<br>Inpatient<br>Ratio                             |         |
|  | 6.00          | 7.00          | 8.00                     | 9.00  | 10.00   |         |
| INPATIENT ROUTINE SERVICE COST CENTERS           |               |               | •                        |   |   |         |
| 30. 00 03000 ADULTS & PEDI ATRI CS               | 6, 281, 746   |               | 6, 281, 74               | 16  |   | 30.00   |
| 31. 00 03100 I NTENSI VE CARE UNI T              | 1, 215, 408   |               | 1, 215, 40               | 08  |   | 31.00   |
| 43. 00 04300 NURSERY                             | 279, 672      |               | 279, 67                  | /2  |   | 43.00   |
| ANCILLARY SERVICE COST CENTERS                   |               |               |                          |   |   | 1       |
| 50. 00 05000 OPERATI NG ROOM                     | 3, 750, 542   | 11, 975, 325  | 15, 725, 86              | 0. 165835                                   | 0.00000   | 50.00   |
| 51.00 05100 RECOVERY ROOM                        | 630, 374      | 2, 465, 692   | 3, 096, 06               | 0. 191390                                   | 0.00000   | 51.00   |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM           | 0             | 0             |                          | 0 0.000000                                  | 0.00000   | 52.00   |
| 53. 00 05300 ANESTHESI OLOGY                     | 0             | 0             |                          | 0 0.000000                                  | 0.00000   | 53.00   |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C             | 6, 559, 551   | 35, 708, 638  | 42, 268, 18              | 0. 071474                                   | 0.00000   | 54.00   |
| 54. 01 05401 ULTRASOUND                          | 0             | 0             |                          | 0 0.000000                                  | 0.00000   | 54.01   |
| 56. 00 05600 RADI OI SOTOPE                      | 0             | 0             |                          | 0 0.000000                                  | 0.00000   | 56.00   |
| 57.00 05700 CT SCAN                              | 0             | 0             |                          | 0 0.000000                                  | 0.00000   | 57.00   |
| 58. 00 05800 MRI                                 | 0             | 0             | 1                        | 0 0.000000                                  | 0.00000   | 58.00   |
| 60. 00 06000 LABORATORY                          | 5, 890, 532   | 17, 967, 190  | 23, 857, 72              | 0. 101347                                   | 0.00000   | 60.00   |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 269, 536      | 233, 199      | 502, 73                  | 0. 287477                                   | 0.00000   | 62.00   |
| 65. 00 06500 RESPI RATORY THERAPY                | 3, 326, 268   | 1, 011, 897   | 4, 338, 16               | 0. 261430                                   | 0.00000   | 65.00   |
| 66.00 06600 PHYSI CAL THERAPY                    | 618, 040      | 2, 128, 144   | 2, 746, 18               | 0. 508335                                   | 0.00000   | 66.00   |
| 67.00 06700 OCCUPATIONAL THERAPY                 | 553, 850      | 680, 333      | 1, 234, 18               | 0. 199605                                   | 0.00000   | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                     | 102, 216      | 103, 928      | 206, 14                  | 0. 423466                                   | 0.00000   | 68.00   |
| 69. 00 06900 ELECTROCARDI OLOGY                  | 1, 692, 000   | 5, 118, 792   | 6, 810, 79               | 0. 108463                                   | 0.00000   | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 1, 700, 730   | 2, 701, 910   | 4, 402, 64               | 0. 020813                                   | 0.00000   | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 1, 137, 799   | 632, 381      | 1, 770, 18               | 0. 202980                                   | 0.00000   | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 11, 391, 707  | 15, 119, 836  | 26, 511, 54              | 0. 096634                                   | 0.00000   | 73.00   |
| 76.00 03610 SLEEP LAB                            | 0             | 0             |                          | 0 0.000000                                  | 0.00000   | 76.00   |
| OUTPATIENT SERVICE COST CENTERS                  |               |               |                          |   |   |         |
| 90. 00 09000 CLI NI C                            | 39, 458       | 60, 333       | 99, 79                   | 4. 332485                                   | 0.00000   | 90.00   |
| 91.00 09100 EMERGENCY                            | 2, 573, 685   | 21, 455, 487  | 24, 029, 17              | 0. 279181                                   | 0.00000   | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 636, 416      | 2, 378, 929   |                          |   | 0.00000   |         |
| OTHER REIMBURSABLE COST CENTERS                  |               |               |                          |   |   | 1       |
| 95.00 09500 AMBULANCE SERVICES                   | 0             | 8, 044, 648   | 8, 044, 64               | 0. 118365                                   | 0.00000   | 95.00   |
| 200.00 Subtotal (see instructions)               | 48, 649, 530  | 127, 786, 662 | 176, 436, 19             | 92  |   | 200.00  |
| 201.00 Less Observation Beds                     |               |               |                          |   |   | 201.00  |
| 202.00 Total (see instructions)                  | 48, 649, 530  | 127, 786, 662 | 176, 436, 19             | 22  |   | 202.00  |

| Health Financial Systems                         | DUKES MEMORIAL | HOSPI TAL             | In Lieu                                      | u of Form CMS-:   | 2552-10         |
|--|----------------|-----------------------|--|---|-----------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES         |                | Provider CCN: 15-1318 | Peri od:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet C<br>Part I<br>Date/Time Pre<br>8/28/2020 10: | pared:<br>36 am |
|  |                | Title XVIII           | Hospi tal                                    | Cost  |                 |
| Cost Center Description                          | PPS Inpatient  |                       |  |   |                 |
|  | Ratio          |                       |  |   |                 |
|  | 11.00          |                       |  |   |                 |
| INPATIENT ROUTINE SERVICE COST CENTERS           |                |                       |  |   |                 |
| 30. 00 03000 ADULTS & PEDI ATRI CS               |                |                       |  |   | 30.00           |
| 31.00 03100 INTENSIVE CARE UNIT                  |                |                       |  |   | 31.00           |
| 43. 00 04300 NURSERY                             |                |                       |  |   | 43.00           |
| ANCI LLARY SERVI CE COST CENTERS                 |                |                       |  |   |                 |
| 50.00 05000 OPERATING ROOM                       | 0. 000000      |                       |  |   | 50.00           |
| 51.00 05100 RECOVERY ROOM                        | 0. 000000      |                       |  |   | 51.00           |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM           | 0. 000000      |                       |  |   | 52.00           |
| 53. 00 05300 ANESTHESI OLOGY                     | 0. 000000      |                       |  |   | 53.00           |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C             | 0. 000000      |                       |  |   | 54.00           |
| 54. 01 05401 ULTRASOUND                          | 0. 000000      |                       |  |   | 54.01           |
| 56. 00 05600 RADI OI SOTOPE                      | 0. 000000      |                       |  |   | 56.00           |
| 57.00 05700 CT SCAN                              | 0. 000000      |                       |  |   | 57.00           |
| 58. 00 05800 MRI                                 | 0. 000000      |                       |  |   | 58.00           |
| 60. 00 06000 LABORATORY                          | 0. 000000      |                       |  |   | 60.00           |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000      |                       |  |   | 62.00           |
| 65. 00 06500 RESPI RATORY THERAPY                | 0. 000000      |                       |  |   | 65.00           |
| 66.00 06600 PHYSI CAL THERAPY                    | 0. 000000      |                       |  |   | 66.00           |
| 67.00 06700 OCCUPATIONAL THERAPY                 | 0. 000000      |                       |  |   | 67.00           |
| 68.00 06800 SPEECH PATHOLOGY                     | 0. 000000      |                       |  |   | 68.00           |
| 69. 00 06900 ELECTROCARDI OLOGY                  | 0. 000000      |                       |  |   | 69.00           |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0. 000000      |                       |  |   | 71.00           |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0. 000000      |                       |  |   | 72.00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000      |                       |  |   | 73.00           |
| 76.00 03610 SLEEP LAB                            | 0. 000000      |                       |  |   | 76.00           |
| OUTPATIENT SERVICE COST CENTERS                  | · · ·          |                       |  |   | 1               |
| 90. 00 09000 CLINIC                              | 0. 000000      |                       |  |   | 90.00           |
| 91.00 09100 EMERGENCY                            | 0. 000000      |                       |  |   | 91.00           |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 0.000000       |                       |  |   | 92.00           |
| OTHER REIMBURSABLE COST CENTERS                  |                |                       |  |   |                 |
| 95. 00 09500 AMBULANCE SERVICES                  | 0.000000       |                       |  |   | 95.00           |
| 200.00 Subtotal (see instructions)               |                |                       |  |   | 200.00          |
| 201.00 Less Observation Beds                     |                |                       |  |   | 201.00          |
| 202.00 Total (see instructions)                  |                |                       |  |   | 202.00          |
|  | i l            |                       |  |   |                 |

| Health Financial Systems                                     | DUKES MEMORIA                                       | AL HOSPITAL           |             | In Lie                                      | u of Form CMS-:   | 2552-10          |
|--|---|-----------------------|-------------|---|---|------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES                     |   | Provider C            |             | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet C<br>Part I<br>Date/Time Pre<br>8/28/2020 10: | epared:<br>36 am |
|  |   | Titl                  | e XIX       | Hospi tal                                   | PPS   |                  |
|  |   |                       |             | Costs                                       |   |                  |
| Cost Center Description                                      | Total Cost<br>(from Wkst. B,<br>Part I, col.<br>26) | Therapy Limit<br>Adj. | Total Costs | RCE<br>Di sal I owance                      | Total Costs   |                  |
|  | 1.00  | 2.00                  | 3.00        | 4.00  | 5.00  |                  |
| INPATIENT ROUTINE SERVICE COST CENTERS                       |   |                       |             | -   |   |                  |
| 30. 00 03000 ADULTS & PEDIATRICS                             | 7,013,669   |                       | 7, 013, 66  |   | 7, 013, 669   |                  |
| 31. 00 03100 I NTENSI VE CARE UNI T                          | 1, 156, 507   |                       | 1, 156, 50  |   | 1, 156, 507   |                  |
| 43. 00 04300 NURSERY   | 525, 259  |                       | 525, 25     | 9 0   | 525, 259  | 43.00            |
| ANCI LLARY SERVI CE COST CENTERS                             |   |                       |             |   |   |                  |
| 50. 00 05000 OPERATING ROOM                                  | 2, 607, 904   |                       | 2, 607, 90  |   | 2, 607, 904   |                  |
| 51.00 O5100 RECOVERY ROOM                                    | 592, 557  |                       | 592, 55     | / 0   | 592, 557  |                  |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM                      | 0   |                       |             | 0 0   | 0   |                  |
| 53. 00 05300 ANESTHESI OLOGY                                 | 0   |                       | 0.001.00    | 0 0   | 0   |                  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                         | 3, 021, 097   |                       | 3, 021, 09  | 7 0   | 3, 021, 097   |                  |
| 54. 01 05401 ULTRASOUND<br>56. 00 05600 RADI 0I SOTOPE       | 0   |                       |             | 0 0   | 0   |                  |
| 57. 00 05700 CT SCAN   | 0   |                       |             | 0 0   | 0   |                  |
| 58. 00 05800 MRI   | 0   |                       |             | 0 0   | 0   |                  |
| 60. 00 06000 LABORATORY                                      | 2, 417, 917   |                       | 2, 417, 91  | 7 0   | 2, 417, 917   |                  |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS            | 144, 525  |                       | 2, 417, 91  |   | 2, 417, 917<br>144, 525                                 |                  |
| 65. 00 06500 RESPIRATORY THERAPY                             | 1, 134, 128   | 0                     | 1, 134, 12  |   | 1, 134, 128   |                  |
| 66. 00 06600 PHYSI CAL THERAPY                               | 1, 134, 128   | 0                     | 1, 395, 98  |   | 1, 134, 128   |                  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                           | 246, 349  | 0                     | 246, 34     |   | 246, 349  |                  |
| 68. 00 06800 SPEECH PATHOLOGY                                | 87, 295   | 0                     | 87, 29      |   | 87, 295   |                  |
| 69. 00 06900 ELECTROCARDI OLOGY                              | 738, 722  | 0                     | 738, 72     |   | 738, 722  |                  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT              | 91,633  |                       | 91, 63      |   | 91,633  |                  |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS                  | 359, 312  |                       | 359, 31     |   | 359, 312  |                  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                       | 2, 561, 927   |                       | 2, 561, 92  |   | 2, 561, 927   |                  |
| 76. 00 03610 SLEEP LAB                                       | 2, 301, 727   |                       |             | 0 0   | 2, 301, 727   |                  |
| OUTPATIENT SERVICE COST CENTERS                              | 0   |                       | 1           | 0   | 0   | /0.00            |
| 90. 00 09000 CLINIC  | 432, 343  |                       | 432, 34     | 3 0   | 432, 343  | 90.00            |
| 91. 00 09100 EMERGENCY                                       | 6, 708, 487   |                       | 6, 708, 48  |   | 6, 708, 487   |                  |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART             | 1, 750, 350   |                       | 1, 750, 35  |   | 1, 750, 350   |                  |
| OTHER REIMBURSABLE COST CENTERS                              | .,  |                       |             | -   | .,  |                  |
| 95. 00 09500 AMBULANCE SERVICES                              | 952, 201  |                       | 952, 20     | 1 0   | 952, 201  | 95.00            |
|  | 33, 938, 163  | 0                     |             |   | 33, 938, 163  |                  |
|  | 33, 730, 103  | 0                     |             |   |   |                  |
| 200.00Subtotal (see instructions)201.00Less Observation Beds | 1, 750, 350   | 0                     | 1, 750, 35  |   | 1, 750, 350   |                  |

| Health Financial Systems                         | DUKES MEMORIA | L HOSPI TAL                  |              | In Lie                                      | u of Form CMS-  | 2552-10          |
|--|---------------|------------------------------|--------------|---|---|------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES         |               | Provider C                   | CN: 15-1318  | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet C<br>Part I<br>Date/Time Pre<br>8/28/2020 10: | epared:<br>36 am |
|  |               | Titl                         | e XIX        | Hospi tal                                   | PPS   |                  |
|  |               | Charges                      |              |   |   |                  |
| Cost Center Description                          | I npati ent   | Outpati ent                  | Total (col.  | 6 Cost or Other                             | TEFRA   |                  |
|  |               |                              | + col. 7)    | Ratio                                       | Inpati ent  |                  |
|  |               |                              |              |   | Ratio   |                  |
|  | 6.00          | 7.00                         | 8.00         | 9.00  | 10.00   |                  |
| INPATIENT ROUTINE SERVICE COST CENTERS           |               |                              |              |   |   |                  |
| 30. 00 03000 ADULTS & PEDIATRICS                 | 6, 281, 746   |                              | 6, 281, 74   |   |   | 30.00            |
| 31. 00 03100 INTENSIVE CARE UNIT                 | 1, 215, 408   |                              | 1, 215, 40   |   |   | 31.00            |
| 43. 00 04300 NURSERY                             | 279, 672      |                              | 279, 67      | 2   |   | 43.00            |
| ANCI LLARY SERVI CE COST CENTERS                 |               |                              |              |   |   |                  |
| 50.00 05000 OPERATING ROOM                       | 3, 750, 542   | 11, 975, 325                 |              |   | 0.00000   |                  |
| 51.00 05100 RECOVERY ROOM                        | 630, 374      | 2, 465, 692                  | 3, 096, 06   |   | 0.00000   |                  |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM           | 0             | 0                            |              | 0 0.000000                                  | 0.00000   | 52.00            |
| 53.00 05300 ANESTHESI OLOGY                      | 0             | 0                            |              | 0 0.000000                                  | 0. 000000   | 53.00            |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C              | 6, 559, 551   | 35, 708, 638                 | 42, 268, 18  | 0. 071474                                   | 0. 000000   | 54.00            |
| 54.01 05401 ULTRASOUND                           | 0             | 0                            |              | 0 0.000000                                  | 0.00000   | 54.01            |
| 56. 00 05600 RADI 0I SOTOPE                      | 0             | 0                            |              | 0 0.000000                                  | 0. 000000   | 56.00            |
| 57.00 05700 CT SCAN                              | 0             | 0                            |              | 0 0.000000                                  | 0.00000   | 57.00            |
| 58. 00 05800 MRI                                 | 0             | 0                            |              | 0 0.000000                                  | 0. 000000   | 58.00            |
| 60. 00 06000 LABORATORY                          | 5, 890, 532   | 17, 967, 190                 | 23, 857, 72  | 0. 101347                                   | 0. 000000   | 60.00            |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 269, 536      | 233, 199                     |              |   | 0.00000   |                  |
| 65. 00 06500 RESPI RATORY THERAPY                | 3, 326, 268   | 1, 011, 897                  |              |   | 0.00000   |                  |
| 66.00 06600 PHYSI CAL THERAPY                    | 618,040       | 2, 128, 144                  |              |   | 0. 000000   |                  |
| 67.00 06700 OCCUPATI ONAL THERAPY                | 553, 850      | 680, 333                     |              |   | 0. 000000   |                  |
| 68. 00 06800 SPEECH PATHOLOGY                    | 102, 216      | 103, 928                     |              |   | 0. 000000   |                  |
| 69. 00 06900 ELECTROCARDI OLOGY                  | 1, 692, 000   | 5, 118, 792                  |              |   | 0. 000000   |                  |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 1, 700, 730   | 2, 701, 910                  |              |   | 0. 000000   |                  |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS     | 1, 137, 799   | 632, 381                     |              |   | 0. 000000   |                  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS           | 11, 391, 707  | 15, 119, 836                 |              |   | 0.000000  |                  |
| 76. 00 03610 SLEEP LAB                           | 0             | 0                            |              | 0 0.000000                                  | 0.000000  |                  |
| OUTPATIENT SERVICE COST CENTERS                  | ц 0           | 0                            |              | 0 0.000000                                  | 0.00000   | / /0.00          |
| 90. 00 09000 CLINIC                              | 39, 458       | 60, 333                      | 99, 79       | 4. 332485                                   | 0.00000   | 90.00            |
| 91. 00 09100 EMERGENCY                           | 2, 573, 685   | 21, 455, 487                 |              |   | 0. 000000   |                  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 636, 416      | 2, 378, 929                  |              |   | 0. 000000   |                  |
| OTHER REIMBURSABLE COST CENTERS                  | 030,410       | 2, 310, 929                  | 3,015,34     | 0.000481                                    | 0.00000   | 72.00            |
| 95. 00 09500 AMBULANCE SERVICES                  | o             | 8, 044, 648                  | 8, 044, 64   | 0. 118365                                   | 0. 000000   | 95.00            |
| 200.00 Subtotal (see instructions)               | 48, 649, 530  | 8, 044, 648<br>127, 786, 662 |              |   | 0.00000   | 200.00           |
| 201.00 Less Observation Beds                     | 40, 049, 530  | 121, 100, 002                | 170, 430, 19 | <sup>7</sup> <sup>2</sup>                   |   | 200.00           |
| 201.00 Total (see instructions)                  | 10 640 520    | 127, 786, 662                | 176, 436, 19 | 17  |   | 201.00           |
|  | 48, 649, 530  | 121, 100, 002                | 170, 430, 19 | <sup>7</sup> 4                              |   | 1202. UU         |

| COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1318 Period:<br>From 01/01/20<br>To 12/31/20 | 9 Date/Time Prepared: |
|--|-----------------------|
|  | 8/28/2020 10:36 am    |
| Title XIX Hospital   | PPS                   |
| Cost Center Description PPS Inpatient  |                       |
| Ratio  |                       |
| 11.00  |                       |
| INPATIENT ROUTINE SERVICE COST CENTERS   |                       |
| 30. 00 03000 ADULTS & PEDIATRICS   | 30.00                 |
| 31.00 03100 INTENSIVE CARE UNIT  | 31.00                 |
| 43. 00 04300 NURSERY   | 43.00                 |
| ANCI LLARY SERVICE COST CENTERS  |                       |
| 50. 00 05000 OPERATING ROOM 0. 165835  | 50.00                 |
| 51. 00 05100 RECOVERY ROOM 0. 191390   | 51.00                 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 000000  | 52.00                 |
| 53. 00 05300 ANESTHESI OLOGY 0. 000000   | 53.00                 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 071474   | 54.00                 |
| 54. 01 05401 ULTRASOUND 0. 000000  | 54.01                 |
| 56. 00 05600 RADI 0I SOTOPE 0. 000000  | 56.00                 |
| 57. 00 05700 CT SCAN 0. 000000   | 57.00                 |
| 58. 00 05800 MRI 0. 000000   | 58.00                 |
| 60. 00 06000 LABORATORY 0. 101347  | 60.00                 |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 287477  | 62.00                 |
| 65. 00 06500 RESPI RATORY THERAPY 0. 261430  | 65.00                 |
| 66. 00 06600 PHYSICAL THERAPY 0. 508335  | 66.00                 |
| 67. 00 06700 OCCUPATI ONAL THERAPY 0. 199605   | 67.00                 |
| 68. 00 06800 SPEECH PATHOLOGY 0. 423466  | 68.00                 |
| 69. 00 06900 ELECTROCARDI OLOGY 0. 108463  | 69.00                 |
| 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 020813  | 71.00                 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 202980  | 72.00                 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 096634   | 73.00                 |
| 76. 00 03610 SLEEP LAB 0. 000000   | 76.00                 |
| OUTPATIENT SERVICE COST CENTERS  |                       |
| 90. 00 09000 CLINIC 4. 332485  | 90.00                 |
| 91. 00 09100 EMERGENCY 0. 279181   | 91.00                 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 580481   | 92.00                 |
| OTHER REIMBURSABLE COST CENTERS  |                       |
| 95. 00 09500 AMBULANCE SERVICES 0. 118365  | 95.00                 |
| 200.00 Subtotal (see instructions)   | 200.00                |
| 201.00 Less Observation Beds   | 201.00                |
| 202.00 Total (see instructions)  | 202.00                |

| Health Financial Systems  | DUKES MEMORI | AL HOSPI TAL   |            | In Lie                                      | u of Form CMS-2             | 2552-10 |
|---|--------------|----------------|------------|---|-----------------------------|---------|
| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA<br>REDUCTIONS FOR MEDICAID ONLY | TIOS NET OF  | Provider C     |            | Period:<br>From 01/01/2019<br>To 12/31/2019 | Date/Time Pre 8/28/2020 10: |         |
|   |              |                | e XIX      | Hospi tal                                   | PPS                         |         |
| Cost Center Description   | Total Cost   | Capital Cost   |            |   | Operating Cost              |         |
|   |              | (Wkst. B, Part |            |   | Reduction                   |         |
|   | I, col. 26)  | II col. 26)    |            | -   | Amount                      |         |
|   |              |                | col. 2)    |   |                             |         |
|   | 1.00         | 2.00           | 3.00       | 4.00  | 5.00                        |         |
| ANCI LLARY SERVI CE COST CENTERS  |              | i              |            | - 1   |                             |         |
| 50.00 05000 OPERATI NG ROOM   | 2, 607, 904  |                |            |   | 0                           | 50.00   |
| 51.00 05100 RECOVERY ROOM   | 592, 557     | 49, 566        | 542, 99    | 01 0  | 0                           | 51.00   |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM  | 0            | 0              |            | 0 0   | 0                           | 52.00   |
| 53. 00 05300 ANESTHESI OLOGY  | 0            | 0              |            | 0 0   | 0                           | 53.00   |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  | 3, 021, 097  | 479, 211       | 2, 541, 88 | 36 0  | 0                           | 54.00   |
| 54. 01 05401 ULTRASOUND   | 0            | 0              |            | 0 0   | 0                           | 54.01   |
| 56. 00 05600 RADI OI SOTOPE   | 0            | C              |            | 0 0   | 0                           | 56.00   |
| 57.00 05700 CT SCAN   | 0            | C              |            | 0 0   | 0                           | 57.00   |
| 58. 00 05800 MRI  | 0            | 0              |            | 0 0   | 0                           | 58.00   |
| 60. 00 06000 LABORATORY   | 2, 417, 917  | 154, 622       | 2, 263, 29 | 95 0  | 0                           | 60.00   |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                                    | 144, 525     | 11, 180        | 133, 34    | 15 0  | 0                           | 62.00   |
| 65. 00 06500 RESPI RATORY THERAPY   | 1, 134, 128  | 135, 132       | 998, 99    | 0 0   | 0                           | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY  | 1, 395, 981  | 358, 521       | 1, 037, 46 | 0 0   | 0                           | 66.00   |
| 67.00 06700 OCCUPATI ONAL THERAPY   | 246, 349     | 11, 475        | 234, 87    | 4 0   | 0                           | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY  | 87, 295      | 854            | 86, 44     | 1 0   | 0                           | 68.00   |
| 69. 00 06900 ELECTROCARDI OLOGY   | 738, 722     | 162, 115       | 576, 60    | 07 0  | 0                           | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                     | 91, 633      | 3, 731         | 87, 90     | 02 0  | 0                           | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS  | 359, 312     | 17, 834        | 341, 47    | /8 0  | 0                           | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | 2, 561, 927  | 170, 555       | 2, 391, 37 | 2 0   | 0                           | 73.00   |
| 76.00 03610 SLEEP LAB   | 0            | 0              |            | 0 0   | 0                           | 76.00   |
| OUTPATIENT SERVICE COST CENTERS   |              |                |            |   |                             |         |
| 90. 00 09000 CLINIC   | 432, 343     | 108, 096       | 324, 24    | 17 0  | 0                           | 90.00   |
| 91.00 09100 EMERGENCY   | 6, 708, 487  | 397, 276       | 6, 311, 21 | 1 0   | 0                           | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                                     | 1,750,350    | 338, 316       | 1, 412, 03 | 34 0  | 0                           | 92.00   |
| OTHER REIMBURSABLE COST CENTERS   |              |                |            |   |                             |         |
| 95. 00 09500 AMBULANCE SERVICES   | 952, 201     | 116, 518       | 835, 68    | 33 0  | 0                           | 95.00   |
| 200.00 Subtotal (sum of lines 50 thru 199)  | 25, 242, 728 |                |            |   | 0                           | 200.00  |
| 201.00 Less Observation Beds  | 1, 750, 350  |                |            |   | 0                           | 201.00  |
| 202.00 Total (line 200 minus line 201)  | 23, 492, 378 |                |            |   | 0                           | 202.00  |

| Health Financial Systems                            | DUKES MEMORIA  | AL HOSPI TAL   |              | In Li                                 | eu of Form CMS-2552-10                    |
|---|----------------|----------------|--------------|---------------------------------------|---|
| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA | ATIOS NET OF   | Provider C     | CN: 15-1318  | Peri od:                              | Worksheet C                               |
| REDUCTIONS FOR MEDICAID ONLY                        |                |                |              | From 01/01/2019                       |   |
|   |                |                |              | To 12/31/2019                         | Date/Time Prepared:<br>8/28/2020 10:36 am |
|   |                | Ti tl          | e XIX        | Hospi tal                             | PPS                                       |
| Cost Center Description                             | Cost Net of    | Total Charges  | Outpati ent  | · · · · · · · · · · · · · · · · · · · |   |
|   | Capital and    | (Worksheet C,  | Cost to Char | ge                                    |   |
|   | Operating Cost | Part I, column | Ratio (col.  | 6                                     |   |
|   | Reduction      | 8)             | / col. 7)    |                                       |   |
|   | 6.00           | 7.00           | 8.00         |                                       |   |
| ANCI LLARY SERVI CE COST CENTERS                    |                |                |              | -                                     |   |
| 50.00 05000 OPERATI NG ROOM                         | 2, 607, 904    | 15, 725, 867   | 0. 1658      | 35                                    | 50.00                                     |
| 51.00 05100 RECOVERY ROOM                           | 592, 557       | 3, 096, 066    |              |                                       | 51.00                                     |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM              | 0              | 0              | 0.0000       | 00                                    | 52.00                                     |
| 53. 00 05300 ANESTHESI OLOGY                        | 0              | 0              | 0.0000       | 00                                    | 53.00                                     |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | 3, 021, 097    | 42, 268, 189   | 0.0714       | 74                                    | 54.00                                     |
| 54. 01 05401 ULTRASOUND                             | 0              | 0              | 0.0000       | 00                                    | 54.01                                     |
| 56. 00 05600 RADI OI SOTOPE                         | 0              | 0              | 0.0000       | 00                                    | 56.00                                     |
| 57.00 05700 CT SCAN                                 | 0              | 0              | 0.0000       | 00                                    | 57.00                                     |
| 58.00 05800 MRI                                     | 0              | 0              | 0.0000       | 00                                    | 58.00                                     |
| 60. 00 06000 LABORATORY                             | 2, 417, 917    | 23, 857, 722   | 0. 1013      | 47                                    | 60.00                                     |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 144, 525       | 502, 735       | 0. 2874      | 77                                    | 62.00                                     |
| 65. 00 06500 RESPI RATORY THERAPY                   | 1, 134, 128    | 4, 338, 165    | 0. 2614      | 30                                    | 65.00                                     |
| 66. 00 06600 PHYSI CAL THERAPY                      | 1, 395, 981    | 2, 746, 184    | 0. 5083      | 35                                    | 66.00                                     |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 246, 349       | 1, 234, 183    | 0. 1996      | 05                                    | 67.00                                     |
| 68.00 06800 SPEECH PATHOLOGY                        | 87, 295        | 206, 144       | 0. 4234      | 66                                    | 68.00                                     |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 738, 722       | 6, 810, 792    | 0. 1084      | 63                                    | 69.00                                     |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 91, 633        | 4, 402, 640    | 0. 0208      | 13                                    | 71.00                                     |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 359, 312       | 1, 770, 180    | 0. 2029      | 80                                    | 72.00                                     |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 2, 561, 927    | 26, 511, 543   | 0. 0966      | 34                                    | 73.00                                     |
| 76.00 03610 SLEEP LAB                               | 0              | 0              | 0.0000       | 00                                    | 76.00                                     |
| OUTPATIENT SERVICE COST CENTERS                     |                |                |              |                                       |   |
| 90. 00 09000 CLINIC                                 | 432, 343       | 99, 791        | 4. 3324      | 85                                    | 90.00                                     |
| 91.00 09100 EMERGENCY                               | 6, 708, 487    | 24, 029, 172   | 0. 2791      | 81                                    | 91.00                                     |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 1, 750, 350    | 3, 015, 345    | 0. 5804      | 81                                    | 92.00                                     |
| OTHER REIMBURSABLE COST CENTERS                     | · · · · · · ·  |                |              |                                       |   |
| 95.00 09500 AMBULANCE SERVICES                      | 952, 201       | 8,044,648      | 0. 1183      | 65                                    | 95.00                                     |
| 200.00 Subtotal (sum of lines 50 thru 199)          | 25, 242, 728   | 168, 659, 366  |              |                                       | 200.00                                    |
| 201.00 Less Observation Beds                        | 1, 750, 350    | 0              |              |                                       | 201.00                                    |
| 202.00 Total (line 200 minus line 201)              | 23, 492, 378   | 168, 659, 366  |              |                                       | 202.00                                    |

| Health Financial Systems                            | DUKES MEMORIA  | AL HOSPITAL    |              | In Lie                           | u of Form CMS-:          | 2552-10  |
|---|----------------|----------------|--------------|----------------------------------|--------------------------|----------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS        | Provider C     | CN: 15-1318  | Peri od:                         | Worksheet D              |          |
|   |                |                |              | From 01/01/2019<br>To 12/31/2019 | Part II<br>Date/Time Pre | norod.   |
|   |                |                |              | 10 12/31/2019                    | 8/28/2020 10:            |          |
|   |                | Title          | × XVIII      | Hospi tal                        | Cost                     | 00 0     |
| Cost Center Description                             | Capi tal       | Total Charges  | Ratio of Cos | t Inpatient                      | Capital Costs            |          |
|   |                | (from Wkst. C, |              | Program                          | (column 3 x              |          |
|   | (from Wkst. B, |                |              | . Charges                        | column 4)                |          |
|   | Part II, col.  | 8)             | 2)           |                                  |                          |          |
|   | 26)            |                |              |                                  |                          |          |
|   | 1.00           | 2.00           | 3.00         | 4.00                             | 5.00                     |          |
| ANCI LLARY SERVICE COST CENTERS                     |                |                |              |                                  |                          |          |
| 50. 00 05000 OPERATING ROOM                         | 564, 155       |                |              |                                  |                          |          |
| 51.00 05100 RECOVERY ROOM                           | 49, 566        | 3, 096, 066    |              |                                  | 2, 633                   |          |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM              | 0              | 0              | 0.0000       |                                  | 0                        |          |
| 53. 00 05300 ANESTHESI OLOGY                        | 0              | 0              | 0.0000       |                                  | 0                        | 00.00    |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | 479, 211       | 42, 268, 189   |              |                                  | 37, 919                  |          |
| 54. 01 05401 ULTRASOUND                             | 0              | 0              | 0.0000       |                                  | 0                        |          |
| 56. 00 05600 RADI 0I SOTOPE                         | 0              | 0              | 0.0000       |                                  | 0                        |          |
| 57. 00 05700 CT SCAN                                | 0              | 0              | 0.0000       |                                  | 0                        | 07100    |
| 58.00 05800 MRI                                     | 0              | 0              | 0.0000       |                                  | 0                        | 00.00    |
| 60. 00 06000 LABORATORY                             | 154, 622       |                |              |                                  | 18, 301                  | 60.00    |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 11, 180        |                |              |                                  | 3, 398                   | •        |
| 65.00 06500 RESPI RATORY THERAPY                    | 135, 132       |                |              |                                  |                          |          |
| 66. 00 06600 PHYSI CAL THERAPY                      | 358, 521       | 2, 746, 184    |              |                                  |                          | •        |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 11, 475        |                |              |                                  |                          |          |
| 68.00 06800 SPEECH PATHOLOGY                        | 854            |                |              |                                  |                          |          |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 162, 115       |                |              |                                  |                          |          |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 3, 731         | 4, 402, 640    |              |                                  |                          |          |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 17, 834        |                |              |                                  |                          |          |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 170, 555       |                |              |                                  |                          |          |
| 76.00 03610 SLEEP LAB                               | 0              | 0              | 0.0000       | 0 0                              | 0                        | 76.00    |
| OUTPATIENT SERVICE COST CENTERS                     |                |                |              |                                  |                          |          |
| 90. 00 09000 CLINIC                                 | 108, 096       |                |              |                                  | 0                        |          |
| 91.00 09100 EMERGENCY                               | 397, 276       |                |              |                                  |                          | •        |
| 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART  | 338, 316       | 3, 015, 345    | 0. 11219     | 255, 148                         | 28, 627                  | 92.00    |
| OTHER REI MBURSABLE COST CENTERS                    | 1              |                | 1            |                                  |                          | 05.00    |
| 95.00 09500 AMBULANCE SERVICES                      | 2 0/2 /22      | 1/0 /14 740    |              | 10 005 (0)                       | 200 (22                  | 95.00    |
| 200.00   Total (lines 50 through 199)               | 2, 962, 639    | 160, 614, 718  | 1            | 18, 885, 626                     | 308, 638                 | 1200. OO |

| Health Financial Systems   | DUKES MEMORIA   | AL HOSPI TAL  |             | In Lie                                      | u of Form CMS-2 | 2552-10 |
|--|-----------------|---------------|-------------|---|-----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER<br>THROUGH COSTS | VICE OTHER PASS | S Provider C  | CN: 15-1318 | Period:<br>From 01/01/2019<br>To 12/31/2019 |                 |         |
|  |                 | Titl€         | e XVIII     | Hospi tal                                   | Cost            |         |
| Cost Center Description  |                 |               |             | Allied Health                               | Allied Health   |         |
|  | Anesthetist     | Post-Stepdown |             | Post-Stepdown                               |                 |         |
|  | Cost            | Adjustments   |             | Adjustments                                 |                 |         |
|  | 1.00            | 2A            | 2.00        | 3A  | 3.00            |         |
| ANCI LLARY SERVI CE COST CENTERS                                     |                 |               |             |   |                 |         |
| 50.00 05000 OPERATI NG ROOM  | 0               | C             |             | 0 0   | 0               | 50.00   |
| 51.00 05100 RECOVERY ROOM  | 0               | C             | )           | 0 0   | 0               | 51.00   |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM                               | 0               | C             | )           | 0 0   | 0               | 52.00   |
| 53. 00 05300 ANESTHESI OLOGY   | 0               | C             |             | 0 0   | 0               | 53.00   |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                                 | 0               | C             |             | 0 0   | 0               | 54.00   |
| 54. 01 05401 ULTRASOUND  | 0               | C             |             | 0 0   | 0               | 54.01   |
| 56. 00 05600 RADI 0I SOTOPE  | 0               | C             |             | 0 0   | 0               | 56.00   |
| 57.00 05700 CT SCAN  | 0               | C             |             | 0 0   | 0               | 57.00   |
| 58. 00 05800 MRI   | 0               | C             |             | 0 0   | 0               | 58.00   |
| 60. 00 06000 LABORATORY  | 0               | C             |             | 0 0   | 0               | 60.00   |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                     | 0               | C             |             | 0 0   | 0               | 62.00   |
| 65. 00 06500 RESPI RATORY THERAPY                                    | 0               | C             |             | 0 0   | 0               | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                                       | 0               | C             |             | 0 0   | 0               | 66.00   |
| 67.00 06700 OCCUPATI ONAL THERAPY                                    | 0               | C             |             | 0 0   | 0               | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY   | 0               | C             |             | 0 0   | 0               | 68.00   |
| 69. 00 06900 ELECTROCARDI OLOGY                                      | 0               | C             |             | 0 0   | 0               | 69.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                      | 0               | C             |             | 0 0   | 0               | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                           | 0               | C             |             | 0 0   | 0               | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                                | 0               | C             |             | 0 0   | 0               | 73.00   |
| 76.00 03610 SLEEP LAB  | 0               | C             |             | 0 0   | 0               | 76.00   |
| OUTPATIENT SERVICE COST CENTERS                                      |                 |               |             |   | -               | 1       |
| 90, 00 09000 CLINIC  | 0               | C             | )           | 0 0   | 0               | 90.00   |
| 91. 00 09100 EMERGENCY   | 0               | C             |             | 0 0   | 0               | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                      | 0               |               |             | 0   | 0               | 92.00   |
| OTHER REIMBURSABLE COST CENTERS                                      |                 |               |             |   | -               | 1       |
| 95. 00 09500 AMBULANCE SERVICES                                      |                 |               |             |   |                 | 95.00   |
| 200.00 Total (lines 50 through 199)                                  | 0               | C             |             | 0 0   | 0               | 200. 00 |

| Health Financial Systems   | DUKES MEMORIA   | AL HOSPI TAL  |              | In Lie                           | eu of Form CMS-: | 2552-10 |
|--|-----------------|---------------|--------------|----------------------------------|------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA                      | RVICE OTHER PAS | S Provider C  | CN: 15-1318  | Peri od:                         | Worksheet D      |         |
| THROUGH COSTS  |                 |               |              | From 01/01/2019<br>To 12/31/2019 |                  | narod   |
|  |                 |               |              | 10 12/31/2019                    | 8/28/2020 10:    |         |
|  |                 | Title         | 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             |         |
|  | 4.00            | 5.00          | ( 00         | 7.00                             | instructions)    |         |
|  | 4.00            | 5.00          | 6.00         | 7.00                             | 8.00             |         |
| ANCI LLARY SERVI CE COST CENTERS<br>50. 00 05000 OPERATI NG ROOM         |                 |               |              | 0 15, 725, 867                   | 0. 000000        | 50.00   |
| 51.00 05100 RECOVERY ROOM  | 0               |               |              | 0 15, 725, 867<br>0 3, 096, 066  |                  |         |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM                                  | 0               | 0             |              | 0 3, 090, 000                    | 0.000000         | 52.00   |
| 53. 00 05200 DELIVERT ROOM & LABOR ROOM<br>53. 00 05300 ANESTHESI OLOGY  | 0               | 0             |              | 0 0                              | 0.000000         | 52.00   |
| 54. 00  05500  ANESTHEST OLOGY<br>54. 00  05400  RADI OLOGY-DI AGNOSTI C | 0               | 0             |              | 0 42, 268, 189                   |                  | 54.00   |
| 54. 01 05401 ULTRASOUND  | 0               | 0             |              | 42, 200, 109                     | 0.000000         |         |
| 56. 00 05600 RADI 0I SOTOPE  | 0               | 0             |              | 0 0                              | 0.000000         | 56.00   |
| 57. 00 05700 CT SCAN   | 0               | 0             |              |                                  | 0.000000         | 57.00   |
| 58. 00  05800 MRI  | 0               |               |              |                                  | 0.000000         | 58.00   |
| 60. 00 06000 LABORATORY  | 0               |               |              | 0 23, 857, 722                   |                  |         |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                         | 0               |               |              | 0 23, 037, 722                   |                  |         |
| 65. 00 06500 RESPIRATORY THERAPY   | 0               |               |              | 0 4, 338, 165                    |                  |         |
| 66. 00 06600 PHYSI CAL THERAPY   | 0               | 0             |              | 0 2, 746, 184                    |                  |         |
| 67. 00 06700 OCCUPATI ONAL THERAPY                                       | 0               | 0             |              | 0 1, 234, 183                    |                  | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY   | 0               | 0             |              | 0 206, 144                       |                  |         |
| 69. 00 06900 ELECTROCARDI OLOGY  | 0               | 0             |              | 0 6, 810, 792                    |                  |         |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                          | 0               | 0             | )            | 0 4, 402, 640                    |                  |         |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                               | 0               | 0             | )            | 0 1, 770, 180                    |                  | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                                    | 0               | 0             |              | 0 26, 511, 543                   |                  | 73.00   |
| 76.00 03610 SLEEP LAB  | 0               | 0             | )            | 0 0                              | 0.000000         | 76.00   |
| OUTPATIENT SERVICE COST CENTERS  |                 |               |              |                                  |                  |         |
| 90. 00 09000 CLI NI C  | 0               | 0             | )            | 0 99, 791                        | 0.000000         | 90.00   |
| 91.00 09100 EMERGENCY  | 0               | 0             | )            | 0 24, 029, 172                   | 0. 000000        | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                          | 0               | 0             |              | 0 3, 015, 345                    |                  | 92.00   |
| OTHER REIMBURSABLE COST CENTERS  |                 |               |              |                                  |                  |         |
| 95. 00 09500 AMBULANCE SERVICES  |                 |               |              |                                  |                  | 95.00   |
| 200.00 Total (lines 50 through 199)                                      | 0               | 0             |              | 0 160, 614, 718                  |                  | 200. 00 |
|  |                 |               |              |                                  |                  |         |

| Health Financial Systems                            | DUKES MEMORIAL   | HOSPI TAL    |             |    | In Lie        | u of Form CMS-2                | 2552-10         |
|---|------------------|--------------|-------------|----|---------------|--------------------------------|-----------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA | RVICE OTHER PASS | Provider C   | CN: 15-1318 |    | ri od:        | Worksheet D                    |                 |
| THROUGH COSTS                                       |                  |              |             |    | om 01/01/2019 | Part IV                        |                 |
|   |                  |              |             | To | 12/31/2019    | Date/Time Pre<br>8/28/2020 10: | pared:<br>36 am |
|   |                  | Title        | × XVIII     |    | Hospi tal     | Cost                           | <u>50 alli</u>  |
| Cost Center Description                             | Outpati ent      | Inpati ent   | I npati ent |    | Outpati ent   | Outpati ent                    |                 |
|   | Ratio of Cost    | Program      | Program     |    | Program       | Program                        |                 |
|   | to Charges       | Charges      | Pass-Throug | h  | Charges       | Pass-Through                   |                 |
|   | (col. 6 ÷ col.   |              | Costs (col. | 8  |               | Costs (col. 9                  |                 |
|   | 7)               |              | x col. 10)  |    |               | x col. 12)                     |                 |
|   | 9.00             | 10.00        | 11.00       |    | 12.00         | 13.00                          |                 |
| ANCI LLARY SERVI CE COST CENTERS                    |                  |              | 1           |    |               |                                |                 |
| 50. 00 05000 OPERATI NG ROOM                        | 0. 000000        | 1, 079, 957  |             | 0  | 0             | 0                              | 50.00           |
| 51.00 05100 RECOVERY ROOM                           | 0. 000000        | 164, 447     |             | 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        | 0            |             | 0  | 0             | 0                              | 53.00           |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | 0.000000         | 3, 344, 741  |             | 0  | 0             | 0                              | 54.00           |
| 54. 01 05401 ULTRASOUND                             | 0. 000000        | 0            |             | 0  | 0             | 0                              | 54.01           |
| 56. 00 05600 RADI OI SOTOPE                         | 0. 000000        | 0            |             | 0  | 0             | 0                              | 56.00           |
| 57.00 05700 CT SCAN                                 | 0. 000000        | 0            |             | 0  | 0             | 0                              | 57.00           |
| 58. 00 05800 MRI                                    | 0. 000000        | 0            |             | 0  | 0             | 0                              | 58.00           |
| 60. 00 06000 LABORATORY                             | 0. 000000        | 2, 823, 771  |             | 0  | 0             | 0                              | 60.00           |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 0.000000         | 152, 821     |             | 0  | 0             | 0                              | 62.00           |
| 65. 00 06500 RESPI RATORY THERAPY                   | 0.000000         | 1, 653, 366  |             | 0  | 0             | 0                              | 65.00           |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0.000000         | 326, 209     |             | 0  | 0             | 0                              | 66.00           |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 0. 000000        | 298, 259     |             | 0  | 0             | 0                              | 67.00           |
| 68.00 06800 SPEECH PATHOLOGY                        | 0. 000000        | 41, 239      |             | 0  | 0             | 0                              | 68.00           |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0.000000         | 929, 406     |             | 0  | 0             | 0                              | 69.00           |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0, 000000        | 727,066      |             | 0  | 0             | 0                              | 71.00           |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0.000000         | 342,010      |             | 0  | 0             | 0                              | 72.00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0.000000         | 5, 519, 943  |             | 0  | 0             | 0                              | 73.00           |
| 76.00 03610 SLEEP LAB                               | 0.000000         | 0            |             | 0  | 0             | 0                              | 76.00           |
| OUTPATIENT SERVICE COST CENTERS                     |                  |              |             |    |               |                                |                 |
| 90, 00 09000 CLINIC                                 | 0.000000         | 0            |             | 0  | 0             | 0                              | 90.00           |
| 91. 00 09100 EMERGENCY                              | 0,000000         | 1, 227, 243  |             | 0  | 0             | 0                              | 91.00           |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0.000000         | 255, 148     |             | 0  | 0             | 0                              | 92.00           |
| OTHER REIMBURSABLE COST CENTERS                     |                  |              |             |    |               |                                |                 |
| 95. 00 09500 AMBULANCE SERVICES                     |                  |              |             |    |               |                                | 95.00           |
| 200.00 Total (lines 50 through 199)                 |                  | 18, 885, 626 |             | 0  | 0             | 0                              | 200.00          |
|   |                  |              | •           |    |               |                                | •               |

| Health Financial Systems                            | DUKES MEMORIA  | AL HOSPI TAL   |               | In Lie                                      | u of Form CMS-:   | 2552-10         |
|---|----------------|----------------|---------------|---|---|-----------------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST   | Provider C     |               | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet D<br>Part V<br>Date/Time Pre<br>8/28/2020 10: | pared:<br>36 am |
|   |                | Title          | XVIII         | Hospi tal                                   | Cost  |                 |
|   |                |                | Charges       |   | Costs   |                 |
| Cost Center Description                             | Cost to Charge | PPS Reimbursed | Cost          | Cost  | PPS Services  |                 |
|   | Ratio From     | Services (see  | Reimbursed    | Reimbursed                                  | (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           | 3.00          | 4.00  | 5.00  |                 |
| ANCILLARY SERVICE COST CENTERS                      |                |                |               |   |   |                 |
| 50.00 05000 OPERATING ROOM                          | 0. 165835      | 0              | 2, 306, 54    | 3 0   | 0   | 50.00           |
| 51.00 05100 RECOVERY ROOM                           | 0. 191390      | 0              | 513, 73       | 7 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      | 0              |               | 0 0   | 0   | 53.00           |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | 0. 071474      | 0              | 11, 103, 18   | 9 0   | 0   | 54.00           |
| 54. 01 05401 ULTRASOUND                             | 0. 000000      | 0              |               | 0 0   | 0   | 54.01           |
| 56. 00 05600 RADI OI SOTOPE                         | 0. 000000      | 0              |               | 0 0   | 0   | 56.00           |
| 57.00 05700 CT SCAN                                 | 0. 000000      | 0              |               | 0 0   | 0   | 57.00           |
| 58. 00 05800 MRI                                    | 0. 000000      | 0              |               | 0 0   | 0   | •               |
| 60. 00 06000 LABORATORY                             | 0. 101347      | 0              | 4, 698, 97    | 0 0   | 0   | 60.00           |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 0. 287477      | l o            | 124, 10       | 9 0   | 0   | 62.00           |
| 65. 00 06500 RESPI RATORY THERAPY                   | 0. 261430      |                | 322, 19       |   | 0   | 65.00           |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0. 508335      |                | 470, 96       |   | 0   | 66.00           |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 0. 199605      |                | 28, 03        |   | 0   | 67.00           |
| 68.00 06800 SPEECH PATHOLOGY                        | 0, 423466      |                | 9, 79         |   | 0   | 68.00           |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0. 108463      |                | 1, 451, 30    |   | 0   |                 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT    | 0. 020813      |                | 267, 02       |   | 0   |                 |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS         | 0. 202980      |                | 140, 81       |   | 0   | 72.00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0. 096634      |                |               |   | 0   |                 |
| 76. 00 03610 SLEEP LAB                              | 0. 000000      |                |               | 0 0   | 0   | •               |
| OUTPATIENT SERVICE COST CENTERS                     |                | -              |               |   |   |                 |
| 90. 00 09000 CLINIC                                 | 4. 332485      | 0              | 10, 57        | 3 5,060                                     | 0   | 90.00           |
| 91. 00 09100 EMERGENCY                              | 0. 279181      |                |               |   | 0   |                 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART    | 0. 580481      | 0              |               |   | 0   |                 |
| OTHER REIMBURSABLE COST CENTERS                     | 01000101       |                | ,,,,,,,,      | 0   |   | 12100           |
| 95. 00 09500 AMBULANCE SERVICES                     | 0, 118365      |                |               | 0   |   | 95.00           |
| 200.00 Subtotal (see instructions)                  | 0.110000       | 0              | 31, 910, 82   | 4 20, 301                                   | 0   | 200.00          |
| 201.00 Less PBP Clinic Lab. Services-Program        |                | Ĭ              |               | 0 0   | Ű   | 201.00          |
| Only Charges  |                |                |               |   |   |                 |
| 202.00 Net Charges (line 200 - line 201)            |                | 0              | 31, 910, 82   | 4 20, 301                                   | 0   | 202.00          |

|           | inancial Systems                             | DUKES MEMORIA | AL HOSPI TAL  |             | In Lie                                      | u of Form CMS   | -2552-10 |
|-----------|--|---------------|---------------|-------------|---|---|----------|
| APPORTI C | DNMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST  | Provider CO   | CN: 15-1318 | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet D<br>Part V<br>Date/Time Pr<br>8/28/2020 10 |          |
|           |  |               | Title         | XVIII       | Hospi tal                                   | Cost  |          |
|           |  | Cos           | sts           |             |   |   |          |
|           | Cost Center Description                      | Cost          | Cost          |             |   |   |          |
|           |  | Reimbursed    | Reimbursed    |             |   |   |          |
|           |  | Servi ces     | Services Not  |             |   |   |          |
|           |  | Subject To    | Subject To    |             |   |   |          |
|           |  | Ded. & Coins. | Ded. & Coins. |             |   |   |          |
|           |  | (see inst.)   | (see inst.)   |             |   |   |          |
|           |  | 6.00          | 7.00          |             |   |   |          |
|           | NCILLARY SERVICE COST CENTERS                |               |               |             |   |   |          |
|           | 5000 OPERATING ROOM                          | 382, 506      |               |             |   |   | 50.00    |
|           | 5100 RECOVERY ROOM                           | 98, 324       |               |             |   |   | 51.00    |
|           | 5200 DELIVERY ROOM & LABOR ROOM              | 0             | -             |             |   |   | 52.00    |
|           | 5300 ANESTHESI OLOGY                         | 0             | 0             |             |   |   | 53.00    |
|           | 5400 RADI OLOGY-DI AGNOSTI C                 | 793, 589      | 0             |             |   |   | 54.00    |
|           | 5401 ULTRASOUND                              | 0             | -             |             |   |   | 54.01    |
|           | 5600 RADI OI SOTOPE                          | 0             | 0             |             |   |   | 56.00    |
|           | 5700 CT SCAN                                 | 0             | 0             |             |   |   | 57.00    |
|           | 5800 MRI                                     | 0             | 0             |             |   |   | 58.00    |
|           | 6000 LABORATORY                              | 476, 227      | 0             |             |   |   | 60.00    |
| 62.00 0   | 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 35, 678       | 0             |             |   |   | 62.00    |
|           | 6500 RESPI RATORY THERAPY                    | 84, 232       | 0             |             |   |   | 65.00    |
| 66.00 0   | 6600 PHYSI CAL THERAPY                       | 239, 410      | 0             |             |   |   | 66.00    |
| 67.00 0   | 6700 OCCUPATI ONAL THERAPY                   | 5, 596        | 0             |             |   |   | 67.00    |
| 68.00 0   | 6800 SPEECH PATHOLOGY                        | 4, 147        | 0             |             |   |   | 68.00    |
| 69.00 0   | 6900 ELECTROCARDI OLOGY                      | 157, 413      | 0             |             |   |   | 69.00    |
| 71.00 0   | 7100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 5, 558        | 0             |             |   |   | 71.00    |
| 72.00 0   | 7200 IMPL. DEV. CHARGED TO PATIENTS          | 28, 583       | 0             |             |   |   | 72.00    |
|           | 7300 DRUGS CHARGED TO PATIENTS               | 496, 642      | 1, 473        |             |   |   | 73.00    |
| 76.00 0   | 3610 SLEEP LAB                               | 0             | 0             |             |   |   | 76.00    |
|           | UTPATIENT SERVICE COST CENTERS               |               |               |             |   |   |          |
| 90.00 0   | 9000 CLI NI C                                | 45, 807       | 21, 922       |             |   |   | 90.00    |
|           | 9100 EMERGENCY                               | 1, 275, 218   | 0             |             |   |   | 91.00    |
| 92.00 0   | 9200 OBSERVATION BEDS (NON-DISTINCT PART     | 439, 101      | 0             |             |   |   | 92.00    |
| 0         | THER REIMBURSABLE COST CENTERS               |               |               |             |   |   |          |
| 95.00 0   | 9500 AMBULANCE SERVICES                      | 0             |               |             |   |   | 95.00    |
| 200.00    | Subtotal (see instructions)                  | 4, 568, 031   | 23, 395       |             |   |   | 200.00   |
| 201.00    | Less PBP Clinic Lab. Services-Program        | 0             |               |             |   |   | 201.00   |
|           | Only Charges                                 |               |               |             |   |   |          |
| 202.00    | Net Charges (line 200 - line 201)            | 4, 568, 031   | 23, 395       |             |   |   | 202.00   |

| Health Financial Systems                            | DUKES MEMORIAL  | HOSPI TAL     |              | In Lie           | u of Form CMS-                 | 2552-10         |
|---|-----------------|---------------|--------------|------------------|--------------------------------|-----------------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST    | Provider CO   | CN: 15-1318  | Peri od:         | Worksheet D                    |                 |
|   |                 | Composit      | DON 15 7010  | From 01/01/2019  | Part V                         |                 |
|   |                 | Component (   | CCN: 15-Z318 | To 12/31/2019    | Date/Time Pre<br>8/28/2020 10: | pared:<br>36 am |
|   |                 | Title         | XVIII        | Swing Beds - SNF |                                | <u>30 ani</u>   |
|   |                 |               | Charges      |                  | Costs                          |                 |
| Cost Center Description                             | Cost to ChargeP | PS Reimbursed |              | Cost             | PPS Services                   |                 |
|   |                 | Services (see | Reimbursed   | Reimbursed       | (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          | 3.00         | 4.00             | 5.00                           |                 |
| ANCILLARY SERVICE COST CENTERS                      | · · · ·         |               |              |                  |                                |                 |
| 50. 00 05000 OPERATI NG ROOM                        | 0. 165835       | 0             |              | 0 0              | 0                              | 50.00           |
| 51.00 05100 RECOVERY ROOM                           | 0. 191390       | 0             |              | 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       | 0             |              | 0 0              | 0                              | 53.00           |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C                 | 0.071474        | 0             |              | 0 0              | 0                              | 54.00           |
| 54. 01 05401 ULTRASOUND                             | 0. 000000       | 0             |              | 0 0              | 0                              | 54.01           |
| 56. 00 05600 RADI OI SOTOPE                         | 0. 000000       | 0             |              | 0 0              | 0                              | 56.00           |
| 57. 00 05700 CT SCAN                                | 0. 000000       | 0             |              | 0 0              | 0                              | 57.00           |
| 58. 00 05800 MRI                                    | 0. 000000       | 0             |              | 0 0              | 0                              | 58.00           |
| 60. 00 06000 LABORATORY                             | 0. 101347       | 0             |              | 0 0              | 0                              | 60.00           |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 0. 287477       | 0             |              | 0 0              | 0                              | 62.00           |
| 65. 00 06500 RESPI RATORY THERAPY                   | 0. 261430       | 0             |              | 0 0              | 0                              | 65.00           |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0. 508335       | 0             |              | 0 0              | 0                              | 66,00           |
| 67. 00 06700 OCCUPATI ONAL THERAPY                  | 0. 199605       | 0             |              | 0 0              | 0                              | 67.00           |
| 68.00 06800 SPEECH PATHOLOGY                        | 0. 423466       | 0             |              | 0 0              | 0                              | 68.00           |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0. 108463       | 0             |              | 0 0              | 0                              | 69.00           |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0. 020813       | 0             |              | 0 0              | 0                              | 71.00           |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0. 202980       | 0             |              | 0 0              | 0                              | 72.00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0. 096634       | 0             |              | 0 0              | 0                              | 73.00           |
| 76. 00 03610 SLEEP LAB                              | 0. 000000       | 0             |              | 0 0              | 0                              | 76.00           |
| OUTPATIENT SERVICE COST CENTERS                     | 0.000000        |               |              | <u> </u>         |                                | 1 0.00          |
| 90. 00 09000 CLINIC                                 | 4. 332485       | 0             |              | 0 0              | 0                              | 90.00           |
| 91. 00 09100 EMERGENCY                              | 0. 279181       | 0             |              | 0 0              | 0                              | 91.00           |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART    | 0, 580481       | 0             |              | 0 0              | 0                              |                 |
| OTHER REIMBURSABLE COST CENTERS                     | 01000101        |               |              | <u> </u>         |                                | /2.00           |
| 95. 00 09500 AMBULANCE SERVICES                     | 0. 118365       |               |              | 0                |                                | 95.00           |
| 200.00 Subtotal (see instructions)                  |                 | 0             |              | 0 0              | 0                              | 200.00          |
| 201.00 Less PBP Clinic Lab. Services-Program        |                 | 0             |              | 0 0              |                                | 201.00          |
| Only Charges  |                 |               |              |                  |                                |                 |
| 202.00 Net Charges (line 200 - line 201)            |                 | 0             |              | 0 0              | 0                              | 202.00          |

| Heal th Fina | ancial Systems  | DUKES MEMORIA | L HOSPI TAL   |              | In Lie               | u of Form CMS-                 | 2552-10        |
|--------------|---|---------------|---------------|--------------|----------------------|--------------------------------|----------------|
| APPORTI ONME | ENT OF MEDICAL, OTHER HEALTH SERVICES AND                       | VACCINE COST  | Provider C    | CN: 15-1318  | Peri od:             | Worksheet D                    |                |
|              |   |               | Comment       | CON 15 7010  | From 01/01/2019      | Part V                         |                |
|              |   |               | Component     | CCN: 15-Z318 | To 12/31/2019        | Date/Time Pre<br>8/28/2020 10: | ared:<br>36 am |
|              |   |               | Title         | e XVIII      | Swing Beds - SNF     |                                | JU ulli        |
|              |   | Cos           |               |              | Joining Boddo - oini | 0001                           |                |
|              | Cost Center Description   | Cost          | Cost          | 1            |                      |                                |                |
|              | •   | Reimbursed    | Reimbursed    |              |                      |                                |                |
|              |   | Servi ces     | Services Not  |              |                      |                                |                |
|              |   | Subject To    | Subject To    |              |                      |                                |                |
|              |   | Ded. & Coins. | Ded. & Coins. |              |                      |                                |                |
|              |   | (see inst.)   | (see inst.)   | _            |                      |                                |                |
|              |   | 6.00          | 7.00          |              |                      |                                |                |
|              | LLARY SERVICE COST CENTERS                                      | -             |               | 1            |                      |                                |                |
|              | O OPERATI NG ROOM   | 0             | C             | •            |                      |                                | 50.00          |
|              | O RECOVERY ROOM   | 0             | C             |              |                      |                                | 51.00          |
|              | O DELIVERY ROOM & LABOR ROOM                                    | 0             | C             |              |                      |                                | 52.00          |
|              | 0 ANESTHESI OLOGY   | 0             | C             |              |                      |                                | 53.00          |
|              | 0 RADI OLOGY-DI AGNOSTI C                                       | 0             | C             |              |                      |                                | 54.00          |
|              | 1 ULTRASOUND  | 0             | C             |              |                      |                                | 54.01          |
|              | 0 RADI OI SOTOPE  | 0             | C             |              |                      |                                | 56.00          |
|              | O CT SCAN   | 0             | C             |              |                      |                                | 57.00          |
| 58.00 0580   |   | 0             | C             |              |                      |                                | 58.00          |
|              | O LABORATORY  | 0             | C             |              |                      |                                | 60.00          |
|              | O WHOLE BLOOD & PACKED RED BLOOD CELLS                          | 0             | C             |              |                      |                                | 62.00          |
|              | 0 RESPI RATORY THERAPY  | 0             | C             |              |                      |                                | 65.00          |
|              | O PHYSI CAL THERAPY   | 0             | C             | 0            |                      |                                | 66.00          |
|              | O OCCUPATI ONAL THERAPY   | 0             | C             | 0            |                      |                                | 67.00          |
|              | O SPEECH PATHOLOGY  | 0             | C             | )            |                      |                                | 68.00          |
|              |   | 0             | C             |              |                      |                                | 69.00          |
|              | MEDICAL SUPPLIES CHARGED TO PATIENT                             | 0             | C C           |              |                      |                                | 71.00          |
|              | 0 IMPL. DEV. CHARGED TO PATIENTS<br>0 DRUGS CHARGED TO PATIENTS | 0             | 0             |              |                      |                                | 72.00          |
|              | 0 SLEEP LAB   | 0             | C             | •            |                      |                                | 76.00          |
|              | ATIENT SERVICE COST CENTERS                                     | 0             | Ĺ             | /            |                      |                                | 76.00          |
|              | O CLINIC  | 0             | C             |              |                      |                                | 90.00          |
|              | O EMERGENCY   | 0             | C             | •            |                      |                                | 91.00          |
|              | 0 OBSERVATION BEDS (NON-DISTINCT PART                           | 0             | C             | •            |                      |                                | 92.00          |
|              | R REIMBURSABLE COST CENTERS                                     | 0             |               | <u>'I</u>    |                      |                                | /2.00          |
|              | O AMBULANCE SERVICES  | 0             |               |              |                      |                                | 95.00          |
| 200.00       | Subtotal (see instructions)                                     | 0             | C             |              |                      |                                | 200.00         |
| 201.00       | Less PBP Clinic Lab. Services-Program                           | 0             | G             |              |                      |                                | 201.00         |
|              | Only Charges  |               |               |              |                      |                                |                |
| 1            | Net Charges (line 200 - line 201)                               | 0             | C             |              |                      |                                | 202.00         |

| Health Financial Systems                           | DUKES MEMORI   | AL HOSPI TAL   |                | In Lie          | u of Form CMS-                 | 2552-10 |
|--|----------------|----------------|----------------|-----------------|--------------------------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS          | Provi der C    |                | Peri od:        | Worksheet D                    |         |
|  |                |                |                | From 01/01/2019 |                                |         |
|  |                |                |                | To 12/31/2019   | Date/Time Pre<br>8/28/2020 10: | pared:  |
|  |                | Ti +1          | e XIX          | Hospi tal       | PPS                            | SO alli |
| Cost Center Description                            | Capi tal       | Swing Bed      | Reduced        |                 | Per Diem (col.                 |         |
| cost center bescription                            | Related Cost   | Adjustment     | Capi tal       | Days            | 3 / col. 4)                    |         |
|  | (from Wkst. B, | Aujustillerit  | Related Cost   |                 | 3 / COI. 4)                    |         |
|  | Part II, col.  |                | (col , 1 - col |                 |                                |         |
|  | 26)            |                | 2)             |                 |                                |         |
|  | 1.00           | 2.00           | 3.00           | 4.00            | 5.00                           |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |                | 2:00           | 0.00           |                 | 0.00                           |         |
| 30. 00 ADULTS & PEDIATRICS                         | 1, 355, 640    | 100, 819       | 1, 254, 82     | 1 3, 709        | 338.32                         | 30.00   |
| 31. 00 I NTENSI VE CARE UNI T                      | 172, 922       |                | 172, 92        |                 |                                |         |
| 43.00 NURSERY                                      | 47,866         |                | 47,86          |                 |                                | •       |
| 200.00 Total (lines 30 through 199)                | 1, 576, 428    |                | 1, 475, 60     |                 |                                | 200.00  |
| Cost Center Description                            | I npati ent    | Inpati ent     | .,             |                 |                                |         |
|  | Program days   | Program        |                |                 |                                |         |
|  |                | Capital Cost   |                |                 |                                |         |
|  |                | (col. 5 x col. |                |                 |                                |         |
|  |                | 6)             |                |                 |                                |         |
|  | 6.00           | 7.00           |                |                 |                                |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |                |                |                |                 | -                              |         |
| 30. 00 ADULTS & PEDIATRICS                         | 53             | 17, 931        |                |                 |                                | 30.00   |
| 31.00 INTENSIVE CARE UNIT                          | 11             | 4, 674         | +              |                 |                                | 31.00   |
| 43.00 NURSERY                                      | 37             | 5, 318         |                |                 |                                | 43.00   |
| 200.00 Total (lines 30 through 199)                | 101            | 27, 923        |                |                 |                                | 200.00  |
|  |                |                |                |                 |                                |         |

| Health Financial Systems                            | DUKES MEMORIA  | AL HOSPITAL    |              | In Lie          | u of Form CMS-:             | 2552-10      |
|---|----------------|----------------|--------------|-----------------|-----------------------------|--------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS        | Provider C     | CN: 15-1318  | Peri od:        | Worksheet D                 |              |
|   |                |                |              | From 01/01/2019 |                             |              |
|   |                |                |              | To 12/31/2019   | Date/Time Pre 8/28/2020 10: |              |
|   |                | Titl           | e XIX        | Hospi tal       | PPS                         | <u>50 am</u> |
| Cost Center Description                             | Capi tal       | Total Charges  | Ratio of Cos | t Inpatient     | Capital Costs               |              |
|   | Related Cost   | (from Wkst. C, |              | Program         | (column 3 x                 |              |
|   | (from Wkst. B, |                |              | . Charges       | column 4)                   |              |
|   | Part II, col.  | 8)             | 2)           |                 |                             |              |
|   | 26)            |                |              |                 |                             |              |
|   | 1.00           | 2.00           | 3.00         | 4.00            | 5.00                        |              |
| ANCI LLARY SERVI CE COST CENTERS                    | 1              |                | 1            |                 |                             |              |
| 50.00 05000 OPERATI NG ROOM                         | 564, 155       |                |              |                 |                             |              |
| 51.00 05100 RECOVERY ROOM                           | 49, 566        | 3, 096, 066    |              |                 |                             | 51.00        |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM              | 0              | 0              | 0.0000       |                 | e e e                       | 52.00        |
| 53.00 05300 ANESTHESI OLOGY                         | 0              | 0              | 0.0000       |                 | 0                           | 53.00        |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C                 | 479, 211       | 42, 268, 189   |              |                 |                             | 54.00        |
| 54.01 05401 ULTRASOUND                              | 0              | 0              | 0.0000       |                 | 0                           | 54.01        |
| 56. 00 05600 RADI OI SOTOPE                         | 0              | 0              | 0.0000       |                 | 0                           | 56.00        |
| 57.00 05700 CT SCAN                                 | 0              | 0              | 0.0000       |                 | 0                           | 57.00        |
| 58. 00 05800 MRI                                    | 0              | 0              | 0.0000       |                 | 0                           | 58.00        |
| 60. 00 06000 LABORATORY                             | 154, 622       |                |              |                 |                             |              |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 11, 180        |                |              |                 |                             | 62.00        |
| 65. 00 06500 RESPI RATORY THERAPY                   | 135, 132       |                |              |                 |                             | 65.00        |
| 66. 00 06600 PHYSI CAL THERAPY                      | 358, 521       | 2, 746, 184    |              |                 | 530                         | 66.00        |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 11, 475        |                |              |                 | -                           | 67.00        |
| 68.00 06800 SPEECH PATHOLOGY                        | 854            |                |              |                 |                             | 68.00        |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 162, 115       |                |              |                 |                             | 69.00        |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 3, 731         | 4, 402, 640    |              |                 |                             | 71.00        |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 17, 834        |                |              |                 |                             | 72.00        |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 170, 555       | 26, 511, 543   |              |                 |                             | 73.00        |
| 76.00 03610 SLEEP LAB                               | 0              | 0              | 0.0000       | 0 0             | 0                           | 76.00        |
| OUTPATIENT SERVICE COST CENTERS                     | 1              |                |              | 1               |                             |              |
| 90. 00 09000 CLINIC                                 | 108, 096       |                |              |                 |                             |              |
| 91.00 09100 EMERGENCY                               | 397, 276       |                |              |                 |                             | 91.00        |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 338, 316       | 3, 015, 345    | 0. 11219     | 7, 445          | 835                         | 92.00        |
| OTHER REIMBURSABLE COST CENTERS                     | 1              |                | I            |                 |                             |              |
| 95. 00 09500 AMBULANCE SERVICES                     |                |                |              |                 |                             | 95.00        |
| 200.00  Total (lines 50 through 199)                | 2, 962, 639    | 160, 614, 718  | l            | 890, 950        | 16, 430                     | 200. 00      |

| Health Financial Systems  | DUKES MEMORIAL  | HOSPI TAL   |   | In Lie                                      | u of Form CMS-:                                | 2552-10                           |
|---|---|---|---|---|--|-----------------------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER  | R PASS THROUGH COSTS  |   |   | Period:<br>From 01/01/2019<br>To 12/31/2019 | Date/Time Pre 8/28/2020 10:                    |                                   |
|   |   |   | e XIX   | Hospi tal                                   | PPS  |                                   |
| Cost Center Description   | Nursing School Nu<br>Post-Stepdown<br>Adjustments<br>1A                   | 1.00  | Allied Health<br>Post-Stepdowr<br>Adjustments<br>2A | Cost  | All Other<br>Medical<br>Education Cost<br>3.00 |                                   |
| INPATIENT ROUTINE SERVICE COST CENTERS  |   | 1.00  | 28  | 2.00  | 3.00   | -                                 |
| INFATURIT ROUTINE SERVICE COST CENTERS           30. 00         03000 ADULTS & PEDIATRICS           31. 00         03100 INTENSIVE CARE UNIT           43. 00         04300 NURSERY           200. 00         Total (lines 30 through 199)                                | 000000000000000000000000000000000000000                                   | 0<br>0<br>0<br>0  |   |   | 0<br>0<br>0<br>0                               | 31.00                             |
| Cost Center Description   | Adjustment (s<br>Amount (see 1<br>instructions) mi                        | Total Costs<br>sum of cols.<br>through 3,<br>inus col. 4) | Days  | Per Diem (col.<br>5 ÷ col. 6)               | Inpatient<br>Program Days                      |                                   |
|   | 4.00  | 5.00  | 6.00  | 7.00  | 8.00   |                                   |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           43. 00         04300         NURSERY           200. 00         Total (lines 30 through 199) | 0   | 000000000000000000000000000000000000000                   | 3, 70<br>40<br>33<br>4, 44                          | 7 0.00<br>3 0.00                            | 11<br>37                                       | 30.00<br>31.00<br>43.00<br>200.00 |
| Cost Center Description   | Inpatient<br>Program<br>Pass-Through<br>Cost (col. 7 x<br>col. 8)<br>9.00 |   |   |   |  |                                   |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           43. 00         04300         NURSERY           200. 00         Total (lines 30 through 199) | 0<br>0<br>0<br>0  |   |   |   |  | 30.00<br>31.00<br>43.00<br>200.00 |

| Image: Non Physician Anesthetist         Non Physician Adjustments         Nursing School Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments           Image: Non Physician Anesthetist         Non Physician Australian Adjustments         Non Physician Australian Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments         Non Physician Adjustments         Non Physician Adjustments         Stepdown | AL In Lieu of Form CMS-2552-10   | HOSPI TAL | DUKES MEMORIAI  | th Financial Systems                         | Heal th |
|--|--|-----------|-----------------|--|---------|
| Cost Center Description         Non Physician<br>Anesthetist<br>Cost         Nursing School<br>Post-Stepdown<br>Adjustments         Allied Health<br>Post-Stepdown<br>Adjustments         Allied Health<br>Post-Stepdown<br>Adjustments           ANCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           50.00         05000         OPERATING ROOM         0         0         0         0         50           51.00         05100         RECOVERY ROOM         0         0         0         0         51   | From 01/01/2019 Part IV<br>To 12/31/2019 Date/Time Prepared:<br>8/28/2020 10:36 am |           | VICE OTHER PASS |  |         |
| Anesthetist<br>Cost         Post-Stepdown<br>Adjustments         Post-Stepdown<br>Adjustments         Post-Stepdown<br>Adjustments           ANCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           50.00         05000         OPERATING ROOM         0         0         0         50         50           51.00         05100         RECOVERY ROOM         0         0         0         0         51   |  |           |                 |  |         |
| Cost         Adjustments         Adjustments         Image: Cost         Adjustments         Image: Cost         Adjustments         Image: Cost         Adjustments         Image: Cost         Image: Cost         Adjustments         Image: Cost   |  |           |                 | Cost Center Description                      |         |
| Image: Note of the system   |  |           |                 |  |         |
| ANCI LLARY SERVICE COST CENTERS           50. 00         05000         OPERATI NG ROOM         0         0         0         50.           51. 00         05100         RECOVERY ROOM         0         0         0         0         51.  |  |           |                 |  |         |
| 50. 00         05000         OPERATI NG ROOM         0         0         0         0         50.           51. 00         05100         RECOVERY ROOM         0         0         0         0         0         51.  | 2.00 3A 3.00   | 2A        | 1.00            |  |         |
| 51. 00 05100 RECOVERY ROOM 0 0 0 0 51.   |  |           |                 |  |         |
|  | 0 0 0 50.00  | 0         | 0               | 0 05000 OPERATING ROOM                       | 50.00   |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52   | 0 0 0 51.00  | 0         | 0               | 0 05100 RECOVERY ROOM                        | 51.00   |
|  | 0 0 0 52.00  | 0         | 0               | 0 05200 DELIVERY ROOM & LABOR ROOM           | 52.00   |
| 53. 00 05300 ANESTHESI OLOGY 0 0 0 53.   | 0 0 0 53.00  | 0         | 0               | 0 05300 ANESTHESI OLOGY                      | 53.00   |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54  | 0 0 0 54.00  | 0         | 0               | 0 05400 RADI OLOGY-DI AGNOSTI C              | 54.00   |
| 54. 01 05401 ULTRASOUND 0 0 0 0 54   | 0 0 0 54.01  | 0         | 0               | 1 05401 ULTRASOUND                           | 54.01   |
| 56. 00 05600 RADI 0I SOTOPE 0 0 0 0 0 56   | 0 0 0 56.00  | О         | 0               | 0 05600 RADI OI SOTOPE                       | 56.00   |
| 57. 00 05700 CT SCAN 0 0 0 0 57  | 0 0 0 57.00  | О         | 0               | 0 05700 CT SCAN                              | 57.00   |
| 58.00 05800 MRI 0 0 0 0 58   | 0 0 0 58.00  | o         | 0               | 0 05800 MRI                                  | 58.00   |
| 60. 00 06000 LABORATORY 0 0 0 0 0 0 0  | 0 0 0 0 60.00  | o         | 0               | 0 06000 LABORATORY                           | 60.00   |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62  | 0 0 0 62.00  | o         | 0               | 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 62.00   |
| 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 65  | 0 0 0 65.00  | o         | 0               | 0 06500 RESPI RATORY THERAPY                 | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66  | 0 0 0 66.00  | o         | 0               | 0 06600 PHYSI CAL THERAPY                    | 66.00   |
| 67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 67.  | 0 0 0 67.00  | o         | 0               | 0 06700 OCCUPATIONAL THERAPY                 | 67.00   |
|  | 0 0 0 68.00  | o         | o               | 0 06800 SPEECH PATHOLOGY                     | 68.00   |
| 69. 00 lo6900 ELECTROCARDIOLOGY OL 0 0 0 0 0 0   | 0 0 0 0 69.00  | o         | o               | 0 06900 ELECTROCARDI OLOGY                   | 69.00   |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 71  | 0 0 0 71.00  | o         | o               | 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 71.00   |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 72   | 0 0 0 72.00  | o         | 0               | 0 07200 IMPL. DEV. CHARGED TO PATIENTS       | 72.00   |
|  | 0 0 0 73.00  | 0         | 0               |  |         |
|  |  | o         | 0               |  |         |
| OUTPATI ENT SERVICE COST CENTERS   |  | -1        | -1              |  |         |
|  | 0 0 0 90.00  | 0         | 0               |  |         |
|  |  | ol        | Ő               |  |         |
|  |  | -         | 0               |  |         |
| OTHER REIMBURSABLE COST CENTERS  |  | I         |                 |  |         |
|  | 95.00  |           |                 |  |         |
|  |  | 0         | 0               |  |         |

| Health Financial Systems                            | DUKES MEMORIA   | AL HOSPI TAL  |              | In Lie                           | eu of Form CMS-2 | 2552-10 |
|---|-----------------|---------------|--------------|----------------------------------|------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PAS | S Provider C  | CN: 15-1318  | Peri od:                         | Worksheet D      |         |
| THROUGH COSTS                                       |                 |               |              | From 01/01/2019<br>To 12/31/2019 |                  | narod   |
|   |                 |               |              | 10 12/31/2019                    | 8/28/2020 10:    | 36 am   |
|   |                 | Titl          | e XIX        | Hospi tal                        | PPS              |         |
| 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)    |         |
|   | 4.00            | 5.00          | 6.00         | 7.00                             | 8.00             |         |
| ANCI LLARY SERVI CE COST CENTERS                    |                 | 0             |              | 0 15, 725, 867                   | 0. 000000        | 50.00   |
| 51. 00 05100 RECOVERY ROOM                          | 0               |               |              | 0 3, 096, 066                    |                  |         |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM             | 0               |               |              | 0 3, 090, 000                    | 0.000000         |         |
| 53. 00 05300 ANESTHESI OLOGY                        | 0               | 0             |              | 0 0                              | 0.000000         | 1       |
| 54. 00  05400  RADI OLOGY-DI AGNOSTI C              | 0               |               |              | 0 42, 268, 189                   |                  |         |
| 54. 01 05401 ULTRASOUND                             |                 |               |              | 0 42,200,109                     | 0.000000         | 1       |
| 56. 00 05600 RADI OI SOTOPE                         | 0               |               |              |                                  | 0. 000000        | 1       |
| 57. 00 05700 CT SCAN                                | 0               |               |              | 0 0                              | 0.000000         |         |
| 58. 00 05800 MRI                                    | 0               |               |              | 0 0                              | 0.000000         |         |
| 60. 00 06000 LABORATORY                             | 0               |               |              | 0 23, 857, 722                   |                  |         |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 0               | 0             |              | 0 502, 735                       |                  | 1       |
| 65. 00 06500 RESPIRATORY THERAPY                    | 0               | 0             |              | 0 4, 338, 165                    |                  | 1       |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0               | 0             |              | 0 2, 746, 184                    |                  |         |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 0               | 0             |              | 0 1, 234, 183                    |                  | 1       |
| 68.00 06800 SPEECH PATHOLOGY                        | 0               | 0             |              | 0 206, 144                       |                  | 68.00   |
| 69.00 06900 ELECTROCARDI OLOGY                      | 0               | 0             |              | 0 6, 810, 792                    | 0.000000         | 69.00   |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT    | 0               | 0             |              | 0 4, 402, 640                    | 0. 000000        | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 0               | 0             | 1            | 0 1, 770, 180                    | 0. 000000        | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0               | 0             |              | 0 26, 511, 543                   | 0. 000000        | 73.00   |
| 76.00 03610 SLEEP LAB                               | 0               | 0             |              | 0 0                              | 0.000000         | 76.00   |
| OUTPATIENT SERVICE COST CENTERS                     |                 |               | -            |                                  |                  |         |
| 90. 00 09000 CLI NI C                               | 0               | 0             |              | 0 99, 791                        | 0.000000         |         |
| 91. 00 09100 EMERGENCY                              | 0               | 0             |              | 0 24, 029, 172                   |                  | 1       |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0               | 0             |              | 0 3, 015, 345                    | 0.00000          | 92.00   |
| OTHER REIMBURSABLE COST CENTERS                     | 1               |               |              |                                  |                  |         |
| 95. 00 09500 AMBULANCE SERVICES                     | _               | _             |              |                                  |                  | 95.00   |
| 200.00   Total (lines 50 through 199)               | 0               | 0             | l            | 0 160, 614, 718                  |                  | 200. 00 |

| Health Financial Systems                            | DUKES MEMORIAL                          | HOSPI TAL  |             |            | In Lie                      | u of Form CMS-2                | 2552-10         |
|---|---|------------|-------------|------------|-----------------------------|--------------------------------|-----------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE | RVICE OTHER PASS                        | Provider C | CN: 15-1318 |            | ri od:                      | Worksheet D                    |                 |
| THROUGH COSTS                                       |   |            |             | Frc<br> To | om 01/01/2019<br>12/31/2019 | Part IV                        |                 |
|   |   |            |             | 10         | 12/31/2019                  | Date/Time Pre<br>8/28/2020 10: | pareu:<br>36 am |
|   |   | Titl       | e XIX       |            | Hospi tal                   | PPS                            |                 |
| Cost Center Description                             | Outpati ent                             | Inpati ent | I npati ent |            | Outpati ent                 | Outpati ent                    |                 |
|   | Ratio of Cost                           | Program    | Program     |            | Program                     | Program                        |                 |
|   | to Charges                              | Charges    | Pass-Throug | h          | Charges                     | Pass-Through                   |                 |
|   | (col. 6 ÷ col.                          |            | Costs (col. | 8          |                             | Costs (col. 9                  |                 |
|   | 7)                                      |            | x col. 10)  |            |                             | x col. 12)                     |                 |
|   | 9.00                                    | 10.00      | 11.00       |            | 12.00                       | 13.00                          |                 |
| ANCI LLARY SERVI CE COST CENTERS                    |   |            | 1           |            |                             |                                |                 |
| 50. 00 05000 OPERATI NG ROOM                        | 0. 000000                               | 100, 822   |             | 0          | 0                           | 0                              | 50.00           |
| 51.00 05100 RECOVERY ROOM                           | 0. 000000                               | 17, 713    |             | 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                                | 0          |             | 0          | 0                           | 0                              | 53.00           |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | 0. 000000                               | 124, 910   |             | 0          | 0                           | 0                              | 54.00           |
| 54.01 05401 ULTRASOUND                              | 0. 000000                               | 0          |             | 0          | 0                           | 0                              | 54.01           |
| 56. 00 05600 RADI OI SOTOPE                         | 0. 000000                               | 0          |             | 0          | 0                           | 0                              | 56.00           |
| 57.00 05700 CT SCAN                                 | 0. 000000                               | 0          |             | 0          | 0                           | 0                              | 57.00           |
| 58. 00 05800 MRI                                    | 0.000000                                | 0          |             | 0          | 0                           | 0                              | 58.00           |
| 60. 00 06000 LABORATORY                             | 0.000000                                | 159, 355   |             | 0          | 0                           | 0                              | 60.00           |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 0. 000000                               | 3, 128     |             | 0          | 0                           | 0                              | 62.00           |
| 65. 00 06500 RESPI RATORY THERAPY                   | 0. 000000                               | 49, 980    |             | 0          | 0                           | 0                              | 65.00           |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0. 000000                               | 4, 056     |             | 0          | 0                           | 0                              | 66.00           |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 0. 000000                               | 0          |             | 0          | 0                           | 0                              | 67.00           |
| 68.00 06800 SPEECH PATHOLOGY                        | 0.000000                                | 470        |             | 0          | 0                           | 0                              | 68.00           |
| 69. 00 06900 ELECTROCARDI OLOGY                     | 0. 000000                               | 41, 964    |             | 0          | 0                           | 0                              | 69.00           |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0,000000                                | 38, 355    |             | 0          | 0                           | 0                              | 71.00           |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS         | 0. 000000                               | 1, 772     |             | 0          | 0                           | 0                              | 72.00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0. 000000                               | 290, 252   |             | 0          | 0                           | 0                              | 73.00           |
| 76. 00 03610 SLEEP LAB                              | 0. 000000                               | 0          |             | 0          | 0                           | 0                              | 76.00           |
| OUTPATIENT SERVICE COST CENTERS                     |   |            | 1           |            | -                           |                                |                 |
| 90, 00 09000 CLINIC                                 | 0,000000                                | 3, 123     |             | 0          | 0                           | 0                              | 90.00           |
| 91. 00 09100 EMERGENCY                              | 0,000000                                | 47,605     |             | 0          | 0                           | 0                              | 91.00           |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0.000000                                | 7, 445     |             | 0          | 0                           | 0                              | 92.00           |
| OTHER REIMBURSABLE COST CENTERS                     | , · · · · · · · · · · · · · · · · · · · |            |             | - 1        | -                           |                                |                 |
| 95. 00 09500 AMBULANCE SERVICES                     |   |            |             |            |                             |                                | 95.00           |
| 200.00 Total (lines 50 through 199)                 |   | 890, 950   |             | 0          | 0                           | 0                              | 200.00          |
|   |   |            | •           |            | -                           |                                | •               |

| Health Financial Systems                                     | DUKES MEMORI   |                |              |   | u of Form CMS-  | 2552-10        |
|--|----------------|----------------|--------------|---|---|----------------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND          | VACCINE COST   | Provider C     | CN: 15-1318  | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet D<br>Part V<br>Date/Time Pre<br>8/28/2020 10: | pared:         |
|  |                | Titl           | e XIX        | Hospi tal                                   | PPS   | <u>50 alli</u> |
|  |                |                | Charges      | noopritai                                   | Costs   |                |
| Cost Center Description                                      | Cost to Charge | PPS Reimbursed |              | Cost  | PPS Services  |                |
|  | Ratio From     | Services (see  | Reimbursed   | Reimbursed                                  | (see inst.)   |                |
|  | Worksheet C,   | inst.)         | Servi ces    | Services Not                                | ()  |                |
|  | Part I, col. 9 |                | Subject To   | Subject To                                  |   |                |
|  |                |                | Ded. & Coins |   |   |                |
|  |                |                | (see inst.)  | (see inst.)                                 |   |                |
|  | 1.00           | 2.00           | 3.00         | 4.00  | 5.00  |                |
| ANCI LLARY SERVI CE COST CENTERS                             |                |                |              |   |   |                |
| 50. 00 05000 OPERATI NG ROOM                                 | 0. 165835      | 0              |              | 0 366, 882                                  | 0   | 50.00          |
| 51.00 05100 RECOVERY ROOM                                    | 0. 191390      | 0              |              | 0 73,756                                    | 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       | 0              |              | 0 0   | 0   | 53.00          |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                         | 0. 071474      |                |              | 0 1,022,664                                 | 0   |                |
| 54. 01 05401 ULTRASOUND                                      | 0. 000000      |                |              | 0 0   | 0   |                |
| 56. 00 05600 RADI 0I SOTOPE                                  | 0. 000000      |                |              | 0 0   | 0   |                |
| 57. 00 05700 CT SCAN   | 0. 000000      |                |              |   | 0   |                |
| 58. 00 05800 MRI   | 0. 000000      |                |              |   | 0   |                |
| 60. 00 06000 LABORATORY                                      | 0. 101347      |                |              | 0 712, 105                                  | 0   | 60.00          |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS             | 0. 287477      |                |              | 0 5,403                                     | 0   | 62.00          |
| 65. 00 06500 RESPIRATORY THERAPY                             | 0. 261430      |                |              | 0 16, 254                                   | 0   | 1              |
| 66. 00 06600 PHYSI CAL THERAPY                               | 0. 508335      |                |              | 0 24, 588                                   | 0   |                |
| 67. 00 06700 OCCUPATI ONAL THERAPY                           | 0. 199605      |                |              | 0 61, 173                                   | 0   | 67.00          |
| 68. 00 06800 SPEECH PATHOLOGY                                | 0. 423466      |                |              | 0 2,801                                     | 0   |                |
| 69. 00 06900 ELECTROCARDI OLOGY                              | 0. 108463      |                |              | 0 139, 396                                  | 0   |                |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT             | 0. 020813      |                |              | 0 78, 725                                   | 0   | 1              |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS                  | 0. 202980      |                |              | 0 2,430                                     | 0   |                |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                       | 0. 202980      |                |              | 0 462, 667                                  | 0   |                |
| 76. 00 03610 SLEEP LAB                                       | 0. 000000      |                |              | 0 402,007                                   | 0   |                |
| OUTPATIENT SERVICE COST CENTERS                              | 0.00000        | 0              |              | 0 0   | 0   | /8.00          |
| 90. 00 09000 CLINIC  | 4. 332485      | 0              |              | 0 745                                       | 0   | 90.00          |
| 91. 00 09100 EMERGENCY                                       | 0. 279181      |                |              | 0 1, 233, 739                               | 0   |                |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART              | 0. 580481      |                |              | 0 1, 233, 739                               | 0   |                |
| OTHER REIMBURSABLE COST CENTERS                              | 0. 00461       | 0              |              | 120,055                                     | 0   | 92.00          |
| 95. 00 09500 AMBULANCE SERVICES                              | 0. 118365      | 0              |              | 0   |   | 95.00          |
|  | 0. 110300      |                |              |   | 0   |                |
| 200.00 Subtotal (see instructions)                           |                | 0              |              | 0 4, 323, 383                               | 0   | 200.00         |
| 201.00 Less PBP Clinic Lab. Services-Program<br>Only Charges |                |                |              | 0 0   |   | 201.00         |
| 202.00 Net Charges (line 200 - line 201)                     |                | 0              |              | 0 4, 323, 383                               | 0   | 202.00         |
|  | 1              | 1 0            | 1            | 0 4, 323, 383                               | 0   | 1202.00        |

|              | ncial Systems  | DUKES MEMORIA |               |             | In Lie                                      | u of Form CMS-  | 2552-1  |
|--------------|--|---------------|---------------|-------------|---|---|---------|
| APPORTI ONME | ENT OF MEDICAL, OTHER HEALTH SERVICES AND              | VACCINE COST  | Provider C    | CN: 15-1318 | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet D<br>Part V<br>Date/Time Pre<br>8/28/2020 10: |         |
|              |  |               | Titl          | e XIX       | Hospi tal                                   | PPS   |         |
|              |  |               | sts           |             |   |   |         |
|              | Cost Center Description                                | Cost          | Cost          |             |   |   |         |
|              |  | Reimbursed    | Reimbursed    |             |   |   |         |
|              |  | Servi ces     | Services Not  |             |   |   |         |
|              |  | Subject To    | Subject To    |             |   |   |         |
|              |  |               | Ded. & Coins. |             |   |   |         |
|              |  | (see inst.)   | (see inst.)   | -           |   |   |         |
|              |  | 6.00          | 7.00          |             |   |   | _       |
|              | LLARY SERVICE COST CENTERS                             | 0             | (0.042        |             |   |   | 50.00   |
|              | O RECOVERY ROOM  | 0             | 60, 842       |             |   |   |         |
|              |  | 0             |               |             |   |   | 51.00   |
|              | O DELIVERY ROOM & LABOR ROOM                           | 0             | 0             |             |   |   | 52.00   |
|              | O ANESTHESI OLOGY                                      | 0             | 72 004        |             |   |   | 53.00   |
|              | 0 RADI OLOGY-DI AGNOSTI C                              | 0             | 73, 094       | 1           |   |   | 54.00   |
|              |  | 0             | 0             | 1           |   |   | 54.0    |
|              | O RADI OI SOTOPE                                       | 0             | 0             |             |   |   | 56.00   |
|              | O CT SCAN  | 0             |               | 1           |   |   | 57.00   |
|              |  | 0             | -             | 1           |   |   | 58.00   |
|              | 0 LABORATORY<br>0 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0             | 72, 170       |             |   |   | 60.00   |
|              | 0 RESPIRATORY THERAPY                                  | 0             | 4, 249        |             |   |   | 65.00   |
|              | 0 PHYSI CAL THERAPY                                    | 0             | 12, 499       |             |   |   | 66.00   |
|              | 0 OCCUPATIONAL THERAPY                                 | 0             | 12, 499       |             |   |   | 67.00   |
|              | 0 SPEECH PATHOLOGY                                     | 0             | 1, 186        |             |   |   | 68.00   |
|              | 0 ELECTROCARDI OLOGY                                   | 0             | 15, 119       | •           |   |   | 69.00   |
|              | 0 MEDICAL SUPPLIES CHARGED TO PATIENT                  | 0             | 1, 639        |             |   |   | 71.00   |
|              | 0 IMPL. DEV. CHARGED TO PATIENTS                       | 0             | 493           |             |   |   | 72.00   |
|              | 0 DRUGS CHARGED TO PATIENTS                            | 0             |               |             |   |   | 73.00   |
|              | O SLEEP LAB  | 0             |               |             |   |   | 76.00   |
|              | ATIENT SERVICE COST CENTERS                            | 0             |               | 1           |   |   | - /0.00 |
|              |  | 0             | 3, 228        |             |   |   | 90.00   |
|              | 0 EMERGENCY  | 0             |               | 1           |   |   | 91.00   |
|              | 0 OBSERVATION BEDS (NON-DISTINCT PART                  | 0             |               |             |   |   | 92.00   |
|              | R REIMBURSABLE COST CENTERS                            |               |               | 1           |   |   | 1       |
|              | O AMBULANCE SERVICES                                   | 0             |               |             |   |   | 95.00   |
| 200.00       | Subtotal (see instructions)                            | 0             |               |             |   |   | 200.00  |
| 201.00       | Less PBP Clinic Lab. Services-Program                  | 0             |               |             |   |   | 201.00  |
|              | Only Charges   |               |               |             |   |   |         |
| 202.00       | Net Charges (line 200 - line 201)                      | 0             | 731, 233      |             |   |   | 202.00  |

|          | Financial         Systems         DUKES         MEMORIAL           ATION OF INPATIENT OPERATING COST <t< th=""><th>Provider CCN: 15-1318</th><th>Peri od:</th><th>u of Form CMS-2<br/>Worksheet D-1</th><th></th></t<> | Provider CCN: 15-1318        | Peri od:                         | u of Form CMS-2<br>Worksheet D-1 |    |
|----------|--|------------------------------|----------------------------------|----------------------------------|----|
|          |  |                              | From 01/01/2019<br>To 12/31/2019 | Date/Time Prep<br>8/28/2020 10:3 |    |
|          |  | Title XVIII                  | Hospi tal                        | Cost                             |    |
|          | Cost Center Description  |                              |                                  | 1 00                             |    |
|          | PART I – ALL PROVIDER COMPONENTS   |                              |                                  | 1.00                             |    |
|          | I NPATI ENT DAYS   |                              |                                  |                                  |    |
| 00       | Inpatient days (including private room days and swing-bed day  |                              |                                  | 4,014                            | 1  |
| 00<br>00 | Inpatient days (including private room days, excluding swing-<br>Private room days (excluding swing-bed and observation bed da   |                              | rivate room davs                 | 3, 709<br>0                      |    |
| 00       | do not complete this line.   |                              | rvate room days,                 | 0                                |    |
| 00       | Semi-private room days (excluding swing-bed and observation b  |                              |                                  | 2, 709                           |    |
| 00       | Total swing-bed SNF type inpatient days (including private ro reporting period   | oom days) through Decembe    | er 31 of the cost                | 298                              | 5  |
| 00       | Total swing-bed SNF type inpatient days (including private ro  | om davs) after December      | 31 of the cost                   | 0                                | 6  |
|          | reporting period (if calendar year, enter 0 on this line)  | 5                            |                                  |                                  |    |
| 00       | Total swing-bed NF type inpatient days (including private roo  | m days) through December     | 31 of the cost                   | 7                                | 7  |
| 00       | reporting period<br>Total swing-bed NF type inpatient days (including private roo  | m days) after December 3     | 1 of the cost                    | 0                                | 8  |
| 00       | reporting period (if calendar year, enter 0 on this line)  | all days) all tel becomber t |                                  | 0                                |    |
| 00       | Total inpatient days including private room days applicable t  | o the Program (excluding     | g swing-bed and                  | 1, 383                           | 9  |
| . 00     | newborn days) (see instructions)<br>Swing-bed SNF type inpatient days applicable to title XVIII o  | ply (including privato r     | coom davic)                      | 281                              | 10 |
| . 00     | through December 31 of the cost reporting period (see instruc  |                              | oom days)                        | 201                              |    |
| . 00     | Swing-bed SNF type inpatient days applicable to title XVIII o  |                              | room days) after                 | 0                                | 11 |
|          | December 31 of the cost reporting period (if calendar year, e  |                              |                                  | 0                                | 1. |
| . 00     | Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period   | x only (Including privat     | e room days)                     | 0                                | 12 |
| . 00     | Swing-bed NF type inpatient days applicable to titles V or XI  | X only (including privat     | e room days)                     | 0                                | 13 |
|          | after December 31 of the cost reporting period (if calendar y  |                              |                                  |                                  |    |
|          | Medically necessary private room days applicable to the Progr  | am (excluding swing-bed      | days)                            | 0                                |    |
|          | Total nursery days (title V or XIX only)<br>Nursery days (title V or XIX only)   |                              |                                  | 0                                |    |
|          | SWING BED ADJUSTMENT   |                              |                                  |                                  |    |
| . 00     | Medicare rate for swing-bed SNF services applicable to servic  | es through December 31 d     | of the cost                      |                                  | 17 |
| . 00     | reporting period<br>Medicare rate for swing-bed SNF services applicable to servic  | oc after December 21 of      | the cost                         |                                  | 18 |
| . 00     | reporting period   | es alter becember 31 01      | the cost                         |                                  |    |
| . 00     | Medicaid rate for swing-bed NF services applicable to service  | es through December 31 of    | the cost                         | 0.00                             | 19 |
|          | reporting period   |                              |                                  | 0.00                             |    |
| 0. 00    | Medicaid rate for swing-bed NF services applicable to service<br>reporting period  | is after December 31 of 1    | ne cost                          | 0.00                             | 20 |
| . 00     | Total general inpatient routine service cost (see instruction  | is)                          |                                  | 7, 013, 669                      | 21 |
| 2.00     | Swing-bed cost applicable to SNF type services through Decemb  | er 31 of the cost report     | ing period (line                 | 0                                | 22 |
| 3. 00    | 5 x line 17)<br>Swing-bed cost applicable to SNF type services after December  | 21 of the cost constit       | a pariod (line 6                 | 0                                | 23 |
| 5. 00    | x line 18)   | ST OF THE COST TEPOLET       | ig period (Title o               | 0                                | 23 |
| 1.00     | Swing-bed cost applicable to NF type services through Decembe  | er 31 of the cost reporti    | ng period (line                  | 0                                | 24 |
|          | 7 x line 19)   |                              |                                  |                                  |    |
| o. 00    | Swing-bed cost applicable to NF type services after December x line 20)  | 31 of the cost reporting     | period (line 8                   | 0                                | 25 |
| 5.00     | Total swing-bed cost (see instructions)  |                              |                                  | 521, 604                         | 26 |
| . 00     | General inpatient routine service cost net of swing-bed cost   | (line 21 minus line 26)      |                                  | 6, 492, 065                      | 27 |
|          | PRIVATE ROOM DI FFERENTI AL ADJUSTMENT   |                              | <u> </u>                         |                                  |    |
|          | General inpatient routine service charges (excluding swing-be<br>Private room charges (excluding swing-bed charges)  | d and observation bed cr     | narges)                          | 0                                |    |
|          | Semi-private room charges (excluding swing-bed charges)  |                              |                                  | 0                                | 30 |
|          | General inpatient routine service cost/charge ratio (line 27   | ÷line 28)                    |                                  | 0. 000000                        |    |
| . 00     | Average private room per diem charge (line 29 ÷ line 3)  |                              |                                  | 0.00                             |    |
|          | Average semi-private room per diem charge (line 30 ÷ line 4)   | nue line 22) (coo instruct   | stions)                          | 0.00                             |    |
|          | Average per diem private room charge differential (line 32 mi<br>Average per diem private room cost differential (line 34 x li   |                              |                                  | 0.00<br>0.00                     |    |
| b. 00    | Private room cost differential adjustment (line 3 x line 35)   |                              |                                  | 0.00                             |    |
|          | General inpatient routine service cost net of swing-bed cost   | and private room cost di     | fferential (line                 | 6, 492, 065                      | 37 |
|          | 27 minus line 36)  |                              |                                  |                                  | -  |
|          |  |                              |                                  |                                  | 1  |
|          | PART II - HOSPITAL AND SUBPROVIDERS ONLY<br>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ  | USTMENTS                     |                                  |                                  |    |
| . 00     | PART II - HOSPITAL AND SUBPROVIDERS ONLY<br>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ<br>Adjusted general inpatient routine service cost per diem (see   |                              |                                  | 1, 750. 35                       | 38 |
| 7.00     | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ  | instructions)<br>38)         |                                  | 1, 750. 35<br>2, 420, 734<br>0   | 39 |

| OMPUT        | Financial Systems<br>ATION OF INPATIENT OPERATING COST   |                     | Provider C     | CN: 15-1318       | Peri od:                         | Worksheet D-1         |      |
|--------------|--|---------------------|----------------|-------------------|----------------------------------|-----------------------|------|
|              |  |                     |                |                   | From 01/01/2019<br>To 12/31/2019 |                       |      |
|              |  |                     |                | × XVIII           | Hospi tal                        | 8/28/2020 10:<br>Cost | 36 a |
|              | Cost Center Description  | Total               | Total          | Average Per       |                                  | Program Cost          |      |
|              |  | Inpatient Costl     | npatient Days  |                   | ÷                                | (col. 3 x col.        |      |
|              |  | 1.00                | 2.00           | col. 2)<br>3.00   | 4.00                             | 4)                    |      |
| 2.00         | NURSERY (title V & XIX only)   | 0                   | 2.00           |                   |                                  |                       | 42.  |
|              | Intensive Care Type Inpatient Hospital Units   |                     |                |                   |                                  |                       |      |
| . 00         | INTENSIVE CARE UNIT  | 1, 156, 507         | 407            | 2, 841. 5         | 54 221                           | 627, 980              |      |
| . 00<br>. 00 | CORONARY CARE UNIT<br>BURN INTENSIVE CARE UNIT   |                     |                |                   |                                  |                       | 44.  |
|              | SURGI CAL I NTENSI VE CARE UNI T   |                     |                |                   |                                  |                       | 46.  |
|              | OTHER SPECIAL CARE (SPECIFY)   |                     |                |                   |                                  |                       | 47.  |
|              | Cost Center Description  |                     |                |                   |                                  | 1.00                  |      |
| . 00         | Program inpatient ancillary service cost (Wks  | st D-3 col 3        | Line 200)      |                   |                                  | 1.00<br>2,664,309     | 48   |
|              | Total Program inpatient costs (sum of lines 4  |                     |                | ns)               |                                  | 5, 713, 023           |      |
|              | PASS THROUGH COST ADJUSTMENTS  |                     |                |                   |                                  |                       |      |
| . 00         | Pass through costs applicable to Program inpa  | atient routine s    | services (from | ı Wkst. D, sum    | n of Parts I and                 | 0                     | 50   |
| . 00         | <pre>III) Pass through costs applicable to Program inpa</pre>                                  | tiont ancillar      | , convigos (fr | om What D a       | um of Parts II                   | 0                     | 51   |
| . 00         | and IV)  |                     | JEIVICES (II   | UM WKSL D, S      |                                  |                       |      |
| 2.00         | Total Program excludable cost (sum of lines !  |                     |                |                   |                                  | 0                     |      |
| 8.00         | Total Program inpatient operating cost exclud  |                     | ated, non-phy  | sician anesth     | netist, and                      | 0                     | 53   |
|              | medical education costs (line 49 minus line 5<br>TARGET AMOUNT AND LIMIT COMPUTATION           | o2)                 |                |                   |                                  |                       |      |
| . 00         | Program di scharges  |                     |                |                   |                                  | 0                     | 54   |
| . 00         | Target amount per discharge  |                     |                |                   |                                  | 0.00                  |      |
| . 00         | Target amount (line 54 x line 55)  |                     |                |                   |                                  | 0                     |      |
| . 00<br>. 00 | Difference between adjusted inpatient operati<br>Bonus payment (see instructions)              | ng cost and tar     | get amount (I  | ine 56 minus      | line 53)                         | 0                     |      |
| 9.00<br>9.00 | Lesser of lines 53/54 or 55 from the cost rep  | orting period e     | endina 1996 u  | indated and co    | mpounded by the                  | -                     |      |
|              | market basket  | bor tring portion o | inding 1770, c |                   | inpoundou by the                 |                       |      |
| . 00         | Lesser of lines 53/54 or 55 from prior year of   |                     |                |                   |                                  | 0.00                  |      |
| . 00         | If line 53/54 is less than the lower of lines<br>which operating costs (line 53) are less than |                     |                |                   |                                  | 0                     | 61   |
|              | amount (line 56), otherwise enter zero (see i  |                     | 5 (TTTES 54 X  | 00), 01 1/8 01    | the target                       |                       |      |
| 2.00         | Relief payment (see instructions)  | ,                   |                |                   |                                  | 0                     | 62   |
| . 00         | Allowable Inpatient cost plus incentive payme  | ent (see instruc    | ctions)        |                   |                                  | 0                     | 63   |
| . 00         | PROGRAM INPATIENT ROUTINE SWING BED COST<br>Medicare swing-bed SNF inpatient routine cost      | ts through Decem    | nher 31 of the | cost reporti      | na period (See                   | 491, 848              | 64   |
| 1.00         | instructions) (title XVIII only)   | thi ough beech      |                |                   | ng period (bee                   |                       |      |
| 5.00         | Medicare swing-bed SNF inpatient routine cost  | ts after Decembe    | er 31 of the c | ost reporting     | period (See                      | 0                     | 65   |
| 5. 00        | instructions)(title XVIII only)  | no costs (lino f    | A plue line 6  | 5) (+i +l o X)/11 |                                  | 491, 848              | 66   |
| . 00         | Total Medicare swing-bed SNF inpatient routin<br>CAH (see instructions)                        | le costs (The c     | 54 prus rine d | s)(title xvii     | i oniy). For                     | 491,848               |      |
| . 00         | Title V or XIX swing-bed NF inpatient routine  | e costs through     | December 31 c  | of the cost re    | porting period                   | 0                     | 67   |
|              | (line 12 x line 19)  |                     |                | ***               |                                  |                       |      |
| 3. 00        | Title V or XIX swing-bed NF inpatient routine<br>(line 13 x line 20)                           | e costs atter De    | ecember 31 or  | the cost repo     | orting period                    | 0                     | 68   |
| 9.00         | Total title V or XIX swing-bed NF inpatient i  | routine costs (I    | ine 67 + line  | 68)               |                                  | 0                     | 69.  |
|              | PART III - SKILLED NURSING FACILITY, OTHER NU  |                     |                |                   |                                  | L                     |      |
| ). 00        | Skilled nursing facility/other nursing facili  | 2                   |                |                   |                                  |                       | 70   |
| . 00         | Adjusted general inpatient routine service co<br>Program routine service cost (line 9 x line 7 |                     | ne /0 ÷ iine   | 2)                |                                  |                       | 71   |
| . 00         | Medically necessary private room cost applica  | · ·                 | (line 14 x li  | ne 35)            |                                  |                       | 73   |
| . 00         | Total Program general inpatient routine servi  |                     |                |                   |                                  |                       | 74   |
| 6.00         | Capital-related cost allocated to inpatient i  | routine service     | costs (from W  | lorksheet B, F    | Part II, column                  |                       | 75   |
| . 00         | 26, line 45)<br>Per diem capital-related costs (line 75 ÷ lin                                  | ne 2)               |                |                   |                                  |                       | 76   |
| . 00         | Program capital -related costs (line 9 x line  | ,                   |                |                   |                                  |                       | 77   |
| . 00         | Inpatient routine service cost (line 74 minus  |                     |                |                   |                                  |                       | 78   |
| . 00         | Aggregate charges to beneficiaries for excess  | • •                 |                |                   |                                  |                       | 79   |
| . 00         | Total Program routine service costs for compa<br>Inpatient routine service cost per diem limit |                     | ost limitation | ı (IINE /8 mir    | ius line /9)                     |                       | 80   |
| . 00         | Inpatient routine service cost per drem finm<br>Inpatient routine service cost limitation (li  |                     | )              |                   |                                  |                       | 82   |
| . 00         | Reasonable inpatient routine service costs (s  | ,                   |                |                   |                                  |                       | 83   |
| . 00         | Program inpatient ancillary services (see ins  | structions)         |                |                   |                                  |                       | 84   |
|              | Utilization review - physician compensation  |                     |                |                   |                                  |                       | 85   |
| . 00         | Total Program inpatient operating costs (sum<br>PART IV - COMPUTATION OF OBSERVATION BED PASS  |                     | ougn 85)       |                   |                                  |                       | 86   |
| . 00         | Total observation bed days (see instructions)  |                     |                |                   |                                  | 1, 000                | 87   |
| 3.00         | Adjusted general inpatient routine cost per o  | diem (line 27 ÷     | line 2)        |                   |                                  | 1, 750. 35            | 88   |
|              | Observation bed cost (line 87 x line 88) (see  |                     |                |                   |                                  | 1, 750, 350           |      |

| Health Financial Systems                      | DUKES MEMORIA | AL HOSPI TAL   |            | In Lie                           | u of Form CMS-2                | 2552-10 |
|---|---------------|----------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST       |               | Provider CC    |            | Period:                          | Worksheet D-1                  |         |
|   |               |                |            | From 01/01/2019<br>To 12/31/2019 | Date/Time Pre<br>8/28/2020 10: |         |
|   |               | Title          | XVIII      | Hospi tal                        | Cost                           |         |
| 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 ( | COST          |                |            |                                  |                                |         |
| 90.00 Capital-related cost                    | 1, 355, 640   | 7, 013, 669    | 0. 19328   | 5 1, 750, 350                    | 338, 316                       | 90.00   |
| 91.00 Nursing School cost                     | 0             | 7, 013, 669    | 0.00000    | 0 1, 750, 350                    | 0                              | 91.00   |
| 92.00 Allied health cost                      | 0             | 7, 013, 669    | 0.00000    | 0 1, 750, 350                    | 0                              | 92.00   |
| 93.00 All other Medical Education             | 0             | 7, 013, 669    | 0.00000    | 0 1, 750, 350                    | 0                              | 93.00   |

| INPAT         00       Inpat         00       Inpat         00       Priva         00       Total         repor       Total         newbo       Swing         throut       Swing         throut       Swing         after       Swing         after       Swing         5.00       Total         repor       SWING         6.00       Nurse         SWING       repor         7.00       Mediator         repor       Notal         5.00       Total         repor       Notal         6.00       Nurse         7.00       Mediator         repor       Repor         0.00       Mediator         repor       Repor   | Cost Center Description<br>I - ALL PROVIDER COMPONENTS<br>ITENT DAYS<br>tient days (including private room days and swing-bed day<br>tient days (including private room days, excluding swing-<br>ate room days (excluding swing-bed and observation bed da<br>ot complete this line.<br>-private room days (excluding swing-bed and observation bed<br>t swing-bed SNF type inpatient days (including private roor<br>rting period<br>I swing-bed SNF type inpatient days (including private roor<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roor<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roor<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roor<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable to<br>or ndays) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (if calendar year, en-<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>we comber 31 of the cost reporting period (if calendar year, en   | bed and newborn days)<br>ays). If you have only pr<br>bed days)<br>boom days) through Decembe<br>boom days) after December<br>om days) after December 3<br>to the Program (excluding<br>bonly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>X only (including privat<br>X only (including privat<br>year, enter 0 on this ling)  | er 31 of the cost<br>31 of the cost<br>31 of the cost<br>1 of the cost<br>1 swing-bed and<br>room days)<br>room days) after<br>e room days)<br>e room days)                    | Date/Time Prep<br>8/28/2020 10:3<br>PPS<br>1.00<br>4,014<br>3,709<br>0<br>2,709<br>298<br>0<br>298<br>0<br>7<br>0<br>53<br>0<br>53<br>0<br>0<br>0<br>53<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 |
|--|---|--|--|---|
| INPAT         00       Inpat         00       Inpat         00       Priva         00       Total         repor       Total         newbo       Swing         throut       Swing         throut       Swing         after       Swing         after       Swing         5.00       Total         repor       SWING         6.00       Nurse         SWING       repor         7.00       Mediator         repor       Notal         5.00       Total         repor       Notal         6.00       Nurse         7.00       Mediator         repor       Repor         0.00       Mediator         repor       Repor   | I - ALL PROVIDER COMPONENTS<br>TIENT DAYS<br>tient days (including private room days and swing-bed day<br>tient days (including private room days, excluding swing-<br>date room days (excluding swing-bed and observation bed day<br>ot complete this line.<br>-private room days (excluding swing-bed and observation bed<br>swing-bed SNF type inpatient days (including private room<br>rting period<br>I swing-bed SNF type inpatient days (including private room<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private room<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private room<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable to<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruct<br>g-bed SNF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31   | ys, excluding newborn)<br>-bed and newborn days)<br>ays). If you have only pr<br>bed days)<br>bom days) through December<br>bom days) after December<br>om days) after December<br>om days) after December 3<br>to the Program (excluding<br>ponly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>X only (including privat<br>Y only (including privat<br>year, enter 0 on this ling) | ivate room days,<br>r 31 of the cost<br>31 of the cost<br>a1 of the cost<br>a1 of the cost<br>wing-bed and<br>room days)<br>room days) after<br>re room days)<br>re room days) | PPS<br>1.00<br>4,014<br>3,709<br>0<br>2,709<br>298<br>0<br>7<br>0<br>53<br>0<br>53<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   |
| INPAT         00       Inpat         00       Inpat         00       Priva         00       Total         repor       Total         newbo       Swing         throut       Swing         throut       Swing         after       Swing         after       Swing         5.00       Total         repor       SWING         6.00       Nurse         SWING       repor         7.00       Mediator         repor       Notal         5.00       Total         repor       Notal         6.00       Nurse         7.00       Mediator         repor       Repor         0.00       Mediator         repor       Repor   | I - ALL PROVIDER COMPONENTS<br>TIENT DAYS<br>tient days (including private room days and swing-bed day<br>tient days (including private room days, excluding swing-<br>date room days (excluding swing-bed and observation bed day<br>ot complete this line.<br>-private room days (excluding swing-bed and observation bed<br>swing-bed SNF type inpatient days (including private room<br>rting period<br>I swing-bed SNF type inpatient days (including private room<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private room<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private room<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable to<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruct<br>g-bed SNF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31   | ys, excluding newborn)<br>-bed and newborn days)<br>ays). If you have only pr<br>bed days)<br>bom days) through December<br>bom days) after December<br>om days) after December<br>om days) after December 3<br>to the Program (excluding<br>ponly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>X only (including privat<br>Y only (including privat<br>year, enter 0 on this ling) | ivate room days,<br>r 31 of the cost<br>31 of the cost<br>a1 of the cost<br>a1 of the cost<br>wing-bed and<br>room days)<br>room days) after<br>re room days)<br>re room days) | 1.00<br>4,014<br>3,709<br>0<br>2,709<br>298<br>0<br>7<br>0<br>53<br>0<br>0<br>0<br>0<br>0   |
| INPAT         00       Inpat         00       Inpat         00       Priva         00       Total         repor       Total         newbo       Swing         throut       Swing         throut       Swing         after       Swing         after       Swing         5.00       Total         repor       SWING         6.00       Nurse         SWING       repor         7.00       Mediator         repor       Notal         5.00       Total         repor       Notal         6.00       Nurse         7.00       Mediator         repor       Repor         0.00       Mediator         repor       Repor   | FIENT DAYS<br>tient days (including private room days and swing-bed day<br>tient days (including private room days, excluding swing-<br>ate room days (excluding swing-bed and observation bed da<br>ot complete this line.<br>-private room days (excluding swing-bed and observation be<br>I swing-bed SNF type inpatient days (including private roo<br>rting period<br>I swing-bed SNF type inpatient days (including private roo<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roo<br>rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable t<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII o<br>ugh December 31 of the cost reporting period (see instruc<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>(if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | bed and newborn days)<br>ays). If you have only pr<br>bed days)<br>boom days) through Decembe<br>boom days) after December<br>om days) after December 3<br>to the Program (excluding<br>bonly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>X only (including privat<br>X only (including privat<br>year, enter 0 on this ling)  | er 31 of the cost<br>31 of the cost<br>31 of the cost<br>1 of the cost<br>1 swing-bed and<br>room days)<br>room days) after<br>e room days)<br>e room days)                    | 4, 014<br>3, 709<br>0<br>2, 709<br>298<br>0<br>7<br>0<br>53<br>0<br>0<br>0<br>0   |
| 00       Inpat         00       Inpat         00       Prive         dono       Genid         00       Total         repor       00         00       Swing         after       4.00         4.00       Medic         7.00       Medic         repor       3.00         SWING       7.00         7.00       Medic         repor       1.00         0.00       Medic         repor       1.00         1.00       Total   | tient days (including private room days and swing-bed day<br>tient days (including private room days, excluding swing-<br>ate room days (excluding swing-bed and observation bed da<br>ot complete this line.<br>-private room days (excluding swing-bed and observation be<br>I swing-bed SNF type inpatient days (including private roo<br>rting period<br>I swing-bed SNF type inpatient days (including private roo<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roo<br>rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable t<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruc<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or X | bed and newborn days)<br>ays). If you have only pr<br>bed days)<br>boom days) through Decembe<br>boom days) after December<br>om days) after December 3<br>to the Program (excluding<br>bonly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>X only (including privat<br>X only (including privat<br>year, enter 0 on this ling)  | er 31 of the cost<br>31 of the cost<br>31 of the cost<br>1 of the cost<br>1 swing-bed and<br>room days)<br>room days) after<br>e room days)<br>e room days)                    | 3, 709<br>0<br>2, 709<br>298<br>0<br>7<br>0<br>53<br>0<br>0<br>0<br>0   |
| 00       Inpat         00       Privation         00       Semi-         00       Total         repor       Total         newbo       Swing         0.00       Swing         1.00       Swing         2.00       Swing         6.00       Nurse         5.00       Total         repor       O         3.00       Swing         6.00       Nurse         6.00       Nurse         6.00       Nurse         7.00       Medic         repor       Pool         9.00       Medic         repor       Pool         9.00       Medic         repor       Pool         1.00       Total         1.00       Swing         1.00       Swing         1.00       Total    <  | tient days (including private room days, excluding swing-<br>ate room days (excluding swing-bed and observation bed da<br>ot complete this line.<br>-private room days (excluding swing-bed and observation be<br>I swing-bed SNF type inpatient days (including private roor<br>rting period<br>I swing-bed SNF type inpatient days (including private roor<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roor<br>rting period<br>I swing-bed NF type inpatient days (including private roor<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roor<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable to<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V III of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>(if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>I nursery days (title V or XIX only)  | bed and newborn days)<br>ays). If you have only pr<br>bed days)<br>boom days) through Decembe<br>boom days) after December<br>om days) after December 3<br>to the Program (excluding<br>bonly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>X only (including privat<br>X only (including privat<br>year, enter 0 on this ling)  | er 31 of the cost<br>31 of the cost<br>31 of the cost<br>1 of the cost<br>1 swing-bed and<br>room days)<br>room days) after<br>e room days)<br>e room days)                    | 3, 709<br>0<br>2, 709<br>298<br>0<br>7<br>0<br>53<br>0<br>0<br>0<br>0   |
| 00     Priva       do no     Semi-1       00     Total       repor     00       00     Swing       Decer     Decer       2.00     Swing       after     4.00       4.00     Medic       5.00     Total       repor     3.00       SWING     Teopor       3.00     Medic       repor     2.00       3.00     Medic       repor     2.00       Medic     repor       2.00     Medic       repor     1.00       1.00     Total  | ate room days (excluding swing-bed and observation bed da<br>ot complete this line.<br>-private room days (excluding swing-bed and observation b<br>I swing-bed SNF type inpatient days (including private ro<br>rting period<br>I swing-bed SNF type inpatient days (including private ro<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private ro<br>rting period<br>I swing-bed NF type inpatient days (including private ro<br>rting period<br>I swing-bed NF type inpatient days (including private ro<br>rting period<br>I swing-bed NF type inpatient days (including private ro<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable to<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>(if calendar ye<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)  | ays). If you have only pr<br>bed days)<br>boom days) through December<br>boom days) after December<br>bom days) after December<br>bom days) after December 3<br>to the Program (excluding<br>bonly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>X only (including privat<br>year, enter 0 on this lin   | er 31 of the cost<br>31 of the cost<br>31 of the cost<br>1 of the cost<br>1 swing-bed and<br>room days)<br>room days) after<br>e room days)<br>e room days)                    | 0<br>2,709<br>298<br>0<br>7<br>0<br>53<br>0<br>0<br>0   |
| 00       Semi -         00       Total         repor       Total         00       Total         repor       Total         00       Total         repor       Total         00       Total         repor       Total         repor       Total         newbo       Total         newbo       Swing         throu       Swing         after       Media         4.00       Media         5.00       Total         7.00       Media         repor       Repor         3.00       SWING         5.00       Nurss         SWING       repor         3.00       Media         repor       Repor         3.00       Media         repor       Repor         0.00       Media         repor       Repor         1.00       Total         2.00       Swing  | -private room days (excluding swing-bed and observation b<br>I swing-bed SNF type inpatient days (including private ro<br>rting period<br>I swing-bed SNF type inpatient days (including private ro<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private ro<br>rting period<br>I swing-bed NF type inpatient days (including private ro<br>rting period<br>I swing-bed NF type inpatient days (including private ro<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable t<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruc<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>(if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | boom days) through December<br>boom days) after December<br>bom days) through December<br>bom days) after December 3<br>to the Program (excluding<br>bonly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>IX only (including privat<br>vear, enter 0 on this ling   | 31 of the cost<br>31 of the cost<br>1 of the cost<br>1 swing-bed and<br>room days)<br>room days) after<br>re room days)<br>re room days)                                       | 298<br>0<br>7<br>0<br>53<br>0<br>0<br>0   |
| 00       Total<br>repor         1.00       Swing<br>after         4.00       Media         5.00       Total         5.00       Total         6.00       Nurse         SWING       Redia         7.00       Media         repor       repor         2.00       Media         repor       Total         5.00       Total         6.00       Nurse         6.00       Media         repor       repor         7.00       Media         repor       Total         1.00       Total         2.00       Swing  | I swing-bed SNF type inpatient days (including private ro<br>rting period<br>I swing-bed SNF type inpatient days (including private ro<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private ro<br>rting period<br>I swing-bed NF type inpatient days (including private ro<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable t<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruc<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>(if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | boom days) through December<br>boom days) after December<br>bom days) through December<br>bom days) after December 3<br>to the Program (excluding<br>bonly (including private r<br>ctions)<br>bonly (including private r<br>enter 0 on this line)<br>IX only (including privat<br>vear, enter 0 on this ling   | 31 of the cost<br>31 of the cost<br>1 of the cost<br>1 swing-bed and<br>room days)<br>room days) after<br>re room days)<br>re room days)                                       | 298<br>0<br>7<br>0<br>53<br>0<br>0<br>0   |
| repor         00       Total         newbo         0.00       Swing         bccer       Decer         2.00       Swing         after       4.00         4.00       Medic         5.00       Total         6.00       Nurse         SWING       repor         3.00       Medic         6.00       Nurse         SWING       repor         7.00       Medic         7.00       Medic         repor       7.00         0.00       Medic         repor       7.00         0.00       Medic         repor       7.00         0.00       Swing         1.00       Total         2.00       Swing         5.00       Total<   | rting period<br>I swing-bed SNF type inpatient days (including private ro<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roc<br>rting period<br>I swing-bed NF type inpatient days (including private roc<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable t<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruct<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | pom days) after December<br>om days) through December<br>om days) after December 3<br>to the Program (excluding<br>ponly (including private r<br>enter 0 on this line)<br>IX only (including privat<br>IX only (including privat<br>year, enter 0 on this lin  | 31 of the cost<br>31 of the cost<br>1 of the cost<br>1 swing-bed and<br>room days)<br>room days) after<br>re room days)<br>re room days)                                       | 0<br>7<br>0<br>53<br>0<br>0<br>0  |
| 00       Total<br>repor         00       Swing<br>throu         2.00       Swing<br>after         4.00       Medic         5.00       Nurse         5.00       Nurse         6.00       Medic         7.00       Swing         2.00       Swing         2.00       Swing         3.00       Swing         0.00       Swing         0.00       Swing         0.00       Swing         0.00       Swing         0.00       Swing   | I swing-bed SNF type inpatient days (including private ro<br>rting period (if calendar year, enter 0 on this line)<br>I swing-bed NF type inpatient days (including private roo<br>rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable to<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruct<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>(if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | om days) through December<br>om days) after December 3<br>to the Program (excluding<br>only (including private r<br>ctions)<br>only (including private r<br>enter 0 on this line)<br>X only (including privat<br>year, enter 0 on this lin   | * 31 of the cost<br>11 of the cost<br>11 wing-bed and<br>room days)<br>room days) after<br>12 room days)<br>re room days)  | 7<br>0<br>53<br>0<br>0<br>0   |
| 00       Total<br>repor         00       Total<br>repor         00       Total<br>newbo         00       Swing<br>throu         1.00       Swing<br>throu         2.00       Swing<br>throu         3.00       Swing<br>throu         4.00       Media G<br>repor         5.00       Nurse         SWING       Repor         6.00       Media G<br>repor         7.00       Media G<br>repor         9.00       Swing         1.00       Total         2.00       Swing         5 x 1       Swing  | I swing-bed NF type inpatient days (including private roo<br>rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable t<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruct<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>(if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)  | om days) after December 3<br>to the Program (excluding<br>only (including private r<br>ctions)<br>only (including private r<br>enter 0 on this line)<br>IX only (including privat<br>VX only (including privat<br>vear, enter 0 on this lin  | 1 of the cost<br>swing-bed and<br>room days)<br>room days) after<br>e room days)<br>re room days)  | 0<br>53<br>0<br>0<br>0  |
| repor<br>00 Total<br>repor<br>00 Total<br>repor<br>00 Swing<br>throu<br>1.00 Swing<br>0 Swing<br>0 Swing<br>1.00 Swing<br>1.00 Swing<br>3.00 Swing<br>3.00 Swing<br>SWING<br>7.00 Media<br>repor<br>3.00 Media<br>repor<br>3.00 Media<br>repor<br>3.00 Media<br>2.00 Media<br>repor<br>3.00 Media<br>SWING<br>5.00 Total<br>5.00 Total<br>5.00 Total<br>5.00 Media<br>repor<br>3.00 Media<br>SWING<br>5.00 Total<br>5.00 Swing<br>5.00 S | rting period<br>I swing-bed NF type inpatient days (including private roo<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable t<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruct<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>(if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)  | om days) after December 3<br>to the Program (excluding<br>only (including private r<br>ctions)<br>only (including private r<br>enter 0 on this line)<br>IX only (including privat<br>VX only (including privat<br>vear, enter 0 on this lin  | 1 of the cost<br>swing-bed and<br>room days)<br>room days) after<br>e room days)<br>re room days)  | 0<br>53<br>0<br>0<br>0  |
| 00 Total<br>repor<br>00 Total<br>newbo<br>0.00 Swing<br>throu<br>1.00 Swing<br>2.00 Swing<br>after<br>4.00 Medic<br>5.00 Total<br>5.00 Nurse<br>SWING<br>7.00 Medic<br>repor<br>3.00 Medic<br>repor<br>0.00 Medic<br>repor<br>0.00 Medic<br>repor<br>0.00 Medic<br>repor<br>0.00 Medic<br>SWING<br>7.00 Medic<br>repor<br>0.00 Medic<br>SWING<br>7.00 Medic<br>repor<br>0.00 Swing<br>5 x 1  | I swing-bed NF type inpatient days (including private roo<br>rting period (if calendar year, enter 0 on this line)<br>I inpatient days including private room days applicable to<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruc<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>agbed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to titles V or XI<br>g-bed NF type inpatient days applicable to the Progr   | to the Program (excluding<br>only (including private r<br>ctions)<br>only (including private r<br>enter 0 on this line)<br>X only (including privat<br>X only (including privat<br>year, enter 0 on this lin   | y swing-bed and<br>room days)<br>room days) after<br>e room days)<br>re room days)   | 53<br>0<br>0<br>0   |
| 00       Total newbo         0.00       Swing throu         1.00       Swing throu         2.00       Swing throu         3.00       Swing after         4.00       Media         5.00       Total         6.00       Nursa         5.00       Total         6.00       Nursa         7.00       Media         7.00       Swing         7.00       Media         7.00       Media         7.00       Swing         8.00       Swing         9.00       Media         9.00       Swing         9.00 <td>I inpatient days including private room days applicable t<br/>orn days) (see instructions)<br/>g-bed SNF type inpatient days applicable to title XVIII of<br/>ugh December 31 of the cost reporting period (see instruc<br/>g-bed SNF type inpatient days applicable to title XVIII of<br/>mber 31 of the cost reporting period (if calendar year, e<br/>g-bed NF type inpatient days applicable to titles V or XI<br/>ugh December 31 of the cost reporting period<br/>g-bed NF type inpatient days applicable to titles V or XI<br/>ugh December 31 of the cost reporting period<br/>g-bed NF type inpatient days applicable to titles V or XI<br/>r December 31 of the cost reporting period (if calendar y<br/>cally necessary private room days applicable to the Progr<br/>I nursery days (title V or XIX only)</td> <td>only (including private r<br/>ctions)<br/>only (including private r<br/>enter 0 on this line)<br/>IX only (including privat<br/>VX only (including privat<br/>vear, enter 0 on this lin</td> <td>room days)<br/>room days) after<br/>e room days)<br/>re room days)</td> <td>0<br/>0<br/>0</td>   | I inpatient days including private room days applicable t<br>orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruc<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period (if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)  | only (including private r<br>ctions)<br>only (including private r<br>enter 0 on this line)<br>IX only (including privat<br>VX only (including privat<br>vear, enter 0 on this lin  | room days)<br>room days) after<br>e room days)<br>re room days)  | 0<br>0<br>0   |
| newbo<br>Swing<br>throu<br>Decer<br>2.00 Swing<br>throu<br>3.00 Swing<br>after<br>4.00 Media<br>5.00 Nurse<br>SWING<br>7.00 Media<br>repor<br>3.00 Media<br>repor<br>9.00 Media<br>repor<br>1.00 Total<br>2.00 Swing<br>5.00 Total<br>5.00 Swing<br>7.00 Media<br>7.00 Media<br>7.00 Media<br>7.00 Media<br>7.00 Media<br>7.00 Media<br>7.00 Swing<br>5.00 Swing<br>5.00 Swing<br>5.00 Swing<br>5.00 Swing<br>5.00 Swing   | orn days) (see instructions)<br>g-bed SNF type inpatient days applicable to title XVIII of<br>ugh December 31 of the cost reporting period (see instruc<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period<br>(if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | only (including private r<br>ctions)<br>only (including private r<br>enter 0 on this line)<br>IX only (including privat<br>VX only (including privat<br>vear, enter 0 on this lin  | room days)<br>room days) after<br>e room days)<br>re room days)  | 0<br>0<br>0   |
| throu<br>becer<br>2.00 Swing<br>3.00 Swing<br>after<br>4.00 Medic<br>5.00 Total<br>5.00 Nurse<br>SWING<br>7.00 Medic<br>repor<br>3.00 Medic<br>repor<br>9.00 Medic<br>repor<br>0.00 Medic<br>repor<br>1.00 Total<br>2.00 Swing<br>5 x Ì  | ugh December 31 of the cost reporting period (see instruct<br>g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period (if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | ctions)<br>only (including private r<br>enter 0 on this line)<br>IX only (including privat<br>IX only (including privat<br>year, enter 0 on this lin   | room days) after<br>re room days)<br>re room days)   | 0   |
| 1. 00 Swing<br>Decen<br>2. 00 Swing<br>after<br>3. 00 Media<br>5. 00 Nursa<br>5. 00 Nursa<br>5. 00 Media<br>repor<br>3. 00 Media<br>repor<br>9. 00 Media<br>repor<br>1. 00 Total<br>2. 00 Swing<br>5 x 1   | g-bed SNF type inpatient days applicable to title XVIII of<br>mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period (if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | only (including private r<br>enter O on this line)<br>X only (including privat<br>X only (including privat<br>year, enter O on this lin  | e room days)<br>e room days)   | 0   |
| Decen<br>Decen<br>2. 00 Swing<br>throi<br>3. 00 Swing<br>4. 00 Medic<br>5. 00 Total<br>5. 00 Nurse<br>SWING<br>7. 00 Medic<br>repor<br>3. 00 Medic<br>repor<br>9. 00 Medic<br>repor<br>0. 00 Medic<br>repor<br>1. 00 Total<br>2. 00 Swing<br>5. x 1  | mber 31 of the cost reporting period (if calendar year, e<br>g-bed NF type inpatient days applicable to titles V or XI<br>ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period (if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | enter 0 on this line)<br> X only (including privat<br> X only (including privat<br>year, enter 0 on this lin   | e room days)<br>e room days)   | 0   |
| 4. 00 Swing<br>4. 00 Media<br>5. 00 Total<br>5. 00 Media<br>7. 00                                       | ugh December 31 of the cost reporting period<br>g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period (if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | IX only (including privat<br>year, enter 0 on this lin   | e room days)   |   |
| 3. 00 Swing<br>after<br>4. 00 Medic<br>5. 00 Total<br>5. 00 Nurse<br>SWING<br>7. 00 Medic<br>repor<br>3. 00 Medic<br>repor<br>9. 00 Medic<br>repor<br>0. 00 Medic<br>repor<br>1. 00 Total<br>2. 00 Swing<br>5 x Ì  | g-bed NF type inpatient days applicable to titles V or XI<br>r December 31 of the cost reporting period (if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)   | year, enter 0 on this lin  |  | 0   |
| after<br>4.00 Medic<br>5.00 Total<br>6.00 Nurse<br><u>SWING</u><br>7.00 Medic<br>repor<br>9.00 Medic<br>repor<br>9.00 Medic<br>repor<br>1.00 Total<br>2.00 Swing<br>5 x Ì  | r December 31 of the cost reporting period (if calendar y<br>cally necessary private room days applicable to the Progr<br>I nursery days (title V or XIX only)  | year, enter 0 on this lin  |  | -   |
| 5. 00         Total           b. 00         Nurse           SWING         SWING           7. 00         Media           repor         repor           8. 00         Media           repor         repor           0. 00         Media           repor         repor           0.00         Media           repor         repor           0.00         Media           repor         repor           0.00         Media           repor         repor           0.00         Swing           2.00         Swing   | I nursery days (title V or XIX only)  | ram (excluding swing-bed   |  |   |
| Nurse       SWING       Y. 00       Media       repor       8. 00       Media       repor       9. 00       Media       repor       0.00       Media       repor       0.00       Media       repor       0.00       Media       repor       0.00       Media       repor       1.00       Total       2.00       Swing       5 x 1  |   |  | days)  | 0   |
| SWING<br>repor<br>3. 00 Media<br>repor<br>2. 00 Media<br>repor<br>0. 00 Media<br>repor<br>1. 00 Total<br>2. 00 Swing<br>5 x Ì  | ery days (title V or XIX only)  |  |  | 333<br>37   |
| 2.00 Redic<br>repor<br>2.00 Medic<br>repor<br>0.00 Medic<br>repor<br>1.00 Total<br>2.00 Swing<br>5 x I   | G BED ADJUSTMENT  |  |  |   |
| 3.00         Media           repor         repor           9.00         Media           repor         repor           0.00         Media           repor         repor           0.00         Media           repor         repor           1.00         Total           2.00         Swing           5         x  | care rate for swing-bed SNF services applicable to servic   | ces through December 31 o  | of the cost  |   |
| 9.00 Media<br>repor<br>0.00 Media<br>repor<br>1.00 Total<br>2.00 Swing<br>5 x I  | rting period<br>care rate for swing-bed SNF services applicable to servic   | ces after December 31 of   | the cost   |   |
| D. 00 Medic<br>repor<br>1. 00 Total<br>2. 00 Swing<br>5 x I  | rting period  |  |  |   |
| 0.00 Medio<br>repor<br>1.00 Total<br>2.00 Swing<br>5 x I   | caid rate for swing-bed NF services applicable to service<br>rting period   | es through December 31 of  | the cost   | 0.00  |
| 1.00   Total<br>2.00   Swing<br>5 x  | caid rate for swing-bed NF services applicable to service   | es after December 31 of t  | he cost  | 0.00  |
| 2.00 Swing<br>5 x I  | rting period  | >  |  | 7 010 //0   |
| 5 x Ì  | l general inpatient routine service cost (see instruction<br>g-bed cost applicable to SNF type services through Decemb  |  | ing period (line   | 7, 013, 669<br>0  |
| 3.00 Swind   | line 17)  | ·  | 51 (   | U U   |
|  | g-bed cost applicable to SNF type services after December   | r 31 of the cost reportin  | g period (line 6   | 0   |
|  | ne 18)<br>g-bed cost applicable to NF type services through Decembe   | er 31 of the cost reporti  | ng period (line  | 0   |
| 7 x Ì  | line 19)  | ·  | 0.   |   |
| 5.00 Swing   | g-bed cost applicable to NF type services after December ne 20)   | 31 of the cost reporting   | period (line 8   | 0   |
|  | I swing-bed cost (see instructions)   |  |  | 521, 604  |
|  | ral inpatient routine service cost net of swing-bed cost  | (line 21 minus line 26)  |  | 6, 492, 065   |
|  | ATE ROOM DIFFERENTIAL ADJUSTMENT  | ad and observation had ab  | argos)   | 0   |
|  | ral inpatient routine service charges (excluding swing-be<br>ate room charges (excluding swing-bed charges)   | ed and observation bed ch  | lai yes)   | 0   |
| 0.00 Semi-   | -private room charges (excluding swing-bed charges)   |  |  | 0   |
|  | ral inpatient routine service cost/charge ratio (line 27  | ÷line 28)  |  | 0.00000   |
|  | age private room per diem charge (line 29 ÷ line 3)<br>age semi-private room per diem charge (line 30 ÷ line 4)   |  |  | 0.00<br>0.00  |
|  | age per diem private room charge differential (line 32 mi   | nus line 33)(see instruc   | tions)   | 0.00  |
|  | age per diem private room cost differential (line 34 x li   | ne 31)   |  | 0.00  |
|  | ate room cost differential adjustment (line 3 x line 35)  |  | fferential (line   | 0<br>6, 492, 065  |
| 27 mi  |   | and private room cost di   | risientiai (inie   | 0, 472, 005   |
| PART   | ral inpatient routine service cost net of swing-bed cost inus line 36)  | and private room cost di   |  |   |
|  | ral inpatient routine service cost net of swing-bed cost<br>inus line 36)<br>II - HOSPITAL AND SUBPROVIDERS ONLY  | ·  |  |   |
|  | ral inpatient routine service cost net of swing-bed cost<br>inus line 36)<br>II - HOSPITAL AND SUBPROVIDERS ONLY<br>RAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ   | JUSTMENTS  |  | 1 750 25  |
| 0.00 Medio<br>1.00 Total   | ral inpatient routine service cost net of swing-bed cost<br>inus line 36)<br>II - HOSPITAL AND SUBPROVIDERS ONLY  | JUSTMENTS<br>e instructions)   |  | 1, 750. 35<br>92, 769   |

| OMPUT          | Financial Systems<br>TATION OF INPATIENT OPERATING COST  | DUKES MEMORIA           | Provi der C    | CN: 15-1318                 | Peri od:                         | u of Form CMS-<br>Worksheet D-1 |       |
|----------------|--|-------------------------|----------------|-----------------------------|----------------------------------|---------------------------------|-------|
|                |  |                         |                |                             | From 01/01/2019<br>To 12/31/2019 |                                 |       |
|                |  |                         | Titl           | e XIX                       | Hospi tal                        | 8/28/2020 10:<br>PPS            | 36 ai |
|                | Cost Center Description  | Total<br>Inpatient Cost | Total          | Average Per<br>Diem (col. 1 | Program Days                     | Program Cost<br>(col. 3 x col.  |       |
|                |  | 1.00                    | 2.00           | col. 2)<br>3.00             | 4.00                             | <u>4)</u><br>5. 00              |       |
| 2.00           |  | 525, 259                | 333            |                             |                                  |                                 | 2 42. |
| 00             | Intensive Care Type Inpatient Hospital Units   | 1 154 507               | 407            | 2 9/1                       | - 11                             | 21 257                          | 1 12  |
| 3.00<br>1.00   | I NTENSI VE CARE UNI T<br>CORONARY CARE UNI T  | 1, 156, 507             | 407            | 2, 841.                     | 54 11                            | 31, 257                         | 43.   |
| 5.00           | BURN INTENSIVE CARE UNIT   |                         |                |                             |                                  |                                 | 45.   |
| . 00           | SURGICAL INTENSIVE CARE UNIT   |                         |                |                             |                                  |                                 | 46.   |
| . 00           | OTHER SPECIAL CARE (SPECIFY)   |                         |                |                             |                                  |                                 | 47.   |
|                | Cost Center Description  |                         |                |                             |                                  | 1.00                            | -     |
| . 00           | Program inpatient ancillary service cost (Wks  |                         |                |                             |                                  | 126, 314                        |       |
| . 00           | Total Program inpatient costs (sum of lines 4<br>PASS THROUGH COST ADJUSTMENTS                 | 1 through 48)(          | see instructio | ns)                         |                                  | 308, 702                        | 2 49. |
| . 00           | Pass through costs applicable to Program inpa  | atient routine          | services (from | Wkst. D. sur                | n of Parts I and                 | 27, 923                         | 3 50. |
|                |  |                         |                |                             |                                  |                                 |       |
| . 00           | Pass through costs applicable to Program inpa  | atient ancillar         | y services (fr | om Wkst. D, s               | sum of Parts II                  | 16, 430                         | 51    |
| 2.00           | and IV)<br>Total Program excludable cost (sum of lines 5                                       | 50 and 51)              |                |                             |                                  | 44, 353                         | 3 52. |
| 3.00           | Total Program inpatient operating cost exclud  |                         | lated, non-phy | sician anestl               | netist, and                      | 264, 349                        |       |
|                | medical education costs (line 49 minus line 5  | 52)                     |                |                             |                                  |                                 |       |
| . 00           | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges   |                         |                |                             |                                  | С                               | 54    |
| . 00           | Target amount per discharge  |                         |                |                             |                                  | 0.00                            |       |
| . 00           | 0  |                         |                |                             |                                  | C                               |       |
| . 00           | Difference between adjusted inpatient operati  | ng cost and ta          | rget amount (I | ine 56 minus                | line 53)                         | C                               |       |
| . 00<br>. 00   | Bonus payment (see instructions)<br>Lesser of lines 53/54 or 55 from the cost rep              | porting period          | onding 1006 u  | ndated and co               | mounded by the                   | 0. 00                           |       |
| . 00           | market basket  | bor tring period        | ending 1770, u |                             | inpounded by the                 | 0.00                            |       |
| 0. 00          | Lesser of lines 53/54 or 55 from prior year of   |                         |                |                             |                                  | 0.00                            |       |
| I. 00          | If line 53/54 is less than the lower of lines<br>which operating costs (line 53) are less than |                         |                |                             |                                  | C                               | 61    |
|                | amount (line 56), otherwise enter zero (see i  |                         | S (TITIES 54 X | 00), 01 1% 0                | the target                       |                                 |       |
| 2.00           | Relief payment (see instructions)  |                         |                |                             |                                  | C                               |       |
| . 00           | Allowable Inpatient cost plus incentive payme  | ent (see instru         | ctions)        |                             |                                  | C                               | ) 63  |
| . 00           | PROGRAM INPATIENT ROUTINE SWING BED COST<br>Medicare swing-bed SNF inpatient routine cost      | s through Dece          | mber 31 of the | cost reporti                | na period (See                   | C                               | 64.   |
|                | instructions)(title XVIII only)  | Ũ                       |                |                             | 0 1 1                            |                                 |       |
| 6. 00          | Medicare swing-bed SNF inpatient routine cost  | s after Decemb          | er 31 of the c | ost reporting               | g period (See                    | C                               | 65.   |
| 5.00           | instructions)(title XVIII only)<br>Total Medicare swing-bed SNF inpatient routir               | ne costs (line          | 64 plus line 6 | 5)(title XVI)               | l only). For                     | C                               | 66.   |
|                | CAH (see instructions)   |                         |                | -, (                        | · ···· <b>J</b> ) · · · ··       | -                               |       |
| 7.00           | Title V or XIX swing-bed NF inpatient routine<br>(line 12 x line 19)                           | e costs through         | December 31 c  | f the cost re               | eporting period                  | C                               | 67.   |
| 3. 00          | Title V or XIX swing-bed NF inpatient routine  | e costs after D         | ecember 31 of  | the cost rep                | orting period                    | C                               | 68.   |
|                | (line 13 x line 20)  |                         |                |                             |                                  |                                 |       |
| 9.00           | Total title V or XIX swing-bed NF inpatient r<br>PART III - SKILLED NURSING FACILITY, OTHER NU |                         |                |                             |                                  | C                               | ) 69. |
| . 00           | Skilled nursing facility/other nursing facili  |                         |                |                             | )                                |                                 | 70    |
| . 00           | Adjusted general inpatient routine service co  |                         | ine 70 ÷ line  | 2)                          |                                  |                                 | 71.   |
| . 00           | Program routine service cost (line 9 x line 7  |                         | (lipo 14 v li  | no 2E)                      |                                  |                                 | 72    |
| . 00           | Medically necessary private room cost applica<br>Total Program general inpatient routine servi | U U                     | •              |                             |                                  |                                 | 74    |
| . 00           | Capital-related cost allocated to inpatient r  | •                       |                |                             | Part II, column                  |                                 | 75    |
| 00             | 26, line 45)   | 2)                      |                |                             |                                  |                                 | -,    |
| b. 00<br>7. 00 | Per diem capital-related costs (line 75 ÷ lir<br>Program capital-related costs (line 9 x line  |                         |                |                             |                                  |                                 | 76    |
| . 00           | Inpatient routine service cost (line 74 minus  |                         |                |                             |                                  |                                 | 78    |
| . 00           | Aggregate charges to beneficiaries for excess  | s costs (from p         |                | ,                           |                                  |                                 | 79    |
| . 00           | Total Program routine service costs for compa  |                         | ost limitation | (line 78 mi)                | nus line 79)                     |                                 | 80    |
| . 00<br>. 00   | Inpatient routine service cost per diem limit<br>Inpatient routine service cost limitation (li |                         | )              |                             |                                  |                                 | 81    |
| . 00           | Reasonable inpatient routine service cost (s   |                         |                |                             |                                  |                                 | 83    |
| . 00           | Program inpatient ancillary services (see ins  |                         | -              |                             |                                  |                                 | 84    |
|                | Utilization review - physician compensation (  |                         |                |                             |                                  |                                 | 85    |
| o. 00          | Total Program inpatient operating costs (sum<br>PART IV - COMPUTATION OF OBSERVATION BED PASS  |                         | rough 85)      |                             |                                  |                                 | 86    |
| 7.00           | Total observation bed days (see instructions)  |                         |                |                             |                                  | 1,000                           | 87.   |
| 8.00           | Adjusted general inpatient routine cost per o  | liem (line 27 ÷         | line 2)        |                             |                                  | 1, 750. 35                      | 5 88. |
|                | Observation bed cost (line 87 x line 88) (see  |                         |                |                             |                                  | 1, 750, 350                     |       |

| Health Financial Systems                    | DUKES MEMORI | AL HOSPI TAL   |            | In Lie                           | u of Form CMS-2                | 2552-10 |
|---|--------------|----------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |              | Provider CO    |            | Period:                          | Worksheet D-1                  |         |
|   |              |                |            | From 01/01/2019<br>To 12/31/2019 | Date/Time Pre<br>8/28/2020 10: |         |
|   |              | Titl           | e XIX      | Hospi tal                        | PPS                            |         |
| 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 | COST         |                |            |                                  |                                |         |
| 90.00 Capital-related cost                  | 1, 355, 640  | 7, 013, 669    | 0. 19328   | 5 1, 750, 350                    | 338, 316                       | 90.00   |
| 91.00 Nursing School cost                   | 0            | 7, 013, 669    | 0.00000    | 0 1, 750, 350                    | 0                              | 91.00   |
| 92.00 Allied health cost                    | 0            | 7,013,669      | 0.00000    | 0 1, 750, 350                    | 0                              | 92.00   |
| 93.00 All other Medical Education           | 0            | 7, 013, 669    | 0. 00000   | 0 1, 750, 350                    | 0                              | 93.00   |

| Health Financial Systems DUKES MEMORIAL                         | Provi der C  | CN: 15-1318        | Peri od:        | eu of Form CMS-2<br>Worksheet D-3 |       |
|---|--------------|--------------------|-----------------|-----------------------------------|-------|
|   |              |                    | From 01/01/2019 |                                   |       |
|   |              |                    | To 12/31/2019   |                                   |       |
|   | Ti tl c      | • XVIII            | Hospi tal       | 8/28/2020 10:<br>Cost             | 36 am |
| Cost Center Description   |              | Ratio of Cos       |                 | Inpatient                         |       |
| cost center bescription   |              | To Charges         |                 | Program Costs                     |       |
|   |              |                    | Charges         | $(col \cdot 1 \times col \cdot$   |       |
|   |              |                    |                 | 2)                                |       |
|   |              | 1.00               | 2.00            | 3.00                              |       |
| INPATIENT ROUTINE SERVICE COST CENTERS                          |              |                    |                 |                                   |       |
| 30. 00 03000 ADULTS & PEDIATRICS                                |              |                    | 2, 674, 013     |                                   | 30.0  |
| 31. 00 03100 INTENSIVE CARE UNIT                                |              |                    | 645, 759        |                                   | 31.0  |
| 43. 00 04300 NURSERY  |              |                    |                 |                                   | 43.0  |
| ANCI LLARY SERVI CE COST CENTERS                                |              |                    |                 |                                   |       |
| 50.00 O5000 OPERATING ROOM                                      |              | 0. 1658            |                 |                                   |       |
| 51.00 O5100 RECOVERY ROOM                                       |              | 0. 1913            |                 |                                   |       |
| 52.00 O5200 DELIVERY ROOM & LABOR ROOM                          |              | 0.0000             |                 |                                   |       |
| 53.00 O5300 ANESTHESI OLOGY                                     |              | 0.0000             |                 | 0                                 |       |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C<br>54. 01 05401 ULTRASOUND |              | 0.0714             |                 |                                   |       |
| 54. 01  05401 ULTRASOUND<br>56. 00  05600 RADI 0I SOTOPE        |              | 0. 0000<br>0. 0000 |                 |                                   |       |
| 57. 00 05700 CT SCAN  |              | 0.0000             |                 |                                   | 57.0  |
| 58. 00 05800 MRI  |              | 0.0000             |                 | 0                                 |       |
| 60. 00 06000 LABORATORY   |              | 0. 1013            |                 |                                   |       |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                |              | 0. 2874            |                 |                                   |       |
| 65. 00 06500 RESPIRATORY THERAPY                                |              | 0. 2614            |                 |                                   |       |
| 56. 00 06600 PHYSI CAL THERAPY                                  |              | 0. 5083            |                 |                                   |       |
| 67. 00 06700 OCCUPATI ONAL THERAPY                              |              | 0. 1996            |                 |                                   |       |
| 68.00 06800 SPEECH PATHOLOGY                                    |              | 0. 4234            |                 |                                   |       |
| 59. 00 06900 ELECTROCARDI OLOGY                                 |              | 0. 1084            | 63 929, 406     | 100, 806                          | 69. C |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                 |              | 0. 0208            | 13 727, 066     | 15, 132                           | 71.0  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                      |              | 0. 2029            | 80 342, 010     | 69, 421                           | 72.0  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                           |              | 0. 0966            | 34 5, 519, 943  | 533, 414                          | 73. C |
| 76.00 03610 SLEEP LAB   |              | 0.0000             | 00 0            | 0                                 | 76.0  |
| OUTPATIENT SERVICE COST CENTERS                                 |              |                    |                 |                                   |       |
| 70. 00 09000 CLINIC   |              | 4. 3324            |                 |                                   | 1     |
| 91. 00 09100 EMERGENCY  |              | 0. 2791            |                 |                                   |       |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART             |              | 0. 5804            | 81 255, 148     | 148, 109                          | 92.0  |
| OTHER REI MBURSABLE COST CENTERS                                |              | 1                  |                 | 1                                 |       |
| 95. 00 09500 AMBULANCE SERVICES                                 |              |                    | 10.005          |                                   | 95.0  |
| Total (sum of lines 50 through 94 and 96 through 98)            |              |                    | 18, 885, 626    | 2, 664, 309                       |       |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges | s (II ne 61) |                    |                 |                                   | 201.0 |
| 202.00 Net charges (line 200 minus line 201)                    |              | 1                  | 18, 885, 626    | 1                                 | 202.0 |

| Health Financial Systems DUKES MEMORIAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT |              | CN: 15-1318  | Period:          | eu of Form CMS-2<br>Worksheet D-3 |              |
|--|--------------|--------------|------------------|-----------------------------------|--------------|
| INPATTENT ANGILLARY SERVICE CUST APPORTIONMENT   | Provider C   | CN: 15-1318  | From 01/01/2019  |                                   | ,<br>,       |
|  | Component    | CCN: 15-Z318 | To 12/31/2019    |                                   | parec        |
|  |              |              |                  | 8/28/2020 10:                     | <u>36 an</u> |
|  | Titl€        | XVIII        | Swing Beds - SNF |                                   |              |
| Cost Center Description  |              | Ratio of Cos |                  | Inpati ent                        |              |
|  |              | To Charges   |                  | Program Costs                     |              |
|  |              |              | Charges          | (col. 1 x col.                    |              |
|  |              | 1.00         |                  | 2)                                |              |
|  |              | 1.00         | 2.00             | 3.00                              | -            |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS   |              | 1            |                  |                                   |              |
| 30. 00 03000 ADULTS & PEDIATRICS   |              |              | 0                |                                   | 30.          |
| 31. 00 03100 I NTENSI VE CARE UNI T  |              |              | 0                |                                   | 31.          |
| 43.00 04300 NURSERY  |              |              |                  |                                   | 43.0         |
| ANCI LLARY SERVICE COST CENTERS<br>50. 00 05000 OPERATI NG ROOM                        |              | 0. 1658      | 25 0 1 4 1       | 1 250                             | 50.          |
| 50. 00  05000 0PERATING ROOM<br>51. 00  05100 RECOVERY ROOM                            |              | 0. 1658      |                  |                                   |              |
|  |              |              |                  |                                   |              |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM   |              | 0.0000       |                  |                                   |              |
| 53. 00 05300 ANESTHESI OLOGY   |              | 0.0000       |                  | 0                                 |              |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   |              | 0.0714       |                  |                                   |              |
| 54. 01 05401 ULTRASOUND  |              | 0.0000       |                  | -                                 |              |
| 56. 00 05600 RADI 0I SOTOPE  |              | 0.0000       |                  | -                                 |              |
| 57. 00 05700 CT SCAN   |              | 0.0000       |                  |                                   | 57.          |
| 58. 00 05800 MRI   |              | 0.0000       |                  | Ŭ                                 |              |
| 50.00 06000 LABORATORY   |              | 0. 1013      |                  |                                   |              |
| 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                                       |              | 0. 2874      |                  |                                   |              |
| 55. 00 06500 RESPI RATORY THERAPY  |              | 0. 2614      |                  |                                   |              |
| 66.00 06600 PHYSI CAL THERAPY  |              | 0. 5083      |                  |                                   |              |
| 57.00 06700 OCCUPATI ONAL THERAPY  |              | 0. 1996      |                  |                                   |              |
| 58.00 06800 SPEECH PATHOLOGY   |              | 0. 4234      |                  |                                   |              |
| 69.00 06900 ELECTROCARDI OLOGY   |              | 0. 1084      |                  |                                   |              |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  |              | 0. 0208      |                  |                                   |              |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS  |              | 0. 2029      |                  |                                   | 1            |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  |              | 0.0966       |                  |                                   |              |
| 76.00 03610 SLEEP LAB  |              | 0.0000       | 00 0             | 0                                 | 76. (        |
| OUTPATIENT SERVICE COST CENTERS  |              | 4 0004       | 0.5              |                                   |              |
| 20. 00 09000 CLINIC  |              | 4. 3324      |                  |                                   |              |
| 01.00 09100 EMERGENCY  |              | 0. 2791      |                  |                                   | 1            |
| 02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART  |              | 0. 5804      | 81 0             | 0                                 | 92.          |
|  |              | 1            |                  | 1                                 |              |
| 25.00 09500 AMBULANCE SERVICES   |              |              | 4 07/ 010        | 040 700                           | 95.          |
| Total (sum of lines 50 through 94 and 96 through 98)                                   | (1) (3)      |              | 1, 076, 310      | 213, 782                          |              |
| Less PBP Clinic Laboratory Services-Program only charge                                | es (line 61) |              | 0                |                                   | 201.         |
| 202.00 Net charges (line 200 minus line 201)   |              | 1            | 1, 076, 310      | 1                                 | 202. (       |

| ealth Financial Systems DUKES MEMORIAL F<br>NPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CO | CN: 15-1318        | In Lie<br>Period: | Worksheet D-3               |        |
|---|-------------|--------------------|-------------------|-----------------------------|--------|
|   |             |                    | From 01/01/2019   |                             |        |
|   |             |                    | To 12/31/2019     | Date/Time Pre 8/28/2020 10: |        |
|   | Ti †I       | e XIX              | Hospi tal         | PPS                         | 30 ali |
| Cost Center Description   |             | Ratio of Cos       |                   | I npati ent                 |        |
|   |             | To Charges         | Program           | Program Costs               |        |
|   |             | ··· ···· · ···     | Charges           | (col. 1 x col.              |        |
|   |             |                    | 5                 | 2)                          |        |
|   |             | 1.00               | 2.00              | 3.00                        |        |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS  |             |                    |                   |                             |        |
| 0. 00 03000 ADULTS & PEDIATRICS   |             |                    | 162, 805          |                             | 30.    |
| 1.00 03100 INTENSIVE CARE UNIT  |             |                    | 43, 845           |                             | 31.0   |
| 3. 00 04300 NURSERY   |             |                    | 31, 220           |                             | 43.0   |
| ANCI LLARY SERVI CE COST CENTERS  |             | 0.4/50             |                   | 4 / 700                     | 1 - 0  |
| 0. 00 05000 OPERATING ROOM  |             | 0. 1658            |                   | 16, 720                     |        |
| 1.00 05100 RECOVERY ROOM  |             | 0. 1913            |                   | 3, 390                      |        |
| 2. 00 05200 DELIVERY ROOM & LABOR ROOM  |             | 0.0000             |                   | 0                           | 52.    |
| 3. 00 05300 ANESTHESI OLOGY   |             | 0.0000             |                   | 0                           | 53.    |
| 4. 00 05400 RADI OLOGY-DI AGNOSTI C   |             | 0.0714             |                   | 8, 928                      | 54.    |
| 4. 01 05401 ULTRASOUND  |             | 0.0000             |                   | 0                           | 54.    |
| 6. 00 05600 RADI OI SOTOPE  |             | 0.0000             |                   | 0                           | 56.    |
| 7. 00 05700 CT SCAN   |             | 0.0000             |                   | 0                           | 57.    |
| 8. 00 05800 MRI   |             | 0.0000             |                   | 0                           | 58.    |
|   |             | 0. 1013            |                   |                             |        |
| 2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS<br>5. 00 06500 RESPI RATORY THERAPY      |             | 0. 2874<br>0. 2614 |                   |                             |        |
| 6. 00 106600 PHYSI CAL THERAPY  |             | 0. 2014            |                   | 13,066                      |        |
| 7. 00 06700 OCCUPATIONAL THERAPY  |             | 0. 5083            |                   | 2, 062<br>0                 | 67.    |
| 8. 00 1068001 SPEECH PATHOLOGY  |             | 0. 1998            |                   | 199                         |        |
| 9. 00 06900 ELECTROCARDI OLOGY  |             | 0. 1084            |                   | 4, 552                      |        |
| 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  |             | 0. 0208            |                   | 4, 332                      |        |
| 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS   |             | 0. 2029            |                   | 360                         |        |
| 3. 00 07300 DRUGS CHARGED TO PATIENTS   |             | 0. 2029            |                   |                             |        |
| 6. 00  03610 SLEEP LAB  |             | 0.0000             |                   | 28, 048                     |        |
| OUTPATIENT SERVICE COST CENTERS   |             | 0.0000             | 0                 | 0                           | /0.    |
| 0. 00 09000 CLINIC  |             | 4.3324             | 3, 123            | 13, 530                     | 90.    |
| 1. 00 09100 EMERGENCY   |             | 0. 2791            |                   |                             |        |
| 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART   |             | 0. 5804            |                   |                             |        |
| OTHER REIMBURSABLE COST CENTERS   |             | 0.0001             | , 110             | ., 022                      | 1      |
| 5. 00 09500 AMBULANCE SERVICES  |             |                    |                   |                             | 95.    |
| 00.00 Total (sum of lines 50 through 94 and 96 through 98)                                |             |                    | 890, 950          | 126, 314                    |        |
| 01.00 Less PBP Clinic Laboratory Services-Program only charges                            | (line 61)   |                    | 0                 |                             | 201.   |
| 02.00 Net charges (line 200 minus line 201)   | /           |                    | 890, 950          |                             | 202.   |

|                  | Financial Systems         DUKES MEMORIAL HOSPITAL           ATION OF REIMBURSEMENT SETTLEMENT         Provider                                    | CCN: 15-1318   | In Lie<br>Period:<br>From 01/01/2019<br>To 12/31/2019 | u of Form CMS-2<br>Worksheet E<br>Part B<br>Date/Time Pre<br>8/28/2020 10: | pared:         |
|------------------|---|----------------|---|--|----------------|
|                  | Tit   | le XVIII       | Hospi tal   | Cost   |                |
|                  |   |                |   | 1.00   |                |
|                  | PART B - MEDICAL AND OTHER HEALTH SERVICES  |                |   | 1.00   |                |
| 1.00             | Medical and other services (see instructions)   |                |   | 4, 591, 426  |                |
| 2.00             | Medical and other services reimbursed under OPPS (see instructions)   |                |   | 0  | 2.00           |
| 3.00<br>4.00     | OPPS payments<br>Outlier payment (see instructions)   |                |   | 6, 385, 400<br>0   | 3.00<br>4.00   |
| 4.00             | Outlier reconciliation amount (see instructions)  |                |   | 0  | 4.00           |
| 5.00             | Enter the hospital specific payment to cost ratio (see instructions)  |                |   | 0. 000   | 5.00           |
| 6.00             | Line 2 times line 5   |                |   | 0  |                |
| 7.00<br>8.00     | Sum of lines 3, 4, and 4.01, divided by line 6<br>Transitional corridor payment (see instructions)  |                |   | 0. 00<br>0   |                |
| 9.00             | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 1   | 3, line 200    |   | 0  | •              |
| 10.00            | Organ acqui si ti ons   |                |   | 0  | 10.00          |
| 11.00            | Total cost (sum of lines 1 and 10) (see instructions)   |                |   | 4, 591, 426  | 11.00          |
|                  | COMPUTATION OF LESSER OF COST OR CHARGES<br>Reasonable charges  |                |   |  |                |
| 12.00            | Ancillary service charges   |                |   | 0  | 12.00          |
| 13.00            | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)  |                |   | 0  |                |
| 14.00            | Total reasonable charges (sum of lines 12 and 13)   |                |   | 0  | 14.00          |
| 15.00            | Customary charges<br>Aggregate amount actually collected from patients liable for payment fo  | r services on  | a charge basis  | 0  | 15.00          |
| 16.00            | Amounts that would have been realized from patients liable for payment  |                |   | 0  | 16.00          |
|                  | had such payment been made in accordance with 42 CFR §413.13(e)   |                |   | -  |                |
| 17.00            | Ratio of line 15 to line 16 (not to exceed 1.000000)  |                |   | 0.000000   |                |
| 18.00<br>19.00   | Total customary charges (see instructions)  | 19 overade Li  | no 11) (coo   | 0  |                |
| 19.00            | Excess of customary charges over reasonable cost (complete only if line instructions)   | 18 exceeds 11  | ne II) (see   | 0  | 19.00          |
| 20.00            | Excess of reasonable cost over customary charges (complete only if line   | 11 exceeds li  | ne 18) (see   | 0  | 20.00          |
| 04 00            | instructions)   |                |   | 4 ( 07 040   | 01 00          |
| 21.00<br>22.00   | Lesser of cost or charges (see instructions)<br>Interns and residents (see instructions)  |                |   | 4, 637, 340<br>0   | 1              |
| 22.00            | Cost of physicians' services in a teaching hospital (see instructions)  |                |   | 0  |                |
| 24.00            | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)  |                |   | 6, 385, 400  |                |
|                  | COMPUTATION OF REIMBURSEMENT SETTLEMENT   |                |   |  |                |
| 25.00<br>26.00   | Deductibles and coinsurance amounts (for CAH, see instructions)   | CALL coo inct  | suctions)   | 36, 608<br>5, 452, 464   |                |
| 28.00            | Deductibles and Coinsurance amounts relating to amount on line 24 (for<br>Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the s |                |   | -851, 732  |                |
|                  | instructions)   |                | ] (   |  |                |
| 28.00            | Direct graduate medical education payments (from Wkst. E-4, line 50)  |                |   | 0  |                |
| 29.00<br>30.00   | ESRD direct medical education costs (from Wkst. E-4, line 36)<br>Subtotal (sum of lines 27 through 29)  |                |   | 0<br>-851, 732   |                |
| 31.00            | Primary payer payments  |                |   | 405  |                |
| 32.00            | Subtotal (line 30 minus line 31)  |                |   | -852, 137  | 32.00          |
| 22.00            | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   |                |   | 0  |                |
| 33.00<br>34.00   | Composite rate ESRD (from Wkst. 1-5, line 11)<br>Allowable bad debts (see instructions)   |                |   | 0<br>1, 115, 358   |                |
| 35.00            | Adjusted reimbursable bad debts (see instructions)  |                |   | 724, 983   |                |
| 36.00            | Allowable bad debts for dual eligible beneficiaries (see instructions)  |                |   | 833, 710   |                |
| 37.00            | Subtotal (see instructions)   |                |   | -127, 154  |                |
| 38. 00<br>39. 00 | MSP-LCC reconciliation amount from PS&R<br>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |                |   | 0  | 38.00<br>39.00 |
| 39.50            | Pioneer ACO demonstration payment adjustment (see instructions)   |                |   |  | 39.50          |
| 39.97            | Demonstration payment adjustment amount before sequestration  |                |   | 0  |                |
| 39.98            | Partial or full credits received from manufacturers for replaced device   | s (see instruc | ctions)   | 0  |                |
| 39. 99<br>40. 00 | RECOVERY OF ACCELERATED DEPRECIATION<br>Subtotal (see instructions)   |                |   | 0<br>-127, 154   | 39.99<br>40.00 |
| 40.00            | Sequestration adjustment (see instructions)   |                |   | 0  | 40.00          |
| 40. 02           | Demonstration payment adjustment amount after sequestration   |                |   | 0  | 40. 02         |
| 40.03            | Sequestration adjustment-PARHM pass-throughs  |                |   | 077 (50  | 40.03          |
| 41.00<br>41.01   | Interim payments<br>Interim payments-PARHM  |                |   | 877, 452   | 41.00          |
| 42.00            | Tentative settlement (for contractors use only)   |                |   | 0  | 1              |
| 42.01            | Tentative settlement-PARHM (for contractor use only)  |                |   |  | 42.01          |
| 43.00            | Balance due provider/program (see instructions)   |                |   | -1, 004, 606   |                |
| 43. 01<br>44. 00 | Balance due provider/program-PARHM (see instructions)<br>Protested amounts (nonallowable cost report items) in accordance with C                  | MS Dub 15 0    | chanter 1   | 0  | 43.01<br>44.00 |
| 44.00            | §115. 2   | m3 rub. ru-z,  |   | 0  | +4.00          |
|                  | TO BE COMPLETED BY CONTRACTOR   |                |   |  | 1              |
|                  | 5   |                |   | 0  |                |
| 91.00<br>92.00   | Outlier reconciliation adjustment amount (see instructions)<br>The rate used to calculate the Time Value of Money                                 |                |   | 0<br>0.00  |                |
| ,∠. UU           | Time Value of Money (see instructions)  |                |   | 0.00   |                |
| 93.00            |   |                |   |  |                |

| ANALY        | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED   | Provider CC | CN: 15-1318 | Period:<br>From 01/01/2019<br>To 12/31/2019 |                     |              |
|--------------|--|-------------|-------------|---|---------------------|--------------|
|              |  |             | XVIII       | Hospi tal                                   | Cost                |              |
|              |  | I npati en  | t Part A    | Par   | rt B                |              |
|              |  | mm/dd/yyyy  | Amount      | mm/dd/yyyy                                  | Amount              |              |
|              |  | 1.00        | 2.00        | 3.00  | 4.00                |              |
| 1.00         | Total interim payments paid to provider  |             | 4, 288, 4   |   | 877, 452            | 1.00         |
| 2.00         | Interim payments payable on individual bills, either<br>submitted or to be submitted to the contractor for<br>services rendered in the cost reporting period. If none,<br>write "NONE" or enter a zero |             |             | 0   | 0                   | 2.00         |
| 3. 00        | List separately each retroactive lump sum adjustment<br>amount based on subsequent revision of the interim rate<br>for the cost reporting period. Also show date of each                               |             |             |   |                     | 3.00         |
|              | payment. If none, write "NONE" or enter a zero. (1)<br>Program to Provider   |             |             |   |                     |              |
| 3.01         | ADJUSTMENTS TO PROVIDER  | 07/25/2019  | 565, 90     | 00  | 0                   | 3. 01        |
| 3.02         |  | 12/20/2019  | 175, 50     | 00  | 0                   | 3. 02        |
| 3.03         |  |             |             | 0   | 0                   | 3.03         |
| 3.04         |  |             |             | 0   | 0                   | 3.04         |
| 3.05         | Provider to Program  |             |             | 0   | 0                   | 3. 05        |
| 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<br>3.99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines  |             | 741, 40     | 0   | 0                   | 3.54<br>3.99 |
| 3.77         | 3. 50-3. 98)   |             | 741,40      | 50  | 0                   | 3. 77        |
| 4.00         | Total interim payments (sum of lines 1, 2, and 3.99)   |             | 5, 029, 8   | 84  | 877, 452            | 4.00         |
|              | (transfer to Wkst. E or Wkst. E-3, line and column as  |             |             |   |                     |              |
|              | appropriate)<br>TO BE COMPLETED BY CONTRACTOR  |             |             |   |                     |              |
| 5.00         | List separately each tentative settlement payment after  |             |             |   |                     | 5.00         |
|              | desk review. Also show date of each payment. If none,<br>write "NONE" or enter a zero. (1)<br>Program to Provider  |             |             |   |                     |              |
| 5.01         | TENTATI VE TO PROVI DER  |             |             | 0   | 0                   | 5.01         |
| 5.02         |  |             |             | 0   | 0                   | 5.02         |
| 5.03         |  |             |             | 0   | 0                   | 5.03         |
|              | Provider to Program  |             |             |   |                     |              |
| 5.50<br>5.51 | TENTATI VE TO PROGRAM  |             |             | 0   | 0                   | 5.50<br>5.51 |
| 5.52         |  |             |             | 0   | 0                   | 5.52         |
| 5.99         | Subtotal (sum of lines 5.01–5.49 minus sum of lines  |             |             | 0   | 0                   | 5.99         |
|              | 5. 50-5. 98)   |             |             |   |                     |              |
| 6.00         | Determined net settlement amount (balance due) based on<br>the cost report. (1)  |             |             |   |                     | 6.00         |
| 6. 01        | SETTLEMENT TO PROVIDER   |             | 249, 1      | 15  | 0                   | 6. Oʻ        |
| 6.02         | SETTLEMENT TO PROGRAM  |             |             | 0   | 1, 004, 606         | 6. 02        |
| 7.00         | Total Medicare program liability (see instructions)  |             | 5, 278, 9   |   | -127, 154           | 7.00         |
|              |  |             |             | Contractor<br>Number                        | NPR Date            |              |
|              |  | C           | )           | 1, 00                                       | (Mo/Day/Yr)<br>2.00 |              |
| 8.00         | Name of Contractor   |             |             |   | 2.00                | 8.00         |

| IALY:    | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED   | Provider Component ( | CN: 15-1318<br>CCN: 15-Z318 | Period:<br>From 01/01/2019<br>To 12/31/2019 |               |     |
|----------|--|----------------------|-----------------------------|---|---------------|-----|
|          |  | component            | JON: 13-2310                | 10 12/31/2013                               | 8/28/2020 10: |     |
|          |  |                      |                             | Swing Beds - SN                             |               |     |
|          |  | Inpatien             | t Part A                    | Pai   | rt B          |     |
|          |  | mm/dd/yyyy           | Amount                      | mm/dd/yyyy                                  | Amount        |     |
|          |  | 1.00                 | 2.00                        | 3.00  | 4.00          |     |
| 00       | Total interim payments paid to provider  |                      | 650, 27                     |   | 0             | 1.0 |
| 00       | Interim payments payable on individual bills, either   |                      |                             | 0   | 0             | 2.  |
|          | submitted or to be submitted to the contractor for   |                      |                             |   |               |     |
|          | services rendered in the cost reporting period. If none,   |                      |                             |   |               |     |
| ~~       | write "NONE" or enter a zero   |                      |                             |   |               |     |
| 00       | List separately each retroactive lump sum adjustment   |                      |                             |   |               | 3.  |
|          | amount based on subsequent revision of the interim rate<br>for the cost reporting period. Also show date of each |                      |                             |   |               |     |
|          | payment. If none, write "NONE" or enter a zero. (1)  |                      |                             |   |               |     |
|          | Program to Provider  |                      | <u>.</u>                    |   | 1             |     |
| 01       | ADJUSTMENTS TO PROVIDER  |                      |                             | 0   | 0             | 3.  |
| 02       |  |                      |                             | 0   | 0             | 3.  |
| 03       |  |                      |                             | 0   | 0             | 3.  |
| 04       |  |                      |                             | 0   | 0             |     |
| 05       |  |                      |                             | 0   | 0             | 3.  |
|          | Provider to Program  |                      |                             | _   | -             |     |
| 50       | ADJUSTMENTS TO PROGRAM   |                      |                             | 0   | 0             |     |
| 51       |  |                      |                             | 0   | 0             |     |
| 52<br>53 |  |                      |                             | 0   |               |     |
| 53<br>54 |  |                      |                             | 0   |               |     |
| 99       | Subtotal (sum of lines 3.01-3.49 minus sum of lines  |                      |                             | 0   | 0             |     |
| , ,      | 3. 50-3. 98)   |                      |                             | 0   |               |     |
| 00       | Total interim payments (sum of lines 1, 2, and 3.99)   |                      | 650, 27                     | 77  | 0             | 4   |
|          | (transfer to Wkst. E or Wkst. E-3, line and column as  |                      |                             |   |               |     |
|          | appropri ate)  |                      |                             |   |               |     |
|          | TO BE COMPLETED BY CONTRACTOR  |                      |                             |   |               |     |
| 00       | List separately each tentative settlement payment after  |                      |                             |   |               | 5   |
|          | desk review. Also show date of each payment. If none,<br>write "NONE" or enter a zero. (1)                       |                      |                             |   |               |     |
|          | Program to Provider  |                      |                             |   |               |     |
| 01       | TENTATI VE TO PROVI DER  |                      |                             | 0   | 0             | 15  |
| )2       |  |                      |                             | 0   | 0             | 5   |
| )3       |  |                      |                             | 0   | 0             | 5   |
|          | Provider to Program  |                      | -                           |   |               |     |
| 50       | TENTATI VE TO PROGRAM  |                      |                             | 0   | 0             |     |
| 51       |  |                      |                             | 0   | 0             |     |
| 52       |  |                      |                             | 0   | 0             |     |
| 99       | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   |                      |                             | 0   | 0             | 5   |
| 00       | Determined net settlement amount (balance due) based on  |                      |                             |   |               | 6   |
| .0       | the cost report. (1)   |                      |                             |   |               |     |
| )1       | SETTLEMENT TO PROVIDER   |                      | 40, 63                      | 37  | 0             | 6   |
| )2       | SETTLEMENT TO PROGRAM  |                      |                             | 0   | 0             |     |
| 00       | Total Medicare program liability (see instructions)  |                      | 690, 9 <sup>-</sup>         | 14  | 0             | 7   |
|          |  |                      |                             | Contractor                                  | NPR Date      |     |
|          |  |                      |                             | Number                                      | (Mo/Day/Yr)   |     |
|          |  | (                    | )                           | 1.00  | 2.00          |     |

| Heal th | Health Financial Systems         DUKES MEMORIAL HOSPITAL         In Lieu  |                           |                  |      |       |  |  |
|---------|---|---------------------------|------------------|------|-------|--|--|
| CALCUL  | CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1318 Period: Wor From 01/01/2019 Par To 12/31/2019 Dat 8/2 |                           |                  |      |       |  |  |
|         |   |                           |                  |      |       |  |  |
|         |   |                           |                  | 1.00 |       |  |  |
|         | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  |                           |                  |      |       |  |  |
|         | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIC  | DN                        |                  |      |       |  |  |
| 1.00    | ) Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14                                  |                           |                  |      |       |  |  |
| 2.00    | 00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12   |                           |                  |      |       |  |  |
| 3.00    | .00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2   |                           |                  |      |       |  |  |
| 4.00    | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,   | 8-12                      |                  |      | 4.00  |  |  |
| 5.00    | Total hospital charges from Wkst C, Pt. I, col. 8 line 200  |                           |                  |      | 5.00  |  |  |
| 6.00    | Total hospital charity care charges from Wkst. S-10, col. 3   | line 20                   |                  |      | 6.00  |  |  |
| 7.00    | CAH only - The reasonable cost incurred for the purchase of line 168 $$   | certified HIT technology  | Wkst. S-2, Pt. I |      | 7.00  |  |  |
| 8.00    | Calculation of the HIT incentive payment (see instructions)   |                           |                  |      | 8.00  |  |  |
| 9.00    | Sequestration adjustment amount (see instructions)  |                           |                  |      | 9.00  |  |  |
| 10.00   | Calculation of the HIT incentive payment after sequestration  | n (see instructions)      |                  |      | 10.00 |  |  |
|         | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  |                           |                  |      |       |  |  |
| 30.00   | Initial/interim HIT payment adjustment (see instructions)   |                           |                  |      | 30.00 |  |  |
| 31.00   | Other Adjustment (specify)  |                           |                  |      | 31.00 |  |  |
| 32.00   | Balance due provider (line 8 (or line 10) minus line 30 and   | line 31) (see instruction | is)              |      | 32.00 |  |  |

|   | Provider CCN: 15-1318<br>Component CCN: 15-Z318 | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet E-2<br>Date/Time Pre<br>8/28/2020 10:3 | pared:        |
|---|---|---|--|---------------|
|   | Title XVIII                                     | Swing Beds - SNF                            |  |               |
|   |   | Part A                                      | Part B   |               |
| CONDUTATION OF NET COST OF COVEDED SEDVICES   |   | 1.00  | 2.00   |               |
| COMPUTATION OF NET COST OF COVERED SERVICES<br>Inpatient routine services - swing bed-SNF (see instructions)                            |   | 496, 766                                    | 0  | 1.00          |
| 00 [Inpatient routine services - swing bed-NF (see instructions)  |   | 170, 700                                    | 0  | 2.00          |
| OO Ancillary services (from Wkst. D-3, col. 3, line 200, for Part   | A, and sum of Wkst. D,                          | 215, 920                                    | 0  | 3.00          |
| Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing   |   |   | -  |               |
| instructions)   |   |   |  |               |
| 01 Nursing and allied health payment-PARHM (see instructions)   | ,   |   |  | 3.0           |
| 20 Per diem cost for interns and residents not in approved teachin  | g program (see                                  |   | 0.00   | 4.00          |
| instructions)<br>D0 Program days  |   | 281   | 0  | 5.00          |
| 00  Interns and residents not in approved teaching program (see ins   | tructions)                                      | 201   | 0  | 6.00          |
| 00 Utilization review - physician compensation - SNF optional meth  |   | 0   | 0  | 7.00          |
| 00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7)   |   | 712, 686                                    | 0  | 8.00          |
| 00 Primary payer payments (see instructions)  |   | 0   | 0  | 9.00          |
| .00 Subtotal (line 8 minus line 9)  |   | 712, 686                                    | 0  | 10.00         |
| .00 Deductibles billed to program patients (exclude amounts applica   | ble to physician                                | 0   | 0  | 11.00         |
| professional services)  |   | 740 (0)                                     |  | 10.0          |
| .00 Subtotal (line 10 minus line 11)  | (avaluda asi nouranaa                           | 712, 686                                    | 0  | 12.00         |
| 00 Coinsurance billed to program patients (from provider records) for physician professional services)                                  | (exclude collisurance                           | 7, 672                                      | 0  | 13.00         |
| .00 80% of Part B costs (line 12 x 80%)   |   |   | 0  | 14.0          |
| 00 Subtotal (see instructions)  |   | 705, 014                                    | 0  | 15.0          |
| 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |   | 0   | 0  | 16.0          |
| .50 Pioneer ACO demonstration payment adjustment (see instructions)   |   |   |  | 16.5          |
| .55 Rural community hospital demonstration project (§410A Demonstra   | tion) payment                                   | 0   |  | 16.5          |
| adjustment (see instructions)   |   |   |  |               |
| . 99 Demonstration payment adjustment amount before sequestration   |   | 0   | 0  |               |
| .00 Allowable bad debts (see instructions)<br>.01 Adjusted reimbursable bad debts (see instructions)                                    |   | 0   | 0  | 17.00<br>17.0 |
| .00 Allowable bad debts for dual eligible beneficiaries (see instru   | ctions)   | 0   | 0  | 18.00         |
| .00 Total (see instructions)  |   | 705, 014                                    | 0  | 19.0          |
| .01 Sequestration adjustment (see instructions)   |   | 14, 100                                     | 0  | 19.0          |
| 02 Demonstration payment adjustment amount after sequestration)   |   | 0   | 0  | 19.0          |
| 03 Sequestration adjustment-PARHM pass-throughs   |   |   |  | 19.0          |
| .00 Interim payments  |   | 650, 277                                    | 0  | 20.0          |
| .01 Interim payments-PARHM  |   |   |  | 20.0          |
| .00 Tentative settlement (for contractor use only)  |   | 0   | 0  | 21.0          |
| .01 Tentative settlement-PARHM (for contractor use only)<br>.00 Balance due provider/program (line 19 minus lines 19.01, 20, an         | 4 21)   | 40, 637                                     | 0  | 21.0<br>22.0  |
| .01 Balance due provider/program-PARHM (see instructions)   | u 21)   | 40, 037                                     | 0  | 22.0          |
| .00 Protested amounts (nonallowable cost report items) in accordanc   | e with CMS Pub 15-2                             | 0   | 0  |               |
| chapter 1, §115.2   |   |   | -  |               |
| Rural Community Hospital Demonstration Project (§410A Demonstra   |   |   |  |               |
| D.00 Is this the first year of the current 5-year demonstration peri  | od under the 21st                               |   |  | 200. 0        |
| Century Cures Act? Enter "Y" for yes or "N" for no.   |   |   |  |               |
| Cost Reimbursement  | -+ D 1 D+ 11 13                                 |   |  | 201 0         |
| 1.00 Medicare swing-bed SNF inpatient routine service costs (from Wk<br>66 (title XVIII hospital))                                      | st. D-I, Pt. II, line                           |   |  | 201. 0        |
| 2.00 Medicare swing-bed SNF inpatient ancillary service costs (from   | Wkst D-3 col 3 lin                              | ۵   |  | 202. 0        |
| 200 (title XVIII swing-bed SNF))  |   | 0   |  | 20210         |
| 3.00 Total (sum of lines 201 and 202)   |   |   |  | 203. 0        |
| 4.00 Medicare swing-bed SNF discharges (see instructions)   |   |   |  | 204. 0        |
| Computation of Demonstration Target Amount Limitation (N/A in f   | irst year of the curre                          | nt 5-year demonst                           | ration   |               |
| period)   |   |   |  |               |
| 5.00 Medicare swing-bed SNF target amount   | 1 201   |   |  | 205.0         |
| 6.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 tim  |   |   |  | 206. 0        |
| Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse<br>7.00 Program reimbursement under the §410A Demonstration (see instru |   |   |  | 207. 0        |
| 8.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,  | -   | 1   |  | 207.0         |
| and 3)  | Soli i, Sun Of FINCS                            | ·   |  |               |
| 9.00 Adjustment to Medicare swing-bed SNF PPS payments (see instruct  | i ons)  |   |  | 209. 00       |
| 0.00 Reserved for future use  |   |   |  | 210. 0        |
| Comparision of PPS versus Cost Reimbursement  |   |   |  |               |
| 5.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 20  | 9 plus line 210) (see                           |   |  | 215.0         |

|                | Financial Systems DUKES MEMORIA<br>ATION OF REIMBURSEMENT SETTLEMENT                            | Provider CCN: 15-1318      | Peri od:                         | u of Form CMS-2<br>Worksheet E-3 |       |
|----------------|---|----------------------------|----------------------------------|----------------------------------|-------|
|                |   |                            | From 01/01/2019<br>To 12/31/2019 |                                  | pared |
|                |   |                            |                                  | 8/28/2020 10:                    |       |
|                |   | Title XVIII                | Hospi tal                        | Cost                             |       |
|                |   |                            |                                  | 1.00                             |       |
|                | PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR                                    | RE PART A SERVICES - COST  | REIMBURSEMENT                    | 1.00                             |       |
| 1.00           | Inpatient services  |                            |                                  | 5, 713, 023                      | 1. C  |
| 2.00           | Nursing and Allied Health Managed Care payment (see instruct                                    | tions)                     |                                  | 0                                |       |
| 3.00           | Organ acquisition   |                            |                                  | 0                                |       |
| 4.00           | Subtotal (sum of lines 1 through 3)   |                            |                                  | 5, 713, 023                      |       |
| 5.00<br>5.00   | Primary payer payments<br>Total cost (line 4 less line 5). For CAH (see instructions)           |                            |                                  | 13, 792<br>5, 756, 361           |       |
| 5.00           | COMPUTATION OF LESSER OF COST OR CHARGES  |                            |                                  | 5,750,301                        | 0.0   |
|                | Reasonable charges  |                            |                                  |                                  | 1     |
| 7.00           | Routi ne servi ce charges   |                            |                                  | 0                                | 7.0   |
| 3.00           | Ancillary service charges   |                            |                                  | 0                                |       |
| 9.00           | Organ acquisition charges, net of revenue   |                            |                                  | 0                                |       |
| 10.00          | Total reasonable charges  |                            |                                  | 0                                | 10. ( |
| 1.00           | Customary charges<br>Aggregate amount actually collected from patients liable for               | r navment for services on  | a charge basis                   | 0                                | 11. ( |
| 12.00          | Amounts that would have been realized from patients liable f                                    |                            |                                  |                                  | 12. ( |
| 2.00           | had such payment been made in accordance with 42 CFR 413.13(                                    |                            | a onargo baoro                   | 0                                |       |
| 3.00           | Ratio of line 11 to line 12 (not to exceed 1.000000)  | . ,                        |                                  | 0.00000                          | 13.   |
| 4.00           | Total customary charges (see instructions)  |                            |                                  | 0                                |       |
| 5.00           | Excess of customary charges over reasonable cost (complete o                                    | only if line 14 exceeds li | ne 6) (see                       | 0                                | 15.0  |
| 16.00          | instructions)<br>Excess of reasonable cost over customary charges (complete o                   | only if line 6 exceeds lin | 0 14) (500                       | 0                                | 16.0  |
| 10.00          | instructions)   | only if the o exceeds iff  | 16 14) (See                      | 0                                | 10.0  |
| 17.00          | Cost of physicians' services in a teaching hospital (see ins                                    | structions)                |                                  | 0                                | 17. ( |
|                | COMPUTATION OF REIMBURSEMENT SETTLEMENT   |                            |                                  |                                  |       |
| 18.00          | Direct graduate medical education payments (from Worksheet E                                    | E-4, line 49)              |                                  | 0                                |       |
| 19.00<br>20.00 | Cost of covered services (sum of lines 6, 17 and 18)  |                            |                                  | 5, 756, 361                      |       |
| 20.00          | Deductibles (exclude professional component)<br>Excess reasonable cost (from line 16)           |                            |                                  | 428, 176<br>0                    |       |
| 22.00          | Subtotal (line 19 minus line 20 and 21)   |                            |                                  | 5, 328, 185                      |       |
| 23.00          | Coinsurance   |                            |                                  |                                  | 23.   |
| 4. 00          | Subtotal (line 22 minus line 23)  |                            |                                  | 5, 328, 185                      |       |
| 5.00           | Allowable bad debts (exclude bad debts for professional serv                                    | vices) (see instructions)  |                                  | 90, 076                          |       |
| 6.00           | Adjusted reimbursable bad debts (see instructions)  |                            |                                  | 58, 549                          |       |
| 7.00           | Allowable bad debts for dual eligible beneficiaries (see ins                                    | structions)                |                                  | 20, 248                          |       |
| 8.00<br>9.00   | Subtotal (sum of lines 24 and 25, or line 26)<br>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) |                            |                                  | 5, 386, 734<br>0                 |       |
| 29.50          | Pioneer ACO demonstration payment adjustment (see instruction                                   | ons)                       |                                  | 0                                |       |
| 9.99           | Demonstration payment adjustment amount before sequestration                                    |                            |                                  | 0                                |       |
| 80.00          | Subtotal (see instructions)   |                            |                                  | 5, 386, 734                      | 30.   |
| 0. 01          | Sequestration adjustment (see instructions)   |                            |                                  | 107, 735                         |       |
| 0. 02          | Demonstration payment adjustment amount after sequestration                                     |                            |                                  | 0                                |       |
| 0.03           | Sequestration adjustment-PARHM  |                            |                                  | E 000 004                        | 30.   |
| 31.00<br>31.01 | Interim payments<br>Interim payments-PARHM  |                            |                                  | 5, 029, 884                      | 31.0  |
| 32.00          | Tentative settlement (for contractor use only)  |                            |                                  | 0                                |       |
| 32.00          | Tentative settlement-PARHM (for contractor use only)  |                            |                                  | 0                                | 32.   |
| 33.00          | Balance due provider/program (line 30 minus lines 30.01, 30.                                    | .02, 31, and 32)           |                                  | 249, 115                         |       |
| 33. 01         | Bal ance due provi der/program-PARHM (lines 2, 3, 18, and 26,                                   |                            |                                  |                                  | 33.   |
| 34.00          | Protested amounts (nonallowable cost report items) in accord                                    | dance with CMS Pub 15-2    | chanter 1                        | 0                                | 34.0  |

| CALCUL         | ATION OF REIMBURSEMENT SETTLEMENT  | Provider CCN: 15-1318     | Peri od:                         | Worksheet E-3                              |                 |
|----------------|--|---------------------------|----------------------------------|--|-----------------|
|                |  |                           | From 01/01/2019<br>To 12/31/2019 | Part VII<br>Date/Time Pre<br>8/28/2020 10: | pared:<br>36 am |
|                |  | Title XIX                 | Hospi tal                        | PPS  | _               |
|                |  |                           | Inpati ent                       | Outpati ent                                |                 |
|                |  |                           | 1.00                             | 2.00                                       |                 |
|                | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE<br>COMPUTATION OF NET COST OF COVERED SERVICES | RVICES FOR TITLES V OR X  | IX SERVICES                      |  | -               |
| 1.00           | Inpatient hospital/SNF/NF services   |                           | 0                                |  | 1.00            |
| 2.00           | Medical and other services   |                           | Ū                                | 731, 233                                   | •               |
| 3.00           | Organ acquisition (certified transplant centers only)  |                           | 0                                |  | 3.00            |
| 4.00           | Subtotal (sum of lines 1, 2 and 3)   |                           | 0                                | 731, 233                                   |                 |
| 5.00           | Inpatient primary payer payments   |                           | 0                                | 0  | 5.00            |
| 6.00<br>7.00   | Outpatient primary payer payments<br>Subtotal (line 4 less sum of lines 5 and 6)                             |                           | 0                                | 0<br>731, 233                              |                 |
| 7.00           | COMPUTATION OF LESSER OF COST OR CHARGES   |                           | 0                                | /31,233                                    | 1 7.00          |
|                | Reasonable Charges   |                           |                                  |  | 1               |
| 8.00           | Routine service charges  |                           | 237, 870                         |  | 8.00            |
| 9.00           | Ancillary service charges  |                           | 890, 950                         | 4, 323, 383                                | 9.00            |
| 10. 00         | Organ acquisition charges, net of revenue  |                           | 0                                |  | 10.00           |
| 11.00          | Incentive from target amount computation   |                           | 0                                |  | 11.00           |
| 12.00          | Total reasonable charges (sum of lines 8 through 11)   |                           | 1, 128, 820                      | 4, 323, 383                                | 12.00           |
| 13.00          | CUSTOMARY CHARGES<br>Amount actually collected from patients liable for payment for                          | or services on a charge   | 0                                | 0  | 13.00           |
| 15.00          | basi s   | Services on a charge      | Ŭ                                | 0  | 15.00           |
| 14.00          | Amounts that would have been realized from patients liable for   | or payment for services o | n 0                              | 0  | 14.00           |
|                | a charge basis had such payment been made in accordance with   | 42 CFR §413.13(e)         |                                  |  |                 |
| 15.00          | Ratio of line 13 to line 14 (not to exceed 1.000000)   |                           | 0. 000000                        | 0.00000                                    |                 |
| 16.00          | Total customary charges (see instructions)   |                           | 1, 128, 820                      | 4, 323, 383                                |                 |
| 17.00          | Excess of customary charges over reasonable cost (complete or<br>line 4) (see instructions)                  | ify if line to exceeds    | 1, 128, 820                      | 3, 592, 150                                | 17.00           |
| 18.00          | Excess of reasonable cost over customary charges (complete or  | ulvifline 4 exceeds lin   | e 0                              | 0  | 18.00           |
|                | 16) (see instructions)   |                           | о<br>- С                         | Ũ  |                 |
| 19.00          | Interns and Residents (see instructions)   |                           | 0                                | 0  | 19.00           |
| 20. 00         | Cost of physicians' services in a teaching hospital (see inst  | -                         | 0                                | 0  |                 |
| 21.00          |  |                           | 0                                | 731, 233                                   | 21.00           |
| 22.00          | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be  | e completed for PPS provi | ders.<br>0                       | 0  |                 |
|                | Other than outlier payments<br>Outlier payments  |                           | 0                                | 0  |                 |
| 24.00          | Program capital payments   |                           | 0                                | 0  | 24.00           |
|                | Capital exception payments (see instructions)  |                           | 0                                |  | 25.00           |
| 26.00          | Routine and Ancillary service other pass through costs   |                           | 0                                | 0  | 26.00           |
| 27.00          | Subtotal (sum of lines 22 through 26)  |                           | 0                                | 0  |                 |
| 28.00          | Customary charges (title V or XIX PPS covered services only)   |                           | 0                                | 0  |                 |
| 29.00          | Titles V or XIX (sum of lines 21 and 27)   |                           | 0                                | 731, 233                                   | 29.00           |
| 30.00          | COMPUTATION OF REIMBURSEMENT SETTLEMENT<br>Excess of reasonable cost (from line 18)                          |                           | 0                                | 0  | 30.00           |
| 31.00          | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6  | 5)                        | 0                                | 731, 233                                   |                 |
| 32.00          | Deducti bl es  |                           | 0                                | 01,200                                     | 1               |
|                | Coinsurance  |                           | 0                                | 0  | •               |
| 34.00          | Allowable bad debts (see instructions)   |                           | 0                                | 0  | 34.00           |
| 35.00          | Utilization review   |                           | 0                                |  | 35.00           |
| 36.00          | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar  | nd 33)                    | 0                                | 731, 233                                   |                 |
| 37.00<br>38.00 | OTHER ADJUSTMENTS - PAYMENT  |                           | 0                                | 0<br>201 000                               | 37.00<br>38.00  |
| 38.00          | Subtotal (line 36 ± line 37)<br>Direct graduate medical education payments (from Wkst. E-4)                  |                           |                                  | 731, 233                                   | 38.00           |
| 40.00          | Total amount payable to the provider (sum of lines 38 and 39)  |                           | 0                                | 731, 233                                   |                 |
| 41.00          | Interim payments   |                           | 0                                | 731, 233                                   |                 |
| 42.00          | Balance due provider/program (line 40 minus line 41)   |                           | 0                                | 0  | 1               |
| 43.00          | Protested amounts (nonallowable cost report items) in accorda  | ance with CMS Pub 15-2,   | 0                                | 0  | 43.00           |
|                | chapter 1, §115.2  |                           |                                  |  | 1               |

| ALANC          | Financial Systems DUKES MEMORIA<br>E SHEET (If you are nonproprietary and do not maintain<br>yoe accounting records, complete the Constal Fund column | Provider C                |                          | Period:<br>From 01/01/2019 | u of Form CMS-:<br>Worksheet G |          |
|----------------|---|---------------------------|--------------------------|----------------------------|--------------------------------|----------|
| una-t<br>nl y) | ype accounting records, complete the General Fund column  |                           |                          | To 12/31/2019              | Date/Time Pre<br>8/28/2020 10: |          |
|                |   | General Fund              | Specific<br>Purpose Fund | Endowment Fund             | Plant Fund                     |          |
|                | CURRENT ASSETS  | 1.00                      | 2.00                     | 3.00                       | 4.00                           |          |
| 00             | Cash on hand in banks   | -113, 654                 |                          | 0 0                        | 0                              | 1.       |
| 00             | Temporary investments   | 0                         |                          | 0 0                        | 0                              |          |
| 00             | Notes receivable  | 0                         |                          | 0 0                        | 0                              | 3.       |
| 00             | Accounts receivable   | 20, 224, 624              |                          | 0 0                        | 0                              |          |
| 00             | Other receivable<br>Allowances for uncollectible notes and accounts receivable  | 0<br>-6, 284, 997         |                          |                            | 0                              |          |
| 00             | Inventory   | -0, 284, 997<br>872, 192  |                          | 0 0                        | 0                              |          |
| 00             | Prepaid expenses  | 507, 378                  |                          | 0 0                        | 0                              |          |
| 00             | Other current assets  | -218, 626                 |                          | 0 0                        | 0                              |          |
| 0. 00          | Due from other funds  | 0                         |                          | 0 0                        | 0                              | 10       |
| . 00           | Total current assets (sum of lines 1-10)  | 14, 986, 917              |                          | 0 0                        | 0                              | 11       |
|                | FI XED ASSETS   |                           |                          |                            |                                |          |
| 2.00           | Land  | 500, 000                  |                          | 0 0                        | 0                              | 12       |
| 3.00           | Land improvements   | 223, 845                  |                          | 0 0                        | 0                              | 13       |
|                | Accumulated depreciation<br>Buildings   | -135, 093<br>10, 565, 163 |                          |                            | 0                              |          |
|                | Accumulated depreciation  | -3, 796, 915              |                          | 0 0                        | 0                              | 16       |
|                | Leasehold improvements  | 10, 326, 930              |                          | 0 0                        | 0                              | 17       |
|                | Accumulated depreciation  | -3, 835, 139              |                          | 0 0                        | 0                              | 18       |
|                | Fixed equipment   | 3, 203, 321               |                          | 0 0                        | 0                              | 19       |
| 0. 00          | Accumulated depreciation  | -1, 441, 095              |                          | 0 0                        | 0                              | 20       |
| . 00           | Automobiles and trucks  | 583, 590                  |                          | 0 0                        | 0                              | 21       |
| 2.00           | Accumulated depreciation  | -533, 272                 |                          | 0 0                        | 0                              | 22       |
|                | Major movable equipment   | 7, 632, 904               |                          | 0 0                        | 0                              | 23       |
|                | Accumulated depreciation  | -6, 418, 161              |                          | 0 0                        | 0                              | 24       |
|                | Minor equipment depreciable   | 4, 743, 858               |                          | 0 0                        | 0                              | 25       |
|                | Accumulated depreciation  | -2, 920, 816              |                          | 0 0                        | 0                              | 26       |
|                | HIT designated Assets<br>Accumulated depreciation   | 0                         |                          |                            | 0                              | 27       |
|                | Mi nor equi pment-nondepreci abl e  | 0                         |                          | 0 0                        | 0                              | 29       |
| ). 00          | Total fixed assets (sum of lines 12-29)   | 18, 699, 120              |                          | 0 0                        | 0                              |          |
|                | OTHER ASSETS  | 10,077,120                |                          | <u> </u>                   |                                |          |
| 1.00           | Investments   | 0                         |                          | 0 0                        | 0                              | 31       |
| 2.00           | Deposits on Leases  | 0                         |                          | 0 0                        | 0                              | 32       |
| 3.00           | Due from owners/officers  | 0                         |                          | 0 0                        | 0                              | 33       |
| 1.00           | Other assets  | 11, 362, 663              |                          | 0 0                        | 0                              | 34       |
| 5.00           | Total other assets (sum of lines 31-34)   | 11, 362, 663              |                          | 0 0                        | 0                              | 35       |
| 5.00           | Total assets (sum of lines 11, 30, and 35)  | 45, 048, 700              |                          | 0 0                        | 0                              | 36       |
|                | CURRENT LI ABI LI TI ES   |                           |                          | -                          | -                              |          |
|                | Accounts payable  | 1,012,003                 |                          | 0 0                        | 0                              |          |
| 3.00<br>9.00   | Salaries, wages, and fees payable   | 1, 185, 276               |                          |                            | 0                              |          |
|                | Payroll taxes payable<br>Notes and Loans payable (short term)   | -9, 622<br>150, 172       |                          |                            | 0                              | 40       |
|                | Deferred income   | 130, 172                  |                          | 0 0                        | 0                              |          |
| 2.00           | Accel erated payments   | 0                         |                          | 0                          | Ŭ                              | 42       |
| 3.00           | Due to other funds  | -10, 177, 873             |                          | 0 0                        | 0                              |          |
|                | Other current liabilities   | 322, 532                  |                          | 0 0                        | 0                              |          |
| 5.00           | Total current liabilities (sum of lines 37 thru 44)   | -7, 517, 512              |                          | 0 0                        | 0                              | 45       |
|                | LONG TERM LIABILITIES   |                           | r                        |                            |                                |          |
| 5.00           | Mortgage payable  | 0                         |                          | 0 0                        | 0                              |          |
| 7.00           | Notes payable   | 281, 074                  |                          | 0 0                        | 0                              | 47       |
| 3.00           | Unsecured Loans   | 0                         |                          | 0 0                        | 0                              |          |
| 9.00           | Other long term liabilities   | 0                         |                          | 0 0                        | 0                              | 49       |
|                | Total long term liabilities (sum of lines 46 thru 49)   | 281,074                   |                          |                            | 0                              | 50<br>51 |
| . 00           | Total liabilities (sum of lines 45 and 50)<br>CAPITAL ACCOUNTS  | -7, 236, 438              |                          | J                          | 0                              | 1 31     |
| . 00           | General fund balance  | 52, 285, 138              |                          |                            |                                | 52       |
| . 00           | Specific purpose fund   | 52,205,130                |                          | D                          |                                | 53       |
|                | Donor created - endowment fund balance - restricted   |                           |                          | 0                          |                                | 54       |
| 5.00           | Donor created - endowment fund balance - unrestricted   |                           |                          | 0                          |                                | 55       |
| b. 00          | Governing body created - endowment fund balance   |                           |                          | 0                          |                                | 56       |
| 7.00           | Plant fund balance - invested in plant  |                           |                          |                            | 0                              |          |
| 3.00           | Plant fund balance - reserve for plant improvement,   |                           |                          |                            | 0                              |          |
|                | replacement, and expansion  |                           |                          |                            |                                |          |
| 9.00           | Total fund balances (sum of lines 52 thru 58)   | 52, 285, 138              |                          | 0 0                        | 0                              |          |
| 0. 00          | Total liabilities and fund balances (sum of lines 51 and  | 45,048,700                |                          | 0 0                        | 0                              | 60       |

| Heal th   | Financial Systems  | DUKES MEMORIAL   | HOSPI TAL  |             | In Lie                                      | eu of Form CMS-2   | 2552-10  |
|---|--|------------------|--|-------------|---|--|--|
|   | IENT OF CHANGES IN FUND BALANCES   |                  | Provider CC  | CN: 15-1318 | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet G-1  | pared:   |
|   |  | General          | Fund   | Speci al    | Purpose Fund                                | Endowment Fund   |  |
|   |  |                  |  |             |   |  |  |
| 1.00  |  | 1.00             | 2.00   | 3.00        | 4.00  | 5.00   | 1 00   |
| $\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$ | Fund balances at beginning of period<br>Net income (loss) (from Wkst. G-3, line 29)<br>Total (sum of line 1 and line 2)<br>Additions (credit adjustments) (specify)<br>Total additions (sum of line 4-9)<br>Subtotal (line 3 plus line 10)<br>Deductions (debit adjustments) (specify)<br>Total deductions (sum of lines 12-17)<br>Fund balance at end of period per balance |                  | 56, 584, 135<br>-4, 298, 997<br>52, 285, 138<br>0<br>52, 285, 138<br>0<br>52, 285, 138 |             |   | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | $\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$ |
|   | sheet (line 11 minus line 18)  | Endowment Fund   | PI ant   | Fund        |   |  |  |
|   |  |                  |  |             |   |  |  |
| 1 00  | Fund halanses at basismiss of second   | 6.00             | 7.00   | 8.00        | -   |  | 1.00   |
| 1.00<br>2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00  | Fund balances at beginning of period<br>Net income (loss) (from Wkst. G-3, line 29)<br>Total (sum of line 1 and line 2)<br>Additions (credit adjustments) (specify)  | 0                | 0<br>0<br>0<br>0<br>0  |             | 0   |  | 1.00<br>2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00   |
| 10.00<br>11.00<br>12.00<br>13.00<br>14.00<br>15.00<br>16.00<br>17.00<br>18.00<br>19.00  | Total additions (sum of line 4-9)<br>Subtotal (line 3 plus line 10)<br>Deductions (debit adjustments) (specify)<br>Total deductions (sum of lines 12-17)<br>Fund balance at end of period per balance<br>sheet (line 11 minus line 18)   | 0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>0   |             | 0<br>0<br>0<br>0                            |  | 10.00<br>11.00<br>12.00<br>13.00<br>14.00<br>15.00<br>16.00<br>17.00<br>18.00<br>19.00   |

| STATEN | ENT OF PATIENT REVENUES AND OPERATING EXPENSES                 | Provider CCN | l: 15-1318 | Period:<br>From 01/01/2019<br>To 12/31/2019 | Worksheet G-2<br>Parts I & II<br>Date/Time Pre<br>8/28/2020 10: | pared |
|--------|--|--------------|------------|---|---|-------|
|        | Cost Center Description  |              | Inpati ent | Outpati ent                                 | Total   |       |
|        |  |              | 1.00       | 2.00  | 3.00  |       |
|        | PART I – PATIENT REVENUES                                      |              |            |   |   |       |
|        | General Inpatient Routine Services                             |              |            |   |   |       |
| . 00   | Hospi tal  |              | 6, 494, 8  | 74  | 6, 494, 874   | 1.    |
| 2.00   | SUBPROVIDER - IPF  |              |            |   |   | 2.    |
| 8.00   | SUBPROVIDER – IRF  |              |            |   |   | 3.    |
| l. 00  | SUBPROVI DER   |              |            |   |   | 4.    |
| 5.00   | Swing bed - SNF  |              |            | 0   | 0   | 5.    |
| o. 00  | Swing bed - NF   |              |            | 0   | 0   | 6.    |
| . 00   | SKILLED NURSING FACILITY                                       |              |            |   |   | 7.    |
| 3.00   | NURSING FACILITY   |              |            |   |   | 8.    |
| 9.00   | OTHER LONG TERM CARE   |              |            |   |   | 9.    |
| 0.00   | Total general inpatient care services (sum of lines 1-9)       |              | 6, 494, 8  | 74  | 6, 494, 874   | 10.   |
|        | Intensive Care Type Inpatient Hospital Services                | · · ·        |            |   |   | 1     |
| 1.00   | INTENSIVE CARE UNIT  |              | 1, 215, 40 | 08  | 1, 215, 408   | 11.   |
| 2.00   | CORONARY CARE UNIT   |              |            |   |   | 12.   |
| 3.00   | BURN INTENSIVE CARE UNIT                                       |              |            |   |   | 13.   |
| 4.00   | SURGICAL INTENSIVE CARE UNIT                                   |              |            |   |   | 14.   |
| 5.00   | OTHER SPECIAL CARE (SPECIFY)                                   |              |            |   |   | 15.   |
|        | Total intensive care type inpatient hospital services (sum of  | lines        | 1, 215, 40 | 08  | 1, 215, 408   | 16.   |
|        | 11-15)   |              | .,,        |   | .,,   |       |
| 7.00   | Total inpatient routine care services (sum of lines 10 and 16) |              | 7, 710, 2  | 32  | 7, 710, 282   | 17.   |
| 8.00   | Ancillary services   |              | 37, 677, 8 |   | 133, 530, 193   |       |
|        | Outpatient services  |              | 3, 256, 3  |   | 27, 151, 068  |       |
|        | RURAL HEALTH CLINIC  |              | -, -, -    | 0 0   | 0   | 20.   |
|        | FEDERALLY QUALIFIED HEALTH CENTER                              |              |            | 0 0   | 0   | 21.   |
|        | HOME HEALTH AGENCY   |              |            |   | -   | 22.   |
|        | AMBULANCE SERVICES   |              |            | 0 8, 044, 648                               | 8, 044, 648   |       |
| 24.00  |  |              |            |   | -, ,  | 24.   |
| 25.00  | AMBULATORY SURGICAL CENTER (D. P. )                            |              |            |   |   | 25.   |
| 26.00  | HOSPICE  |              |            |   |   | 26.   |
| 27.00  | OTHER (SPECIFY)  |              |            | 0 0   | 0   | 27.   |
|        | Total patient revenues (sum of lines 17-27)(transfer column 3  | to Wkst      | 48, 644, 4 | 77 127, 791, 714                            | 176, 436, 191   | 28.   |
| 0.00   | G-3, line 1)   | to more      | 10, 011, 1 |   | 170, 100, 171   | 20.   |
|        | PART II - OPERATING EXPENSES                                   |              |            |   |   | 1     |
| 29.00  | Operating expenses (per Wkst. A, column 3, line 200)           |              |            | 34, 010, 586                                |   | 29.   |
|        | ADD (SPECIFY)  |              |            | 0   |   | 30.   |
| 31.00  |  |              |            | 0   |   | 31.   |
| 32.00  |  |              |            | 0   |   | 32.   |
| 33.00  |  |              |            | 0   |   | 33.   |
| 34.00  |  |              |            | 0   |   | 34.   |
| 35.00  |  |              |            | 0   |   | 35.   |
| 36.00  | Total additions (sum of lines 30-35)                           |              |            | 0   |   | 36.   |
| 37.00  | DEDUCT (SPECIFY)   |              |            | 0   |   | 37.   |
| 38.00  |  |              |            | 0   |   | 37.   |
| 39.00  |  |              |            | 0   |   | 30.   |
| 40.00  |  |              |            | 0   |   | 40.   |
| 1. 00  |  |              |            | 0   |   | 40.   |
|        | Total doductions (sum of lines 27 41)                          |              |            |   |   | 41.   |
| 2.00   | Total deductions (sum of lines 37-41)                          | (transfor    |            | 24 010 504                                  |   |       |
| 3.00   | Total operating expenses (sum of lines 29 and 36 minus line 42 | ) (transfer  |            | 34, 010, 586                                |   | 43.   |

| Heal th                            | alth Financial Systems DUKES MEMORIAL HOSPITAL In Li                                      |                     | In Lie                | u of Form CMS-2                  | 2552-10        |               |
|------------------------------------|---|---------------------|-----------------------|----------------------------------|----------------|---------------|
| STATEMENT OF REVENUES AND EXPENSES |   |                     | Provider CCN: 15-1318 | Peri od:                         | Worksheet G-3  |               |
|                                    |   |                     |                       | From 01/01/2019<br>To 12/31/2019 | Date/Time Pre  | nared         |
|                                    |   |                     |                       | 10 12/01/2017                    | 8/28/2020 10:  |               |
|                                    |   |                     |                       |                                  |                |               |
|                                    |   |                     |                       |                                  | 1.00           |               |
| 1.00                               | Total patient revenues (from Wkst. G-2, Part  |                     |                       |                                  | 176, 436, 191  | 1.00          |
| 2.00                               | Less contractual allowances and discounts or  | n patrents' account | IS                    |                                  | 146, 913, 944  | 2.00          |
| 3.00                               | Net patient revenues (line 1 minus line 2)  |                     |                       |                                  | 29, 522, 247   | 3.00          |
| 4.00                               | Less total operating expenses (from Wkst. G-  |                     | 13)                   |                                  | 34, 010, 586   | 4.00          |
| 5.00                               | Net income from service to patients (line 3   | minus line 4)       |                       |                                  | -4, 488, 339   | 5.00          |
| ( 00                               | OTHER INCOME  |                     |                       |                                  | 0              | ( 00          |
| 6.00                               | Contributions, donations, bequests, etc   |                     |                       |                                  | 0              | 6.00          |
| 7.00<br>8.00                       | Income from investments   |                     |                       |                                  | 0              | 7.00<br>8.00  |
| 8.00<br>9.00                       | Revenues from telephone and other miscellane<br>Revenue from television and radio service | eous communication  | Ser VI Ces            |                                  | -              | 8.00<br>9.00  |
| 9.00<br>10.00                      | Purchase di scounts   |                     |                       |                                  | 0              | 9.00<br>10.00 |
|                                    |   |                     |                       |                                  | 0              | 10.00         |
| 11. 00<br>12. 00                   | Rebates and refunds of expenses<br>Parking lot receipts                                   |                     |                       |                                  | 0              | 12.00         |
| 12.00                              | Revenue from Laundry and Linen service  |                     |                       |                                  | 0              | 12.00         |
| 13.00                              | Revenue from meals sold to employees and gue  | octo                |                       |                                  | 0              | 13.00         |
| 14.00                              | Revenue from rental of living quarters  | ests                |                       |                                  | 0              |               |
|                                    | Revenue from sale of medical and surgical su  | upplies to other th | an nationts           |                                  | 0              | 16.00         |
|                                    | Revenue from sale of drugs to other than pat  |                     |                       |                                  | 0              |               |
| 18.00                              | Revenue from sale of medical records and abs  |                     |                       |                                  | 0              | 18.00         |
|                                    | Tuition (fees, sale of textbooks, uniforms,   |                     |                       |                                  | 0              | 19.00         |
| 20,00                              | Revenue from gifts, flowers, coffee shops, a  | ,                   |                       |                                  | 0              | 20.00         |
| 20.00                              | Rental of vending machines  |                     |                       |                                  | 0              | 20.00         |
| 22.00                              | Rental of hospital space  |                     |                       |                                  | 0              | 22.00         |
| 23.00                              | Governmental appropriations   |                     |                       |                                  | 0              | 23.00         |
| 24.00                              | OTHER INCOME  |                     |                       |                                  | 189, 342       |               |
| 24.00                              | Total other income (sum of lines 6-24)  |                     |                       |                                  | 189, 342       |               |
| 26.00                              | Total (line 5 plus line 25)   |                     |                       |                                  | -4, 298, 997   |               |
| 27.00                              | OTHER EXPENSES (SPECIFY)  |                     |                       |                                  | -4, 290, 997   | 27.00         |
| 28.00                              | Total other expenses (sum of line 27 and sub  | bscripts)           |                       |                                  | 0              | 28.00         |
|                                    | Net income (or loss) for the period (line 26  |                     |                       |                                  | -4, 298, 997   |               |
| 27.00                              |   | 2                   |                       | I                                | ., _, 0, , , , |               |