## PART II - CERTIFICATION

(3)

(4) Reopened (5) Amended

Settled with Audit

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUPONT HOSPITAL ( 15-0150 ) for the cost reporting period beginning 04/01/2018 and ending 03/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regul ati ons.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si aned) Officer or Administrator of Provider(s)

> VICE PRESIDENT - REIMBURSEMENT Title

number of times reopened = 0-9.

Date

Title XVIII Title V Part B Cost Center Description Part A HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 175, 258 -2, 972 0 Hospi tal 0 1.00 0 Subprovi der - IPF 2 00 2 00 C 0 3.00 Subprovider - IRF C 0 0 3.00 0 5.00 Swing bed - SNF 0 0 C 5.00 Swing bed - NF 0 6 00 0 6.00 SKILLED NURSING FACILITY 7.00 0 Ω 0 7.00 175, 258 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. 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.

Health Financial Systems DUPONT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0150 Peri od: Worksheet S-2 From 04/01/2018 Part I 03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 2520 E. DUPONT ROAD PO Box: 1.00 State: IN 2.00 City: FORT WAYNE Zi p Code: 46825-County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 DUPONT HOSPITAL 150150 23060 05/24/2001 Ν 3.00 Hospi tal 4.00 Subprovider - IPF 4.00 5.00 Subprovider - IRF 5.00 Subprovider - (Other) 6.00 6.00 7.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospital-Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 04/01/2018 03/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for Υ Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Υ 22 01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care 22 02 N N payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas 22.03 Ν Ν N 22.03 adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no In-State In-State Out-of Out-of Medi cai d 0ther HMO days Medi cai d Medi cai d State State Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2. 00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 538 5.249 283 24.00 623 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column

4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der C	CN: 15-0150	Peri od: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Pre 9/3/2019 3:51	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports	N			0.00	0.00	61. 0
ending and submitted before March 23, 2010. (see instructions)  Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61. 0
and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61. 0
instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 0
	Pro	ogram Name	Ü		Direct GME FTE Count	
ol. 10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00	4.00	61. 1
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00		61. 2
					1.00	
ACA Provisions Affecting the Health Resources and Ser 52.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc- 52.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc	trainec ctions) a Teachi gram. (s	lin this cost ng Health Cen see instructio	reporting pe ter (THC) int			62.00
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63. 00
,	11110	o. tin ougil	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi o	der Settinas	1.00 This base yea	2.00 Ir is your cost r	3.00 reporting	
period that begins on or after July 1, 2009 and befor 64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June cy trair n-primar all nor d non-pr n columr	30, 2010.  ded residents by care aprovider bimary care a 3 the ratio	0.			64.00

From 04/01/2018 Part I Date/Time Prepared: 03/31/2019 9/3/2019 3:51 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Statis a LiOi co-located within another hospital for part or all of the cost reporting period? Enter   N   Y   Y   For yes and YN   For no.		Worksheet S- Part I Date/Time Pr 9/3/2019 3:5	eriod: rom 04/01/2018 o 03/31/2019	Provider CCN: 15-0150	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					
1.00 Is this a Long term care hospital (LTCH)? Enter "Y" for yea and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no. IEEEA Providers.  1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "N" for no. IEEEA Providers.  1.00 Id this should the part of the cost of the		1. 00								
Statis a LiGit co-located within another hospital for part or all of the cost reporting period? Enter   N   Y   YF   YF   YF   YF   YF   YF										
1.00 bit this Facility establish a new Drospital under 42 CFR Section \$413.40(f)(1)(1) TERRA? Enter "Y" for yes or "N" for no. 0 bit this Facility establish a new Drospital or executed unit) under 42 CFR Section \$413.40(f)(1)(1)? Enter "Y" for yes and "N" for no. 0 bit this hospital an extended neoplastic disease care hospital classified under section 0 bit this hospital and standard the section of the secti	80. 81.	t	period? Enter		Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.					
1.00   St his hospital an extended neoplastic disease care hospital classified under section   N   St   1886(d)(1)(0)(1)(2) Finter "Y" for yes or "N" for no.   Y   XIX   XI	85. 86.	N	•	3	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i Did this facility establish a new Other subprovider (exclud					
Title V and XIX Services  1.00 Does this Facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.  1.00 Is this hospital relimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  1.00 Is this hospital relimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.  1.00 Does this facility aperate an ICE/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  1.00 Does this facility operate an ICE/IID facility for purposes of title V and XIX? Enter "N" for yes or "N" for no in the applicable column.  1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  1.01 If line V4 is "", enter the reduction percentage in the applicable column.  1.02 If line V6 is "Y", enter the reduction percentage in the applicable column.  1.03 In line V6 is "Y", enter the reduction percentage in the applicable column.  1.04 If line V6 is "Y", enter the reduction percentage in the applicable column.  1.05 In line V6 is "Y", enter the reduction percentage in the applicable column.  1.06 Does title V or XIX follow Medicare (title XIXI) for the interns and residents post stopdown adjustments on Wkst. B, Pt. 1, col. 25° Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  1.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1, Chart "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  1.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89° Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  1.05 Does title V or XIX follow Medicare (title XVIII) for a calculation of observation bed costs on Wkst.	87.	N		classified under section	Is this hospital an extended neoplastic disease care hospit					
Title V and XIX Services   Do.   Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for   N   Y   Comparison of the publicable column.   Y   Y   Comparison of the publicable column.   Y   Y   Y   Y   Y   Y   Y   Y   Y	_									
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 0.01 is this hospital relimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 0.00 Are title XIX MF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 0.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 0.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 0.00 Does title V or XIX reduce applicable column. 0.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 0.01 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.02 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 0.03 Does title V or XIX follow Medicare (title XVIII) for the interens and residents post yes stepdown adjustments on Wkst. B. Pt. 1, col. 257 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 0.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Y yes column 1 for title V, and in column 2 for title XIX. 0.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 899 Enter "Y" for yes or "N" for no in column 1 for for title V, and in column 2 for title XIX. 0.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no incolumn 1 for title V, and in column 2 for title XIX. 0.04 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) no incolumn 1 for title V, and in column 2 for title XIX. 0.05 Does title V or XIX follow Medicare (title XVIII) for a critical incolumn 1 for		2.00	1.00		Title V and VIV Services					
1.00 is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "y" for yes or "N" for no in the applicable column.  2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "y" for yes or "N" for no in the applicable column.  3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "y" for yes or "N" for no in the applicable column.  3.00 Does title V or XIX reduce capital cost? Enter "y" for yes, and "N" for no in the applicable column.  3.00 Does title V or XIX reduce capital cost? Enter "y" for yes, and "N" for no in the applicable column.  3.00 Does title V or XIX reduce operating cost? Enter "y" for yes or "N" for no in the applicable column.  3.00 Does title V or XIX reduce operating cost? Enter "y" for yes or "N" for no in the applicable column.  3.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25F. Enter "y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  3.00 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Y  4.01 C, Pt. 1? Enter "y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  3.02 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed tolls of inpatient services cost? Enter "y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  3.00 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed tolls of inpatient services cost? Enter "y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  3.01 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on West Love XIX follow Medicare (title XVIII) for a CAH relmbursed 101% of No	90.	Y	N	services? Enter "Y" for	Does this facility have title V and/or XIX inpatient hospit					
2.00 Are title XIX NP patients occupying title XVIII SNP beds (dual certification)? (see instructions) Enter "" for yes or "N" for on in the applicable column. 3.00 Does title V or XIX reduce capital cost? Enter "" for yes, and "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "" for yes, and "N" for no in the applicable column. 5.00 [If line 94 is "", enter the reduction percentage in the applicable column. 6.00 [If line 94 is "", enter the reduction percentage in the applicable column. 6.00 [Does title V or XIX reduce operating cost? Enter "" for yes or "N" for no in the N N N On N N N N N N N N N N N N N N N	91.	Y	N		Is this hospital reimbursed for title V and/or XIX through					
3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "V" for yes, and "N" for no in the applicable column. 2.00 Does title V or XIX reduce operating cost? Enter "V" for yes or "N" for no in the applicable column. 3.00 If I line 94 is "Y", enter the reduction percentage in the applicable column. 3.00 Does title V or XIX reduce operating cost? Enter "V" for yes or "N" for no in the applicable column. 3.00 Does title V or XIX foll ow Medicare (title XVIII) for the interns and residents post y stepdown adjustments on Wast. B, Pt. I, col. 25? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.01 Does title V or XIX foll ow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 17. Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.02 Does title V or XIX foll ow Medicare (title XVIII) for the calculation of observation Y 4.03 Does title V or XIX foll ow Medicare (title XVIII) for a critical access hospital (CAH) for title V, and in column 2 for title XIX. 3.0 Does title V or XIX foll ow Medicare (title XVIII) for a critical access hospital (CAH) for title V, and in column 2 for title XIX. 4.04 Does title V or XIX foll ow Medicare (title XVIII) for a critical access hospital (CAH) for title V, and in column 2 for title XIX. 4.04 Does title V or XIX foll ow Medicare (title XVIII) for a critical access hospital (CAH) for title V, and in column 2 for title XIX. 4.05 Does title V or XIX foll ow Medicare (title XVIII) for a critical access hospital (CAH) for the V or XIX foll ow Medicare (title XVIII) for a critical access hospital (CAH) for the V or XIX foll ow Medicare (title XVIII) for a critical XIX for title XIX. 4.05 Does title V or XIX foll ow Medicare (title XVIII) for a critical XIX for title XIX follow Medicare (title XVIII) for the internation of title V, and in column 2 for title XI	92.	N		OO Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						
applicable column.  (a) If I line 94 is "Y", enter the reduction percentage in the applicable column.  (b) Ones title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  (c) Ones title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  (c) Ones title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on West are to the treat of the tre	93.	N	N	DO Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter						
0.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 1.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 2.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 1 for title V, and in column 2 for title XIX. 2.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. V Y Y C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1. Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	94.				applicable column.					
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3.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  3.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  3.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  Rural Providers  3.05 Doll f this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  3.07 Doll f this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.  3.08 Dolls this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00  9.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	98.	Y	Y		Does title V or XIX follow Medicare (title XVIII) for the cobed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes					
0.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  0.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  0.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  0.05 Does this Nospital qualify as a CAH?  0.06 Does this hospital qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  10.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "V" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.  10.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42  10.01 Sthis a rural hospital qualifying for an exception to the CRNA fee schedule? See 42  10.02 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  10.09 00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	98.	N	N		Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y					
3.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  3.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  Rural Providers  35.00 Does this hospital qualify as a CAH?  36.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  37.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.  38.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42  39.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	98.	N	N		Does title V or XIX follow Medicare (title XVIII) for a CAP outpatient services cost? Enter "Y" for yes or "N" for no i					
8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  Rural Providers  05.00 Does this hospital qualify as a CAH?  06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42  CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00  109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	98.	Y	Y		Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in					
Does this hospital qualify as a CAH?  Does this hospital qualify as a CAH, has it elected the all-inclusive method of payment  Does this hospital qualifies as a CAH, has it elected the all-inclusive method of payment  Does this hospital qualifies as a CAH, has it elected the all-inclusive method of payment  Does this hospital qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this hospital qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this hospital qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive method of payment  N  Does this facility qualifies as a CAH, has it elected the all-inclusive methods as a cather of the payment for law and the program is	98.	Y	Y		Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.					
10.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N  109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	105.		N							
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N  109.00 Frequency See 42 N  109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N  109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N  109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N  100 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N  100 If this hospital qualifies as a CAH or a cost provider, are therapy Services provided by outside supplier? Enter "Y" N  100 If this hospital qualifies as a CAH or a cost provider, are therapy Services provided by outside supplier? Enter "Y" N  100 If this hospital qualifies as a CAH or a cost provider, are therapy Services provided by outside supplier? Enter "Y" N  100 If this hospital qualifies as a CAH or a cost provider, are therapy Services provided by outside supplier? Enter "Y" N  100 If this hospital qualifies as a CAH or a cost provider, are the provider of the program is cost provider of the program is cost program is cos	106.		1	nclusive method of paymer	If this facility qualifies as a CAH, has it elected the all					
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Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00  1.00 Physical Occupational Speech Respiratory 1.00 Physical Occupational Speech Physical P	108.		N	CRNA fee schedule? See 42	Is this a rural hospital qualifying for an exception to the					
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			<u> </u>							
	109.				therapy services provided by outside supplier? Enter "Y"					
			•	,	· · · · · · · · · · · · · · · · · · ·					
1.00		1.00								

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) For the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-01		eriod: com 04/01/: o 03/31/:	2018 2019	Workshe Part I Date/Ti 9/3/201	me Pr	epared:
			1. 00		2. 0	0	1
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting period? umn 1 is Y, enter th icipating in column	Enter e 2.	N				111. 0
				1. 00	2.00	3. 00	
Miscellaneous Cost Reporting Information  15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2.  3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.  16.00 Is this facility classified as a referral center? Enter "Y" for yes or is yes.	If column 2 is "E", for long term care) based on the defin	enter i (includ ition i	n column les	N N		0	115. 0
17.00 s this facility legally-required to carry malpractice insura no.	nce? Enter "Y" for y	es or "		Υ			117. 0
18.00 s the malpractice insurance a claims-made or occurrence policelaim-made. Enter 2 if the policy is occurrence.			s	1			118. 0
	Prem	ums	Losses	6	Insura	ance	
	1. (	00	2.00		3. 0	0	-
18.01 List amounts of malpractice premiums and paid losses:		326, 378	184	1, 143			0 118. 0
18.02 Are malpractice premiums and paid losses reported in a cost c			1. 00 N		2. 0	0	118. 0
Administrative and General? If yes, submit supporting schedul and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment: Enter in column 2, "Y" for yes or "N" for no.	Harmless provision i column 1, "Y" for ye Lifies for the Outpa	n ACA s or tient	N		N		119. C
21.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	table devices charge	d to	Y				121. 0
22.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y		5. 0	3	122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no.	lf	N				125. (
yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 If this is a Medicare certified kidney transplant center, enti-	er the certification	date					126. (
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification	date					127. (
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification	date					128. (
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.							129. (
0.00 lf this is a Medicare certified pancreas transplant center, eldate in column 1 and termination date, if applicable, in colum	mn 2.						130.
(1.00) If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in columns of the columns of t	mn 2.						131.
22.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.							132.
33.00   If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. 34.00   If this is an organ procurement organization (OPO), enter the							133. (
and termination date, if applicable, in column 2.  All Providers							- 54.
40.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y			Y		4490	08	140. (

Health Financial Systems DUPONT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0150 Peri od: Worksheet S-2 From 04/01/2018 Part I 03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the Contractor's Number: 10301 141 OO Name: CHS/COMMUNITY HEALTH SYSTEMS 141 00 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 City: FRANKLIN 37067 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N 155.00 Ν 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)

169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 168. 01 9. 99169. 00

transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	03/31/2018	170. 00
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171. 00

	Financial Systems DUPONT HO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 15-0150	Peri od: From 04/01/2018 To 03/31/2019	u of Form CMS- Worksheet S-2 Part II Date/Time Pro 9/3/2019 3:5	epared:
		Descri	pti on	Y/N	Y/N	
		(	)	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	DT CHILDDENS H	OSDITALS)		1.00	
	Capital Related Cost	I I CHI LUNLING II	OSI I IALS)			+
	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 0
3. 00	Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost	N	23. 0
.5. 00	reporting period? If yes, see instructions.	duc to apprais	ar 3 made dar	ring the cost		25.00
4. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	d into during	this cost re	porting period?	N	24. 00
5. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	'lf yes, see	N	25. 0
	instructions.			6		
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reporti	ng period? I	т yes, see	N	26. 00
7. 00	Has the provider's capitalization policy changed during the	cost reportin	g period? If	yes, submit	N	27. 0
	сору.	·				
8. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting	N	28. 00
0. 00	period? If yes, see instructions.	.,,	20.0			
9. 00	Did the provider have a funded depreciation account and/or	,	bt Service R	deserve Fund)	N	29. 0
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		dobt2 Lf voc	500	N	30.00
0.00	instructions.	iiity with new	debt? II yes	o, see	IN	30.00
1. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	s, see	N	31.00
	Purchased Services					
2.00	Have changes or new agreements occurred in patient care ser		d through co	ntractual	N	32. 00
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		a to compoti	tivo bidding2 lf	N	33. 0
55.00	no, see instructions.	irea pertariiri	g to competi	tive brading: 11	IN	33.0
	Provi der-Based Physi ci ans					
4. 00	Are services furnished at the provider facility under an ar	rangement with	provi der-ba	sed physicians?	N	34.0
	If yes, see instructions.	3		. 3		
35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	N	35. 0
	physicians during the cost reporting period? If yes, see in	structions.				_
				Y/N	Date	
	Home Office Costs			1.00	2. 00	
	monie office Costs					
				V		24 0
6. 00	Were home office costs claimed on the cost report?	enared by the	home office?	Y		
6. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	epared by the	home office?			
6. 00 7. 00	Were home office costs claimed on the cost report?			Υ	12/31/2017	37. 0
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	ice different	from that of	Υ	12/31/2017	37.00
36. 00 37. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr  If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off  the provider? If yes, enter in column 2 the fiscal year end  If line 36 is yes, did the provider render services to othe	ice different of the home o	from that of ffice.	Y Y	12/31/2017	37. 00 38. 00
36. 00 37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	ice different of the home o r chain compon	from that of ffice. ents? If yes	Y Y	12/31/2017	37. 00 38. 00 39. 00
36. 00 37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	ice different of the home o r chain compon	from that of ffice. ents? If yes	Y Y Si, N	12/31/2017	36. 00 37. 00 38. 00 39. 00 40. 00
6. 00 7. 00 8. 00 9. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr  If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off  the provider? If yes, enter in column 2 the fiscal year end  If line 36 is yes, did the provider render services to othe  see instructions.  If line 36 is yes, did the provider render services to the	ice different of the home o r chain compon home office?	from that of ffice. ents? If yes If yes, see	Y Y Y N N N		37. 00 38. 00 39. 00
6. 00 .7. 00 .8. 00 .9. 00 .0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions.	ice different of the home o r chain compon	from that of ffice. ents? If yes If yes, see	Y Y Y N N N	12/31/2017 00	37. 00 38. 00 39. 00
6. 00 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information	rice different of the home o r chain compon home office?	from that of ffice. ents? If yes If yes, see	Y Y Y S, N N N 2.		37. 0 38. 0 39. 0 40. 0
6. 00 .7. 00 .8. 00 .9. 00 .0. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information	ice different of the home o r chain compon home office?	from that of ffice. ents? If yes If yes, see	Y Y Y N N N		37. 00 38. 00 39. 00 40. 00
6. 00 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information Enter the first name, last name and the title/position	rice different of the home o r chain compon home office?	from that of ffice. ents? If yes If yes, see	Y Y Y S, N N N 2.		37. 00 38. 00 39. 00 40. 00
86. 00 87. 00 88. 00 89. 00 40. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	rice different of the home o r chain compon home office?	from that of ffice. ents? If yes If yes, see	Y Y Y S, N N N 2.		37. 00 38. 00 39. 00
36. 00 37. 00 38. 00 39. 00	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been pr If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.  If line 36 is yes, did the provider render services to the instructions.  Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	rice different of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	Y Y Y S, N N N 2.	00	37. 00 38. 00 39. 00 40. 00

Health Financial Systems DUI	ONT HOSPITAL	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAII	Provider CCN: 15-0150	Peri od:	Worksheet S-2	
		From 04/01/2018 To 03/31/2019	Part II  Date/Time Pre	nared:
		10 03/31/201/	9/3/2019 3: 51	_pm
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position		IT		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 c	st			43. 00
report preparer in columns 1 and 2, respectively.				

| Peri od: | Worksheet S-3 | From 04/01/2018 | Part I | To 03/31/2019 | Date/Time Prepared:

					''	03/31/2019	9/3/2019 3:51	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		92	33, 580	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			92	33, 580	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		10	3, 650	0. 00	1	8.00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01		29	10, 585	0.00	0	8. 01
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			131	47, 815	0.00	0	14.00
15. 00	CAH visits						0	15.00
16. 00	SUBPROVI DER - I PF	40. 00		0	0		0	16.00
17. 00	SUBPROVI DER - I RF							17.00
18. 00	SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY	44. 00		0	0		0	19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25.00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			131				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

Provider CCN: 15-0150

Peri od: Worksheet S-3
From 04/01/2018 Part I
To 03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm

						9/3/2019 3: 51	pm	
		I/P Days	s / O/P Visits	/ Trips	Full Time Equivalents			
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
		6.00	7. 00	8. 00	9. 00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 821	250	10, 656			1.00	
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)	1, 498	4, 074				2. 00	
3.00	HMO IPF Subprovider	0	0				3. 00	
4.00	HMO IRF Subprovider	0	0				4.00	
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00	
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00	
7.00	Total Adults and Peds. (exclude observation	1, 821	250	10, 656			7. 00	
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	191	12	631			8. 00	
8. 01	NEONATAL INTENSIVE CARE UNIT	0	115	4, 978			8. 01	
9.00	CORONARY CARE UNIT						9. 00	
10.00	BURN INTENSIVE CARE UNIT						10. 00	
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00	
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00	
13.00	NURSERY		2, 137	3, 937			13. 00	
14.00	Total (see instructions)	2, 012	2, 514	20, 202	0.00	575. 65	14. 00	
15. 00	CAH visits	0	0	0			15. 00	
16.00	SUBPROVI DER - I PF	0	0	0	0.00	0.00	16. 00	
17. 00	SUBPROVI DER - I RF						17. 00	
18.00	SUBPROVI DER						18. 00	
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19. 00	
20.00	NURSING FACILITY						20. 00	
21.00	OTHER LONG TERM CARE						21. 00	
22. 00	HOME HEALTH AGENCY						22. 00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00	
24.00	HOSPI CE						24. 00	
24. 10	HOSPICE (non-distinct part)			0			24. 10	
25.00	CMHC - CMHC						25. 00	
26.00	RURAL HEALTH CLINIC						26. 00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25	
27.00	Total (sum of lines 14-26)				0.00	575. 65	27. 00	
28. 00	Observation Bed Days		0	1, 918			28. 00	
29. 00	Ambul ance Trips	0					29. 00	
30.00	Employee discount days (see instruction)			0			30. 00	
31.00	Employee discount days - IRF			0			31.00	
32.00	Labor & delivery days (see instructions)	0	283	945			32. 00	
32. 01	Total ancillary labor & delivery room			0			32. 01	
	outpatient days (see instructions)							
33.00	LTCH non-covered days	0					33. 00	
33. 01	LTCH site neutral days and discharges	0					33. 01	

| Peri od: | Worksheet S-3 | From 04/01/2018 | Part I | To 03/31/2019 | Date/Time Prepared:

				''	03/31/2019	9/3/2019 3:51	
		Full Time	_	Di sch	arges		
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 535	877	4, 488	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			369	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 01
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGI CAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00		0 535	877	4, 488	
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00		0	0	0	
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days			0 0			33.00
33. UI	LTCH site neutral days and discharges			1			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0150

					10	03/31/2019	Date/lime Prep   9/3/2019 3:51	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200. 00	36, 517, 271	0	36, 517, 271	1, 197, 358. 00	30. 50	1. 00
	instructions)			_				
2.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3. 00
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4. 00
4.00	Admi ni strati ve		0			0.00	0.00	4.00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00		
5. 00	Physician and Non Physician-Part B		0	0	0	0.00	0. 00	5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0.00	7. 00
7 04	approved program)							
7. 01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7. 01
8. 00	Home office and/or related		0	0	0	0.00	0.00	8. 00
9. 00	organization personnel SNF	44. 00	0	0	0	0.00	0. 00	9. 00
10. 00	Excluded area salaries (see		21, 048	531, 196	552, 244	14, 580. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		342, 416	0	342, 416	5, 216. 00	65. 65	11. 00
12. 00	Carte		0	0	0	0.00	0.00	12. 00
12.00	Contract labor: Top level management and other		U			0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		256, 017	0	256, 017	1, 646. 00	155, 54	13. 00
	A - Administrative		200,017			·		
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		3, 583, 674	0	3, 583, 674	122, 713. 00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		
13.00	- Administrative		0			0.00	0.00	15.00
16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		6, 801, 355	0	6, 801, 355			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
	(see instructions)							
19. 00 20. 00	Excluded areas		97, 099					19.00
20.00	Non-physician anesthetist Part A		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
	Admi ni strati ve		_	_				
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC)		Ö	Ö	ő			24. 00
25. 00	Interns & residents (in an		0	0	0			25. 00
25. 50	approved program) Home office wage-related		706, 365	0	706, 365			25. 50
	(core)			_				
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0	О			25. 52
25. 53	wage-related (core) Home office & Contract		0	0	0			25. 53
20.00	Physicians Part A - Teaching -		O					20.00
	wage-related (core)  OVERHEAD COSTS - DIRECT SALARIE	- C						
26. 00	Employee Benefits Department	4. 00	216, 837	0	216, 837	7, 331. 00	29. 58	26. 00
27. 00	Administrative & General	5. 00	5, 321, 414					27. 00

| Peri od: | Worksheet S-3 | From 04/01/2018 | Part II | To 03/31/2019 | Date/Time Prepared:

					''	0 03/31/2019	9/3/2019 3: 51	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		139, 224	0	139, 224	1, 033. 00	134. 78	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30.00	Operation of Plant	7. 00	· ·	0	876, 671	39, 533. 00	22. 18	30.00
31. 00	Laundry & Linen Service	8. 00		0	0	0.00		
32.00	Housekeepi ng	9. 00	515, 136	0	515, 136	37, 780. 00	13. 64	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 184, 459	-453, 792	730, 667	40, 242. 00		34.00
35.00	Di etary under contract (see		0	0	0	0.00	0.00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00		453, 792	453, 792	29, 921. 00	15. 17	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38. 00	Nursing Administration	13. 00	1, 995, 005	157, 251	2, 152, 256	56, 167. 00	38. 32	38.00
39.00	Central Services and Supply	14. 00	417, 049	0	417, 049	21, 698. 00	19. 22	39.00
40.00	Pharmacy	15. 00	1, 684, 450	0	1, 684, 450	33, 774. 00	49. 87	40.00
41.00	Medical Records & Medical	16. 00	289, 818	0	289, 818	14, 217. 00	20. 39	41.00
	Records Library							
42.00	Social Service	17. 00	· ·	0	581, 229	15, 103. 00	38. 48	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION DUPONT HOSPITAL Provider CCN: 15-0150

Worksheet A   Li ne Number   Recl assi fi cati on of Sal ari es (col. 2 ± col.   Sal ari es in col. 4   Col. 5)								77 07 2017 0.01	PIII
Col. 2 ± col.   Salaries in col. 5   Col. 4   Col. 5			Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
Net salaries (see instructions)   30, 656, 495   0, 36, 656, 495   1, 198, 391.00   30.59   1.00   30.00   3			Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
1.00   2.00   3.00   4.00   5.00   6.00					(from	(col.2 ± col.	Salaries in	col . 5)	
PART III - HOSPITAL WAGE INDEX SUMMARY  1.00 Net salaries (see instructions)  2.00 Excluded area salaries (see 21,048 531,196 552,244 14,580.00 37.88 2.00 instructions)  3.00 Subtotal salaries (line 1 36,635,447 -531,196 36,104,251 1,183,811.00 30.50 3.00 minus line 2)  4.00 Subtotal other wages & related 4,182,107 0 4,182,107 129,575.00 32.28 4.00 costs (see inst.)					Worksheet A-6)	3)	col. 4		
1.00 Net salaries (see instructions) 2.00 Excluded area salaries (see 21,048 531,196 552,244 14,580.00 37.88 2.00 instructions) 3.00 Subtotal salaries (line 1 36,635,447 -531,196 36,104,251 1,183,811.00 30.50 3.00 Subtotal other wages & related costs (see inst.)			1.00	2.00	3. 00	4. 00	5. 00	6. 00	
instructions) Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 minus line 2) 4.00 Subtotal other wages & related costs (see inst.)  instructions) 36,635,447 -531,196 36,104,251 1,183,811.00 30.50 3.00 4,182,107 129,575.00 32.28 4.00		PART III - HOSPITAL WAGE INDEX	SUMMARY						
2.00   Excluded area salaries (see inst.)   Excluded area salaries (see   21,048   531,196   552,244   14,580.00   37.88   2.0	1.00	Net salaries (see		36, 656, 495	0	36, 656, 495	1, 198, 391. 00	30. 59	1. 00
instructions) 3.00 Subtotal salaries (line 1 minus line 2) 4.00 Subtotal other wages & related costs (see inst.)  36,635,447 -531,196 36,104,251 1,183,811.00 30.50 3.00 4,182,107 129,575.00 32.28 4.00		instructions)							i
3.00 Subtotal salaries (line 1 minus line 2) 4.00 Subtotal other wages & related costs (see inst.)  36,635,447 -531,196 36,104,251 1,183,811.00 30.50 3.00 4,182,107 0 4,182,107 129,575.00 32.28 4.00	2.00	Excluded area salaries (see		21, 048	531, 196	552, 244	14, 580. 00	37. 88	2.00
mi nus line 2) 4.00 Subtotal other wages & related costs (see inst.)  4,182,107 0 4,182,107 129,575.00 32.28 4.00		instructions)							i
4.00 Subtotal other wages & related costs (see inst.) 0 4,182,107 0 4,182,107 129,575.00 32.28 4.00	3.00	Subtotal salaries (line 1		36, 635, 447	-531, 196	36, 104, 251	1, 183, 811. 00	30. 50	3. 00
costs (see inst.)		minus line 2)							i
	4.00	Subtotal other wages & related		4, 182, 107	' 0	4, 182, 107	129, 575. 00	32. 28	4.00
		costs (see inst.)							i
5.00   Subtotal wage-related costs   7,507,720 0 7,507,720 0.00 20.79 5.00	5.00	Subtotal wage-related costs		7, 507, 720	0	7, 507, 720	0.00	20. 79	5.00
(see inst.)		(see inst.)							i
6.00 Total (sum of lines 3 thru 5) 48,325,274 -531,196 47,794,078 1,313,386.00 36.39 6.00	6.00	Total (sum of lines 3 thru 5)		48, 325, 274	-531, 196	47, 794, 078	1, 313, 386. 00	36. 39	6. 00
7. 00 Total overhead cost (see   13, 221, 292 -551, 511 12, 669, 781 451, 971. 00 28. 03 7. 00	7.00	Total overhead cost (see		13, 221, 292	-551, 511	12, 669, 781	451, 971. 00	28. 03	7. 00
instructions)		instructions)							ì

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPITAL WAGE RELATED COSTS		Peri od: Worksheet S-3 From 04/01/2018 Part IV To 03/31/2019 Date/Time Prepared: 0/3/2019 3:51 pm		

	10 03/31/201	9 Date/lime Prep 9/3/2019 3:51	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		ı
	RETI REMENT COST		ı
1.00	401K Employer Contributions	713, 462	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	•	ı
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		ı
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	3, 196, 768	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	23, 561	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	24, 210	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	117	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	3, 792	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	273, 291	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		1
	TAXES		ı
	FICA-Employers Portion Only	2, 080, 690	
	Medicare Taxes - Employers Portion Only	486, 613	
	Unempl oyment Insurance	0	19.00
20. 00	State or Federal Unemployment Taxes	95, 950	20.00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (se instructions))	е 0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement		23. 00
	Total Wage Related cost (Sum of lines 1 -23)	6, 898, 454	
24.00	Part B - Other than Core Related Cost	0, 070, 434	27.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
20.00	Towner mile hearing soons (or corrin)	1	20.00

Health Financial Systems	DUPONT HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0150	From 04/01/2018	Worksheet S-3 Part V Date/Time Prepared: 9/3/2019 3:51 pm
Cost Contor Doscription		Contract Labor	Popofit Cost

			9/3/2019 3: 51	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	342, 416	6, 898, 454	1.00
2.00	Hospi tal	342, 416	6, 898, 454	2. 00
3.00	Subprovi der - I PF	0	0	3. 00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF	0	0	8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s	0	0	17.00
18. 00	0ther	0	0	18. 00

IOSPI T	Financial Systems DUPONT HOSPITA			In Lie	u of Form CMS-2	2552-1		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CC	N: 15-0150	Peri od:	Worksheet S-1	0		
				From 04/01/2018 To 03/31/2019	Date/Time Pre	nared.		
					1. 00			
$\neg$	Uncompensated and indigent care cost computation				11.00			
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by lir	ne 202 column	1 8)	0. 148434	1.0		
	Medicaid (see instructions for each line)							
	Net revenue from Medicaid				14, 911, 348			
. 00	Did you receive DSH or supplemental payments from Medicaid?		M!:	: -10	Y	3.0		
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa If line 4 is no, then enter DSH and/or supplemental payments from			11 0 ?	Y	4. C		
1	Medicaid charges	Jiii wedi cai (	ı		104, 464, 358			
	Medicaid cost (line 1 times line 6)				15, 506, 063	7.0		
	Difference between net revenue and costs for Medicaid program (I	line 7 minu	us sum of lir	nes 2 and 5; if	594, 715			
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP) (see instructions for	each line	e)					
	Net revenue from stand-alone CHIP				0	9. 0		
	Stand-alone CHIP charges				0	10.0		
1	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (I	line 11 mir	nus lina 0: i	f / zero then	0	11. C		
2.00	enter zero)		ius iiile 7, i	1 < Zero then	0	12.0		
1	Other state or local government indigent care program (see instr	ructions fo	or each line)					
	Net revenue from state or local indigent care program (Not inclu				13, 293	13. (		
4. 00	Charges for patients covered under state or local indigent care	program (1	Not included	in lines 6 or	153, 106	14. (		
	10)				00 704			
	State or local indigent care program cost (line 1 times line 14)		nrogram (lin	sa 15 minua lina	22, 726			
6.00	Difference between net revenue and costs for state or local indi 13; if < zero then enter zero)	igent care	program (III	ie is minus iine	9, 433	16. (		
I	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	e/Local indig	jent care program	ıs (see			
	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fur</pre>	adi na chari	ty care		0	   17. C		
	Government grants, appropriations or transfers for support of ho				0	18.0		
	Total unreimbursed cost for Medicaid , CHIP and state and local			(sum of lines	604, 148			
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1			
			patients	patients	+ col . 2)			
			1.00	2. 00	3. 00			
	Uncompensated Care (see instructions for each line)							
	Charity care charges and uninsured discounts for the entire faci	ility	4, 318, 61	10, 766	4, 329, 376	1		
U. UU						20.0		
	(see instructions)  Cost of nations approved for charity care and uninsured discour	nts (see	641 03	10 766	651 <b>7</b> 05			
	Cost of patients approved for charity care and uninsured discour	nts (see	641, 02	10, 766	651, 795			
1. 00			641, 02			21. (		
21. 00	Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care		67	75 0	675	21. C		
21. 00	Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written of			75 0	675	21. 0 22. 0		
1. 00 2. 00	Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care		67	75 0	675 651, 120	21. C		
1. 00 2. 00 3. 00	Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	off as	640, 35	75 0 64 10, 766	675	21. ( 22. ( 23. (		
1. 00 2. 00 3. 00	Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care	off as  t days beyongram?	640, 35 ond a length	75 0 64 10,766 of stay limit	675 651, 120 1. 00	21. ( 22. ( 23. ( 24. (		
21. 00 22. 00 23. 00	Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care patients.	off as  t days beyongram?	640, 35 ond a length	75 0 64 10,766 of stay limit	675 651, 120 1. 00 N	21. ( 22. ( 23. ( 24. (		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost of patients approved for charity care and uninsured discour instructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care particularly limit Total bad debt expense for the entire hospital complex (see inst	t days beyong the finding the first tructions)	640, 35 ond a Length care program	75 0 64 10,766 of stay limit	675 651, 120 1. 00 N 0 1, 978, 256	21. ( 22. ( 23. ( 24. ( 25. ( 26. (		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care plf line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex	t days beyonogram? e indigent tructions) (see insti	640, 35 ond a Length care program	75 0 64 10,766 of stay limit	675 651, 120 1. 00 N 0 1, 978, 256 155, 405	21. ( 22. ( 23. ( 24. ( 25. ( 26. ( 27. (		
21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01	Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care particularly limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex (see	t days beyonogram? e indigent tructions) (see insti	640, 35 ond a Length care program	75 0 64 10,766 of stay limit	675 651, 120 1.00 N 0 1, 978, 256 155, 405 239, 085	21. (22. (23. (24. (25. (27. (27. (27. (27. (27. (27. (27. (27		
21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00	Cost of patients approved for charity care and uninsured discourinstructions)  Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care partial line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instance) Medicare reimbursable bad debts for the entire hospital complex (see Mon-Medicare bad debt expense (see instructions)	t days beyong the days beyong	640, 35 ond a length care program ructions)	of stay limit	675 651, 120 1. 00 N 0 1, 978, 256 155, 405 239, 085 1, 739, 171	21. C 22. C 23. C 24. C 25. C 26. C 27. C 28. C		
21. 00 22. 00 23. 00 24. 00 26. 00	Cost of patients approved for charity care and uninsured discourinstructions) Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care particularly limit Total bad debt expense for the entire hospital complex (see inst Medicare reimbursable bad debts for the entire hospital complex (see	t days beyong the days beyong	640, 35 ond a length care program ructions)	of stay limit	675 651, 120 1.00 N 0 1, 978, 256 155, 405 239, 085	21. C 22. C 23. C 24. C 25. C 26. C 27. C 28. C 29. C		

Heal th	Financial Systems	DUPONT HOSI	PI TAL		In Lie	u of Form CMS-:	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CO		Period: From 04/01/2018 To 03/31/2019	Worksheet A Date/Time Pre 9/3/2019 3:51	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		1, 463, 217			2, 935, 162	1.00
2. 00 4. 00	O0200 CAP REL COSTS-MVBLE EQUIP   O0400 EMPLOYEE BENEFITS DEPARTMENT	216, 837	3, 289, 617 200, 339			5, 599, 681 4, 723, 034	2. 00 4. 00
5. 01	00570 ADMITTING	210, 837	200, 339		0 2, 435, 891	2, 435, 891	5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	o	0	•	0 2, 206, 225	2, 206, 225	
5.03	00560 OTHER ADMINISTRATIVE AND GENERAL	5, 321, 414	41, 508, 498	46, 829, 91		34, 791, 762	
7.00	00700 OPERATION OF PLANT	876, 671	3, 160, 807			4, 716, 830	
8.00	00800 LAUNDRY & LINEN SERVICE	0	471, 780			471, 780	
9.00	00900   HOUSEKEEPI NG   01000   DI ETARY	515, 136	511, 894			1, 023, 628	
10. 00 11. 00	01100 CAFETERI A	1, 184, 459 0	1, 042, 550 0		9 -993, 428 0 976, 940	1, 233, 581 976, 940	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 995, 005	248, 713			2, 396, 779	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	417, 049	14, 828, 902			1, 795, 548	
15.00	01500 PHARMACY	1, 684, 450	4, 562, 638	6, 247, 08	-4, 483, 666	1, 763, 422	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	289, 818	807, 408			1, 078, 871	1
17. 00	01700 SOCIAL SERVICE	581, 229	45, 962	627, 19	1 -4	627, 187	17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS  03000 ADULTS & PEDI ATRI CS	7, 500, 920	1, 847, 452	9, 348, 37	2 -3, 184, 596	6, 163, 776	30.00
31. 00	03100   NTENSI VE CARE UNIT	1, 047, 434	937, 298			1, 984, 689	1
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	2, 471, 024	691, 422			3, 157, 606	1
40.00	04000 SUBPROVI DER - I PF	0	0		0 0	0	
43.00	04300 NURSERY	527	150, 918	151, 44	5 1, 182, 038	1, 333, 483	
44. 00	04400 SKILLED NURSING FACILITY	0	0		0 0	0	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	3, 253, 912	5, 301, 924	8, 555, 83	6 1, 652, 917	10, 208, 753	50.00
51. 00	05100 RECOVERY ROOM	2, 058, 087	713, 144			10, 200, 753	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-2, 946	915, 298			_	
53.00	05300 ANESTHESI OLOGY	0	1, 494, 876			1, 493, 594	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 869, 495	1, 081, 219			2, 586, 488	
54. 01	05401 ULTRA SOUND	379, 551	36, 317			415, 868	
56. 00 57. 00	05600	101, 624	154, 971	256, 59		235, 445 0	1
58. 00	05800 MRI	191, 125	43, 240 148, 465			225, 090	
60.00	06000 LABORATORY	1, 598, 282	1, 486, 324			· ·	
65.00	06500 RESPI RATORY THERAPY	979, 137	482, 349			1, 460, 669	
66. 00	06600 PHYSI CAL THERAPY	155, 291	38, 348			388, 356	1
67. 00	06700 OCCUPATI ONAL THERAPY	107, 316	8, 137			0	
68. 00 69. 00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY	73, 242	6, 022 24, 824			41.043	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 218 0	24, 024 N	41, 04	0 2, 081, 195	41, 042 2, 081, 195	
	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0		0 11, 346, 961	11, 346, 961	
	07300 DRUGS CHARGED TO PATIENTS	O	0		0 4, 306, 497		
	07400 RENAL DIALYSIS	0	179, 473			179, 473	
76. 00	03950 SLEEP LAB	172, 315	819, 027			990, 954	
76. 02	03560 PSYCH SERVICES/EATINT DISORDER OUTPATIENT SERVICE COST CENTERS	1, 427	108	1, 53	5 -1, 535	0	76. 02
90. 00	09000 CLINIC	331, 845	112, 249	444, 09	4 -258	443, 836	90.00
91. 00	09100 EMERGENCY	1, 108, 329	1, 176, 891				1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		, -, -, -	,		, ,	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	20, 315	287, 225	307, 54	0 -307, 540	0	95. 00
110 00	SPECIAL PURPOSE COST CENTERS	2/ 51/ 520	00 270 047	10/ 70/ 20	4 (02.015	12/ 102 4/0	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)     NONREIMBURSABLE COST CENTERS	36, 516, 538	90, 279, 846	126, 796, 38	4 -602, 915	126, 193, 469	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0		0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	733	16, 836	17, 56	9 -2, 088		192.00
194.00	07950 MARKETI NG	o	0		0 0	0	194. 00
	07951 PHYSICIAN RELATIONS	0	0		0		194. 01
	07952 SENI OR CI RCLE	0	0		0 (05 000		194. 02
200.00	07953 WOMENS RESOURCE CENTER   TOTAL (SUM OF LINES 118 through 199)	36, 517, 271	90, 296, 682	126, 813, 95	0 605, 003 3 0	605, 003 126, 813, 953	200 00
200.00	TIOTHE (SOM OF ETHES THE CHILDREN 199)	30, 317, 271	70, 270, 002	120,013,93	0	120, 013, 733	1200.00

Peri od: From 04/01/2018 To 03/31/2019 Date/Ti me Prepared: 9/3/2019 3:51 pm

				9/3/2019 3:51 pm	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	968, 958	3, 904, 120	1.0	00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 120, 722	6, 720, 403	2.0	00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-6, 920	4, 716, 114		
5. 01	00570 ADMITTING	0	2, 435, 891	·	
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-664, 001	1, 542, 224	1	
5. 03	00560 OTHER ADMINISTRATIVE AND GENERAL	-14, 515, 774	20, 275, 988	1	
7. 00	00700 OPERATION OF PLANT	-27, 356	4, 689, 474	l	
		1		·	
8.00	00800 LAUNDRY & LINEN SERVICE	0	471, 780	·	
9.00	00900 HOUSEKEEPI NG	0	1, 023, 628	1	
10. 00	01000 DI ETARY	0	1, 233, 581	1	
11. 00	O1100  CAFETERI A	-396, 052	580, 888		
13.00	01300 NURSING ADMINISTRATION	-2, 317	2, 394, 462	13.0	00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 795, 548	14.0	00
15.00	01500 PHARMACY	0	1, 763, 422	15. 0	00
16.00	01600 MEDICAL RECORDS & LIBRARY	-681	1, 078, 190	16.0	00
17.00	01700 SOCIAL SERVICE	0	627, 187		00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1			
30.00	03000 ADULTS & PEDI ATRI CS	-807, 946	5, 355, 830	30.0	വ
31. 00	03100 I NTENSI VE CARE UNI T	-527, 966	1, 456, 723		
	I I	1		·	
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	-84, 746	3, 072, 860	·	
40.00	04000 SUBPROVI DER - I PF	0	0	·	
43.00	04300 NURSERY	0	1, 333, 483		
44. 00	04400 SKILLED NURSING FACILITY	0	0	44. 0	00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-12, 940	10, 195, 813	50.0	00
51.00	05100 RECOVERY ROOM	0	0	51. 0	00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-416, 075	2, 474, 295	52.0	00
53.00	05300 ANESTHESI OLOGY	-1, 493, 594	0	53.0	00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-63, 247	2, 523, 241	54.0	00
54. 01	05401 ULTRA SOUND	0	415, 868	·	
56. 00	05600 RADI OI SOTOPE		235, 445	l	
57. 00	05700 CT SCAN	0	255, 449	1	
		0	225, 090		
58.00	05800 MRI	05 770		1	
60.00	06000 LABORATORY	-85, 770	2, 806, 143		
65. 00	06500 RESPI RATORY THERAPY	0	1, 460, 669	· · · · · · · · · · · · · · · · · · ·	
66.00	06600 PHYSI CAL THERAPY	0	388, 356		
67.00	06700 OCCUPATI ONAL THERAPY	0	0	67.0	00
68.00	06800 SPEECH PATHOLOGY	0	0	68.0	00
69.00	06900 ELECTROCARDI OLOGY	0	41, 042	69.0	00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	2, 081, 195	71.0	00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	ol	11, 346, 961	72.0	00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	4, 306, 497	1	
74. 00	07400 RENAL DIALYSIS		179, 473	·	
76. 00	03950 SLEEP LAB	-773, 930	217, 024	1	
76. 02	03560 PSYCH SERVICES/EATINT DISORDER	-773, 730	217,024	1	
70.02		l d	U	70.0	JZ
00 00	OUTPATIENT SERVICE COST CENTERS		442.027	00.6	00
90.00	09000 CLI NI C	0	443, 836		
	09100 EMERGENCY	-577, 137	2, 013, 953		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 0	00
	OTHER REIMBURSABLE COST CENTERS				
95. 00	09500 AMBULANCE SERVI CES	0	0	95. 0	00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-18, 366, 772	107, 826, 697	118. (	00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 0	00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	ا	15, 481	1	
	07950 MARKETI NG		13, 401		
	07951 PHYSICIAN RELATIONS		0	1	
	207951 PHYSICIAN RELATIONS		0	1	
		0	-		
	07953 WOMENS RESOURCE CENTER	10.311.7	605, 003		
200.00	TOTAL (SUM OF LINES 118 through 199)	-18, 366, 772	108, 447, 181	200. 0	JÜ

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0150 

					10 03/31/2019	Date/lime Prepared: 9/3/2019 3:51 pm
	Cook Conton	Increases	C-1	0+1		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFIT RECLASS	3.00	4.00	3.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 306, 162		1.00
2.00		0.00	0_	0		2. 00
	TOTALS  B - RENTAL AND LEASE EXPENSES		0	4, 306, 162		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	O	67, 005		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	2, 304, 043		2.00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	Ö	Ö		7. 00
8.00		0. 00	0	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10.00
12. 00		0.00	0	0		12.00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	o	0		18.00
19.00		0.00	0	0		19.00
	TOTALS		0	2, 371, 048		
1. 00	C - OTHER CAPITAL COSTS CAP REL COSTS-BLDG & FIXT	1.00	ol	104 E72		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	104, 573 1, 300, 367		2. 00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	Ö	6, 021		3. 00
	TOTALS		0	1, 410, 961		
1 00	D - REPAIRS & MAINTENANCE	7 00	ما	(70.252		1.00
1. 00 2. 00	OPERATION OF PLANT	7. 00 0. 00	0	679, 352 0		1.00
3.00		0.00	Ö	Ö		3. 00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00
8. 00		0.00	Ö	Ö		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00
13. 00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	O	0		19. 00
20.00		0.00	0	0		20. 00
21. 00			0	<u>0</u> 679, 352		21. 00
	E - CNO SALARIES		<u> </u>	079, 332		
1.00	NURSING ADMINISTRATION	13.00	157, 251	0		1.00
	TOTALS		157, 251	0		
1 00	F - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71 00	٥	2 001 105		1.00
1. 00	PATIENT	71. 00	0	2, 081, 195		1.00
2.00	IMPL. DEV. CHARGED TO	72.00	О	11, 346, 961		2.00
	PATI ENTS					
	TOTALS		0	13, 428, 156		
1. 00	G - DRUGS/IV SOLUTIONS DRUGS CHARGED TO PATIENTS	73. 00	ol	4, 306, 497		1.00
55	TOTALS		- — — <del>ў</del>	4, 306, 497		1.00
	H - LABOR & DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	86, 789		1.00
2. 00 3. 00	NURSERY DELIVERY ROOM & LABOR ROOM	43. 00 52. 00	1, 023, 954 2, 225, 707	158, 084 0		2. 00 3. 00
5. 55	TOTALS		3, 249, 661	244, 873		3.00
	I - MI SCELLANEOUS	<u>'</u>				
1.00	ADMITTING	5. 01	2, 153, 789	282, 102		1. 00
2.00	CASHI ERI NG/ACCOUNTS	5. 02	0	2, 206, 225		2. 00
	RECEI VABLE	l l	l l			l l

Health Financial Systems	DUPONT HOSPI TAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0150	Period: Worksheet A-6 From 04/01/2018
		To 03/31/2019 Date/Time Prepared:

Cost Center							ne Prepared: 9 3:51 pm
TOTALS   2, 153, 789   2, 488, 327			Increases		•	77 07 20 1	, <u>0.01 p</u>
TOTALS		Cost Center	Li ne #	Sal ary	0ther		
1.00   RADI OLOGY COSTS   54.00   0   43,240   1.00   TOTALS   0   453,792   523,148   1.00   CAFETERI A   11.00   453,792   523,148   1.00   TOTALS   1.00		2. 00	3.00	4.00	5. 00		
1. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 43, 240 TOTALS 0 453, 792 523, 148 TOTALS 1. 00 A53, 792 523, 148 TOTALS 1. 00 PERATI NG ROOM 50. 00 2, 059, 514 709, 371 1. 00 PHYSI CAL THERAPY 66. 00 180, 558 14, 159 2. 00 PHYSI CAL THERAPY 66. 00 180, 558 14, 159 2. 00 PMOMENS RESOURCE CENTER 194. 03 551, 511 53, 492 4. 00 S. 00 0. 00		TOTALS		2, 153, 789	2, 488, 327		
TOTALS		J - RADIOLOGY COSTS					
1.00   CAFETERI A	1.00	RADI OLOGY-DI AGNOSTI C	54.00	0_			1. 00
1. 00 CAFETERI A 11. 00 453, 792 523, 148 TOTALS 453, 792 523, 148 L - MI SC DEPT RECLASS  1. 00 OPERATING ROOM 50. 00 2, 059, 514 709, 371 1. 00 2. 00 PHYSI CAL THERAPY 66. 00 180, 558 14, 159 2. 00 3. 00 EMERGENCY 91. 00 20, 315 287, 225 3. 00 4. 00 WOMENS RESOURCE CENTER 194. 03 551, 511 53, 492 4. 00 5. 00 0. 00 0 0 5. 00 6. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0		TOTALS		0	43, 240		
TOTALS  L - MISC DEPT RECLASS  1. 00 OPERATING ROOM  DPHYSI CAL THERAPY  SOUND SHERGENCY  SOUND SHORE SESSURCE CENTER  DEPT RECLASS  1. 00 OPERATING ROOM  SOUND SHORE SESSURCE CENTER  DEPT RECLASS  1. 00 OPERATING ROOM  SOUND SHORE SESSURCE CENTER  DEPT RECLASS  1. 00 OPERATING ROOM  SOUND SHORE SESSURCE CENTER  DEPT RECLASS  1. 00 OPERATING ROOM  SOUND SHORE SESSURCE CENTER  DEPT RECLASS  1. 00 OPERATING ROOM  SOUND SHORE SESSURCE CENTER  DEPT RECLASS  DEPT RECLA		K - DIETARY					
L - MISC DEPT RECLASS   1.00   OPERATING ROOM   50.00   2,059,514   709,371   1.00	1.00	CAFETERI A	11. 00	<u>453, 7</u> 92			1. 00
1. 00     OPERATING ROOM     50. 00     2, 059, 514     709, 371     1. 00       2. 00     PHYSI CAL THERAPY     66. 00     180, 558     14, 159     2. 00       3. 00     EMERGENCY     91. 00     20, 315     287, 225     3. 00       4. 00     WOMENS RESOURCE CENTER     194. 03     551, 511     53, 492     4. 00       5. 00     0. 00     0     0     5. 00       6. 00     0. 00     0     0     6. 00       7. 00     0. 00     0     0     0       TOTALS     2, 811, 898     1, 064, 247				453, 792	523, 148		
2.00 PHYSI CAL THERAPY 66.00 180, 558 14, 159 2.00 3.00 EMERGENCY 91.00 20, 315 287, 225 3.00 4.00 WOMENS RESOURCE CENTER 194.03 551, 511 53, 492 4.00 5.00 0.00 0 0 5.00 6.00 7.00 0 0 0 6.00 7.00 0 0 0 7.00 0 0 0							
3.00   EMERGENCY   91.00   20,315   287,225   3.00   4.00   5.00   6.00   7.00   TOTALS   2,811,898   1,064,247   3.00	1.00	OPERATING ROOM			·		1. 00
4. 00 WOMENS RESOURCE CENTER 194. 03 551, 511 53, 492 5. 00 6. 00 0 0 0 5. 00 6. 00 7. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					·		4
5. 00     0. 00     0     0       6. 00     0. 00     0     0       7. 00     0. 00     0     0       TOTALS     2, 811, 898     1, 064, 247			91.00	20, 315			
6. 00 7. 00 0 0 0 0 TOTALS 2, 811, 898 1, 064, 247		WOMENS RESOURCE CENTER	194. 03	551, 511	53, 492		4
7. 00				0	0		•
TOTALS 2, 811, 898 1, 064, 247			0.00	0	0		6. 00
	7. 00		0.00	0_	0		7. 00
500, 00   Grand Total: Increases   8, 826, 391   30, 866, 011   500, 00		TOTALS		2, 811, 898	1, 064, 247		
	500.00	Grand Total: Increases		8, 826, 391	30, 866, 011		500. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 04/01/2018 To 03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm Provider CCN: 15-0150

						9	/3/2019 3:51 pm
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - EMPLOYEE BENEFIT RECLASS	7.00	0.00	7. 00	10100		
1.00	OTHER ADMINISTRATIVE AND	5. 03	0	4, 304, 596	0		1. 00
	GENERAL	40.00					
2. 00	NURSING ADMINISTRATION		0	<u>1, 566</u> 4, 306, 162	9		2.00
	B - RENTAL AND LEASE EXPENSES		UU	4, 300, 102			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	264	10		1. 00
2.00	OTHER ADMINISTRATIVE AND	5. 03	0	773, 368	10		2. 00
	GENERAL		_		_		
3.00	HOUSEKEEPI NG	9.00	0	918 3, 738	0		3.00
4. 00 5. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	3, 738 1, 946	0		4. 00 5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	266, 809	0		6. 00
7. 00	PHARMACY	15. 00	Ö	117, 384	0		7. 00
8.00	MEDICAL RECORDS & LIBRARY	16. 00	0	18, 355	0		8. 00
9. 00	SOCI AL SERVI CE	17. 00	0	4	0		9. 00
10.00	ADULTS & PEDIATRICS	30.00	0	21, 244	0		10.00
11. 00 12. 00	INTENSIVE CARE UNIT OPERATING ROOM	31. 00 50. 00	O	36 612, 505	0		11. 00 12. 00
13. 00	RECOVERY ROOM	51.00	0	250	0		13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	321, 571	0		14. 00
15. 00	MRI	58.00	O	114, 500	0		15. 00
16. 00	LABORATORY	60.00	0	117, 352	0		16. 00
17. 00	SLEEP LAB	76. 00	0	383	0		17. 00
18.00	EMERGENCY	91.00	0	300	0		18.00
19. 00	PHYSICIANS' PRIVATE OFFICES TOTALS	1 <u>92.</u> 00		<u>121</u> 2, 371, 048	0		19.00
	C - OTHER CAPITAL COSTS		UU	2, 3/1, 040			
1. 00	OTHER ADMINISTRATIVE AND	5. 03	0	1, 410, 961	12		1. 00
	GENERAL						
2.00		0. 00	0	0	13		2. 00
3.00	L		•	0	12		3.00
	TOTALS  D - REPAIRS & MAINTENANCE		0	1, 410, 961			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	40	0		1.00
2. 00	OTHER ADMINISTRATIVE AND	5. 03	Ö	144, 855			2. 00
	GENERAL			·			
3.00	HOUSEKEEPI NG	9.00	0	2, 484	0		3. 00
4.00	DI ETARY	10.00	0	12, 750	0		4.00
5.00	NURSI NG ADMI NI STRATI ON	13.00	O O	678	0		5. 00
6. 00 7. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	O	128, 148 59, 785	0		6. 00 7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	480	0		8. 00
9. 00	INTENSIVE CARE UNIT	31.00	Ö	7	o		9. 00
10.00	NEONATAL INTENSIVE CARE UNIT	31. 01	0	4, 840	0		10.00
11. 00	OPERATING ROOM	50.00	0	130, 753	0		11. 00
12.00	RECOVERY ROOM	51.00	0	4, 913	0		12. 00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2, 816			13.00
14. 00 15. 00	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54. 00 56. 00	0	85, 895 21, 150	0		14. 00 15. 00
16. 00	LABORATORY	60.00	0	75, 341	0		16. 00
17. 00	RESPI RATORY THERAPY	65. 00	0	817	0		17. 00
18. 00	SLEEP LAB	76. 00	Ö	5	O		18. 00
19. 00	CLINIC	90.00	0	258	0		19. 00
20. 00	EMERGENCY	91.00	0	1, 370			20.00
21. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00		<u>1, 967</u>	0		21. 00
	TOTALS CNO. SALABLES		U	679, 352			
1. 00	E - CNO SALARIES OTHER ADMINISTRATIVE AND	5. 03	157, 251	0	0		1.00
1.00	GENERAL ADMINISTRATIVE AND	5.03	157, 251	U	o o		1.00
	TOTALS		157, 251				
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	13, 055, 446			1. 00
2. 00	OPERATING ROOM	50.00	•	372, 710			2.00
	TOTALS G - DRUGS/IV SOLUTIONS		0	13, 428, 156			
1. 00	PHARMACY	15. 00	ol	4, 306, 497	0		1.00
50	TOTALS		+	4, 306, 497			1.00
	H - LABOR & DELIVERY COSTS		<u> </u>	., 300, .,,			
1. 00	ADULTS & PEDIATRICS	30.00	3, 249, 661	0	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	244, 873	0		2. 00
3.00		0.00	0	0	0		3.00
0.00	TOTALS		3, 249, 661	244, 873			

Health Financial Systems RECLASSIFICATIONS DUPONT HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0150

Peri od: From 04/01/2018 To 03/31/2019 Date/Time Prepared:

						9/3/2019 Date/Time P	
		Decreases		•			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	I - MI SCELLANEOUS						
1.00	OTHER ADMINISTRATIVE AND	5. 03	2, 153, 789	2, 488, 327	(	0	1. 00
	GENERAL						
2.00		0.00	•	0		<u>의</u>	2. 00
	TOTALS		2, 153, 789	2, 488, 327			
	J - RADIOLOGY COSTS						
1.00	CT_SCAN	<u>57.</u> 00	•	4 <u>3, 2</u> 40		<u> </u>	1. 00
	TOTALS		0	43, 240			
	K - DIETARY						
1.00	DI ETARY	1000	453, 792	52 <u>3, 1</u> 48		<u> </u>	1. 00
	TOTALS		453, 792	523, 148			
	L - MISC DEPT RECLASS						
1.00	OTHER ADMINISTRATIVE AND	5. 03	551, 511	53, 492	(	0	1. 00
	GENERAL						
2.00	RECOVERY ROOM	51.00	2, 058, 087	707, 981		0	2. 00
3.00	ANESTHESI OLOGY	53. 00	0	1, 282		0	3. 00
4.00	OCCUPATI ONAL THERAPY	67. 00	107, 316	8, 137		0	4. 00
5.00	SPEECH PATHOLOGY	68. 00	73, 242	6, 022		0	5. 00
6.00	PSYCH SERVICES/EATINT	76. 02	1, 427	108	(	0	6. 00
	DI SORDER						
7.00	AMBULANCE SERVICES	95.00	<u>20, 3</u> 15	28 <u>7, 2</u> 25		<u> </u>	7. 00
	TOTALS		2, 811, 898	1, 064, 247			
500.00	Grand Total: Decreases		8, 826, 391	30, 866, 011			500.00

| Peri od: | Worksheet A-7 | From 04/01/2018 | Part | To 03/31/2019 | Date/Time Prepared:

				1	0 03/31/2019	9/3/2019 3:51	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 732, 541	0	0	0	0	1. 00
2.00	Land Improvements	468, 977	0	0	0	0	2. 00
3.00	Buildings and Fixtures	55, 764, 094	1, 006		1, 006	0	3. 00
4.00	Building Improvements	7, 208, 703	3, 526, 820	0	3, 526, 820		4. 00
5.00	Fixed Equipment	3, 819, 369	217, 663	0	217, 663	732	5. 00
6.00	Movable Equipment	60, 665, 222	5, 994, 233	0	5, 994, 233	2, 726, 623	6. 00
7.00	HIT designated Assets	379, 739	1, 727	0	1, 727	0	7. 00
8.00	Subtotal (sum of lines 1-7)	130, 038, 645	9, 741, 449	0	9, 741, 449	2, 727, 355	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	130, 038, 645	9, 741, 449	0	9, 741, 449	2, 727, 355	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 732, 541	0				1. 00
2.00	Land Improvements	468, 977	0				2. 00
3.00	Buildings and Fixtures	55, 765, 100	0				3. 00
4.00	Building Improvements	10, 735, 523	0				4. 00
5.00	Fixed Equipment	4, 036, 300	0				5. 00
6.00	Movable Equipment	63, 932, 832	0				6. 00
7.00	HIT designated Assets	381, 466	0				7. 00
8.00	Subtotal (sum of lines 1-7)	137, 052, 739	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	137, 052, 739	0				10. 00

Heal th	Financial Systems	DUPONT HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0150	Peri od:	Worksheet A-7	
					From 04/01/2018 To 03/31/2019		pared:
						9/3/2019 3:51	
			SL	JMMARY OF CAF	PI 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 & FLXT	1, 463, 217	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 289, 617	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 752, 834	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 463, 217				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o	3, 289, 617	1			2.00
3. 00	Total (sum of lines 1-2)	o	4, 752, 834	•			3. 00

Heal th	n Financial Systems	DUPONT H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 04/01/2018 To 03/31/2019		pm
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description		Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FIXT	73, 119, 907	l e			0	1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	63, 932, 832	l .				2. 00 3. 00
3.00	Total (sum of lines 1-2)	137, 052, 739		137, 052, 73	SUMMARY OF CAPITAL		3.00
		ALLOCATION OF OTHER CAPITAL			JUIVIIVIAN I U		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6.00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	_	I			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 2, 270, 128		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 4, 192, 529		2.00
3. 00	Total (sum of lines 1-2)	0	0	<u>l</u> JMMARY OF CAPI	0 6, 462, 657	2, 510, 612	3. 00
			SL	JIMIMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	•				Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI				_		
1.00	CAP REL COSTS-BLDG & FIXT	240, 293				3, 904, 120	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0,02.		0	6, 720, 403	2.00
3. 00	Total (sum of lines 1-2)	240, 293	110, 594	1, 300, 36	7  0	10, 624, 523	3. 00

				T.	03/31/2019	Date/Time Prep 9/3/2019 3:51	
				Expense Classification on			рш
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00		1. 00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2) Trade, quantity, and time		0				4. 00
4. 00	discounts (chapter 8)		0		0. 00		
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by suppliers (chapter 8)		0		0. 00	o	6. 00
7. 00	Telephone services (pay	А	-53, 559	OTHER ADMINISTRATIVE AND	5. 03	О	7. 00
	stations excluded) (chapter 21)			GENERAL			
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9.00	Parking Lot (chapter 21)		0		0.00		9.00
10. 00	Provider-based physician adjustment	A-8-2	-4, 898, 689			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	121, 459			0	12. 00
13. 00	Laundry and linen service		0		0. 00		13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-396, 052 0	CAFETERI A	11. 00 0. 00		14. 00 15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than		0		0.00	Ŭ	10.00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-681	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
17.00	education (tuition, fees,		0		0.00	J	17.00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21)		0		0. 00	0	22.00
22.00	overpayments and borrowings to		U		0.00		22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL	A	727 272	CAP REL COSTS-BLDG & FLXT	1. 00	9	26. 00
	COSTS-BLDG & FLXT						
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A		CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00		28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
20.00	limitation (chapter 14)		=		2.5		22.62
	CAH HIT Adjustment for Depreciation and Interest		0		0. 00		
33. 00	SILVER RECOVERY	В	-147	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 00

03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 35. 00 RENTAL INCOME -78, 246 CAP REL COSTS-BLDG & FIXT 35. 00 В 1.00 10 MISC INCOME -607, 014 OTHER ADMINISTRATIVE AND 36.00 В 5.03 36.00 GENERAL 38.00 TRAINING REVENUE В -500 NURSING ADMINISTRATION 13.00 38.00 39.00 PATIENT PHONE BENEFITS COST -6, 920 EMPLOYEE BENEFITS DEPARTMENT o 39.00 4.00 Α PHOTO COMMISSION -1, 732 OTHER ADMINISTRATIVE AND 40.00 40.00 В 5.03 GENERAL 41.00 PATIENT TV EXPENSE Α -27, 356 OPERATION OF PLANT 7.00 41.00 MARKETING EXPENSE -8, 444 OTHER ADMINISTRATIVE AND 42.00 Α 5.03 42.00 GENERAL MARKETING DEPARTMENT -1, 103, 861 OTHER ADMINISTRATIVE AND 42.01 42.01 Α 5.03 GENERAL 43.00 MINORITY INTEREST -11, 496, 662 OTHER ADMINISTRATIVE AND 5.03 43.00 Α GENERAL PHYSICIAN RECRUITING -389, 216 OTHER ADMINISTRATIVE AND 44.00 5.03 44.00 Α GENERAL NON-RESTRICTED DONATIONS -385 OTHER ADMINISTRATIVE AND 45.00 45.00 B 5.03 GENERAL CHARI TABLE CONTRI BUTI ONS -76, 241 OTHER ADMINISTRATIVE AND 45. 01 5.03 45.01 GENERAL 45.02 MEALS & ENTERTAINMENT -42, 258 OTHER ADMINISTRATIVE AND 5.03 45.02 GENERAL MOB SUPPORT COSTS -402, 936 OTHER ADMINISTRATIVE AND 45.03 5.03 45.03 GENERAL 45.04 LEGAL FEES -45, 289 OTHER ADMINISTRATIVE AND 5.03 45.04

GENERAL

GENERAL

-18, 366, 772

-145, 221 OTHER ADMINISTRATIVE AND

45.05

50.00

5.03

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

VALET PARKING

45.05

50.00

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

<sup>(2)</sup> Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0150 Peri od: Worksheet A-8-1 From 04/01/2018 | To 03/31/2019 | Date/Time Prepared: OFFICE COSTS

				lo 03/31/2019	Date/lime Pre   9/3/2019 3:51	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
1. 00	HOME OFFICE COSTS:	CAP REL COSTS-BLDG & FLXT	CAPITAL- RELATED INTEREST	240, 202	0	1. 00
2.00	1	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	240, 293 27, 037		2. 00
3.00	1	CAP REL COSTS-BLDG & FIXI	PASI CAPITAL COSTS - BLDG &	4, 701	0	3. 00
4. 00	1	OTHER ADMINISTRATIVE AND GEN		425, 669	0	4. 00
4. 00	1	OTHER ADMINISTRATIVE AND GEN		1, 879, 235	944, 713	4. 00
4. 01	1		NEW CAPITAL - BUILDING & FIX	52, 602	744, 713	4. 01
4. 03	1	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	332, 305	0	4. 02
4. 04	1	OTHER ADMINISTRATIVE AND GEN		3, 366, 071	0	4. 04
4. 05	1	OTHER ADMINISTRATIVE AND GEN		510, 521	1, 033, 554	4. 05
4. 06	1		CIG LEASED EQUIPMENT	13, 916	114, 714	4. 06
4. 07	1	OTHER ADMINISTRATIVE AND GEN		298, 258		4. 07
4. 08	1	OTHER ADMINISTRATIVE AND GEN		35, 440		4. 08
4. 09	1	CAP REL COSTS-MVBLE EQUIP	DSC BLDG LEASE SJH	721, 544		4. 09
4. 10	1	OTHER ADMINISTRATIVE AND GEN		0	1, 896, 143	4. 10
4. 11	5. 03	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	5, 263	4. 11
4. 12	5. 03	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	214, 977	4. 12
4. 13	5. 03	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	1, 532, 240	4. 13
4.14	5. 03	OTHER ADMINISTRATIVE AND GEN	HIIM ALLOCATION	O	469, 598	4. 14
4. 15	5. 03	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT COLLECTION FE	0	37, 626	4. 15
4. 16	5. 02	CASHI ERI NG/ACCOUNTS RECEI VAB	PASI LIEN UNIT	0	664, 001	4. 16
5.00	TOTALS (sum of lines 1-4).			7, 907, 592	7, 786, 133	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
	1.00	1.00 2.00	Symbol (1) Name Percentage of Ownership	Symbol (1) Name Percentage of Ownership 1.00 2.00 3.00 4.00	Ownershi p         Ownershi p           1.00         2.00         3.00         4.00         5.00

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

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

6.00	В	CHS, INC.	72. 03	CHS, INC.	72. 03	6. 00
7.00	В	HOSPITAL LAUNDR	100.00	HOSPITAL LAUNDR	100. 00	7.00
8.00	В	LUTHERAN HEALTH	100.00	LUTHERAN HEALTH	100. 00	8.00
9.00	В	PASI	100.00	PASI	100. 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.
- 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

\* 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.

4.11

4.12

4.13

4.14

4. 15

4. 16

5.00

Related 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	LAUNDRY	7.00
8.00	HOSPITAL NETWOR	8.00
9.00	DEBT COLLECTION	9.00
10. 00 100. 00		10.00
100.00		100.00

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

0

0

0

0

0

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

4.11

4.12

4.13

4.14

4.15

4.16

5.00

-5, 263

-214, 977

-469, 598

-37, 626

-664, 001

121, 459

-1.532.240

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0150

Peri od: Worksheet A-8-2 From 04/01/2018 To 03/31/2019 Date/Time Prepared:

9/3/2019 3:51 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7. 00 1. 00 5. 03 OTHER ADMINISTRATIVE AND 53, 668 1. 00 53, 668 GENERAL 2.00 13. 00 NURSING ADMINISTRATION 1,817 1,817 2.00 30. 00 ADULTS & PEDIATRICS 0 3.00 807, 946 807, 946 0 3.00 31. 00 I NTENSI VE CARE UNIT 527, 966 0 4.00 527, 966 0 4.00 31. 01 NEONATAL INTENSIVE CARE UNIT 5.00 84, 746 84, 746 5.00 0 6.00 50. 00 OPERATING ROOM 12, 940 12, 940 0 0 6.00 52.00 DELIVERY ROOM & LABOR ROOM 7.00 416, 075 416, 075 7.00 0 0 53. 00 ANESTHESI OLOGY 0 8.00 8.00 1, 493, 594 1, 493, 594 54. 00 RADI OLOGY-DI AGNOSTI C 9.00 63, 100 63, 100 0 0 9.00 10.00 60. 00 LABORATORY 85, 770 85, 770 0 10.00 773, 930 0 0 11.00 76.00 SLEEP LAB 773, 930 11.00 91. 00 EMERGENCY 0 577, 137 12.00 577, 137 0 12.00 200.00 4, 898, 689 4, 898, 689 200.00 Physician Cost Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Unadjusted RCE Memberships & Component of Malpractice I denti fi er Li mi t Share of col Limit Conti nui ng Insurance Educati on 12 9. 00 14. 00 1.00 2.00 8.00 12. 00 13.00 5. 03 OTHER ADMINISTRATIVE AND 1.00 1. 00 **GENERAL** 13. 00 NURSING ADMINISTRATION 2 00 0 0 2 00 0 30.00 ADULTS & PEDIATRICS 3.00 0 0 0 3.00 4.00 31.00 INTENSIVE CARE UNIT 4.00 0 5.00 31. 01 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 0 5.00 50. 00 OPERATING ROOM 0 6.00 0 6.00 52.00 DELIVERY ROOM & LABOR ROOM 7.00 0 0 0 7.00 8.00 53. 00 ANESTHESI OLOGY o 0 8.00 9.00 54. 00 RADI OLOGY-DI AGNOSTI C o 0 0 0 9.00 60. 00 LABORATORY 10.00 0 0 0 10.00 11.00 76. 00 SLEEP LAB 0 0 11.00 12.00 91. 00 EMERGENCY 0 12.00 0 200.00 200.00 Cost Center/Physician Wkst. A Line # Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 15. 00 2.00 16. 00 17. 00 1. 00 18. 00 1.00 5. 03 OTHER ADMINISTRATIVE AND 0 53,668 1.00 GENERAL 2.00 13. 00 NURSING ADMINISTRATION 1,817 2.00 o 807, 946 3.00 30. 00 ADULTS & PEDIATRICS 0 3.00 527, 966 31. 00 INTENSIVE CARE UNIT 4.00 0 0 4.00 31. 01 NEONATAL INTENSIVE CARE UNIT 5.00 0 0 84,746 5.00 50. 00 OPERATING ROOM 0 12, 940 6.00 6.00 52. 00 DELIVERY ROOM & LABOR ROOM 7.00 0 0 416, 075 7.00 53. 00 ANESTHESI OLOGY 0 0 0 1, 493, 594 8.00 8.00 54. 00 RADI OLOGY-DI AGNOSTI C 9.00 0 0 63, 100 9.00 60. 00 LABORATORY 0 0 10.00 0 85, 770 10.00 76. 00 SLEEP LAB 0 773, 930 11 00 11.00 91. 00 EMERGENCY 12.00 577, 137 12.00 4, 898, 689 200.00 200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	DUPONT HC		CN: 15-0150	Peri od:	u of Form CMS- Worksheet B	2332-10
C031 P	ELECCATION - GENERAL SERVICE COSTS		Provider C	CN. 13-0130	From 04/01/2018 To 03/31/2019	Part I	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	
		col. 7) 0	1. 00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	3, 904, 120	3, 904, 120	)			1.00
2. 00 4. 00 5. 01	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING	6, 720, 403 4, 716, 114 2, 435, 891	9, 996 0		06 4, 743, 316 0 281, 431	2, 717, 322	
5. 02 5. 03 7. 00 8. 00	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00560 OTHER ADMINI STRATI VE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE	1, 542, 224 20, 275, 988 4, 689, 474 471, 780	131, 212 1, 080, 840			0 0 0	5. 03 7. 00
9. 00 10. 00 11. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	1, 023, 628 1, 233, 581 580, 888	12, 113 99, 072 0	170, 53	67, 312	0	9. 00 10. 00
13. 00 14. 00 15. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	2, 394, 462 1, 795, 548 1, 763, 422	20, 634 36, 720 0	63, 20	09 54, 495 0 220, 104	0 0 0	14. 00 15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	1, 078, 190 627, 187	12, 946		0 75, 948	0	17. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 355, 830 1, 456, 723	800, 094 116, 999			175, 291 11, 220	1
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	3, 072, 860	168, 800		322, 884	108, 568	31. 01
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	0 1, 333, 483	0 53, 068	91, 34	0 0 19 133, 867	0 27, 615	
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	44. 00
50.00	O5000 OPERATING ROOM	10, 195, 813	783, 382	1, 348, 48		885, 912	
51. 00 52. 00 53. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 2, 474, 295 0	0 0 0		0 0 0 290, 444 0 0	0 59, 916 0	52. 00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRA SOUND	2, 523, 241 415, 868	161, 719	278, 37	78 244, 283 0 49, 595	166, 122 34, 299	
56. 00 57. 00	05401 BLTRA SOUND 05600 RADI OI SOTOPE 05700 CT SCAN	235, 445	0		0 49, 393 0 13, 279 0 0	17, 661 0	56. 00
58. 00	05800 MRI	225, 090	29, 918			28, 295	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 806, 143 1, 460, 669	34, 187 0	58, 84	208, 844 0 127, 942	198, 993 33, 100	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	388, 356 0 0	10, 378 0 0				66. 00 67. 00
69. 00	06900 ELECTROCARDI OLOGY	41, 042	0		0 2, 119	34, 773	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 081, 195	0		0 0	210, 445	
72. 00 73. 00	07300 DRUGS CHARGED TO PATTENTS	11, 346, 961 4, 306, 497	0		0 0	263, 276 317, 958	
74.00	07400 RENAL DIALYSIS	179, 473	20 003	44 70	0 0	3, 245	
76. 00 76. 02	03950 SLEEP LAB 03560 PSYCH SERVICES/EATINT DISORDER	217, 024 0	38, 803 0	66, 79	22, 516 0 0	8, 402 0	1
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	443, 836	0		0 43, 362	10, 342	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 013, 953	138, 361	l .		112, 161	1
95. 00	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES	O	0		0 0	0	95. 00
118.00	SPECIAL PURPOSE COST CENTERS	107, 826, 697	3, 739, 242			2, 717, 322	
	NONREI MBURSABLE COST CENTERS						
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING	0 15, 481 0	9, 805 0 0	1	78 0 0 96 0 0	0	190. 00 192. 00 194. 00

Provider CCN: 15-0150

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | Part | |
| To | 03/31/2019 | Date/Time Prepared: | 9/3/2019 3:51 pm |

COUNTY   C						''	0 03/31/2019	9/3/2019 3: 51	
			Cost Center Description	CASHI ERI NG/ACC	Subtotal	OTHER	OPERATION OF		
Section   Sect							PLANT	LINEN SERVICE	
CEMPAR SERVICE COST CENTERS							7.00		
0.00   0.0100   CAP REL COSTS-BLOG & FIXT		CENED	AL CEDALCE COST CENTERS	5.02	5A. 02	5.03	7.00	8.00	
2.00	1 00								1 00
0.0400   DIPLOYEE BENEFITS BENATIVEN									
5.01   0.0570  ADMITTING 0.00500  OTHER ADMINISTRATIVE AND CEMERAL   1,542,224   2.094,358   20,954,358   9,600,392   5.02   5.02   5.00   5.0		1	l e e e e e e e e e e e e e e e e e e e						
5.02   0.0560 (CASHIFR INK-ACCOUNTS RICE) VARIE   1,542,224   5.03 (0.0560 (DHER ADMINI STRATIVE AND GENERAL   0   20,954,358   20,954,358   5.005   5.005   7.00   0.000 (DHERATION OF PLANT   0   7.745,387   1.855,005   9,600,392   7.00		1							
5. 03 00560 OTHER ADMINISTRATIVE AND CENERAL 0 20, 994, 358		1		1, 542, 224					
0.0000   OURSIANTION OF PLANT   0   7, 745, 397   1, 855, 000   9, 600, 392   7, 70   0   0   0   0   0   0   0   0   0					20. 954. 358	20, 954, 358			
8.00   08000   LAMBRY & LINEN SERVICE   0   471,780   112,990   0   594,770   8.00   0.0000   DISTARY   0   1.733,904   269,173   43,358   0   9.00   0.000   DISTARY   0   1.598,667   302,878   354,627   0   10.00   11.00   0.00   DISTARY   0   0.400,181   33,332   0   0   11.00   11.00   0.00   DISTARY   0   0.400,181   33,332   0   0   11.00   0.00   0.00   DISTARY   0   1.598,667   302,878   354,627   73,955   0.0   11.00   0.00   0.00   DISTARY   0   1.598,852   475,051   131,404   131,404   1.00   15.00   15.00   0.00   0.00   DISTARY   0   1.983,524   475,051   131,404   131,404   0   1.00   15.00   0.00   0.00   DISTARY   0   1.983,524   475,051   131,404   0   0   15.00   0.00   0.00   DISTARY   0   1.511,901   275,732   46,339   0   16.00   0.00   0.00   DISTARY   0   0.00   0.00   DISTARY   0   0.00   0.00   0.00   DISTARY   0   0.00				o					
10.00   01000   DIETARY   0   1.598, 667   328, 878   354, 627   0   10.00   13.00   0300   CAFFTERIA   0   640, 184   153, 332   0   0   11.00   13.00   0300   MURSIN STRATION   0   2.731, 845   654, 271   77, 857   0   13.00   15.00   01500   PHARMARY   0   1.949, 797   467, 014   131, 440   1.00   14.00   01400   CENTRAL SERVICES & SUPPLY   0   1.949, 797   467, 014   131, 440   1.00   14.00   01400   CENTRAL SERVICES & SUPPLY   0   1.949, 797   467, 014   131, 440   1.00   14.00   01400   CENTRAL SERVICES & SUPPLY   0   1.949, 797   467, 014   131, 440   15.00   15.00   01500   PHARMARY   0   1.949, 797   467, 014   131, 440   15.00   15.00   17.00   15.00	8.00	00800	LAUNDRY & LINEN SERVICE	o			0	584, 770	8. 00
11.00   01100   CAFETERI   0   0.40, 184   153, 322   0   0   11.00   13.00   1300   MIRSI NA DINISH NA	9.00	00900	HOUSEKEEPI NG	o	1, 123, 904	269, 173	43, 358	0	9. 00
13.00   01300   NURSING ADMINISTRATION   0   2,731, 845   654, 277   73, 857   0   13.00   15.00   15.00   01500   PHARBACY   0   1,949, 972   467, 014   131, 440   0.105   14.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   15.00   0.00   0.00   0.00   15.00   0	10.00	01000	DI ETARY	0	1, 598, 667	382, 878	354, 627	0	10.00
14.00   01400   CENTRAL SERVICES & SUPPLY   0   1, 949, 972   467, 014   1311, 440   1, 055   14.00   15.00   16.00   01600   MEDICAL RECORDS & LIBRARY   0   1, 983, 526   475, 051   0   0   15.00   16.00	11. 00			0	640, 184	153, 323	0	0	11. 00
15.00   01500   PHARMACY   0   1, 933, 556   475, 051   0   0   16.00   17.00   0100   DELOCAL RECORDS & LIBRARY   0   1, 151, 791   275, 732   46, 339   0   16.00   17.00	13.00	01300	NURSING ADMINISTRATION	0	2, 731, 845	654, 271	73, 857	0	13.00
16.00   01600   MEDICAL RECORDS & LIBRARY   0   1.51, 291   275, 732   46, 339   0   0.70				0	1, 949, 972		131, 440	1, 055	
17. 00   17.00   SOCIAL SERVICE   0   703,135   168,399   0   0   17.00		1		0					
INPAIL ENT ROUTH NE SERVICE COST CENTERS   99, 504   8, 363, 473   2, 003, 035   2, 863, 911   186, 626   30   03100   3100 03100   AUNTES NEPIDIATRICS   99, 504   8, 363, 473   2, 003, 035   2, 863, 911   186, 626   30   031   03100   INTENSIVE CARE UNIT   61, 629   4, 629, 300   940, 653   604, 214   10, 834   31   01   03101   INCONATAL INTENSIVE CARE UNIT   61, 629   4, 625, 300   940, 653   604, 214   10, 834   31   040   00   04000   SUBPROVI DER - I PF   0   0   0   0   0   0   0   0   0				0					
30.00   03000   ADULTS & PEDIATRICS   99,504   8,363,473   2,003,035   2,863,911   186,626   30.00   31.01   03101   INTENSIVE CARE UNIT   61,629   4,025,306   904,053   604,214   10,834   31.01   03101   NONATAL INTENSIVE CARE UNIT   61,629   4,025,306   904,053   604,214   10,834   31.01   03101   NONATAL INTENSIVE CARE UNIT   61,629   4,025,306   904,053   604,214   10,834   31.01   03101   NONATAL INTENSIVE CARE UNIT   61,629   4,025,306   904,053   604,214   10,834   31.01   03101   NONATAL INTENSIVE CARE UNIT   61,676   1,655,058   396,383   189,954   8,390   43.00   04400	17. 00			0	703, 135	168, 399	0	0	17. 00
31.00   03100   INTERSIVE CARE UNIT	20.00			00 504	0.2/2.472	2 002 025	2.0/2.011	10/ /2/	20.00
33.1								1	
40. 00   04000   SUBPROVI DER - I PP								1	
43.00   04300   NURSERY   15.676   1.655, OB   396, 383   189, 954   8.390   43.00				01,029			004, 214		
A-1				15 676	-	_	180 05/		
ANCILLARY SERVICE COST CENTERS				13, 070				1	
50.00     05000     05000   0FEATH ING ROOM   502, 622   14, 410, 516   3, 451, 290   2, 804, 092   131, 145   50.00   51.00   051.00   051.00   0500   RCDVERY ROOM   34, 011   2, 858, 666   684, 645   0   101, 370   52.00   053.00   054.00   054.00   054.00   054.00   054.00   054.00   055.00   056.00   0	44.00			<u> </u>		<u> </u>	<u> </u>		74.00
S1 00   05100   RECOVERY ROOM & LABOR ROOM   34,011   2,858,666   684,645   0   101,370   52,00   52,00   05200   DELIVERY ROOM & LABOR ROOM   34,011   2,858,666   684,645   0   011,370   52,00   53,00   05300   ANESTHESI OLOGY   0   0   0   0   0   0   0   0   53,00   54,00	50.00			502, 622	14, 410, 516	3, 451, 290	2, 804, 092	131, 145	50.00
S3.00   05300   ANESTHESI OLOGY   0   0   0   0   0   53.00				0	0	0	0		
54. 01 05400 RADIOLOGY-DI ARNOSTI C 94, 299 3, 468, 042 830, 589 578, 870 47, 795 54, 00 05401 ULTRA SOUND 19, 470 519, 232 124, 355 0 0 0 54, 01 56. 00 05600 RADIOLOGY-DI ARNOSTI C 10, 025 276, 410 66, 200 0 0 56, 00 570, 00 05700 CT SCAN 0 0 0 0 0 0 0 57, 00 05700 CT SCAN 0 0 0 0 0 0 0 0 57, 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52.00	05200	DELIVERY ROOM & LABOR ROOM	34, 011	2, 858, 666	684, 645	0	101, 370	52.00
54. 01   054.01   UITRA SOUND   19, 470   519, 232   124, 355   0   0   54. 01	53.00	05300	ANESTHESI OLOGY	O	0	0	0	0	53. 00
56. 00   05700   05700   CT SCAN	54.00	05400	RADI OLOGY-DI AGNOSTI C	94, 299	3, 468, 042	830, 589	578, 870	47, 795	54.00
57.00   05700   CT SCAN   0 0 0 0 0 0 0 0 0 0 0 57.00	54. 01	05401	ULTRA SOUND	19, 470	519, 232	124, 355	0	0	54. 01
S8.00   05800   MR    16, 062   375, 838   90, 012   107, 090   0   58.00	56.00			10, 025	276, 410	66, 200	0	0	
60.00   06000   LABORATORY   112,959   3,419,974   819,077   122,371   0 60.00   65.00   06500   RESPI RATORY THERAPY   18,789   1,640,500   392,896   0 0 65.00   66.00   06600   PHYSI CAL THERAPY   5,522   475,732   113,937   37,146   0 66.00   67.00   0 67.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	-	_	0		
65. 00   06500   RESPIRATORY THERAPY   18,789   1,640,500   392,896   0   0   65. 00   66. 00   06600   0600   0600   0600   0   0		1						l	
66.00   06600   PHYSI CAL THERAPY   5,522   475,732   113,937   37,146   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   0   68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   19,739   97,673   23,392   0   0   69.00   71.00   7100   MEDI CAL SUPPLIES CHARGED TO PATIENT   119,460   2,411,100   577,454   0   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   149,449   11,759,686   2,816,421   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   180,490   4,804,945   1,150,775   0   0   73.00   74.00   07400   RENAL DI ALYSIS   1,842   184,560   44,202   0   0   74.00   76.00   03950   SLEEP LAB   4,769   358,308   85,814   138,894   9,624   76.00   76.00   03950   SLEEP LAB   4,769   358,308   85,814   138,894   9,624   76.00   76.00   03950   SLEEP LAB   5,870   503,410   120,566   0   0   0   70.00   09000   CLI NIC   5,870   503,410   120,566   0   0   0   0   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   79.00   09000   09000   09000   09000   09000   09000   09000   09000   79.00   09000							122, 371	l	
67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   19.739   97.673   23.392   0   0   69.00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   119, 460   2.411, 100   577, 454   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   149, 449   11, 759, 686   2.816, 421   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   180, 490   4, 804, 945   1, 150, 775   0   0   73. 00   74. 00   07400   RENAL DIALYSIS   1, 842   184, 560   44, 202   0   0   74. 00   76. 00   03950   SLEEP LAB   4, 769   358, 308   85, 814   138, 894   9, 624   76. 00   76. 02   03560   PSVCH SERVICES/EATINT DI SORDER   0   0   0   0   0   0   79. 00   00900   CLINI C   COST CENTERS   79. 00   09000   CLINI C   COST CENTERS   79. 00   09200   08SERVATI ON BEDS (NON-DI STI NCT PART   0   79. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   79. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   79. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   79. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   79. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   79. 00   097950   MARKETI NG   0   0   0   0   0   79. 00   194. 00   194. 00   794. 00   07950   MARKETI NG   0   0   0   0   0   794. 00   07950   MARKETI NG   0   0   0   0   0   794. 00   07952   SENI OR CIANSE   SENI OR CANTEEN   0   0   0   0   0   794. 00   07952   SENI OR CIANSE   SENI OR CIANSE   0   0   0   0   0   794. 00   07952   SENI OR CIANSE   0   0   0   0   0   0   794. 00   07952   SENI OR CIANSE   0   0   0   0   0   795. 00   00   00   0   0   0   796. 00   00   00   0   0   79752   00   00   0   0   0   0   79753   00   00   0   0   0   79754   00   00   0   0   0   79755   00   00   0   0   0   79756   00   00   0   0   0   79757   00   00   0   0   79758   00   00   0   0   0   79759   00   00   0   0   0   79750   00   00   0   0   0   79750   00   00   0   0   0   79750   00   00   0   0   79750   00   00   0   0   79750   00   00   0   0   79750   00   00   0							0	1	
68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0   68.00   69.00   06900   DELECTROCARDI OLOGY   19,739   97,673   23,392   0   0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   119,460   2,411,100   577,454   0   0   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   149,449   11,759,686   2,816,421   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   180,490   4,804,945   1,150,775   0   0   73.00   74.00   073400   RENAL DI ALYSI S   1,842   184,560   44,202   0   0   0   0   76.00   03950   SLEEP LAB   4,769   358,308   85,814   138,894   9,624   76.00   76.00   03950   SLEEP LAB   4,769   358,308   85,814   138,894   9,624   76.00   76.00   03050   PSYCH SERVICES/EATINT DI SORDER   0   0   0   0   0   76.02   03560   PSYCH SERVICE COST CENTERS    90.00   09000   CLI NI C   5,870   503,410   120,566   0   0   0   91.00   09100   EMERGENCY   63,668   2,713,791   649,948   495,260   57,271   91.00   92.00   090200   DSERVATION BEDS (NON-DI STI NCT PART   0   0   0   0   07HER REI MBURSABLE COST CENTERS    99.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   09500   AMBULANCE SERVICES   0   0   0   0   0   0   190.00   190.00   191.00   191.00   191.00   190.00   190.00   191.00   191.00   191.00   190.00   190.00   191.00   191.00   191.00   191.00   192.00   194.00   194.00   194.00   194.00   19500   MARKETI NG   0   0   0   0   0   0   194.00   194.00   194.00   194.00   194.00   194.00   07950   MARKETI NG   0   0   0   0   0   0   194.00   07950   MARKETI NG   0   0   0   0   0   194.00   07950   MARKETI NG   0   0   0   0   0   194.00   07950   NOMER RESOURCE CENTER   0   1,099,078   263,227   555,079   0   194.03   194.00   07950   MARKETI NG   0   0   0   0   0   194.00   07050   Negative Cost Centers   0   0   0   0   0   194.00   07050   Negative Cost Centers   0   0   0   0   0   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194.00   194		1		5, 522	4/5, /32	113, 937	37, 146		
69.00   66900   ELECTROCARDIOLOGY   19,739   97,673   23,392   0   0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   119,460   2,411,100   577,454   0   0   71.00   72.00   07200   MEDI CAL SUPPLIES CHARGED TO PATIENTS   119,449   11,759,686   2,816,421   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   180,490   4,804,945   1,150,775   0   0   73.00   74.00   07400   RENAL DI ALYSIS   1,842   184,560   44,202   0   0   74.00   76.00   03950   SLEEP LAB   4,769   358,308   85,814   138,894   9,624   76.00   76.02   03560   PSYCH SERVICES/EATINT DI SORDER   0   0   0   0   0   76.02   00100   00000   CLI IN C   5,870   503,410   120,566   0   0   0   76.02   09000   CLI IN C   5,870   503,410   120,566   0   0   0   76.02   09000   EMERGENCY   63,668   2,713,791   649,948   495,260   57,271   91.00   79.00   09000   BMERGENCY   63,668   2,713,791   649,948   495,260   57,271   91.00   79.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   70HER REI MBURSABLE COST CENTERS   795.00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   795.00   SPECIAL PURPOSE COST CENTERS   790.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   26,683   6,391   35,096   0   192.00   794.00   19200   PHYSI CI ANS' PRIVATE OFFICES   0   15,577   3,731   0   0   0   194.00   794.00   194.01   194.01   194.01   194.01   194.01   194.01   794.00   07950   MARKETI NG   0   0   0   0   0   0   0   795.00   0000   0000   0000   0000   0000   0000   795.00   00000   0000   0000   0000   0000   795.00   00000   0000   0000   0000   795.00   00000   0000   0000   0000   795.00   00000   00000   00000   795.00   00000   00000   00000   795.00   000000   000000000000000000000000				0	0	0	0		
71. 00				10.720	07 (72	22 202	0	1	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 149, 449 11, 759, 686 2, 816, 421 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 180, 490 4, 804, 945 1, 150, 775 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 1, 842 184, 560 444, 202 0 0 74. 00 76. 00 03950 SLEEP LAB 4, 769 358, 308 85, 814 138, 894 9, 624 76. 00 76. 02 03500 PSVCH SERVI CES/EATINT DISORDER 0 0 0 0 0 0 0 0 0 0 76. 02 00 09000 CLINI C 0 5, 870 503, 410 120, 566 0 0 0, 90. 00 91. 00 09000 DEMERGENCY 63, 668 2, 713, 791 649, 948 495, 260 57, 271 91. 00 92. 00 095ERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 95. 00 95. 00 09000 BERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			0		
73. 00							0	1	
74. 00 07400 RENAL DIALYSIS 1, 842 184, 560 44, 202 0 0 0 74. 00 76. 00 03950 SLEEP LAB 4, 769 358, 308 85, 814 138, 894 9, 624 76. 00 76. 02 03560 PSYCH SERVICES/EATINT DISORDER 0 0 0 0 0 0 0 0UTPATIENT SERVICE COST CENTERS  90. 00 09100 EMERGENCY 5, 870 503, 410 120, 566 0 0 0 90. 00 91. 00 09100 EMERGENCY 63, 668 2, 713, 791 649, 948 495, 260 57, 271 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00  95. 00 SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 542, 224 107, 305, 843 20, 681, 009 9, 010, 217 584, 770 118. 00  192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 15, 577 3, 731 0 0192. 00  194. 00 107951 PHYSI CI ANS PRI VATE OFFICES 0 194. 00  194. 01 07951 PHYSI CI AN RELATIONS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							_	1	
76. 00 03950   SLEEP LAB							0		
76. 02 03560 PSYCH SERVICES/EATINT DISORDER 0 0 0 0 0 0 0 0 76. 02 0UTPATIENT SERVICE COST CENTERS  90. 00 09000 CLI NI C 5, 870 503, 410 120, 566 0 0 0 90. 00 91. 00 99.							138, 894		
90. 00   09000   CLINIC   5,870   503,410   120,566   0   0   0   0   0   0   0   0   0								1	
91. 00				<u> </u>		•		•	
92. 00   09200   0BSERVATI ON BEDS   (NON-DI STI NCT PART   0   0   0   0   0   0   0   0   0	90.00	09000	CLI NI C	5, 870	503, 410	120, 566	0	0	90. 00
95. 00 OTHER REIMBURSABLE COST CENTERS  095.00 AMBULANCE SERVI CES 0 0 0 0 0 0 0 0 0 0 95. 00  SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 1,542,224 107,305,843 20,681,009 9,010,217 584,770 118. 00  NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 26,683 6,391 35,096 0 190. 00  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 15,577 3,731 0 0 192. 00  194. 00 07950 MARKETI NG 0 0 0 0 0 0 194. 00  194. 01 07951 PHYSI CI AN RELATI ONS 0 0 0 0 0 0 194. 01  194. 02 07952 SENI OR CI RCLE 0 0 0 0 0 0 194. 02  194. 03 07953 WOMENS RESOURCE CENTER 0 1,099,078 263,227 555,079 0 194. 02  200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 201. 00	91.00			63, 668	2, 713, 791	649, 948	495, 260	57, 271	91. 00
95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   95. 00	92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   1,542,224   107,305,843   20,681,009   9,010,217   584,770   118.00   NONREI MBURSABLE COST CENTERS     190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   26,683   6,391   35,096   0   190.00   192.00   192.00   192.00   194.01   194.00   195.00									
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   1,542,224   107,305,843   20,681,009   9,010,217   584,770   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   26,683   6,391   35,096   0   190.00   192.00   192.00   192.00   195.577   3,731   0   0   192.00   192.00   194.00   07950   MARKETI NG   0   0   0   0   0   0   194.00   194.01   07951   PHYSI CI AN RELATI ONS   0   0   0   0   0   194.01   194.02   07952   SENI OR CI RCLE   0   0   0   0   0   194.02   194.03   07953   WOMENS RESOURCE CENTER   0   1,099,078   263,227   555,079   0   194.02   200.00   201.00   Negative Cost Centers   0   0   0   0   0   0   201.00   10	95. 00			0	0	0	0	0	95. 00
NONRE   MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   26,683   6,391   35,096   0   190.00   192.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   15,577   3,731   0   0   192.00   194.00   0   0   0   0   0   0   0   194.00   194.01   07951   PHYSI CI AN RELATI ONS   0   0   0   0   0   0   194.01   194.02   07952   SENI OR CI RCLE   0   0   0   0   0   194.02   194.03   07953   WOMENS RESOURCE CENTER   0   1,099,078   263,227   555,079   0   194.02   194.03   07953   07									
190. 00	118.00			1, 542, 224	107, 305, 843	20, 681, 009	9, 010, 217	584, 770	118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 15, 577 3, 731 0 0 192. 00 194. 00 07950 MARKETI NG 0 0 0 0 0 194. 00 194. 01 07951 PHYSI CI AN RELATI ONS 0 0 0 0 0 194. 01 194. 02 07952 SENIOR CI RCLE 0 0 0 0 0 194. 02 194. 03 07953 WOMEN'S RESOURCE CENTER 0 1, 099, 078 263, 227 555, 079 0 194. 03 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 201. 00	400.5				a		0= 0=:	-	100 00
194. 00   07950   MARKETING   0 0 0 0 0 0 194. 00   194. 00   194. 01   194. 02   07952   SENIOR CIRCLE   0 0 0 0 0 0 194. 01   194. 02   194. 03   07953   WOMENS RESOURCE CENTER   0 1,099,078   263,227   555,079   0 194. 02   194. 02   194. 02   194. 02   194. 03				0	26, 683	6, 391	35, 096		
194. 01 07951 PHYSICIAN RELATIONS 0 0 0 0 0 194. 01 194. 01 194. 02 07952 SENIOR CIRCLE 0 0 0 0 0 194. 02 194. 03 07953 WOMENS RESOURCE CENTER 0 1,099,078 263, 227 555,079 0 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	15, 5//		0		
194. 02 07952 SENI OR CIRCLE 0 0 0 0 0 0 194. 02 194. 03 07953 WOMENS RESOURCE CENTER 0 1,099,078 263,227 555,079 0 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 201. 00					0		0		
194. 03 07953 WOMENS RESOURCE CENTER 0 1,099,078 263,227 555,079 0 194. 03 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00					0				
200.00   Cross Foot Adjustments   0   200.00   201.00   Negative Cost Centers   0   0   0   0   201.00					1 000 070	263 227	555 070		
201.00   Negative Cost Centers   0 0 0 0 0 0 201.00		1			1, U77, U/O	203, 227	555, 079		
		1		n	0	0	n	n	
2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		1		1, 542, 224	108, 447, 181	20, 954, 358	9, 600, 392		
	,	1							

Provider CCN: 15-0150

Peri od: Worksheet B From 04/01/2018 Part I To 03/31/2019 Date/Time Prepared:

				'	0 03/31/2019	9/3/2019 3:51	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
					ADMI NI STRATI ON		
		0.00	10.00	44.00	40.00	SUPPLY	
	GENERAL SERVI CE COST CENTERS	9. 00	10. 00	11. 00	13. 00	14. 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 ADMITTING						5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02
5. 03	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 03
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	1, 436, 435					9. 00
10.00	01000 DI ETARY	53, 301	2, 389, 473				10.00
11. 00	01100 CAFETERI A	0	0	793, 507			11. 00
13. 00	01300 NURSING ADMINISTRATION	11, 101	0	50, 027			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	19, 756	0	19, 325		2, 588, 562	14. 00
15. 00	01500 PHARMACY	0	0	30, 090		10, 964	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 965	0	12, 674		363	16. 00
17. 00		0	0	13, 452	0	256	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	420, 450	1 020 524	100 (70	1 517 414	40.015	20.00
30.00	03000 ADULTS & PEDIATRICS	430, 450	1, 039, 534	122, 678		48, 815	30.00
31. 00 31. 01	03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE UNIT	62, 945 90, 814	44, 337 315, 374	26, 274 63, 535		16, 622 41, 208	31. 00 31. 01
40. 00	04000 SUBPROVIDER - IPF	90, 814	313, 3/4	ნა, ააა ი	000, 602	41, 200	40. 00
43. 00	04300 NURSERY	28, 550	200, 777	26, 514	0	18, 533	43. 00
44. 00	1 1	20, 330	200, 777	20, 314		10, 555	44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		<u> </u>		44.00
50. 00	05000 OPERATI NG ROOM	421, 459	0	154, 992	857, 007	458, 580	50. 00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	O	0	57, 531	2, 910	57, 824	52. 00
53.00	05300 ANESTHESI OLOGY	O	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	87, 005	0	50, 287	97, 297	44, 865	54.00
54.01	05401 ULTRA SOUND	0	0	9, 450	0	792	54. 01
56.00	05600 RADI OI SOTOPE	0	0	2, 483	0	14, 084	56.00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	1 1	16, 096	0	5, 132		2, 401	58. 00
60. 00	06000 LABORATORY	18, 392	0	55, 660		99, 493	60. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	27, 441	1	42, 199	65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 583	0	6, 466		3, 392	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	_	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	-	0	68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		U	93	0	35	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	267, 224 1, 409, 886	71.00
73. 00			0	0	0	1, 409, 880	73.00
74. 00	07400 RENAL DIALYSIS		0	0		0	74. 00
76. 00	03950 SLEEP LAB	20, 876	0	6, 281	12, 686	3, 810	76. 00
76. 02	I I	0	0	0, 201		0, 010	76. 02
	OUTPATIENT SERVICE COST CENTERS	-1	-1	-	-1		
90.00		0	0	7, 226	0	10, 737	90.00
91.00		74, 438	0	32, 925		35, 526	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00		0	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118. 0		1, 347, 731	1, 600, 022	780, 536	3, 521, 101	2, 587, 609	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 275	0	0			190. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	789, 451	19			192. 00
	0 07950 MARKETI NG	0	0	0	0		194. 00
	1 07951 PHYSI CI AN RELATIONS	0	0	0	0		194. 01
	2 07952 SENI OR CI RCLE	02 420	0	10.050	0		194. 02 194. 03
200. 0	3 07953 WOMENS RESOURCE CENTER Cross Foot Adjustments	83, 429	٩	12, 952		933	200. 00
200. 0		0	0	0		Λ	200.00
202. 0		1, 436, 435	2, 389, 473	793, 507	3, 521, 101		
232.0	1.57.12 (56 1.1.155 116 till 64gir 201)	., 700, 100	2,007,170	, , 3, 307	3,021,101	2, 333, 302	

Provider CCN: 15-0150

			To	03/31/2019	Date/Time Prep 9/3/2019 3:51	
Cost Center Description	PHARMACY		SOCIAL SERVICE	Subtotal	Intern &	Pili
		RECORDS &			Residents Cost	
		LI BRARY			& Post Stepdown	
					Adjustments	
JOSEPH ASSUMES AND ASSUES	15. 00	16. 00	17. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS  1. 00 00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00   OO200 CAP REL COSTS-BLDG & FIXT						2. 00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01   00570   ADMI TTI NG						5. 01
5. 02   00580   CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 03   00560   OTHER ADMI NI STRATI VE AND GENERAL						5. 02 5. 03
7.00 O0700 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 11. 00   01100   CAFETERI A						10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY	2, 499, 631					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	1, 493, 364	1			16.00
17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	885, 242			17. 00
30. 00 03000 ADULTS & PEDIATRICS	0	96, 339	469, 124	17, 141, 399	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	6, 166	27, 506	3, 220, 852	0	31. 00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT	0	59, 668	216, 995	6, 945, 853	0	31. 01
40. 00   04000   SUBPROVI DER -   1 PF 43. 00   04300   NURSERY	0	0 15, 177	171, 617	0 2, 710, 953	0	40. 00 43. 00
44. 00   04400   SKILLED NURSING FACILITY	0	15, 177		2, 710, 453	0	44. 00
ANCILLARY SERVICE COST CENTERS	-1					
50. 00   05000   OPERATI NG ROOM	0	486, 833		23, 175, 914	0	50.00
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0 32, 929	0	0 3, 795, 875	0	51. 00 52. 00
53. 00   05200 DELIVERT ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	0	32, 929		3, 793, 673	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	91, 300	Ō	5, 296, 050	0	54.00
54. 01   05401   ULTRA SOUND	0	18, 851	1	672, 680	0	54. 01
56. 00   05600   RADI OI SOTOPE	0	9, 706	0	368, 883	0	56.00
57. 00   05700   CT   SCAN 58. 00   05800   MRI	0	15, 551		612, 120	0	57. 00 58. 00
60. 00 06000 LABORATORY	0	109, 365	_	4, 671, 891	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	18, 192	1	2, 134, 277	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0	5, 346	0	647, 602	0	66.00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	19, 111		140, 304	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	115, 659	0	3, 371, 437	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	144, 695	1	16, 130, 688	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DIALYSIS	2, 499, 631	174, 748 1, 783		8, 630, 099 230, 545	0	73. 00 74. 00
76. 00   03950   SLEEP LAB	0	4, 618		640, 911	0	76. 00
76. 02 03560 PSYCH SERVICES/EATINT DISORDER	0	0	1	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS	1					
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	0	5, 684 61, 643	1	647, 623 4, 364, 284	0	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		01, 043		4, 304, 204	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS	2 400 (21	1, 493, 364	005 242	105 550 240	0	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 499, 631	1, 493, 304	885, 242	105, 550, 240	U	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	73, 445	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	808, 798		192. 00
194. 00 07950 MARKETI NG	0	0	0	0		194. 00
194.01 07951 PHYSICIAN RELATIONS 194.02 07952 SENIOR CIRCLE	0	0	0	0		194. 01 194. 02
194. 03 07953  WOMENS RESOURCE CENTER		0		2, 014, 698		194. 02
200.00 Cross Foot Adjustments	1			0	0	200. 00
201.00 Negative Cost Centers	0 103 131	1 400 0::	0	100 447 15		201. 00
202.00   TOTAL (sum lines 118 through 201)	2, 499, 631	1, 493, 364	885, 242	108, 447, 181	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS DUPONT HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0150

Peri od: Worksheet B From 04/01/2018 Part I To 03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm

			9/3/2019 3:5	
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 01	00570 ADMI TTI NG			5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 02
5. 03	00560 OTHER ADMINISTRATIVE AND GENERAL			5. 03
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY			9. 00 10. 00
11. 00	01100 CAFETERI A			11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	17, 141, 399		30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 220, 852		31.00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	6, 945, 853		31. 01
40.00	04000 SUBPROVI DER - I PF	0		40. 00
43.00	04300 NURSERY	2, 710, 953		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		44. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	23, 175, 914		50.00
51.00	05100 RECOVERY ROOM	0 705 075		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	3, 795, 875		52.00
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 296, 050		53. 00 54. 00
54. 00	05401 ULTRA SOUND	672, 680		54. 00
56. 00	05600 RADI OI SOTOPE	368, 883		56. 00
57. 00	05700 CT SCAN	0		57. 00
58. 00	05800 MRI	612, 120		58. 00
60.00	06000 LABORATORY	4, 671, 891		60.00
65.00	06500 RESPIRATORY THERAPY	2, 134, 277		65. 00
66.00	06600 PHYSI CAL THERAPY	647, 602		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	140, 304		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 371, 437		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 130, 688		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 630, 099		73. 00
74.00	07400 RENAL DIALYSIS	230, 545		74.00
76.00	03950 SLEEP LAB	640, 911 0		76. 00 76. 02
70.02	03560   PSYCH SERVICES/EATINT DISORDER   OUTPATIENT SERVICE COST CENTERS	<u> </u>		- 10. UZ
90 00	09000 CLINIC	647, 623		90.00
	09100 EMERGENCY	4, 364, 284		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 304, 204		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			72.00
95. 00	09500 AMBULANCE SERVI CES	0		95. 00
	SPECIAL PURPOSE COST CENTERS	-1		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	105, 550, 240		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	73, 445		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	808, 798		192. 00
	07950 MARKETI NG	0		194. 00
	07951 PHYSI CI AN RELATI ONS	0		194. 01
	07952 SENI OR CI RCLE	0		194. 02
	07953 WOMENS RESOURCE CENTER	2, 014, 698		194. 03
200.00		0		200. 00
201.00		100 447 101		201. 00
202.00	TOTAL (Suil TITIES TTO LITTOUGH ZUT)	108, 447, 181		202. 00

| Peri od: | Worksheet B | From 04/01/2018 | Part II | To 03/31/2019 | Date/Time Prepared: Provider CCN: 15-0150

				То	03/31/2019	Date/Time Pre 9/3/2019 3:51	pared:
			CAPI TAL REI	LATED COSTS		77 37 2017 3. 31	Į į
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFITS DEPARTMENT	
		Related Costs				DEI / II ( I III E I I I	
		0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT		I				1 00
	00200 CAP REL COSTS-BLDG & FTXT						1.00 2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	9, 996	17, 206	27, 202	27, 202	4. 00
	DO570 ADMITTING	0	0	0	0	1, 613	5. 01
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	0	5. 02
	DO560 OTHER ADMINISTRATIVE AND GENERAL DO700 OPERATION OF PLANT	0	131, 212		357, 075	1, 842	5. 03
	00800 LAUNDRY & LINEN SERVICE	0	1, 080, 840	1, 860, 520 0	2, 941, 360 0	657 0	7. 00 8. 00
4	00900 HOUSEKEEPI NG	0	12, 113		32, 964	386	9. 00
4	D1000 DI ETARY	0	99, 072		269, 611	547	10.00
	D1100 CAFETERI A	0	0	-	0	340	11. 00
	D1300 NURSI NG ADMI NI STRATI ON	0	20, 634		56, 152	1, 612	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	36, 720	63, 209	99, 929	312 1, 262	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	12, 946	-	35, 231	217	16. 00
4	01700 SOCIAL SERVICE	0	0		0	435	17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDI ATRI CS	0			2, 177, 344	3, 184	30.00
	03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE UNIT	0	116, 999 168, 800		318, 396 459, 365	785 1, 851	31. 00 31. 01
	04000 SUBPROVIDER - IPF	0	100, 600	290, 303	459, 365	0	40.00
	04300 NURSERY	0	53, 068	91, 349	144, 417	767	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0		0	0	44. 00
	ANCILLARY SERVICE COST CENTERS	1	700 000	1 4 4 4 4 4 4 4	2 424 244	0.000	
4	D5000 OPERATING ROOM D5100 RECOVERY ROOM	0	783, 382 0		2, 131, 866 0	3, 993 0	50. 00 51. 00
	D5200 DELIVERY ROOM & LABOR ROOM	0	Ö	o	Ö	1, 665	52.00
	D5300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	0	161, 719	278, 378	440, 097	1, 400	1
	D5401 ULTRA SOUND	0	0	0	0	284	54. 01
1	05600  RADI 01 SOTOPE 05700  CT   SCAN	0	0	0	0	76 0	56. 00 57. 00
	05800 MRI	0	29, 918	51, 499	81, 417	143	58. 00
4	06000 LABORATORY	0	34, 187		93, 035	1, 197	60.00
	06500 RESPI RATORY THERAPY	0	0	0	0	733	65. 00
4	06600 PHYSI CAL THERAPY	0	10, 378		28, 241	252	66. 00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	12	69. 00
4	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	Ö	Ö	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	07400 RENAL DIALYSIS 03950 SLEEP LAB	0	0 38, 803	64 704	0 105, 597	0 129	,
	03560 PSYCH SERVICES/EATINT DISORDER	0	38,803		105, 597	0	1
	OUTPATIENT SERVICE COST CENTERS			<u> </u>	<sub>I</sub>	<u> </u>	70.02
	09000 CLI NI C	0			0	249	90. 00
	09100 EMERGENCY	0	138, 361	238, 170	376, 531	845	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92. 00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
9	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 739, 242	6, 436, 588	10, 175, 830	26, 788	118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	9, 805	16, 878	26, 683	n	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	,, 303	0	20, 003		192. 00
	07950 MARKETI NG	0	0	O	o		194. 00
	07951 PHYSICIAN RELATIONS	0	0	0	o		194. 01
	07952 SENI OR CI RCLE	0	0	0	0		194. 02
194. 03 ( 200. 00	D7953 WOMENS RESOURCE CENTER Cross Foot Adjustments	0	155, 073	266, 937	422, 010	413	194. 03 200. 00
200.00	Negative Cost Centers	1	n	0	0	n	200.00
202.00	TOTAL (sum lines 118 through 201)	0	3, 904, 120		10, 624, 523		
				,			

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 04/01/2018 | Part II | To 03/31/2019 | Date/Time Prepared: |

				11	03/31/2019	9/3/2019 3:51	
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	OPERATION OF	LAUNDRY &	
			OUNTS	ADMI NI STRATI VE	PLANT	LINEN SERVICE	
		F 01	RECEI VABLE	AND GENERAL	7.00	0.00	
	GENERAL SERVICE COST CENTERS	5. 01	5. 02	5. 03	7. 00	8. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00570 ADMI TTI NG	1, 613					5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	C				5. 02
5.03	00560 OTHER ADMINISTRATIVE AND GENERAL	0	C	358, 917			5. 03
7.00	00700 OPERATION OF PLANT	0	C	31, 772	2, 973, 789		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	C	1, 935	0	1, 935	1
9.00	00900 HOUSEKEEPI NG	0	C	4, 610	13, 430		1
10.00	01000 DI ETARY 01100 CAFETERI A	0		6, 558	109, 848		1
11. 00 13. 00		0		2, 626 11, 206	22, 878	0	
14. 00	1 1	0		7, 999	40, 714	3	
15. 00	1 1	0		8, 136	40, 714	0	1
16. 00	1 1	0	Č	4, 723	14, 354		
17. 00		0	C	1	0	Ō	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00		92	C	34, 307	887, 119	618	30. 00
31. 00	1	6	C	7, 915	129, 724		1
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	57	C	16, 512	187, 159		1
40. 00		0	C	0	0	0	
43. 00		14	C		58, 840		1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	C	)  0	0	0	44. 00
50. 00		656	C	59, 134	868, 587	434	50.00
51. 00		0			0	0	1
52.00		31	C	11, 726	0	335	1
53.00	05300 ANESTHESI OLOGY	0	C	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	87	C	14, 226	179, 309	158	54.00
54. 01	05401 ULTRA SOUND	18	C	2, 130	0	0	
56. 00	1	9	C	1, 134	0	0	
57. 00	1	0	C	0	0	0	
58. 00	1 1	15		1, 542	33, 172		
60. 00 65. 00	1 1	104 17		14, 029 6, 729	37, 905	0	1
66. 00	1 1	5		1, 951	11, 506		
67. 00	1 1	0	Č		0	Ö	
68. 00	1 1	0	C	o	0	Ō	
69. 00	06900 ELECTROCARDI OLOGY	18	C	401	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	110	C	9, 890	0	0	71. 00
72. 00	1	138	C	48, 238	0	0	
73. 00	1	166	C	19, 710	0	0	
74.00		2	C	757	42.022	0	
76. 00 76. 02	i i	4 0		1, 470	43, 023	32	1
70.02	OUTPATIENT SERVICE COST CENTERS	0		<u> </u>	0	0	70.02
90. 00		5	C	2, 065	0	0	90. 00
91.00		59					1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00		0	C	0	0	0	95. 00
110 0	SPECIAL PURPOSE COST CENTERS	1 /12		254 224	2 700 070	1 025	110 00
118. 0	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 613	C	354, 236	2, 790, 978	1, 935	118. 00
190 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	109	10, 871	0	190. 00
	0 19200 PHYSI CLANS' PRI VATE OFFICES	0	Ċ	1	10, 071		192. 00
	007950 MARKETI NG	o o	Ċ		0		194. 00
	1 07951 PHYSICIAN RELATIONS	Ö	C	o o	0		194. 01
	2 07952 SENI OR CIRCLE	0	C	0	0	0	194. 02
	3 07953 WOMENS RESOURCE CENTER	0	C	4, 508	171, 940	0	194. 03
200.0							200. 00
201. 0		0	C		0 070 700		201. 00
202. 0	0 TOTAL (sum lines 118 through 201)	1, 613	C	358, 917	2, 973, 789	1, 935	202. 00

| Peri od: | Worksheet B | From 04/01/2018 | Part II | To 03/31/2019 | Date/Time Prepared:

				Т	o 03/31/2019	Date/Time Pre 9/3/2019 3:51	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	, j
					ADMI NI STRATI ON	SERVI CES & SUPPLY	
		9. 00	10. 00	11. 00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00							4. 00 5. 01
5. 01 5. 02	00570   ADMI TTI NG   00580   CASHI ERI NG/ACCOUNTS   RECEI VABLE						5. 01
5. 02	00560 OTHER 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	51, 390					9. 00
10.00	01000 DI ETARY	1, 907	388, 471				10. 00
11. 00	01100 CAFETERI A	0	0	2, 966			11. 00
13. 00	01300 NURSING ADMINISTRATION	397	0	187			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	707	0	72	1	149, 736	14. 00
15. 00	01500 PHARMACY	0	0	112	1	634	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	249	0	47		21	16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	U	50	ıl U	15	17. 00
30. 00	03000 ADULTS & PEDIATRICS	15, 399	169, 003	459	39, 838	2, 824	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	2, 252	7, 208	98		961	31. 00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	3, 249	51, 272	237		2, 384	31. 01
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
43.00	04300 NURSERY	1, 021	32, 642	99	0	1, 072	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	45.070	ما	F00	00.405	0/ 50/	F0 00
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	15, 078	0	583 0	· · ·	26, 526 0	50. 00 51. 00
51.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	215	- 1	3, 345	51.00
53. 00	05300 ANESTHESI OLOGY		0	213	1	0, 343	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 113	0	188	-	2, 595	54. 00
54. 01	05401 ULTRA SOUND	0	0	35		46	54. 01
56.00	05600 RADI 0I SOTOPE	O	0	9	1	815	56. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58.00	05800 MRI	576	0	19	1	139	58. 00
60.00	06000 LABORATORY	658	0	208	1	5, 755	60.00
65. 00	06500 RESPI RATORY THERAPY	0	0	103	1	2, 441	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	200	0	24	1	196 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0		0	68.00
69. 00	06900 ELECTROCARDI OLOGY		0	0		2	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		Ö	0	ol ol	15, 457	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	O	0	0	o	81, 557	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	- 1	0	74. 00
76. 00	03950 SLEEP LAB	747	0	23	I I	220	76. 00
76. 02	03560 PSYCH SERVICES/EATINT DISORDER	0	0]	0	0	0	76. 02
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	O	0	27		621	90. 00
91.00	09100 EMERGENCY	2, 663	0	123		2, 055	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,003	Ŭ.	123	0, 371	2,033	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	3 /	48, 216	260, 125	2, 918	92, 432	149, 681	118. 00
400.00	NONREI MBURSABLE COST CENTERS	100	ما		ا		100.00
	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN ) 19200 PHYSICIANS' PRIVATE OFFICES	189	120 244	0	1		190. 00 192. 00
	07950 MARKETING	0	128, 346	0	- 1		194. 00
	107951 PHYSICIAN RELATIONS		0	0	-		194. 00
	2 07952 SENI OR CI RCLE	o o	Ö	0	1 1		194. 02
	07953 WOMENS RESOURCE CENTER	2, 985	o	48	o		194. 03
200.00							200. 00
201.00		0	0	0			201. 00
202.00	TOTAL (sum lines 118 through 201)	51, 390	388, 471	2, 966	92, 432	149, 736	202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 04/01/2018 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0150

					To	03/31/2019		
		Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	Subtotal	9/3/2019 3:51 Intern &	piii
				RECORDS & LI BRARY			Residents Cost & Post	
				LIDRARI			Stepdown	
			15.00	14 00	17.00	24.00	Adjustments	
	GENER	AL SERVICE COST CENTERS	15. 00	16. 00	17. 00	24. 00	25. 00	
1.00	1	CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01		ADMI TTI NG						5. 01
5. 02	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02 5. 03
5. 03 7. 00	1	OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT						7. 00
8.00		LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00	1	CAFETERI A						11. 00
13.00	1	NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY	10, 144					14. 00 15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	O	54, 842				16. 00
17. 00		SOCIAL SERVICE LENT ROUTINE SERVICE COST CENTERS	0	0	3, 384			17. 00
30. 00		ADULTS & PEDIATRICS	0	3, 532	1, 793	3, 335, 512	0	30.00
31. 00		INTENSIVE CARE UNIT	o	226		472, 918	0	31.00
31. 01 40. 00		NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	2, 188 0	1	739, 678 0	0	31. 01 40. 00
43. 00		NURSERY	ő	557	656	246, 902	0	43. 00
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	17, 938	0	3, 147, 290	0	50. 00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	1, 207	0	18, 600	0	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	0	3, 348	O	647, 075	0	54. 00
54. 01	1	ULTRA SOUND	0	691	0	3, 204	0	54. 01
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	0	356 0		2, 399 0	0	56. 00 57. 00
58. 00	05800	MRI	o	570		117, 593	0	58. 00
60. 00 65. 00	1	LABORATORY RESPI RATORY THERAPY	0	4, 010 667		157, 624 11, 033	0	60. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	0	196		42, 571	0	66.00
67. 00	1	OCCUPATI ONAL THERAPY	o	0		0	0	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	701	0	0 1, 134	0	68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	o	4, 241	O	29, 698	0	71. 00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	5, 305		135, 238	0	72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	10, 144	6, 407 65		36, 427 824	0	
		SLEEP LAB	o	169		151, 747	0	l .
76. 02	03560	PSYCH SERVICES/EATINT DISORDER TIENT SERVICE COST CENTERS	0	0	0	0	0	76. 02
90. 00	09000	CLI NI C	0	208	0	3, 175	0	90. 00
91.00		EMERGENCY	0	2, 260	0	555, 659	0	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS					0	92. 00
95. 00	09500	AMBULANCE SERVICES	0	0	0	0	0	95. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	10, 144	54, 842	3, 384	9, 856, 301	0	118. 00
	NONRE	MBURSABLE COST CENTERS	10, 111	01,012	0,001	7, 000, 001		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0		37, 852 128, 412		190. 00 192. 00
	1	MARKETI NG	0	0		120, 412		194. 00
194. 01	07951	PHYSICIAN RELATIONS	0	0	_	0		194. 01
		SENIOR CIRCLE WOMENS RESOURCE CENTER	0	0	0	0 601, 958		194. 02 194. 03
200.00		Cross Foot Adjustments		Ö		0	0	200. 00
201.00 202.00		Negative Cost Centers TOTAL (sum lines 118 through 201)	10 144	0 54, 842	0	10 624 522		201. 00 202. 00
ZUZ. UU	1	TOTAL (Sum TITIES TTO LINDUGH 201)	10, 144	54, 842	3, 384	10, 624, 523	U	<sub> </sub> 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS DUPONT HOSPITAL Provider CCN: 15-0150

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 04/01/2018 | Part II | To 03/31/2019 | Date/Time Prepared: | 9/3/2019 3:51 pm

		9/3/2019 3: 51	pm
Cost Center Description	Total		
CENEDAL CEDALCE COCT CENTEDS	26. 00	 	
GENERAL SERVICE COST CENTERS			1 00
1.00   00100   CAP REL COSTS-BLDG & FLXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP			1.00
1 1			2.00
1 1			4. 00
5. 01   00570   ADMITTING			5. 01
5. 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5. 02
5. 03   00560 OTHER ADMINISTRATIVE AND GENERAL			5. 03
7. 00   00700   OPERATION OF PLANT			7.00
8.00   00800   LAUNDRY & LINEN SERVICE			8.00
9. 00   00900   HOUSEKEEPI NG			9.00
10. 00 01000 DI ETARY			10.00
11. 00 01100 CAFETERI A			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON			13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY			14. 00
15. 00   01500   PHARMACY			15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY			16.00
17. 00 01700 SOCIAL SERVICE			17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.005.540		
30. 00   03000   ADULTS & PEDI ATRI CS	3, 335, 512		30.00
31. 00   03100   I NTENSI VE CARE UNI T	472, 918		31. 00
31. 01   03101   NEONATAL   INTENSIVE CARE UNIT	739, 678		31. 01
40. 00   04000   SUBPROVI DER -   1 PF	0		40.00
43. 00   04300   NURSERY	246, 902		43. 00
44.00 04400 SKILLED NURSING FACILITY	0		44. 00
ANCILLARY SERVICE COST CENTERS			
50. 00   05000   OPERATI NG ROOM	3, 147, 290		50. 00
51. 00   05100   RECOVERY ROOM	0		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	18, 600		52. 00
53. 00   05300   ANESTHESI OLOGY	0		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	647, 075		54. 00
54. 01   05401   ULTRA SOUND	3, 204		54. 01
56. 00   05600   RADI OI SOTOPE	2, 399		56. 00
57.00  05700   CT   SCAN	0		57. 00
58. 00   05800   MRI	117, 593		58. 00
60. 00  06000  LABORATORY	157, 624		60. 00
65. 00  06500 RESPI RATORY THERAPY	11, 033		65. 00
66. 00 06600 PHYSI CAL THERAPY	42, 571		66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0		67. 00
68. 00   06800   SPEECH PATHOLOGY	0		68. 00
69. 00  06900   ELECTROCARDI OLOGY	1, 134		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 698		71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	135, 238		72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	36, 427		73. 00
74.00 07400 RENAL DIALYSIS	824		74.00
76. 00   03950   SLEEP LAB	151, 747		76. 00
76. 02 03560 PSYCH SERVI CES/EATINT DI SORDER	0		76. 02
OUTPATIENT SERVICE COST CENTERS			
90. 00  09000  CLI NI C	3, 175		90.00
91. 00 09100 EMERGENCY	555, 659		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS			
95. 00 09500 AMBULANCE SERVICES	0		95. 00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 856, 301		118. 00
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	37, 852		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	128, 412		192. 00
194. 00 07950 MARKETI NG	0		194. 00
194. 01 07951 PHYSI CI AN RELATIONS	o		194. 01
194. 02 07952 SENI OR CI RCLE	o		194. 02
194. 03 07953 WOMENS RESOURCE CENTER	601, 958		194. 03
200.00 Cross Foot Adjustments	0		200.00
201.00 Negative Cost Centers	o o		201.00
202.00 TOTAL (sum lines 118 through 201)	10, 624, 523		202. 00
1 ( (	, 32 . , 320		,

				Fr   To	com 04/01/2018 0 03/31/2019		pared:
		CADITAL DEL	LATED COSTS			9/3/2019 3: 51	
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	CASHI ERI NG/ACC	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT	(GROSS CHAR GES)	OUNTS RECEI VABLE	
				(GROSS	GL3)	(GROSS CHAR	
				SALARI ES)		GES)	
	GENERAL SERVICE COST CENTERS	1. 00	2.00	4. 00	5. 01	5. 02	
1.00	00100 CAP REL COSTS-BLDG & FLXT	224, 973					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		224, 973				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	576		36, 300, 434			4. 00
5. 01 5. 02	00570   ADMITTING   00580   CASHIERING/ACCOUNTS   RECEIVABLE	0	0	2, 153, 789 0	711, 092, 285 0	l .	5. 01 5. 02
5. 02	00560 OTHER ADMINISTRATIVE AND GENERAL	7, 561	7, 561	2, 458, 863	0	, ,	5. 02
7. 00	00700 OPERATION OF PLANT	62, 283		876, 671	0	Ō	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	698 5, 709		515, 136 730, 667	0	0	9. 00 10. 00
11. 00	01100 CAFETERI A	0,707	0,707	453, 792	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 189	1, 189	2, 152, 256	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 116		417, 049	0	0	14.00
15. 00 16. 00	01500  PHARMACY   01600  MEDI CAL RECORDS & LI BRARY	0 746	0 746	1, 684, 450 289, 818	0	0	15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	0		581, 229	0		17. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					1	
30.00	03000 ADULTS & PEDIATRICS	46, 105		4, 251, 259	45, 875, 700		1
31. 00 31. 01	03100  INTENSIVE CARE UNIT   03101  NEONATAL INTENSIVE CARE UNIT	6, 742 9, 727	6, 742 9, 727	1, 047, 434 2, 471, 024	2, 936, 369 28, 413, 389		31. 00 31. 01
40. 00	04000 SUBPROVI DER – I PF	0		0	0	0	40.00
43.00	04300 NURSERY	3, 058		1, 024, 481	7, 227, 294		43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS    05000   OPERATI NG ROOM	45, 142	45, 142	5, 313, 426	231, 791, 426	231, 791, 426	50.00
51. 00	05100 RECOVERY ROOM	0		0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	_	2, 222, 761	15, 680, 668		1
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	9, 319	0 9, 319	0 1, 869, 495	0 43, 476, 003	0 43, 476, 003	53. 00 54. 00
54. 00	05401 ULTRA SOUND	9, 319	9, 319	379, 551	8, 976, 492		54. 00
56. 00	05600 RADI OI SOTOPE	0	O	101, 624	4, 622, 084		•
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 60. 00	05800   MRI   06000   LABORATORY	1, 724 1, 970		191, 125 1, 598, 282	7, 405, 173 52, 078, 653		58. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	1, 770		979, 137	8, 662, 661		1
66.00	06600 PHYSI CAL THERAPY	598	598	335, 849	2, 545, 872		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1	0	0	1	67.00
68. 00 69. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	0	0	16, 218	9, 100, 461	0 9, 100, 461	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	0	55, 075, 948		1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	68, 902, 478		
73. 00 74. 00	07300   DRUGS CHARGED TO PATIENTS   07400   RENAL DIALYSIS	0	0	0	83, 213, 280 849, 190		
76. 00	03950 SLEEP LAB	2, 236	2, 236	172, 315	2, 198, 869		1
	03560 PSYCH SERVICES/EATINT DISORDER	0	0	0	0		1
	OUTPATIENT SERVICE COST CENTERS		I al	224 245	0 70/ 505		
90. 00 91. 00	09000   CLI NI C   09100   EMERGENCY	7, 973	0 7, 973	331, 845 1, 128, 644	2, 706, 505 29, 353, 770		90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 773	7, 773	1, 120, 044	27, 333, 770	27, 333, 770	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	215, 472	215, 472	35, 748, 190	711, 092, 285	711, 092, 285	118 00
110.00	NONREI MBURSABLE COST CENTERS	213,472	213, 472	33, 740, 170	711, 072, 203	711,072,203	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	565	565	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	733	0		192.00
	07950   MARKETI NG   07951   PHYSI CLAN RELATIONS	0	0	0	0		194. 00 194. 01
	07952 SENIOR CIRCLE		l o	o	0		194. 02
194. 03	07953 WOMENS RESOURCE CENTER	8, 936	8, 936	551, 511	0		194. 03
200. 00 201. 00	1 1	1					200. 00 201. 00
201.00	1 1 9	3, 904, 120	6, 720, 403	4, 743, 316	2, 717, 322	1, 542, 224	1
	Part I)						
203.00		17. 353727	29. 872042	0. 130668	0. 003821		
204.00	Cost to be allocated (per Wkst. B, Part II)			27, 202	1, 613		204. 00
	1	1	, 1	l		1	'

Heal th Fina	ncial Systems	DUPONT HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 04/01/2018 To 03/31/2019		
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)		(GROSS CHAR	CASHI ERI NG/ACC OUNTS	
				DEPARTMENT	GES)	RECEI VABLE (GROSS CHAR	
				(GROSS SALARI ES)		GES)	
		1. 00	2. 00	4.00	5. 01	5. 02	
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00074	9 0. 000002	0.000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0150 

				'	o 03/31/2019	Date/lime Pre   9/3/2019 3:51	
	Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	piii
		5A. 03	5. 03	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 01 5. 02	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						1. 00 2. 00 4. 00 5. 01 5. 02
5. 03 7. 00 8. 00	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-20, 954, 358 0	87, 492, 823 7, 745, 387 471, 780	154, 553	514, 787		5. 03 7. 00 8. 00
9. 00 10. 00	00900 HOUSEKEEPING 01000 DI ETARY	0	1, 123, 904 1, 598, 667	698	0	153, 855 5, 709	9. 00
11. 00	01100 CAFETERI A	0	640, 184	i .	0	0,707	1
13.00	01300 NURSING ADMINISTRATION	0	2, 731, 845	l .	0	1, 189	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 949, 972	1		2, 116	1
15. 00	01500 PHARMACY	0	1, 983, 526	l .	_	0	
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	0	1, 151, 291 703, 135	746		746 0	1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	103, 133	1	0	0	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	0	8, 363, 473	46, 105	164, 292	46, 105	30.00
31.00	03100 INTENSIVE CARE UNIT	0	1, 929, 574			6, 742	1
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	0	4, 025, 306	9, 727	9, 537	9, 727	31. 01
40. 00	04000 SUBPROVI DER - I PF	0	0	C	0	0	
43.00	04300 NURSERY	0	1, 655, 058	· ·		3, 058	1
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0		<u> </u> C	0	0	44. 00
50.00	05000 OPERATING ROOM	0	14, 410, 516	45, 142	115, 450	45, 142	50.00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 858, 666	o c	89, 238	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 468, 042		42, 075	9, 319	1
54. 01 56. 00	05401   ULTRA SOUND   05600   RADI OI SOTOPE	0	519, 232 276, 410	i	0	0	54. 01 56. 00
57. 00	05700 CT SCAN	0	270,410		0	0	57. 00
58. 00	05800 MRI	0	375, 838	1, 724	0	1, 724	58. 00
60.00	06000 LABORATORY	0	3, 419, 974	1, 970	0	1, 970	60.00
65.00	06500 RESPI RATORY THERAPY	0	1, 640, 500		_	0	
66.00	06600 PHYSI CAL THERAPY	0	475, 732	i		598	1
67. 00 68. 00	06700   OCCUPATI ONAL THERAPY   06800   SPEECH PATHOLOGY	0	0	O C	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	97, 673		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 411, 100		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 759, 686	o c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 804, 945		0	0	
74.00	07400 RENAL DIALYSIS	0	184, 560	l .	0 473	0	
	03950 SLEEP_LAB 03560 PSYCH_SERVICES/EATINT_DISORDER	0				2, 236 0	
70.02	OUTPATIENT SERVICE COST CENTERS	0			0	0	70.02
90.00	09000 CLI NI C	0	503, 410	C	0	0	90. 00
	09100 EMERGENCY	0	2, 713, 791	7, 973	50, 417	7, 973	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00	OTHER REIMBURSABLE COST CENTERS			ı			05.00
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	95. 00
118. 00		-20, 954, 358	86, 351, 485	145, 052	514, 787	144, 354	118 00
110.00	NONREI MBURSABLE COST CENTERS	20, 701, 000	00,001,100	110,002	011,707	111,001	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 683	565	0	565	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	15, 577	C	0		192. 00
	07950 MARKETI NG	0	0	C	0		194. 00
	07951   PHYSI CLAN RELATIONS   07952   SENI OR CLRCLE	0 0	0		0		194. 01 194. 02
	07953 WOMENS RESOURCE CENTER		1, 099, 078	8, 936	0		194. 02
200.00			1,077,070	0, 750	0	0, 730	200. 00
201. 00	, ,						201. 00
202.00			20, 954, 358	9, 600, 392	584, 770	1, 436, 435	
203. 00			0. 239498	62. 117151	1. 135946	9. 336291	203. 00
204.00	Cost to be allocated (per Wkst. B,		358, 917	1			204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part		0. 004102	19. 241225	0. 003759	0. 334016	205. 00
206. 00							206. 00
	(per Wkst. B-2)						

Health Financial System	ns	DUPONT HO	SPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STAT	ISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 04/01/2018 Fo 03/31/2019	Date/Time Pre	narod:
						9/3/2019 3: 51	
Cost Cente	r Description	Reconciliation	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			ADMI NI STRATI VE	PLANT	LINEN SERVICE	(SQUARE FEET)	
			AND GENERAL	(SQUARE FEET)	(POUNDS OF		
			(ACCUM. COST)		LAUNDRY)		
		5A. 03	5. 03	7. 00	8. 00	9. 00	
207. 00 NAHE uni t	cost multiplier (Wkst. D,						207. 00
Parts III	and IV)						

Hoal +b	Ei non	cial Systems	DUDONT HOS	DLTAL		In Lio	u of Form CMS-:	DEE2 10
		cial Systems TON - STATISTICAL BASIS	DUPONT HOS	Provi der Co		Peri od:	Worksheet B-1	2332-10
						From 04/01/2018 To 03/31/2019	Date/Time Pre 9/3/2019 3:51	
		Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	NURSING ADMINISTRATIO (NURSING FT ES)	CENTRAL N SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUIS.)	•
	loeves.	AL 0504 05 000 000 000 000 000 000 000 000	10.00	11. 00	13. 00	14. 00	15. 00	
1.00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT			Ι			1.00
2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	00200 00400 00570 00580 00560 00700 00800 01100 01100 01400 01500 01600 01700	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS	145, 729 0 0 0 0 0 0	42, 826 2, 700 1, 043 1, 624 684 726	15, 702, 51	7 0 20, 973, 659 0 88, 838 0 2, 940 0 2, 076	4, 306, 497 0 0	2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
30. 00		ADULTS & PEDIATRICS	63, 399	6, 621	6, 766, 98	3 395, 518	0	30.00
31. 01 40. 00 43. 00	03101 04000 04300 04400	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IPF NURSERY SKILLED NURSING FACILITY	2, 704 19, 234 0 12, 245 0	1, 418 3, 429 0 1, 431	2, 469, 92		0 0 0 0	31. 00 31. 01 40. 00 43. 00 44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM		8, 365	3, 821, 86	4 3, 715, 609	0	50.00
51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 57. 00 58. 00 60. 00	05100 05200 05300 05400 05401 05600 05700 05800 06000	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C ULTRA SOUND RADI OI SOTOPE CT SCAN MRI LABORATORY	0 0 0 0 0 0	0 3, 105 0 2, 714 510 134 0 277 3, 004	12, 97 433, 89 122, 89	0 0 0 8 468, 514 0 0 9 363, 512 0 6, 414 0 114, 113 0 0 0 19, 453 9 806, 136	0 0 0 0 0 0 0	51. 00 52. 00 53. 00 54. 00 54. 01 56. 00 57. 00 58. 00 60. 00
68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 76. 00	06600 06700 06800 06900 07100 07200 07300 07400 03950 03560	RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS RENAL DIALYSIS SLEEP LAB PSYCH SERVICES/EATINT DISORDER	0 0 0 0 0 0 0 0	1, 481 349 0 0 5 0 0 0 0 339		0 27, 483 0 0 0 0 0 282 0 2, 165, 161 0 11, 423, 555 0 0	0 0 0 0 0 0 4, 306, 497 0	
90. 00	09000	TIENT SERVICE COST CENTERS CLINIC	0	390		0 86, 992	0	90.00
	09200	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	1, 777	1, 085, 81	9 287, 847	0	91. 00 92. 00
95. 00	09500	REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	0	0		0 0	0	95. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	97, 582	42, 126	15, 702, 51	7 20, 965, 940	4, 306, 497	118. 00
	NONRE	MBURSABLE COST CENTERS						
192. 00 194. 00 194. 01 194. 02 194. 03 200. 00	19200 07950 07951 07952 07953	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES MARKETING PHYSICIAN RELATIONS SENIOR CIRCLE WOMENS RESOURCE CENTER Cross Foot Adjustments	0 48, 147 0 0 0 0	0 1 0 0 0 699		0 0 161 0 0 0 0 0 0 0 0 7,558	0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 200. 00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	2, 389, 473	793, 507	3, 521, 10	1 2, 588, 562	2, 499, 631	201. 00 202. 00
203. 00 204. 00		Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	16. 396688 388, 471	18. 528627 2, 966	1		0. 580433 10, 144	203. 00 204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part II)	2. 665708	0. 069257	0. 00588	6 0. 007139	0. 002356	205. 00

Health Fina	ncial Systems	DUPONT H	OSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 04/01/2018 To 03/31/2019	Date/Time Pre 9/3/2019 3:51	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)	(FTES)	ADMI NI STRATI ON	SERVICES &	(COSTED	
					SUPPLY	REQUIS.)	
				(NURSING FT	(COSTED		
				ES)	REQUIS.)		
		10.00	11. 00	13.00	14.00	15. 00	
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS DUPONT HOSPITAL In Lieu of Form CMS-2552-10

Peri od: From 04/01/2018 To 03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm Provider CCN: 15-0150

				9/3/2019   Date/Trille Pre	
	Cost Center Description		SOCIAL SERVICE		
		RECORDS &	(TIME OBENT)		
		LI BRARY	(TIME SPENT)		
		(GROSS CHAR GES)			
		16. 00	17. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01 5. 02	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE				5. 01 5. 02
5. 02	00560 OTHER 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				10.00
	01100 CAFETERI A				11. 00
	01300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	711, 092, 285			16. 00
	01700 SOCIAL SERVICE	711, 072, 203	20, 308		17. 00
171.00	INPATIENT ROUTINE SERVICE COST CENTERS		207 000		1 55
30.00	03000 ADULTS & PEDIATRICS	45, 875, 700	10, 762		30.00
	03100 INTENSIVE CARE UNIT	2, 936, 369	631		31. 00
	03101 NEONATAL INTENSIVE CARE UNIT	28, 413, 389	4, 978		31. 01
	04000 SUBPROVI DER - I PF	0	0		40.00
	04300 NURSERY	7, 227, 294	3, 937		43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	0		44. 00
50. 00	05000 OPERATING ROOM	231, 791, 426	0		50.00
	05100 RECOVERY ROOM	0	O		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 680, 668	O		52.00
	05300 ANESTHESI OLOGY	0	0		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	43, 476, 003	0		54.00
	05401 ULTRA SOUND 05600 RADI OI SOTOPE	8, 976, 492 4, 622, 084	0		54. 01 56. 00
	05700 CT SCAN	4, 022, 004 N	0		57. 00
	05800 MRI	7, 405, 173	0		58. 00
60.00	06000 LABORATORY	52, 078, 653	O		60.00
65.00	06500 RESPI RATORY THERAPY	8, 662, 661	O		65. 00
	06600 PHYSI CAL THERAPY	2, 545, 872	0		66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
	06800 SPEECH PATHOLOGY	0 100 4/1	0		68. 00
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 100, 461 55, 075, 948	0		69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	68, 902, 478	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	83, 213, 280	o		73. 00
74.00	07400 RENAL DIALYSIS	849, 190	0		74. 00
	03950 SLEEP LAB	2, 198, 869	0		76. 00
76. 02	03560 PSYCH SERVICES/EATINT DISORDER	0	0		76. 02
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	2, 706, 505	0		90.00
	09100 EMERGENCY	29, 353, 770	0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	27, 333, 170			92. 00
	OTHER REIMBURSABLE COST CENTERS				1
95.00	09500 AMBULANCE SERVI CES	0	0		95. 00
	SPECIAL PURPOSE COST CENTERS				4
118. 00	. 5 /	711, 092, 285	20, 308		118. 00
100 00	NONREIMBURSABLE COST CENTERS  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 00
	07950 MARKETI NG	0	o		194. 00
	07951 PHYSICIAN RELATIONS	0	o		194. 01
	07952 SENI OR CIRCLE	0	O		194. 02
	07953 WOMENS RESOURCE CENTER	0	0		194. 03
200.00	,				200. 00
201.00		1 400 074	005 242		201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 493, 364	885, 242		202. 00
203. 00		0. 002100	43. 590802		203. 00
204.00		54, 842	3, 384		204. 00
	Part II)				
205. 00		0. 000077	0. 166634		205. 00
			I		1

Heal th Fina	ncial Systems	DUPONT H	OSPI TAL			In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi dei	CCN: 15-0150	Peri	od: 04/01/2018	Worksheet B-1	
					To	03/31/2019	Date/Time Pro 9/3/2019 3:51	
	Cost Center Description		SOCIAL SERV	CE				
		RECORDS &						
		LI BRARY	(TIME SPEN	Γ)				
		(GROSS CHAR						
		GES)						
		16.00	17. 00					
206. 00	NAHE adjustment amount to be allocated							206.00
	(per Wkst. B-2)							
207. 00	NAHE unit cost multiplier (Wkst. D,							207. 00
	Parts III and IV)							

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0150	Peri od: Worksheet C
		From 04/01/2018   Part I
		To 02/21/2010 Doto/Time December d.

Total Cost   Tot					To 03/31/2019	Date/Time Pre 9/3/2019 3:51	pared:
Total Cost   Tot			Title	XVIII	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS   Adj   Disal lowance   Part I   Col. 26   1.00   2.00   3.00   4.00   5.00					Costs		
Part 1, col.	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
1.00   2.00   3.00   4.00   5.00		(from Wkst. B,	Adj.		Di sal I owance		
1.00   2.00   3.00   4.00   5.00		Part I, col.	1				
INPATI ENT ROUTI NE SERVICE COST CENTERS   1,00   2,00   3,00   4,00   5,00		26)					
30.00		1.00	2.00	3.00	4. 00	5. 00	
31.00   03100   INTENSIVE CARE UNIT   3,220,852   3,220,852   3,220,852   3,00   3,20,852   31.00   31.01   03101   NEONATAL INTENSIVE CARE UNIT   6,945,853   6,945,853   0,645,853   31.01   40.00   04000   SUBPROVIDER - IPF   0 0 0 0 0 0   0.40.00   0.0	INPATIENT ROUTINE SERVICE COST CENTERS						
33.10   03101   NERONATAL INTENSIVE CARE UNIT   6, 945, 883   0, 0, 945, 883   3.1 0.1	30. 00 03000 ADULTS & PEDIATRICS	17, 141, 399		17, 141, 399	9 0	17, 141, 399	30.00
40.00   04000   SUBPROVI DER - IPF   0   2,710,953   2,710,953   0   2,710,953   34,300   40.00   04300   NURSERY   2,710,953   2,710,953   0, 2,710,953   34,300   44.00   04400   SKI LLED NURSI NG FACI LITY   0   0   0   0   0   0   0   0   0	31.00 03100 INTENSIVE CARE UNIT	3, 220, 852		3, 220, 852	0	3, 220, 852	31.00
43.00   04300   NIRSERY   2,710,953   2,710,953   0   2,710,953   44.00   04400   SKILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0	31.01 03101 NEONATAL INTENSIVE CARE UNIT	6, 945, 853		6, 945, 853	0	6, 945, 853	31. 01
44. 00	40. 00   04000   SUBPROVI DER - 1 PF	0		(	o	0	40.00
44. 00   04400   SKI LLED NURSING FACILITY	43. 00 04300 NURSERY	2, 710, 953		2, 710, 953	0	2, 710, 953	43.00
50. 00	44.00 04400 SKILLED NURSING FACILITY	0		(	o		44. 00
51. 00   05100   RECOVERY ROOM   Color   Col		<u>'</u>			•		
52.00   05200   DELI VERY ROOM & LABOR ROOM   3,795,875   0   3,795,875   52.00	50. 00 05000 OPERATING ROOM	23, 175, 914		23, 175, 914	1 0	23, 175, 914	50.00
53.00     05200   AMESTHESI OLOGY   0   0   0   0   53.00	51. 00   05100   RECOVERY ROOM	0		(	o	0	51.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   5, 296, 050   5, 296, 050   0   5, 296, 050   54. 00   54. 01   05401   ULTRA SOUND   672, 680   672, 680   0   672, 680   0   56. 00   05600   RADI OI SOTOPE   368, 883   368, 883   0   368, 883   56. 00   57. 00   05700   CT SCAN   0   0   0   0   0   58. 00   05800   MRI   612, 120   0   612, 120   0   612, 120   0   60. 00   06000   LABORATORY   4, 671, 891   4, 671, 891   0   4, 671, 891   0   4, 671, 891   0   647, 602   0   65. 00   06500   RESPI RATORY THERAPY   2, 134, 277   0   2, 134, 277   0   2, 134, 277   0   2, 134, 277   0   66. 00   06600   PHYSI CAL THERAPY   647, 602   0   647, 602   0   647, 602   0   67. 00   06700   OCUPATI ONAL THERAPY   0   0   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   140, 304   140, 304   0   140, 304   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   16, 130, 688   16, 130, 688   0   16, 130, 688   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   16, 130, 688   16, 130, 688   0   16, 130, 688   72. 00   74. 00   07400   RENAL DI ALYSI S   230, 545   230, 545   0   230, 545   0   76. 00   03560   PSYCH SERVI CES/EATI NT DI SORDER   0   0   0   0   0   76. 02   00500   AMBULANCE SERVI CES COST CENTERS   0   0   0   0   79. 00   09000   CLINI C   047, 623   0   0   0   0   70   00   00   00   0	52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 795, 875		3, 795, 875	0	3, 795, 875	52.00
54. 01   05401   ULTRA SOUND   672, 680   672, 680   0 672, 680   54. 01   56. 00   05500   RADI OI SOTOPE   368, 883   368, 883   0 368, 883   0   57. 00   05700   CT SCAN   0   0   0   0   0   58. 00   05800   MRI   612, 120   612, 120   0   61. 00   06000   LABORATORY   4, 671, 891   4, 671, 891   0   4, 671, 891   0   65. 00   06500   RESPI RATORY THERAPY   2, 134, 277   0   2, 134, 277   0   66. 00   06600   PHYSI CAL THERAPY   647, 602   0   647, 602   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   68. 00   06800   SPECCH PATHOLOGY   0   0   0   0   69. 00   06800   SPECCH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   140, 304   140, 304   0   140, 304   69, 00 71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   3, 371, 437   3, 371, 437   0   3, 371, 437   71. 00 72. 00   07200   I MPL DEV. CHARGED TO PATI ENTS   16, 130, 688   16, 130, 688   0   16, 130, 688   72. 00 73. 00   07300   DRUGS CHARGED TO PATI ENTS   8, 630, 099   8, 630, 099   0   8, 630, 099   73. 00 74. 00   07400   RENAL DI ALYSIS   230, 545   0   230, 5	53. 00 05300 ANESTHESI OLOGY	0		(	o	0	53.00
56. 00   05600   RADI OI SOTOPE   368, 883   368, 883   0   368, 883   56. 00   57. 00   5700   CT SCAN   0   0   0   0   57. 00   57. 00   58. 00   05800   MRI   612, 120   6612, 120   0   612, 120   58. 00   60. 00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 296, 050		5, 296, 050	o	5, 296, 050	54.00
57. 00   05700   CT SCAN   0   0   0   0   0   57. 00   58. 00   05800   MRI	54. 01 05401 ULTRA SOUND		l .	672, 680	o	672, 680	54. 01
57. 00   05700   CT SCAN   0   0   0   0   57. 00   58. 00   05800   MRI	56. 00 05600 RADI 0I SOTOPE	368, 883		368, 883	0	368, 883	56.00
60. 00   06000   LABORATORY   4, 671, 891   4, 671, 891   0   4, 671, 891   60. 00   65. 00   06500   RESPI RATORY THERAPY   2, 134, 277   0   2, 134, 277   0   2, 134, 277   0   66. 00   06600   PHYSI CAL THERAPY   647, 602   0   647, 602   0   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   140, 304   140, 304   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   3, 371, 437   3, 371, 437   0   3, 371, 437   72. 00   07200   IMPL   DEV   CHARGED TO PATIENTS   16, 130, 688   16, 130, 688   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   16, 130, 688   16, 130, 688   0   74. 00   07400   RENAL DI ALYSIS   230, 545   230, 545   0   76. 00   03950   SLEEP LAB   640, 911   0   640, 911   0   76. 02   03560   PSYCH   SERVI CES / EATINT DI SORDER   0   0   0   79. 00   09000   CLI NI C   0   0   79. 00   09200   OBSERVATI ON BEDS   (NON-DI STI NCT PART   2, 614, 694   2, 614, 694   2, 614, 694   20. 00   70. 00   09500   AMBULANCE SERVI CES   70. 00   09500   AMBULANCE SERVI CES   70. 00   09500   AMBULANCE SERVI CES   70. 00   09500   Lees   Observati on Beds   2, 614, 694   2, 614, 694   20. 00   70. 00   09100   Lees   Observati on Beds   2, 614, 694   2, 614, 694   2, 614, 694   20. 00   70. 00   00100   Lees   Observati on Beds   2, 614, 694   2, 614, 694   2, 614, 694   20. 00   70. 00   00100   Lees   Observati on Beds   2, 614, 694   2, 614, 694   2, 614, 694   20. 00   70. 00   00100   Lees   Observati on Beds   2, 614, 694   2, 614, 694   2, 614, 694   20. 00   70. 00   00100   Lees   Observati on Beds   2, 614, 694   2, 614, 694   2, 614, 694   20. 00   70. 00   00100   Lees   Observati on Beds   2, 614, 694   2, 614, 694   2, 614, 694   20. 00   70. 00   00100   Lees   Observati on Beds   2, 614, 694   2, 614, 694   20. 00   70. 00   00100   00100   00100   00100   00100   00100   00100   00100   00100   00100   00100   00100   001000   00100   00100   001000   00100   001000   001000   001000	57. 00 05700 CT SCAN	0				0	57.00
65. 00	58. 00 05800 MRI	612, 120		612, 120	o	612, 120	58. 00
65. 00	60. 00 06000 LABORATORY	4, 671, 891		4, 671, 89	0	4, 671, 891	60.00
66. 00	65. 00 06500 RESPIRATORY THERAPY		0				65.00
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   0   67. 00   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   140, 304   140, 304   0   140, 304   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   3, 371, 437   3, 371, 437   0   3, 371, 437   10. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   16, 130, 688   16, 130, 688   0   16, 130, 688   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   8, 630, 099   8, 630, 099   0   8, 630, 099   73. 00   74. 00   07400   RENAL DI ALYSI S   230, 545   230, 545   0   230, 545   74. 00   76. 00   03560   PSYCH SERVI CES/EATI NT DI SORDER   0   0   0   0   76. 02   03560   PSYCH SERVI CE COST CENTERS    90. 00   09000   CLI NI C   647, 623   647, 623   0   647, 623   90. 00   91. 00   09100   EMERGENCY   4, 364, 284   4, 364, 284   0   4, 364, 284   91. 00   92. 00   09500   AMBULANCE SERVI CES    95. 00   09500   AMBULANCE SERVI CES    90. 00   Subtotal (see instructions)   108, 164, 934   0   108, 164, 934   0   108, 164, 934   20. 00    201. 00   Less Observation Beds   2, 614, 694   2, 614, 694   2, 614, 694   2, 614, 694   20. 00    201. 00   CI NI C   C   C   C   C   C   C   C   C   C	66. 00 06600 PHYSI CAL THERAPY						66.00
68. 00	67. 00 06700 OCCUPATIONAL THERAPY	. 0	0	. (	0		67.00
69. 00   06900   ELECTROCARDI OLOGY   140, 304   140, 304   3, 371, 437   3, 371, 437   0 3, 371, 437   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   3, 371, 437   3, 371, 437   0 3, 371, 437   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   16, 130, 688   16, 130, 688   0   16, 130, 688   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   8, 630, 099   8, 630, 099   0   8, 630, 099   73. 00   74. 00   07400   RENAL DI ALYSI S   230, 545   230, 545   230, 545   0   230, 545   74. 00   74. 00   03950   SLEEP LAB   0   640, 911   0   640, 911   0   640, 911   76. 00   0   0   0   0   0   0   0   0   0		0	0	(	0	0	
71. 00		140. 304	_	140. 304	0	140. 304	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 16, 130, 688 16, 130, 688 72. 00 7300 DRUGS CHARGED TO PATIENTS 8, 630, 099 8, 630, 099 0 8, 630, 099 73. 00 74. 00 07400 RENAL DI ALYSI S 230, 545 230, 545 0 230, 545 74. 00 03950 SLEEP LAB 640, 911 0 640, 911 0 640, 911 0 640, 911 0 640, 911 0 640, 911 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						-	
73. 00 07300 DRUGS CHARGED TO PATIENTS	· · · · · · · · · · · · · · · · · · ·						
74. 00   07400   RENAL DI ALYSI S   230, 545   230, 545   0   230, 545   74. 00   76. 00   03950   SLEEP LAB   640, 911   640, 911   0   640, 911   76. 00   0   0   0   0   76. 02   000							
76. 00 03950   SLEEP LAB   640, 911   0 640, 911   76. 00   0 0 0   76. 02   03560   PSYCH SERVICES/EATINT DISORDER   0 0 0 0 0   76. 02   00TPATIENT SERVICE COST CENTERS   0 647, 623   647, 623   0 647, 623   90. 00   91. 00   09100   EMERGENCY   4, 364, 284   4, 364, 284   0 4, 364, 284   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   2, 614, 694   2, 614, 694   2, 614, 694   92. 00   09500   AMBULANCE SERVICES   0 0 0 0 0 0 95. 00   09500   AMBULANCE SERVICES   0 0 09500   AMBULANCE SERVICES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l .				
76. 02 03560 PSYCH SERVICES/EATINT DISORDER 0 0 0 0 0 76. 02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
OUTPATI ENT SERVI CE COST CENTERS   OUTPATI ENT SERVI CE COST CE		1		· ·		-	
90. 00   09000   CLINIC   647, 623   647, 623   0 647, 623   90. 00   9100   EMERGENCY   4, 364, 284   4, 364, 284   0 4, 364, 284   91. 00   9200   OBSERVATI ON BEDS (NON-DISTINCT PART   2, 614, 694   2, 614, 694   2, 614, 694   92. 00   OTHER REIMBURSABLE COST CENTERS   0 0 0 0 0 95. 00   OTHER REIMBURSABLE COST CENTERS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					,		70.02
91. 00   09100   EMERGENCY   4, 364, 284   4, 364, 284   0   4, 364, 284   91. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   2, 614, 694   2, 614, 694   92. 00   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   95. 00   00   00   00   00   00   00   00		647, 623		647, 623	3 0	647, 623	90.00
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   2,614,694   2,614,694   2,614,694   2,614,694   92. 00			l .	· ·		-	
OTHER REIMBURSABLE COST CENTERS           95. 00         09500         AMBULANCE SERVI CES         0         0         0         0         95. 00           200. 00         Subtotal (see instructions)         108, 164, 934         0         108, 164, 934         0         108, 164, 934         200. 00           201. 00         Less Observation Beds         2, 614, 694         2, 614, 694         2, 614, 694         201. 00							
95. 00   9500   AMBULANCE SERVICES   0   0   0   95. 00   200. 00   Subtotal (see instructions)   108, 164, 934   0   108, 164, 934   200. 00   201. 00   Less Observation Beds   2, 614, 694   2, 614, 694   201. 00		2,3,071		2,3,07	-1	2,3,071	12.00
200. 00   Subtotal (see instructions)   108, 164, 934   0   108, 164, 934   0   108, 164, 934   200. 00   201. 00   Less Observation Beds   2, 614, 694   201. 00		0		(	0	0	95. 00
201. 00 Less Observation Beds 2, 614, 694 2, 614, 694 2, 614, 694 201. 00		108, 164, 934	0	108, 164, 934		_	
	202.00 Total (see instructions)	105, 550, 240					

					Γο 03/31/2019	Date/Time Pre 9/3/2019 3:51	pared:
			Title	XVIII	Hospi tal	PPS	P
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	32, 872, 031		32, 872, 03	1		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	2, 936, 369		2, 936, 36			31. 00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	28, 413, 389		28, 413, 38			31. 01
40.00	04000 SUBPROVI DER - I PF	0			)		40. 00
43.00	04300 NURSERY	7, 227, 294		7, 227, 29			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0			O		44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	41, 819, 849	189, 971, 577			0. 000000	
51.00	05100 RECOVERY ROOM	0	0		0. 000000	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 680, 668	0	15, 680, 66		0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0.000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 241, 393	37, 234, 610			0. 000000	
54. 01	05401 ULTRA SOUND	1, 437, 017	7, 539, 475			0. 000000	
56.00	05600 RADI OI SOTOPE	333, 118	4, 288, 966			0. 000000	
57. 00	05700 CT SCAN	0	( 755 044		0.000000	0. 000000	
58.00	05800 MRI	649, 232	6, 755, 941	7, 405, 17		0. 000000	
60.00	06000 LABORATORY	21, 091, 431	30, 987, 222			0.000000	
65.00	06500 RESPI RATORY THERAPY	7, 323, 698	1, 338, 963		1	0. 000000	
66.00	06600 PHYSI CAL THERAPY	2, 162, 735	383, 137			0.000000	
67.00	06700 OCCUPATIONAL THERAPY	0	0		0.000000	0.000000	
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2 170 247	/ 020 114		0.000000	0. 000000 0. 000000	
69. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 170, 347	6, 930, 114			0. 000000	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	11, 650, 352	43, 425, 596			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	28, 452, 534 35, 059, 242	40, 449, 944 48, 154, 038			0. 000000	
74.00	07400 RENAL DIALYSIS	776, 699	72, 491		1	0. 000000	1
76. 00	03950 SLEEP LAB	66, 199	2, 132, 670			0. 000000	
76. 00	03560 PSYCH SERVICES/EATINT DISORDER	00, 199	2, 132, 670		0. 291473	0. 000000	
70.02	OUTPATIENT SERVICE COST CENTERS	U U			0. 000000	0.000000	76.02
90. 00	09000 CLINIC	30, 820	2, 675, 685	2, 706, 50	0. 239284	0. 000000	90.00
91. 00	09100 EMERGENCY	4, 327, 557	25, 026, 213			0. 000000	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 218, 546	11, 785, 123			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	1, 210, 340	11, 700, 120	13, 003, 00	0. 201074	0.000000	72.00
95. 00		ol	0		0. 000000	0. 000000	95. 00
200.00	1	251, 940, 520	459, 151, 765			0.000000	200.00
201.00		201, 710, 320	.07, 101, 700	, , , , , , , , , , , , , , , , , , , ,			201. 00
202.00	1	251, 940, 520	459, 151, 765	711, 092, 28	5		202.00
202.00	1.21 (000 1.101. 401. 0.10)		.07, .0., 700	, , , , , , , , , , , , , , , , , , , ,	-1 1		

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0150	Peri od: Worksheet C From 04/01/2018 Part I To 03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm

			10 03/31/2017	9/3/2019 3: 51 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.0
31.00 03100 INTENSIVE CARE UNIT				31.0
31.01 03101 NEONATAL INTENSIVE CARE UNIT				31.0
10. 00   04000   SUBPROVI DER - I PF				40. 0
3. 00   04300   NURSERY				43. 0
14.00 04400 SKILLED NURSING FACILITY				44. 0
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATING ROOM	0. 099986			50.0
51.00   05100   RECOVERY ROOM	0. 000000			51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 242074			52. 0
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 0
64. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 121815			54.0
54. 01   05401   ULTRA SOUND	0. 074938			54.0
6. 00   05600   RADI 0I SOTOPE	0. 079809			56. 0
77.00 05700 CT SCAN	0. 000000			57. 0
88. 00   05800   MRI	0. 082661			58. 0
00. 00   06000   LABORATORY	0. 089708			60. 0
55. 00 06500 RESPI RATORY THERAPY	0. 246377			65. 0
6. 00 06600 PHYSI CAL THERAPY	0. 254373			66. 0
57. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 0
8. 00  06800 SPEECH PATHOLOGY	0. 000000			68. 0
9. 00 06900 ELECTROCARDI OLOGY	0. 015417			69. 0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 061214			71. 0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234109			72. 0
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 103711			73. 0
4.00   07400   RENAL DIALYSIS	0. 271488			74.0
76. 00   03950   SLEEP LAB	0. 291473			76. 0
76. 02 03560 PSYCH SERVICES/EATINT DISORDER	0. 000000			76. 0
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 239284			90. 0
91. 00   09100   EMERGENCY	0. 148679			91. 0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 201074			92. 0
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 0
200.00 Subtotal (see instructions)				200. 0
201.00 Less Observation Beds				201. 0
202.00 Total (see instructions)				202. 0

Health Financial Systems	DUPONT HOSPITAL	In Lieu of		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0150	Peri od:	Worksheet C	
		From 04/01/2018		

					Го 03/31/2019	Date/Time Pre 9/3/2019 3:51	
			Ti tl	e XIX	Hospi tal	PPS	
			<u>'</u>		Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
30. 00	03000 ADULTS & PEDIATRICS	17, 141, 399		17, 141, 39	9 0	17, 141, 399	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 220, 852		3, 220, 85		3, 220, 852	1
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	6, 945, 853		6, 945, 85		6, 945, 853	1
40. 00	04000 SUBPROVI DER - I PF	0		, , , , , , ,	0	0	1
43. 00	04300 NURSERY	2, 710, 953		2, 710, 95	3	2, 710, 953	
44. 00	04400 SKILLED NURSING FACILITY	0			0	0	ı
00	ANCI LLARY SERVI CE COST CENTERS	·			<u>-</u>		
50.00	05000 OPERATING ROOM	23, 175, 914		23, 175, 91	1 0	23, 175, 914	50.00
51. 00	05100 RECOVERY ROOM	20,170,711		20, ., 0, , .	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 795, 875		3, 795, 87	0	3, 795, 875	
53. 00	05300 ANESTHESI OLOGY	0,770,070		0,770,07		0, 7,0, 0,0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 296, 050		5, 296, 050		5, 296, 050	
54. 01	05401 ULTRA SOUND	672, 680		672, 680		672, 680	
56. 00	05600 RADI OI SOTOPE	368, 883		368, 88		368, 883	1
57. 00	05700 CT SCAN	0		000,000		0	
58. 00	05800 MRI	612, 120		612, 120		612, 120	1
60.00	06000 LABORATORY	4, 671, 891		4, 671, 89		4, 671, 891	
65. 00	06500 RESPIRATORY THERAPY	2, 134, 277	0			2, 134, 277	
66. 00	06600 PHYSI CAL THERAPY	647, 602	0	647, 60		647, 602	
67. 00	06700 OCCUPATI ONAL THERAPY	047,002	0			047,002	67. 00
68. 00	06800 SPEECH PATHOLOGY		0			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	140, 304	O	140, 30		140, 304	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 371, 437		3, 371, 43		3, 371, 437	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16, 130, 688		16, 130, 68		16, 130, 688	
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 630, 099		8, 630, 09		8, 630, 099	
74. 00	07400 RENAL DIALYSIS	230, 545		230, 54		230, 545	1
76. 00	03950 SLEEP LAB	640, 911		640, 91		640, 911	76.00
	03560 PSYCH SERVICES/EATINT DISORDER	040, 911		040, 91		040, 911	1
70.02	OUTPATIENT SERVICES COST CENTERS	l o			J <sub>1</sub> U	U	70.02
90. 00	09000 CLINIC	647, 623		647, 623	3 0	647, 623	90.00
91.00	09100 EMERGENCY	4, 364, 284		4, 364, 28		4, 364, 284	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 614, 694		2, 614, 69		2, 614, 694	
92.00	OTHER REIMBURSABLE COST CENTERS	2,014,094		2,014,09	+	2, 014, 094	92.00
05 00	09500 AMBULANCE SERVICES	0		Ι (	0	0	95. 00
200.00	l l	108, 164, 934	0		-	108, 164, 934	
200.00		2, 614, 694	U	2, 614, 69		2, 614, 694	
201.00	1	105, 550, 240	0				
202.00	Total (see Histinctions)	100, 550, 240	U	100, 550, 240		100, 550, 240	1202.00

03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 32, 872, 031 03000 ADULTS & PEDIATRICS 32, 872, 031 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 936, 369 2, 936, 369 31.00 03101 NEONATAL INTENSIVE CARE UNIT 28, 413, 389 31.01 28, 413, 389 31.01 40.00 04000 SUBPROVI DER - I PF 40.00 04300 NURSERY 43.00 7, 227, 294 7, 227, 294 43.00 44.00 04400 SKILLED NURSING FACILITY 44.00 ANCILLARY SERVICE COST CENTERS 41, 819, 849 50.00 05000 OPERATING ROOM 189, 971, 577 0.099986 0.000000 50.00 231, 791, 426 05100 RECOVERY ROOM 51.00 0.000000 0.000000 51.00 15, 680, 668 15, 680, 668 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.242074 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 43, 476, 003 05400 RADI OLOGY-DI AGNOSTI C 6, 241, 393 0.121815 0.000000 54.00 37, 234, 610 54.00 54.01 05401 ULTRA SOUND 1, 437, 017 7, 539, 475 8, 976, 492 0.074938 0.000000 54.01 05600 RADI OI SOTOPE 4, 288, 966 4, 622, 084 0.079809 0.000000 56.00 56.00 333, 118 57.00 05700 CT SCAN 0.000000 0.000000 57.00 05800 MRI 649, 232 6, 755, 941 7, 405, 173 0.082661 58 00 0.000000 58 00 60.00 06000 LABORATORY 21, 091, 431 30, 987, 222 52, 078, 653 0.089708 0.000000 60.00 06500 RESPIRATORY THERAPY 7, 323, 698 1, 338, 963 8, 662, 661 0. 246377 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 383, 137 2, 545, 872 0. 254373 0.000000 66.00 2, 162, 735 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 C 0 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0.000000 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 2, 170, 347 6, 930, 114 9, 100, 461 0.015417 0.000000 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11, 650, 352 43, 425, 596 55, 075, 948 0.000000 71 00 0.061214 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 28, 452, 534 40, 449, 944 68, 902, 478 0.234109 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 35, 059, 242 48, 154, 038 83, 213, 280 0.103711 0.000000 73.00 74.00 07400 RENAL DIALYSIS 776, 699 72, 491 849, 190 0.271488 0.000000 74.00 03950 SLEEP LAB 0.291473 76.00 66, 199 2, 132, 670 2, 198, 869 0.000000 76.00 76.02 03560 PSYCH SERVICES/EATINT DISORDER 0.000000 0.000000 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 30 820 2, 675, 685 2, 706, 505 0 239284 0.000000 90 00 09100 EMERGENCY 91.00 4, 327, 557 25, 026, 213 29, 353, 770 0.148679 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 218, 546 11, 785, 123 13, 003, 669 0.201074 0.000000 92.00 92.00

251, 940, 520

251, 940, 520

459, 151, 765

459, 151, 765

711, 092, 285

711, 092, 285

95 00

200.00

201.00

202.00

0.000000

0.000000

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

09500 AMBULANCE SERVICES

95 00

200.00

201.00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0150	Peri od: Worksheet C From 04/01/2018 Part I To 03/31/2019 Date/Ti me Prepared: 9/3/2019 3:51 pm

				10 03/31/2019	9/3/2019 3: 51	
			Title XIX	Hospi tal	PPS	
Cost Center Description	n	PPS Inpatient				
		Ratio				
		11. 00				
INPATIENT ROUTINE SERVICE CO	OST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS						30.00
31.00 03100 INTENSIVE CARE UNIT						31.00
31. 01 03101 NEONATAL INTENSIVE CAR	RE UNIT					31.01
40. 00   04000   SUBPROVI DER - I PF						40.00
43. 00   04300   NURSERY						43.00
44.00 04400 SKILLED NURSING FACILI						44.00
ANCILLARY SERVICE COST CENTE	ERS					4
50. 00   05000   OPERATI NG ROOM		0. 099986				50.00
51. 00   05100   RECOVERY ROOM		0. 000000				51.00
52. 00   05200   DELIVERY ROOM & LABOR	ROOM	0. 242074				52.00
53. 00   05300   ANESTHESI OLOGY		0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 121815				54.00
54. 01   05401   ULTRA SOUND		0. 074938				54. 01
56. 00   05600   RADI 0I SOTOPE		0. 079809				56.00
57.00  05700 CT SCAN		0. 000000				57.00
58. 00   05800   MRI		0. 082661				58.00
60. 00   06000   LABORATORY		0. 089708				60.00
65. 00 06500 RESPI RATORY THERAPY		0. 246377				65.00
66. 00 06600 PHYSI CAL THERAPY		0. 254373				66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY		0. 000000				68.00
69. 00   06900   ELECTROCARDI OLOGY		0. 015417				69.00
71.00 07100 MEDICAL SUPPLIES CHARG		0. 061214				71.00
72.00 07200 IMPL. DEV. CHARGED TO		0. 234109				72.00
73.00 07300 DRUGS CHARGED TO PATIE	ENTS	0. 103711				73.00
74.00 07400 RENAL DIALYSIS		0. 271488				74.00
76. 00   03950   SLEEP LAB		0. 291473				76. 00
76. 02 03560 PSYCH SERVICES/EATINT		0. 000000				76. 02
OUTPATIENT SERVICE COST CENT	IERS					٠
90. 00 09000 CLI NI C		0. 239284				90.00
91. 00   09100   EMERGENCY	DI CTINOT DADT	0. 148679				91.00
92. 00   09200   0BSERVATI ON BEDS (NON-		0. 201074				92.00
OTHER REIMBURSABLE COST CENT	I EKS	0.000000				05 00
95. 00 09500 AMBULANCE SERVICES		0. 000000				95. 00
200.00 Subtotal (see instruct	nons)					200.00
201.00 Less Observation Beds	,					201.00
202.00   Total (see instruction	is)					202. 00

Health Financial Systems	DUPONT HOSPITAL			u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO	CHARGE RATIOS NET OF	Provider CCN: 15-0150	Peri od:	Worksheet C
REDUCTIONS FOR MEDICALD ONLY			From 04/01/2018	

KEDOOT	TONG FOR MEDICAL DONE			To	03/31/2019	Date/Time Pre 9/3/2019 3:51	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS	1					
	05000 OPERATING ROOM	23, 175, 914	3, 147, 290	20, 028, 624	0	0	00.00
	05100 RECOVERY ROOM	0	C	0	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	3, 795, 875	18, 600	3, 777, 275	0	0	52. 00
	05300 ANESTHESI OLOGY	0	C	0	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	5, 296, 050	647, 075		0	0	54. 00
	05401 ULTRA SOUND	672, 680	3, 204		0	0	54. 01
	05600 RADI OI SOTOPE	368, 883	2, 399		0	0	56. 00
	05700 CT SCAN	0	C	ή	0	0	57. 00
	05800 MRI	612, 120	117, 593		0	0	58. 00
	06000 LABORATORY	4, 671, 891	157, 624		0	0	60.00
	06500 RESPI RATORY THERAPY	2, 134, 277	11, 033		0	0	65. 00
	06600 PHYSI CAL THERAPY	647, 602	42, 571	605, 031	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	C	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	C	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	140, 304	1, 134		0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 371, 437	29, 698		0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	16, 130, 688	135, 238		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	8, 630, 099	36, 427		0	0	73. 00
	07400 RENAL DIALYSIS	230, 545	824		0	0	74. 00
	03950 SLEEP LAB	640, 911	151, 747	489, 164	0	0	70.00
76. 02	03560 PSYCH SERVICES/EATINT DISORDER	0	C	0	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	647, 623	3, 175		0	0	
	09100 EMERGENCY	4, 364, 284	555, 659		0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 614, 694	508, 788	2, 105, 906	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVI CES	0	C	0	0		70.00
200.00		78, 145, 877	5, 570, 079		0		200. 00
201.00		2, 614, 694	508, 788		0		201. 00
202.00	Total (line 200 minus line 201)	75, 531, 183	5, 061, 291	70, 469, 892	0	0	202. 00

Health Financial Systems	DUPONT HOSP	I TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHAREDUCTIONS FOR MEDICALD ONLY	ARGE RATIOS NET OF	Provider CCN: 15-0150	From 04/01/2018	Worksheet C Part II Date/Time Prepared:

					10 03/31/2019	9/3/2019 3: 51 pm
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description		Total Charges			
			(Worksheet C,			
		Operating Cost			6	
		Reduction	8)	/ col. 7)		
		6.00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	23, 175, 914	231, 791, 426	1		50. 00
51. 00	05100 RECOVERY ROOM	0	C	0.00000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 795, 875	15, 680, 668			52.00
53.00	05300 ANESTHESI OLOGY	0	C	0.00000		53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	5, 296, 050	43, 476, 003	1		54.00
54. 01	05401 ULTRA SOUND	672, 680	8, 976, 492	0. 07493	88	54. 01
56. 00	05600 RADI OI SOTOPE	368, 883	4, 622, 084	0. 07980	)9	56.00
57.00	05700 CT SCAN	0	C			57.00
58.00	05800 MRI	612, 120	7, 405, 173	0. 08266	51	58. 00
60.00	06000 LABORATORY	4, 671, 891	52, 078, 653	0. 08970	)8	60. 00
65.00	06500 RESPI RATORY THERAPY	2, 134, 277	8, 662, 661	0. 24637	77	65. 00
66.00	06600 PHYSI CAL THERAPY	647, 602	2, 545, 872	0. 25437	'3	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	0.00000	00	67. 00
68.00	06800 SPEECH PATHOLOGY	0	C	0.00000	00	68. 00
69.00	06900 ELECTROCARDI OLOGY	140, 304	9, 100, 461	0. 01541	7	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 371, 437	55, 075, 948	0. 06121	4	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 130, 688	68, 902, 478	0. 23410	)9	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 630, 099	83, 213, 280	0. 10371	1	73. 00
74.00	07400 RENAL DIALYSIS	230, 545	849, 190	0. 27148	38	74.00
76.00	03950 SLEEP LAB	640, 911	2, 198, 869	0. 29147	'3	76. 00
76. 02	03560 PSYCH SERVICES/EATINT DISORDER	o	C	0.00000	00	76. 02
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	647, 623	2, 706, 505	0. 23928	34	90.00
91.00	09100 EMERGENCY	4, 364, 284	29, 353, 770	0. 14867	79	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 614, 694	13, 003, 669	0. 20107	74	92. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	C	0.00000	00	95. 00
200.00	Subtotal (sum of lines 50 thru 199)	78, 145, 877	639, 643, 202			200. 00
201.00	Less Observation Beds	2, 614, 694	C	)		201. 00
202.00	Total (line 200 minus line 201)	75, 531, 183	639, 643, 202			202. 00

Health Financial Systems	DUPONT HO	OSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 04/01/2018 To 03/31/2019	Date/Time Pre 9/3/2019 3:51	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)		Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	3, 335, 512	0	3, 335, 51	12, 574	265. 27	30.00
31. 00   INTENSIVE CARE UNIT	472, 918	l e	472, 9			
31.01 NEONATAL INTENSIVE CARE UNIT	739, 678		739, 67	4, 978	148. 59	31. 01
40. 00 SUBPROVI DER - I PF	0	0		0 0	0.00	40.00
43. 00 NURSERY	246, 902		246, 90	3, 937	62. 71	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44. 00
200.00 Total (lines 30 through 199)	4, 795, 010		4, 795, 0°	10 22, 120		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	/ 00	6) 7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7.00				
30. 00 ADULTS & PEDIATRICS	1, 821	483, 057				30.00
31. 00 INTENSIVE CARE UNIT	1, 021	143, 149	•			31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	171	143, 147				31.00
40. 00   SUBPROVI DER - I PF	0	0				40.00
43. 00   NURSERY	0	١				43.00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30 through 199)	2, 012	626, 206				200. 00

Health Financial Systems		DUPONT HO	OSDI TAI		In lie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT A	NCILLARY SERVICE CAPITA		Provider Co		Period: From 04/01/2018 To 03/31/2019	Worksheet D Part II	pared:
				XVIII	Hospi tal	PPS	
Cost Center Desc	cri pti on	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)					
ANOLLI ADV. CEDVI OF COC	T OFNITEDS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COS	I CENTERS	0.447.000	004 704 407	0.0405	5 (77 440	77.000	F0 00
50. 00   05000   OPERATI NG ROOM		3, 147, 290	231, 791, 426			77, 088	
51. 00   05100   RECOVERY ROOM	LABOR ROOM	10 (00	45 (00 ((0	0.00000		0	51.00
52. 00   05200   DELI VERY ROOM &	LABUR RUUM	18, 600	15, 680, 668			21	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNO	OCT I C	(47.075	42 477 002	0. 00000 0. 01488		0	53. 00 54. 00
54. 00   05400   RADI OLOGY-DI AGNO 54. 01   05401   ULTRA SOUND	3110	647, 075				29, 544	54.00
56. 00   05600 RADI 0I SOTOPE		3, 204 2, 399		1		92 68	56.00
57. 00   05700 CT SCAN		2, 399	4,022,004	0.0000		00	57.00
58. 00   05700  CT   SCAN		117, 593	7, 405, 173			2. 898	
60. 00   06000 LABORATORY		157, 624		l .		11, 788	
65. 00   06500   RESPIRATORY THE	DADV	11, 033		1		1, 608	1
66. 00 06600 PHYSI CAL THERAP		42, 571	2, 545, 872			9, 368	1
67. 00 06700 OCCUPATI ONAL THE		42,371	2, 545, 672	0.00000		7, 300	67. 00
68. 00 06800 SPEECH PATHOLOGY		0		0. 00000		0	68.00
69. 00 06900 ELECTROCARDI OLO		1, 134	9, 100, 461			83	
71. 00 07100 MEDICAL SUPPLIES		29, 698				1, 386	
72. 00 07200 I MPL. DEV. CHARG		135, 238				10, 864	
73. 00 07300 DRUGS CHARGED TO		36, 427				2, 932	1
74. 00 07400 RENAL DI ALYSI S	, , , , , , , , , , , , , , , , , , , ,	824					ł
76. 00 03950 SLEEP LAB		151, 747		1		1, 369	
76. 02 03560 PSYCH SERVI CES/I	ATINT DISORDER	0	0	0.00000		0	76. 02

3, 175

555, 659

508, 788

5, 570, 079

2, 706, 505

29, 353, 770

13, 003, 669

639, 643, 202

0.001173

0. 018930

0.039126

826

1, 304, 544 435, 387

31, 569, 608

24, 695

17, 035

191, 210 200. 00

90.00

91.00

92.00 95.00

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

91. 00 09100 EMERGENCY

Health Financial Systems	DUPONT H	OSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER		TS Provider C	<u> </u>	Period: From 04/01/2018 Fo 03/31/2019	Worksheet D Part III	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments		Post-Stepdown Adjustments		All Other Medical Education Cost	
INDATI ENT DOUTINE CEDALCE COCT CENTEDO	1A	1. 00	2A	2. 00	3. 00	
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDI ATRICS   31.00   03100   INTENSI VE CARE UNIT   31.01   03101   NEONATAL   INTENSI VE CARE UNIT   40.00   04000   SUBPROVI DER - IPF   43.00   04300   NURSERY   44.00   04400   SKILLED NURSI NG FACILITY   200.00   Total (Lines 30 through 199)					0 0 0 0 0	31. 00 31. 01 40. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.00
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
30. 00	C	C C C C C C C C C C C C C C C C C C C	12, 57- 63 4, 978 3, 93 (22, 120	0.00 0.00 0.00 0.00 0.00 0.00	191 0 0 0 0	31. 00 31. 01 40. 00 43. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		,			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		J				00.65
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 31. 01   03101   NEONATAL INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF 43. 00   04300   NURSERY						30. 00 31. 00 31. 01 40. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0					44. 00 200. 00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AND	CILLARY SERVICE OTHER PASS Provider CCN: 15-0150	Peri od: Worksheet D
THROUGH COSTS		From 04/01/2018   Part IV

TIROUGH COSTS			Ţ.	o 03/31/2019	Date/Time Pre 9/3/2019 3:51	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATI NG ROOM	0	0	(	0	0	50. 00
51.00   05100   RECOVERY ROOM	0	0	(	0	0	51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	(	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
54.01   05401   ULTRA SOUND	0	0	(	0	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	(	0	0	56. 00
57. 00  05700 CT SCAN	0	0	(	0	0	57. 00
58. 00   05800   MRI	0	0	(	0	0	58. 00
60. 00   06000   LABORATORY	0	0	(	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	(	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73.00
74. 00   07400   RENAL DI ALYSI S	0	0	(	0	0	74.00
76. 00  03950   SLEEP LAB	0	0	(	0	0	76. 00
76. 02 03560 PSYCH SERVICES/EATINT DISORDER	0	0	(	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	C	(	0	0	90.00
91. 00 09100 EMERGENCY	0	Ö	·	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(		0	92.00
OTHER REIMBURSABLE COST CENTERS	•		•	•		1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00   Total (lines 50 through 199)	0	0	) c	0	0	200. 00

APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	DUPONT HO VICE OTHER PASS		F	In Lie Period: From 04/01/2018 To 03/31/2019		pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	0	0	(	231, 791, 426		
51. 00	05100 RECOVERY ROOM	0	0	(	0	0.000000	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	15, 680, 668		
	05300 ANESTHESI OLOGY	0	0	(	0	0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	43, 476, 003		
	05401 ULTRA SOUND	0	0	(	8, 976, 492		
	05600 RADI 0I S0T0PE	0	0	(	4, 622, 084		
	05700 CT SCAN	0	0	(	0	0.000000	
	05800 MRI	0	0	(	7, 405, 173		
60.00	06000 LABORATORY	0	0	(	52, 078, 653	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(	8, 662, 661	0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(	2, 545, 872	0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(	9, 100, 461	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	55, 075, 948	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	68, 902, 478	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	83, 213, 280	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(	849, 190	0.000000	74. 00
76.00	03950 SLEEP LAB	0	0	(	2, 198, 869	0.000000	76. 00
76. 02	03560 PSYCH SERVICES/EATINT DISORDER	0	0	(	0	0.000000	76. 02

0

0

0

0

0

2, 706, 505

29, 353, 770

13, 003, 669

639, 643, 202

0 0

0.000000

0.000000

0.000000

90.00

91.00

92.00 95.00

200.00

91. 00 09100 EMERGENCY

200.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

95. 00 09500 AMBULANCE SERVI CES

lealth Financial Systems	DUPONT HOS				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der C		Peri od: From 04/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 03/31/2019	Date/Time Pre	nared·
				10 00/01/201/	9/3/2019 3: 51	pm pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	T		T			
50. 00   05000   OPERATI NG ROOM	0. 000000	5, 677, 440		0 35, 092, 645	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	17, 878		0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	1, 985, 077		0 6, 520, 486	0	54.00
54.01   05401   ULTRA SOUND	0. 000000	257, 061		0 901, 630	0	54. 01
56. 00   05600   RADI 0I SOTOPE	0. 000000	130, 510		0 1, 114, 585	0	56. 00
57.00  05700 CT SCAN	0. 000000	0		0	0	57.00
58. 00   05800   MRI	0. 000000	182, 463		0 1, 130, 217	0	58. 00
60. 00   06000   LABORATORY	0. 000000	3, 894, 214		0 2, 882, 458	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 262, 260		0 170, 226	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	560, 226		0 26, 329	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	662, 254		0 1, 485, 258	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 571, 117		0 10, 403, 324	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 534, 199		0 10, 014, 761	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 692, 949		0 10, 895, 465	0	73. 00
74.00 07400 RENAL DIALYSIS	0. 000000	381, 363		0 28, 544	0	74.00
76. 00   03950   SLEEP LAB	0. 000000	19, 840		0 287, 794	0	76.00
76. 02 03560 PSYCH SERVICES/EATINT DISORDER	0. 000000	0		0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	826		0 438, 982	0	90.00
91. 00   09100   EMERGENCY	0. 000000	1, 304, 544		0 2, 739, 931	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	435, 387		0 785, 829	0	92.00
OTHER REIMBURSABLE COST CENTERS	· '					1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	1	31, 569, 608	I	0 84, 918, 464	0	200. 00

	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 04/01/2018 To 03/31/2019		pared:
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 099986			0	3, 508, 773	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 242074	. 0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 121815	6, 520, 486		0 0	794, 293	54.00
54.01	05401 ULTRA SOUND	0. 074938	901, 630		0 0	67, 566	54. 01
56.00	05600 RADI OI SOTOPE	0. 079809			0 0	88, 954	56.00
57. 00	05700 CT SCAN	0. 000000			0	· ·	1
58. 00	05800 MRI	0. 082661			0	93, 425	1
60. 00	06000 LABORATORY	0. 089708		1	0 0	258, 580	
65. 00	06500 RESPI RATORY THERAPY	0. 246377			o o	41, 940	1
66. 00	06600 PHYSI CAL THERAPY	0. 254373			0 0	6, 697	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0,077	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	1		o o	0	1
69. 00	06900 ELECTROCARDI OLOGY	0. 015417			0	22, 898	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 061214			0 0	636, 829	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 234109		1	0 0		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 234109			-		
					0 12, 146		
74.00	07400 RENAL DIALYSIS	0. 271488			0	7, 749	
76.00	03950 SLEEP LAB	0. 291473			0	83, 884	1
76. 02	03560 PSYCH SERVI CES/EATINT DISORDER	0. 000000	0		0 0	0	76. 02
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	0. 239284	438, 982	I	ol o	105, 041	90.00
90.00	109100 EMERGENCY	0. 239284					
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 148679			0 0		1
92.00	OTHER REIMBURSABLE COST CENTERS	0. 201074	785, 829		0 0	158, 010	92.00
95. 00	09500 AMBULANCE SERVICES	0. 000000	\		ol		95. 00
200.00		0.000000	84, 918, 464	l .	0 12, 146	9, 756, 535	
200.00			04, 910, 404		0 12, 146		1
201. UC	Only Charges				<u>ا</u> 0		201. 00
202.00			84, 918, 464		0 12, 146	9, 756, 535	202 00
202.00	1 3114 903 (11110 200 11110 201)	1	1 01, 710, 404	ı	12, 140	1 7, 700, 000	1-02.00

Health Financial Systems	DUPONT HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0150	From 04/01/2018	Worksheet D Part V Date/Time Prepared:

				To 03/31/2019	Date/Time Pro 9/3/2019 3:5	epared: 1 pm
		Title	: XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	0	0				50.00
51.00   05100   RECOVERY ROOM	0	0	1			51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	1			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1			54.00
54. 01   05401   ULTRA SOUND	0	0	1			54. 01
56. 00   05600   RADI 01 SOTOPE	0	0	1			56. 00
57. 00   05700   CT   SCAN	0	0	1			57. 00
58. 00   05800   MRI	0	0	1			58. 00
60. 00   06000   LABORATORY	0	0	1			60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	1			65. 00
66. 00   06600   PHYSI CAL THERAPY	0	0	1			66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	1 2/0	1			72. 00
73.00 07300 DRUGS CHARGED TO PATTENTS  74.00 07400 RENAL DIALYSIS	0	1, 260 0	1			73. 00 74. 00
74. 00   07400   RENAL DIALYSIS 76. 00   03950   SLEEP LAB		0				76.00
76. 00   03950   SLEEP LAB 76. 02   03560   PSYCH   SERVI CES/EATINT   DI SORDER		0	1			76. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	U	1			70.02
90. 00 09000 CLINIC	O	0	d			90.00
91. 00   09100   EMERGENCY		0	1			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0	1			92. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>		1			72.00
95. 00 09500 AMBULANCE SERVICES	O					95. 00
200.00 Subtotal (see instructions)		1, 260	,			200. 00
201.00 Less PBP Clinic Lab. Services-Program		1, 200				201. 00
Only Charges						[ 01.00
202.00 Net Charges (line 200 - line 201)	o	1, 260	,			202. 00
						•

Health Financial Systems	DUPONT HO	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 04/01/2018 To 03/31/2019		pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col		Per Diem (col. 3 / col. 4)	
	26)	0.00	2)		5.00	
INDATIONE DOUTING CERVILOR COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 225 542		1 2 225 51	10 10 574	2/5 27	20.00
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT	3, 335, 512 472, 918		3, 335, 51 472, 91			
		l .				
31. 01   NEONATAL INTENSIVE CARE UNIT 40. 00   SUBPROVIDER - IPF	739, 678		739, 67	0 4, 9/8		
43. 00   NURSERY	244 002	0	246, 90	-		
44.00 SKILLED NURSING FACILITY	246, 902		240, 90	0 3, 937	0.00	
200.00 Total (lines 30 through 199)	4, 795, 010		4, 795, 01	٥		200. 00
Cost Center Description	Inpati ent	Inpatient	4, 793, 0	22, 120		200.00
cost center bescription	Program days	Program				
	Frogram days	Capital Cost				
		(col. 5 x col.				
		6)				
	6, 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	2. 22					
30. 00 ADULTS & PEDI ATRI CS	250	66, 318				30.00
31.00 INTENSIVE CARE UNIT	12	8, 994				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	115	17, 088	1			31. 01
40. 00 SUBPROVIDER - IPF	0	0	)			40.00
43. 00 NURSERY	2, 137	134, 011				43.00
44.00 SKILLED NURSING FACILITY	0	l .	)			44. 00
200.00 Total (lines 30 through 199)	2, 514	226, 411				200. 00

		BUBBAT III	2001 711			6.5	
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL		DUPONT HO L COSTS	Provi der C		Period: From 04/01/2018 To 03/31/2019	9/3/2019 3:51	pared:
				e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		T				
	05000 OPERATI NG ROOM	3, 147, 290	231, 791, 426			5, 258	
51. 00	05100 RECOVERY ROOM	0	0	0. 00000		0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	18, 600	15, 680, 668			305	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0. 00000		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	647, 075				1, 550	
54. 01	05401 ULTRA SOUND	3, 204		l .		10	54. 01
56.00	05600 RADI 0I SOTOPE	2, 399	4, 622, 084			2	56. 00
57.00	05700 CT SCAN	0	0	0.00000		0	57. 00
58.00	05800 MRI	117, 593	7, 405, 173			303	58. 00
60.00	06000 LABORATORY	157, 624	52, 078, 653	0. 00302	7 494, 749	1, 498	60.00
65.00	06500 RESPI RATORY THERAPY	11, 033	8, 662, 661	0.00127	4 178, 762	228	65. 00
66.00	06600 PHYSI CAL THERAPY	42, 571	2, 545, 872	0. 01672	2 44, 634	746	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0. 00000	0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 134	9, 100, 461	0. 00012	5 44, 479	6	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 698	55, 075, 948	0.00053	9 306, 352	165	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	135, 238	68, 902, 478	0. 00196	3 453, 182	890	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	36, 427	83, 213, 280	0.00043	8 711, 282	312	73. 00
74.00	07400 RENAL DI ALYSI S	824	849, 190	0.00097	0 24, 266	24	74. 00
76.00	03950 SLEEP LAB	151, 747				107	76. 00
76. 02	03560 PSYCH SERVICES/EATINT DISORDER	0	0	0.00000		0	76. 02
	OUTDATIENT CEDVICE COCT CENTERS				•		1

3, 175

555, 659

508, 788

5, 570, 079

2, 706, 505 29, 353, 770

13, 003, 669

639, 643, 202

0. 001173

0. 018930

0.039126

1, 008

113, 778

24, 371

3, 196, 828

2, 154

954

14, 513 200. 00

90.00

91.00

92.00 95.00

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

95. 00 09500 AMBULANCE SERVI CES

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

91. 00 09100 EMERGENCY

Health Financial Systems	DUPONT H	NSDI TAI		In lie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER		TS Provider C	F	Period: From 04/01/2018 To 03/31/2019	Worksheet D Part III Date/Time Pre 9/3/2019 3:51	
			e XIX	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments	Ü	Post-Stepdown Adjustments		All Other Medical Education Cost	
INPATIENT ROUTINE SERVICE COST CENTERS	1A	1.00	2A	2. 00	3. 00	
30. 00	000000000000000000000000000000000000000	000000000000000000000000000000000000000		0 0 0	0 0 0 0	31. 00 31. 01 40. 00 43. 00 44. 00
200.00   Total (lines 30 through 199)  Cost Center Description	Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days 8.00	200.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	0	0	631 4, 978 ( 3, 937	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	250 12 115 0 2, 137 0 2, 514	31. 00 31. 01 40. 00 43. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 31. 01   03101   NEONATAL INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER - IPF 43. 00   04300   NURSERY	000000000000000000000000000000000000000	1				30. 00 31. 00 31. 01 40. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0					44. 00 200. 00

Health Financial Systems	DUPONT HOSE	PI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0150	Peri od:	Worksheet D
THROUGH COSTS			From 04/01/2018	

Non Physician   Non Physicia		666.6			Т	o 03/31/2019	Date/Time Pre 9/3/2019 3:51	
Anesthetist   Cost   Anesthetist   Cost   Anglustments   Adjustments	-			Ti tI	e XIX	Hospi tal		
Anesthetist   Cost   Anesthetist   Cost   Anglustments   Adjustments		Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
1.00   2A   2.00   3A   3.00				Post-Stepdown		Post-Stepdown		
ANCI LLARY SERVI CE COST CENTERS								
50.00			1.00	2A	2.00	3A	3. 00	
51.00								
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   52.00			0	0	) C	0	0	
53. 00   05300   AMESTHESI OLOGY   0   0   0   0   0   53. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   0   54. 01   05401   ULTRA SOUND   0   0   0   0   0   0   55. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   56. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   57. 00   05700   05700   07500   07500   07500   0   0   0   0   0   58. 00   05800   MRI   0   0   0   0   0   0   0   60. 00   05800   MRI   0   0   0   0   0   0   60. 00   05000   LABORATORY   0   0   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   0   0   60. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   60. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   61. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   62. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   63. 00   06800   SPEECH PATHOLOGY   0   0   0   0   64. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   65. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   76. 02   03560   PSYCH SERVI CES/EATI NT DI SORDER   0   0   0   0   76. 02   03560   PSYCH SERVI CES/EATI NT DI SORDER   0   0   0   0   76. 02   03560   PSYCH SERVI CES/EATI NT DI SORDER   0   0   0   76. 02   09000   OSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0   77. 00   07400   REI MBURSABLE COST CENTERS   77. 00   07500   AMBULANCE SERVI CES	51.00		0	0	) C	0	0	51.00
54. 00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       54. 00         54. 01       05401       ULTRA SOUND       0       0       0       0       0       54. 01         56. 00       05600       ADI OI SOTOPE       0       0       0       0       0       56. 00       0       0       0       0       0       56. 00       0       0       0       0       0       0       57. 00       57. 00       58. 00       0       0       0       0       0       0       0       0       0       0       0       0       0        0       0       0       0       0       57. 00       58. 00       0	52.00		0	0	) c	0	0	52. 00
54. 01   05401   ULTRA SOUND   0   0   0   0   0   0   54. 01     56. 00   05600   RADI OI SOTOPE   0   0   0   0   0   0   56. 00     57. 00   05700   CT SCAN   0   0   0   0   0   0   55. 00     58. 00   05800   MRI   0   0   0   0   0   0   0   58. 00     58. 00   05800   MRI   0   0   0   0   0   0   0   58. 00     60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0     65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   0   0     66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   0     67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0     68. 00   06800   SPECH PATHOLOGY   0   0   0   0   0   0     69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0     69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0     71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0     72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0     74. 00   07400   RENNAL DI ALYSI S   0   0   0   0   0   0     76. 00   03950   SLEEP LAB   0   0   0   0   0   0     76. 00   03950   SLEEP LAB   0   0   0   0   0   0     76. 00   09000   CLI NI C   0   0   0   0   0     90. 00   09000   OBSERVATI NO BEDS (NON-DI STI NCT PART   0   0   0   0   0     90. 00   09000   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0      90. 00   00000   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0      000000   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0      0000000   OTHER REI MBURSABLE COST CENTERS   0   0   0   0      95. 00   09500   AMBULANCE SERVI CES	53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
56. 00   05600   RADI OI SOTOPE   0 0 0 0 0 0 0 56. 00	54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
57. 00   05700   CT SCAN   0   0   0   0   0   0   57. 00   58. 00   05800   MRI   0   0   0   0   0   0   58. 00   06. 00   0   0   0   0   0   58. 00   06. 00   06. 00   0   0   0   0   0   0   0   0   0	54. 01	05401 ULTRA SOUND	0	0	C	0	0	54. 01
58. 00       05800 MRI       0	56.00	05600  RADI OI SOTOPE	0	0	) c	0	0	56. 00
60. 00	57.00	05700  CT SCAN	0	0	) c	0	0	57. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 65. 00 66	58.00		0	0	) c	0	0	58. 00
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   0   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   72. 00   07200   IMPL   DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   76. 00   03950   SLEEP LAB   0   0   0   0   0   76. 00   03560   PSYCH   SERVI CES/EATI NT DI SORDER   0   0   0   0   70. 00   09000   CLI NI C   0   0   0   0   70. 00   09000   CLI NI C   0   0   70. 00   09100   EMERGENCY   0   0   0   0   70. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   70. 00   07500   AMBULANCE SERVI CES	60.00	06000 LABORATORY	0	0	) c	0	0	60.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 76. 00 03950 SLEEP LAB 0 0 0 0 0 0 0 76. 00 76. 02 03560 PSYCH SERVI CES/EATI NT DI SORDER 0 0 0 0 0 0 0 76. 02 0UTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0 0 0 0 0 0 91. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS	65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
68. 00	66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 73. 00 76. 00 03950 SLEEP LAB 0 0 0 0 0 0 0 76. 00 76. 00 03560 PSYCH SERVI CES/EATI NT DI SORDER 0 0 0 0 0 0 0 76. 00 76. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
71. 00	68.00	06800 SPEECH PATHOLOGY	0	0	) c	0	0	68. 00
72. 00	69.00	06900 ELECTROCARDI OLOGY	0	0	) c	0	0	69. 00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	) c	0	0	71. 00
74. 00	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	) c	0	0	72. 00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	) c	0	0	73. 00
76. 02 03560 PSYCH SERVICES/EATINT DISORDER 0 0 0 0 0 0 0 0 76. 02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	74.00	07400 RENAL DIALYSIS	0	0	) c	0	0	74. 00
OUTPATIENT SERVICE COST CENTERS     O	76.00	03950 SLEEP LAB	0	0	) c	0	0	76. 00
90. 00	76. 02		0	C	C	0	0	76. 02
91. 00								
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0   0   0   0   0   0   0   0   0			0	0	C	0	0	90.00
OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES 95. 00			0	0	C	0	0	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00		0		C		0	92. 00
200.00   Total (lines 50 through 199)   0  0  0  0  0 200.00	95.00	09500 AMBULANCE SERVI CES						95. 00
	200.00	Total (lines 50 through 199)	0	0	( c	0	0	200.00

Health Financial Systems	DUPONT HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR' THROUGH COSTS	Y SERVICE OTHER PASS	Provider CO		Period: From 04/01/2018 To 03/31/2019		pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5. 00	6.00	7. 00	8. 00	

		liti	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		,	,	1	,	
50.00   05000   OPERATING ROOM	0	0	0	231, 791, 426		
51.00   05100   RECOVERY ROOM	0	0	0	0	0.000000	
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0	15, 680, 668		1
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0.000000	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0	43, 476, 003		1
54.01   05401   ULTRA SOUND	0	0	C	8, 976, 492	0.000000	54. 01
56. 00   05600   RADI 0I SOTOPE	0	0	C	4, 622, 084	0.000000	56. 00
57.00  05700 CT SCAN	0	0	C	0	0.000000	57. 00
58. 00   05800   MRI	0	0	C	7, 405, 173		
60. 00   06000   LABORATORY	0	0	C	52, 078, 653	0.000000	60.00
65. 00   06500   RESPI RATORY THERAPY	0	0	C	8, 662, 661	0.000000	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0	C	2, 545, 872		
67. 00   06700 OCCUPATI ONAL THERAPY	0	0	C	0	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	C	0	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	9, 100, 461	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	55, 075, 948	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	68, 902, 478	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	83, 213, 280	0.000000	73. 00
74.00 07400 RENAL DIALYSIS	0	0	C	849, 190	0.000000	74.00
76.00 03950 SLEEP LAB	0	0	C	2, 198, 869	0.000000	76. 00
76. 02 03560 PSYCH SERVICES/EATINT DISORDER	0	0	C	0	0.000000	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	2, 706, 505	0.000000	90.00
91. 00   09100   EMERGENCY	0	0	l c	29, 353, 770	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	l c	13, 003, 669	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	0	C	639, 643, 202		200. 00
	•	•	•	•	•	

	Financial Systems	DUPONT HOS	_			u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUG	GH COSTS				From 04/01/2018	Part IV	
					To 03/31/2019	Date/Time Pre 9/3/2019 3:51	
-			Ti +I	e XIX	Hospi tal	PPS	рш
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	oost content beschiptron	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	g	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	·		•			
50.00	05000 OPERATI NG ROOM	0. 000000	387, 244		0 0	0	50. 00
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	256, 798		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	104, 120		0 0	0	54. 00
54. 01	05401 ULTRA SOUND	0. 000000	28, 220		0 0	0	54. 01
56.00	05600 RADI OI SOTOPE	0. 000000	2, 965		0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	0		0 0	0	57. 00
58.00	05800 MRI	0. 000000	19, 068		0 0	0	58. 00
60.00	06000 LABORATORY	0. 000000	494, 749		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	178, 762		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	44, 634		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	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	44, 479		0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	306, 352		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	453, 182		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	711, 282		0	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	24, 266		0 0	0	74. 00
76.00	03950 SLEEP LAB	0. 000000	1, 550		0 0	0	76. 00
76. 02	03560 PSYCH SERVICES/EATINT DISORDER	0. 000000	0		0 0	0	76. 02
	OUTDATI ENT CEDVI CE COCT CENTEDO						i

0. 000000

0.000000

0.000000

1, 008

113, 778 24, 371

3, 196, 828

0 0 0

0

0

0

0

0 91.00

0 92.00 95.00

90.00

0 200. 00

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

91. 00 09100 EMERGENCY

200.00

	rindiciai systems	DUPUNT HO			III LI E	u or Form CW3-	2332-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0150	Peri od: From 04/01/2018 To 03/31/2019	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	9/3/2019 3: 51 PPS	pm
			1111	Charges	HOSPI tai	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	oust defiter beschiptron		Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(000 111011)	
		Part I, col. 9		Subject To	Subject To		
		,		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. 099986	O		0 800, 271	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0	1	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 242074	Ö	1	0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	Ö	1	0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 121815	O	)	0 392, 513	0	54.00
54. 01	05401 ULTRA SOUND	0. 074938	O	)	0 90, 987	0	54. 01
56. 00	05600 RADI OI SOTOPE	0. 079809	Ó	)	0 20, 438	0	56.00
57. 00	05700 CT SCAN	0. 000000	Ó	)	0 0	0	1
58. 00	05800 MRI	0. 082661	Ó	)	0 33, 188	0	1
60.00	06000 LABORATORY	0. 089708	Ó	)	0 346, 396	0	60.00
65. 00	06500 RESPIRATORY THERAPY	0. 246377	Ó	)	0 16, 524	0	1
66.00	06600 PHYSI CAL THERAPY	0. 254373	Ó	)	0 6, 986	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	Ó	)	0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	Ó	,	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	0. 015417	Ó	,	0 77, 612	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 061214	Ó	,	0 96, 853	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234109	Ö	,	0 130, 740	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 103711	Ö	,	0 248, 063	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0. 271488	Ö	,	0 3, 467	0	1
	03950 SLEEP LAB	0. 291473	Ö	,	0 29, 680	0	1
	03560 PSYCH SERVICES/EATINT DISORDER	0. 000000	Ö	,	0 0		
	OUTPATIENT SERVICE COST CENTERS	0.00000	_		<u>-,                                      </u>	_	
90.00	09000 CLI NI C	0. 239284	O		0 20, 011	0	90.00
91.00	09100 EMERGENCY	0. 148679	Ö	1	0 555, 759	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 201074	Ö	1	0 118, 686	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0. 000000	O	)	0		95. 00
200.00	Subtotal (see instructions)		0	1	0 2, 988, 174	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	)	0 2, 988, 174	0	202. 00

Health Financial Systems DUPONT HOSPITAL I	n Lieu of Form CMS-2552-10
	Worksheet D 2018 Part V 2019 Date/Time Prepared:

				To 03/31/2019	Date/Time Pre	
		Title	e XIX	Hospi tal	PPS	<u> </u>
	Cost					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces S	Services Not				
	Subject To	Subject To				
		ed. & Coins.				
		(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	80, 016				50.00
51.00   05100   RECOVERY ROOM	0	0				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	47, 814				54. 00
54. 01   05401   ULTRA SOUND	0	6, 818				54. 01
56. 00   05600   RADI 0I SOTOPE	0	1, 631				56. 00
57.00  05700   CT   SCAN	0	0				57. 00
58. 00   05800   MRI	0	2, 743				58. 00
60. 00   06000   LABORATORY	0	31, 074				60.00
65. 00 06500 RESPIRATORY THERAPY	0	4, 071				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 777				66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 197				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 929				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	30, 607				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	25, 727				73. 00
74. 00   07400   RENAL DI ALYSI S	0	941				74. 00
76. 00   03950   SLEEP LAB	0	8, 651				76. 00
76. 02 03560 PSYCH SERVICES/EATINT DISORDER	0	0				76. 02
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLI NI C	0	4, 788				90.00
91. 00   09100   EMERGENCY	0	82, 630				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	23, 865				92. 00
OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 09500 AMBULANCE SERVI CES	0					95. 00
200.00 Subtotal (see instructions)	0	360, 279				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges		2/0 070				202 00
202.00   Net Charges (line 200 - line 201)	0	360, 279				202. 00

Heal th	Financial Systems DUPONT HOSPI	TAI	In lie	u of Form CMS-2	2552-10
		Provi der CCN: 15-0150	Peri od:	Worksheet D-1	
			From 04/01/2018 To 03/31/2019	Date/Time Pre 9/3/2019 3:51	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DADT I ALL DOUBLES COMPONENTO			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days,	oveluding newborn)		12, 574	1. 00
2. 00	Inpatient days (including private room days and swrig-bed days, Inpatient days (including private room days, excluding swing-be			12, 574	
3.00	Private room days (excluding swing-bed and observation bed days		ivate room days	12, 374	
3.00	do not complete this line.	s). It you have only pr	Tvate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		10, 656	4.00
5.00	Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	0	
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 3	21 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at tel beceliber 3	or or the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 821	9. 00
	newborn days)	9 (	,	.,	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		room days)	0	10.00
	through December 31 of the cost reporting period (see instructi				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		room days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, ent			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	Ü	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year			O	13.00
14. 00	Medically necessary private room days applicable to the Program			0	14. 00
15.00	Total nursery days (title V or XIX only)	(	,	0	
16.00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period	through Docombon 21 of	: +ba aaa+	0.00	19. 00
19.00	Medical d rate for swing-bed NF services applicable to services reporting period	through becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period			0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	ı		17, 141, 399	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	ng period (line 6	0	23. 00
	v line 18)				

	Cost Center Description		
		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)	12, 574	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed days, excluding newborn)	12, 574	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	12, 374	3.00
3.00	do not complete this line.		3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	10, 656	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 821	9. 00
9.00	newborn days)	1,021	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period		10.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	17, 141, 399	1
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
23.00	x line 18)		23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
21.00	7 x 1 ine 19)		21.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	17, 141, 399	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	1
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	17, 141, 399	1
57.00	27 minus line 36)	17, 141, 399	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM I NPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 363. 24	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 482, 460	1
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	DUPONT HO	OSPITAL Provider CCN:	15 0150		eu of Form CMS-2 Worksheet D-1	
COMPU	ATTON OF INPATTENT OPERATING COST		Provider CCN:	F	Period: From 04/01/2018 To 03/31/2019		pared:
		_	Title X\		Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total A Inpatient Days Die	verage Per em (col. 1 - col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42. 00
43. 00	INTENSIVE CARE UNIT	3, 220, 852	631	5, 104. 36	191	974, 933	43. 00
43. 01	NEONATAL INTENSIVE CARE UNIT	6, 945, 853	4, 978	1, 395. 3		· ·	43. 01
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					4, 209, 763	
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)(	see instructions;	)		7, 667, 156	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from W	kst. D, sum	of Parts I and	626, 206	50.00
					6.5	404 040	F4 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (from	WKST. D, SL	ım of Parts II	191, 210	51.00
52. 00	Total Program excludable cost (sum of lines !	50 and 51)				817, 416	52. 00
53. 00	Total Program inpatient operating cost exclud		lated, non-physic	cian anesthe	etist, and	6, 849, 740	53. 00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (line	e 56 minus I	ine 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting ported	anding 1004 unde	ated and com	nounded by the	0.00	58. 00 59. 00
39.00	market basket	oor tring perrou	enaring 1990, upua	ateu anu con	ipourided by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year of					0.00	
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x 60)	), or 1% of	the target		
62. 00	Relief payment (see instructions)	listructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	is through Dece	mber 31 of the co	ost reportir	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the cost	t reporting	period (See	0	65. 00
	instructions)(title XVIII only)					_	
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line 65)	(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 of	the cost rep	orting period	0	67. 00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after L	ecember 31 of the	e cost repor	fing period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	outine costs (	line 67 + line 68	3)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU					ı	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co			t (line 37)			70.00
72. 00	Program routine service cost (line 9 x line 3		THE 70 : TIME 2)				72.00
73. 00	Medically necessary private room cost applica		(line 14 x line	35)			73. 00
74. 00	Total Program general inpatient routine servi						74.00
75. 00	Capital-related cost allocated to inpatient (26. line 45)	routine service	costs (from Work	ksheet B, Pa	irt II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78.00	Inpatient routine service cost (line 74 minus	,					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa		· · · · · · · · · · · · · · · · · · ·	line 78 min	ıs line 79)		79. 00 80. 00
81. 00	Inpatient routine service costs for compa		(1		, ,		81.00
82. 00	Inpatient routine service cost limitation (li		)				82. 00
83.00	Reasonable inpatient routine service costs (s		s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ne)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						1
87. 00	Total observation bed days (see instructions)					1, 918	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		iine 2)			1, 363. 24 2, 614, 694	
07.00	Tobaci varion bed cost (Time of A Time oo) (see	, matructions)				1 2,014,074	1 07.00

Health Financial Systems	DUPONT HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 04/01/2018 To 03/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	3, 335, 512	17, 141, 399	0. 19458	8 2, 614, 694	508, 788	90.00
91.00 Nursing School cost	0	17, 141, 399	0.00000	0 2, 614, 694	0	91. 00
92.00 Allied health cost	0	17, 141, 399	0.00000	0 2, 614, 694	0	92.00
93.00 All other Medical Education	0	17, 141, 399	0. 00000	0 2, 614, 694	0	93. 00

Heal th	Financial Systems DUPONT	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0150	Peri od:	Worksheet D-1	
			From 04/01/2018 To 03/31/2019	Date/Time Pre	pared:
		Title XIX	Hospi tal	9/3/2019 3: 51 PPS	рш
	Cost Center Description	TI LI C XIX	1103pi tai	113	
	0001 00111011 001011			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed			12, 574	1.00
2.00	Inpatient days (including private room days, excluding sw			12, 574	2. 00
3.00	Private room days (excluding swing-bed and observation be	ed days). If you have only pr	ivate room days,	0	3. 00
	do not complete this line.			10 /5/	
4.00	Semi-private room days (excluding swing-bed and observati		04 6 11	10, 656	4. 00
5. 00	Total swing-bed SNF type inpatient days (including privat	re room days) through December	er 31 of the cost	0	5. 00
6. 00	reporting period	o maam daya) aftar Dagambar	21 of the cost	0	6. 00
6.00	Total swing-bed SNF type inpatient days (including privat reporting period (if calendar year, enter 0 on this line)		31 OF the Cost	U	6.00
7. 00	Total swing-bed NF type inpatient days (including private		31 of the cost	0	7. 00
7.00	reporting period	r com days) tri odgi becember	01 01 1110 0031		7.00
8.00	Total swing-bed NF type inpatient days (including private	room davs) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicab		swing-bed and	250	9. 00
	newborn days)	0 .			
10.00	Swing-bed SNF type inpatient days applicable to title XVI		oom days)	0	10. 00
	through December 31 of the cost reporting period (see ins				
11. 00	Swing-bed SNF type inpatient days applicable to title XVI		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar years)		a room dovo)	0	12. 00
12.00	Swing-bed NF type inpatient days applicable to titles V o through December 31 of the cost reporting period	or XIX only (Including privat	e room days)	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V o	or XIX only (including privat	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calend				10.00
14.00	Medically necessary private room days applicable to the P			0	14. 00
15.00	Total nursery days (title V or XIX only)	3 ( 3 3	,	3, 937	15. 00
16.00	Nursery days (title V or XIX only)			2, 137	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to se	ervices through December 31 o	of the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to se	ervices after December 31 of	the cost	0. 00	18. 00
40.00	reporting period			0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to ser	vices through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to ser	wices after December 21 of t	ho cost	0.00	20.00
20.00	reporting period	vices arter becember 31 or i	ile cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruc	etions)		17, 141, 399	21. 00
22. 00	Swing-bed cost applicable to SNF type services through De		ing period (line	0	22.00
22.00	5 x line 17)	esimper e. e. e. e. e. eeet reper .	ing portou (inio	· ·	22.00
23.00	Swing-bed cost applicable to SNF type services after Dece	ember 31 of the cost reportir	g period (line 6	0	23. 00
	x line 18)	·			
24.00	Swing-bed cost applicable to NF type services through Dec	ember 31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after Decem	ber 31 of the cost reporting	period (line 8	0	25. 00
2/ 02	x line 20)			_	24 00
26. 00	Total swing-bed cost (see instructions)	unct (line 21 minus li 2/)		17 141 200	
27. 00	General inpatient routine service cost net of swing-bed c	cost (fine 21 minus fine 26)		17, 141, 399	j 27.00

reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.02 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 13.03 Swing-bed NF type ving NF ving N
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through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost or reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.01 Total swing-bed cost (see instructions)  28.02 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  29.00 Total swing-bed cost (see instructions)
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  Nursery days (title V or XIX only)  SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  0 26.00 Total swing-bed cost (see instructions)
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 period notal general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions)
16.00 Nursery days (title V or XIX only)  SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  0 26.00
SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medicaid rate for swing-bed NF services cost (see instructions) 17, 141, 399 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 0.22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0.23.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0.23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0.25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line
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reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  0.00 19.0  17, 141, 399 21.0  17, 141, 399 21.0  22.0  23.0  24.0  25.0  26.00 Total swing-bed cost (see instructions)
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  0.00 18.0  0.00 19.0  17, 141, 399 21.0  17, 141, 399 21.0  20.00 20.0  17, 141, 399 21.0  21.00 22.0  22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25.00 Total swing-bed cost (see instructions)
reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  0 26.00  20.00 Total swing-bed cost (see instructions)
19.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  0.00 19.00  0.00 20.00  17, 141, 399 21.00  22.00  24.00  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)
reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  0 26.00
20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  0 20.00 2
reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  17, 141, 399 21.00  22.00 22.00  23.00 22.00  24.00 25.00  26.00 Total swing-bed cost (see instructions)
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  17, 141, 399 21.0  22.00 23.00  23.00 24.00  24.00 25.00  26.00 Total swing-bed cost (see instructions)
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23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 0 23.00 24.00 25.00 26.00 Total swing-bed cost (see instructions)
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)
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x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.0
26.00 Total swing-bed cost (see instructions) 0 26.0
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 17,141,399 27.0
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.0
29.00 Private room charges (excluding swing-bed charges) 0 29.0
30.00 Semi-private room charges (excluding swing-bed charges) 0 30.0
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.0
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  0.000000 31.00 0.000 32.00 0.000 32.00 0.000
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 32.0
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 32.0 0.00 33.0 0.00 34.0
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 32.00 0.00 33.00 0.00 33.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 0
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 32.00 0.00 33.00 0.00 32.00 0.00 33.00 0.00 33.00 0.00 36.00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 141, 399) 37.00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 32.00 0.00 33.00 0.00 32.00 0.00 33.00 0.00 33.00 0.00 36.00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 141, 399) 37.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 141, 399) 37.00 Average per diem private room cost differential (line 17, 141, 399) 37.00 Average per diem private room cost differential (line 17, 141, 399)
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 141, 399) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00 per line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 363.24
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 17, 141, 399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  1, 363. 24 39.00 Program general inpatient routine service cost (line 9 x line 38)  340, 810

Proof of Corp. 15-010		Financial Systems	DUPONT HO				u of Form CMS-2	2552-10
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	Fi	om 04/01/2018	Date/Time Pre	
Pass through costs applicable to Program inpatient costs (Prom West D. sum of Parts II and Pass Program experient costs (Prom West D. sum of Parts II and Pass Program experient cost cost of more survived by the program experient cost cost of more survived by the program experient cost cost of more survived by the program experient cost (Prom West D. sum of Parts II and Sp. 200 pass through costs applicable to Program inpatient and II are survived by the program experient costs (Best D. survived Best D. sum of Parts II and Pass Program experient costs (Sum of I ines Sp. 400 pass Pass Program experient costs (Sum of I ines Sp. 400 pass Program experient costs (Sp. 400 p				Title	e XIX	Hospi tal		pm
1.00		Cost Center Description			Diem (col. 1 ÷	Program Days	(col. 3 x col.	
Internsive Care Type Impattient Hospital Units   3,220,852   631   5,104.36   12   61,252   43,00   INTERSIVE CARE UNIT   6,945,853   4,976   1,395,31   118   160,461   43,01   43,			1.00	2.00		4. 00		
INTERSIVE CARE UNIT	42. 00		2, 710, 953	3, 937	688. 58	2, 137	1, 471, 495	42. 00
	43 00		3 220 852	631	5 104 36	12	61 252	43.00
45.00   BURNEL INTENSIVE CARE UNIT   45.00   45.00   47.00								ł
SURGICAL INTERSIVE CABE UNIT								
47.00   OTHER SPECIAL CASE (SPECIFY)   47.00   1.		1						•
1.00		1						•
44, 00   Total Program Inpati ent ancil I ray service cost (West D-3, col. 3, 11ne 200)   445, 072   48 00   74, 00   Total Program Inpati ent costs (com of 11nes 4, 11 through 48) (see Instructions)   2,479, 690   49 00   785. THROUGH COST ADJUSTMENTS   2479, 690   49 00   785. THROUGH COST ADJUSTMENTS   2479, 690   49 00   78   78   78   78   78   78   78		Cost Center Description					1 00	
10.00   Pass through costs applicable to Program inpatient costs (sum of lines 41 through 48)(see instructions)   2.479,600   49.00	48 00	Program inpatient ancillary service cost (Wkg	st D-3 col 3	line 200)				48 00
50.00   Pass through costs applicable to Program Inpatient routine services (from West. D., sum of Parts I and I 14,513 51.00					ns)			•
	F0 00				WI 1 D	6.5.1.1.1	00/ 411	F0 00
1.00   Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II   14, s13   51, 00   240, 924   52, 00   70   70   70   70   70   70   70	50. 00		atient routine	services (Trom	WKST. D, SUM C	or Parts I and	226, 411	50.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and nedical education costs (line 49 minus line 52)	51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fro	om Wkst. D, sur	n of Parts II	14, 513	51. 00
medical education costs (line 49 minus line 52)								1
TARGET ANDUM TAID LIMIT COMPUTATION   55.00   1arget amount per discharge   0.00   55.00   1arget amount per discharge   0.00   55.00   56.00   1arget amount per discharge   0.00   56.00	53. 00		9 1	lated, non-phys	sician anesthet	ist, and	2, 238, 766	53.00
55.00   Target amount per discharge   0.00   55.00   0.50   0.00   55.00   0.		TARGET AMOUNT AND LIMIT COMPUTATION	,					
56.00 Target amount (Tine 54 x Tine 55) 57.00 Brows payment (see instructions) 58.00 Bonus payment (see instructions) 58.00 Bonus payment (see instructions) 59.00 Lesser of Tines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  0.00 Lesser of Tines 53/54 or 55 from prior year cost report, updated by the market basket  0.00 Lesser of Tines 53/54 is less than the lower of Tines 55, 59 or 60 enter the Tesser of 50% of the amount by which operating costs (Tine 53) are less than expected costs (Tines 54 x 60), or 1% of the target amount (Tine 56), otherwise enter zero (see Instructions)  2.00 Relief payment (see instructions) 2.01 All owable Inpatient cost plus incentive payment (see instructions) 2.02 Relief payment (see instructions) 2.03 All owable Inpatient cost plus incentive payment (see instructions) 2.04 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (Tite XVIII only). For CAH (see Instructions) 2.03 Title Wedicare swing-bed SNF inpatient routine costs (Tine 64 plus Tine 65) (Title XVIII only). For CAH (see Instructions) 2.04 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 2.05 Title V or XIX swing-bed NF inpatient routine costs (Tine 64 plus Tine 65) (Title XVIII only). For CAH (see Instructions) 2.06 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 2.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 2.01 Title V or XIX swing-bed NF inpatient routine costs (Tine 64 plus Tine 65) (Title 37) 2.02 Title V or XIX swing-bed NF inpatient routine costs (Tine 64 plus Tine 65) 2.03 Title V or XIX swing-bed NF inpatient routine costs (Tine 64 plus Tine 65) 2.04 Title V or XIX swing-bed NF inpatient routine service cost (Tine 74 in Tine 68) 2.05 Title At Title V or XIX swing-bed NF inpatient Tout								•
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 S8.00 Besser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 linies 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 linies 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 linies 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 linies 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 linies 53/54 or 55 from the lower of lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.00 62.00 lester flowable Inpatient cost plus incentive payment (see instructions) 0.00 63.00 linies of the cost reporting period (see instructions) 1.00 linies 10.00 linies 10.								1
59.00   Lesser of I lines 53/54 or 55 from the cost reporting period ending 19%, updated and compounded by the market basket   0.00   60.00   60.00   10.00   1 line 53/54 is less than the lower of I lines 55/55 by or 60 enter the lesser of 50% of the amount by which operating costs (I line 53) are less than expected costs (I lines 54 x 60), or 1% of the target amount (I line 56), otherwise enter zero (see instructions)   0.63.00   20.00   0.00			ng cost and ta	rget amount (li	ne 56 minus li	ne 53)	_	•
market basket   0.00   60.00				1' 4007				•
0.00   Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   60.00   61.00	59.00		porting period	enaing 1996, up	odated and comp	ounded by the	0.00	59.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 All owable inpatient costs plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) (fine payment)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) (fine 64 plus line 65) (title XVIII only) (fine 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) (fine 12 x line 19) (fine 12 x line 19)  67.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (fine 12 x line 19) (fine 13 x line 20) (fine 14 x line 20) (fine 14 x line 20) (fine 15 x line 20) (fine 16 x line 20) (fine 17 x line 20) (fine 17 x line 20) (fine 18 x line 20) (fine 19 x line 20) (fine 20 x line 20 x l	60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60. 00
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62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 68)  60.00 Total trough special spec				S (Tines 54 x 6	50), or 1% or 1	ine target		
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PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70. 00  71. 00  72. 00  72. 00  73. 00  74. 00  75. 00  76. 00  77. 00  77. 00  78. 00  79. 00  70. 00		(line 13 x line 20)			•	ing ported		
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88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,363.24 88.00	87. 00						1, 918	87. 00
89.00   Observation bed cost (line 87 x line 88) (see instructions)   2,614,694   89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 363. 24	88. 00
	89. 00	Ubservation bed cost (line 87 x line 88) (see	e instructions)			l	2, 614, 694	89. 00

Health Financial Systems	DUPONT HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 04/01/2018 To 03/31/2019		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	3, 335, 512	17, 141, 399	0. 19458	8 2, 614, 694	508, 788	90.00
91.00 Nursing School cost	0	17, 141, 399	0.00000	0 2, 614, 694	0	91. 00
92.00 Allied health cost	0	17, 141, 399	0.00000	0 2, 614, 694	0	92.00
93.00 All other Medical Education	0	17, 141, 399	0. 00000	0 2, 614, 694	0	93. 00

Heal th	Financial Systems	DUPONT HOSPITAL		In Li€	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	Worksheet D-3	
				From 04/01/2018	D-+- /T: D	
				To 03/31/2019	Date/Time Pre 9/3/2019 3:51	
		Ti tle	e XVIII	Hospi tal	PPS	РШ
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	LADATI ENT. DOUTLAGE CEDITION CONT. OFFITEDO		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1	F 20F 014	ı	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			5, 285, 014		30.00
	03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE UNIT			960, 626		31. 00 31. 01
	04000 SUBPROVIDER - IPF			0		40.00
	04300 NURSERY					43. 00
	ANCI LLARY SERVI CE COST CENTERS					43.00
	05000 OPERATI NG ROOM		0. 09998	5, 677, 440	567, 665	50.00
	05100 RECOVERY ROOM		0.00000		0	51.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 24207		4, 328	
	05300 ANESTHESI OLOGY		0.00000			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 12181	5 1, 985, 077	241, 812	54.00
54. 01	05401 ULTRA SOUND		0. 07493	8 257, 061	19, 264	54. 01
56.00	05600 RADI OI SOTOPE		0.07980	130, 510	10, 416	56. 00
	05700 CT SCAN		0.00000	0 0	0	57. 00
	05800 MRI		0. 08266			58. 00
	06000 LABORATORY		0. 08970			
	06500 RESPI RATORY THERAPY		0. 24637			1
	06600 PHYSI CAL THERAPY		0. 25437			
	06700 OCCUPATI ONAL THERAPY		0.00000		0	67. 00
	06800 SPEECH PATHOLOGY		0.00000		0	68. 00
	06900 ELECTROCARDI OLOGY		0. 01541			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 06121			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 23410			
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0. 10371 0. 27148			
	07400 RENAL DIALYSIS 03950 SLEEP LAB		0. 27148			
	03560 PSYCH SERVICES/EATINT DISORDER		0. 29147			1
	OUTPATIENT SERVICE COST CENTERS		0.00000	0	1 0	70.02
	09000 CLINIC		0, 23928	826	198	90.00
	09100 EMERGENCY		0. 14867			
71.00	and a personal transfer and the property of th			.,,	1 12, 200	1

0. 201074

31, 569, 608

31, 569, 608

435, 387

4, 209, 763 200. 00 201. 00

92. 00

95.00

202. 00

87, 545

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

95. 00 09500 AMBULANCE SERVICES

200. 00 201. 00

202.00

Health Financial Systems	DUPONT HOSPI	ΤΛΙ		Inlia	u of Form CMS-2	DEED 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider (	CN: 15-0150	Peri od:	Worksheet D-3	
				From 04/01/2018		
				To 03/31/2019	Date/Time Pre	pared:
					Date/Time Prep 9/3/2019 3:51	pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				·	2)	
			1.00	2. 00	3. 00	
INDATIENT POLITIME SERVICE COST CENTERS			•			

	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			555, 887		30.00
31.00   03100   I NTENSI VE CARE UNI T			34, 918		31. 00
31.01 O3101 NEONATAL INTENSIVE CARE UNIT			1, 267, 824		31. 01
40. 00   04000   SUBPROVI DER - 1 PF			0		40.00
43. 00 04300 NURSERY			238, 291		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00   05000   OPERATI NG ROOM		0. 099986	387, 244	38, 719	50.00
51.00   05100   RECOVERY ROOM		0.000000	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 242074	256, 798	62, 164	52.00
53. 00   05300   ANESTHESI OLOGY		0.000000	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 121815	104, 120	12, 683	54.00
54. 01   05401   ULTRA SOUND		0. 074938	28, 220	2, 115	54. 01
56. 00   05600   RADI 0I SOTOPE		0. 079809	2, 965	237	56.00
57. 00   05700   CT   SCAN		0.000000	0	0	57.00
58. 00   05800   MRI		0. 082661	19, 068	1, 576	58. 00
60. 00   06000   LABORATORY		0. 089708	494, 749	44, 383	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 246377	178, 762	44, 043	65.00
66. 00   06600 PHYSI CAL THERAPY		0. 254373	44, 634	11, 354	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 000000	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 000000	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 015417	44, 479	686	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 061214	306, 352	18, 753	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 234109	453, 182	106, 094	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 103711	711, 282	73, 768	73.00
74. 00   07400   RENAL DIALYSIS		0. 271488	24, 266	6, 588	74.00
76. 00 03950 SLEEP LAB		0. 291473	1, 550	452	76. 00
76. 02 03560 PSYCH SERVI CES/EATINT DI SORDER		0. 000000	0	0	76. 02
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 239284	1, 008	241	90.00
91. 00 09100 EMERGENCY		0. 148679	113, 778	16, 916	91. 00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART		0. 201074	24, 371	4, 900	92.00
OTHER REIMBURSABLE COST CENTERS			,	,	
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 196, 828	445, 672	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)	,		3, 196, 828		202. 00
		1	2,, 020		

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: Worksheet E From 04/01/2018 Part A To 03/31/2019 Date/Time Prepared: 9/3/2019 3:51 pm

PART A   IMPATENT HIGHERAL STRUCTS HIDDER 1995   1.00			T: +1 o V/////	Heeni tel	9/3/2019 3: 51	pm
ART A - INPATIENT HOSPITAL SERVICES LINGER IPPS			II LIE XVIII	ноѕрі таі	PPS	
DRC Amounts other than outlier payments for discharges occurring prior to October 1 (see   2,005,007   1.01					1. 00	
1.00   DRG amounts other than outlier payments for discharges occurring on or after October 1 (see   2,095.967   1.01	1 00					1 00
1.02   DRG amounts other than outlier payments for discharges occurring on or after October 1 (see   2,012.743   1.02		DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see		
1.03   10.03	1. 02	DRG amounts other than outlier payments for discharges occurri	ng on or after October	l (see	2, 012, 743	1. 02
1.04   Oktober 1 (see instructions)	1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring p	orior to October	0	1. 03
2.01   OutFiler responsible for discharges for Model 4 BPCI (see Instructions)   0 2.01	1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring o	on or after	0	1. 04
Managed Care Simulated Payments   0   3.00		, ,				
Bed days available divided by number of days in the cost reporting period (see instructions)   125.75   4.00		Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions)   0.00   6.00		9	ting period (see instru	ctions)	- 1	
or before 12/31/1996, (see instructions)  1. 00   MA Section 427 eduction amount to the life cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1)	5. 00		recent cost reporting	period ending on	0.00	5. 00
new programs in accordance with 42 CFR 413. 79(e)   7.00   MACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost cost report straddles July 1, 2011 then see instructions   7.01		or before 12/31/1996. (see instructions)				
ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(1)(8)(2) if the cost report straddles July 1, 2011 then see instructions.   Adjustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).   An amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.   An amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions)   An office of the structions of the count for all opathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   TEE count for all opathic and osteopathic programs in the current year from your records   0.00   11.00   TEE count for residents in dental and podiatric programs.   0.00   12.00		new programs in accordance with 42 CFR 413.79(e)		.		
Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.79(c).2(iv). d4 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA § 5503 reduction amount to the IME cap as specified under				
8. 01   The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions.   8. 01	8. 00	Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7			0. 00	8. 00
8. 02   The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slo	ots under § 5503 of the A	ACA. If the cost	0. 00	8. 01
9.00   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see   0.00   9.00   10.00   FTE count for all opathic and osteopathic programs in the current year from your records   0.00   10.00   FTE count for residents in dental and podiatric programs.   0.00   12.00   12.00   13.00   Total all owable FTE (see instructions)   0.00   13.00   13.00   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   14.00   150   15.00	8. 02	The amount of increase if the hospital was awarded FTE cap slo	ots from a closed teachi	ng hospital	0. 00	8. 02
10.00   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.00   FTE count for residents in dental and podiatric programs.   0.00   11.00   12.00   12.00   13.00   15.00   15.00   15.00   15.00   16.00   16.00   16.00   17.00   16.00	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8, 8,01 and 8,02) (9	see	0. 00	9. 00
13.00   Total all owable FTE count for the prior year.   0.00   13.00   14.00   Total all owable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero.   0.00   14.00	11. 00	FTE count for residents in dental and podiatric programs.	ent year from your record	ds	0. 00	11. 00
14.00		· · · · · · · · · · · · · · · · · · ·				
15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16.00   Adjustment for residents in initial years of the program   0.00   16.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjustment for residents displaced by program or hospital closure   0.00   17.00   18.00   Adjusted rolling average FTE count   0.000   18.00   19.00		Total allowable FTE count for the penultimate year if that yea	ended on or after Sep	tember 30, 1997,		
17. 00       Adjustment for residents displaced by program or hospital closure       0.00       17. 00         18. 00       Adjusted rolling average FTE count       0.00       18. 00         19. 00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19. 00         20. 00       Prior year resident to bed ratio (see instructions)       0.000000       20. 00         21. 00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21. 00         22. 00       IME payment adjustment (see instructions)       0.22. 00         22. 01       IME payment adjustment - Managed Care (see instructions)       0.22. 00         23. 00       Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA         23. 00       IME FTE Resident Count Over Cap (see instructions)       0.00         24. 00       IME FTE Resident Count Over Cap (see instructions)       0.00         25. 00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00         26. 00       Resident to bed ratio (divide line 25 by line 4)       0.000000         27. 00       IME payments adjustment factor. (see instructions)       0.000000         28. 01       IME add-on adjustment amount (see instructions)       0.000000         28. 01       IME add-on adjustme		Sum of lines 12 through 14 divided by 3.				
18.00       Adjusted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (line 18 divided by line 4).       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.22.00         1 ME payment adjustment - Managed Care (see instructions)       0.22.01         1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00         23.00       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00       23.00         (f)(1)(iv)(c).       0.1       0.00       24.00       25.00       16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00       25.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment amount (see instructions)       0.000000       27.00         28.01       IME add-on adjustment amount (see instructions)       0.28						
19.00 Current year resident to bed ratio (line 18 divided by line 4). 20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 25.00 IME FTE Resident Count Over Cap (see instructions) 26.00 IME FTE Resident Count Over Cap (see instructions) 27.00 IME payment adjustment factor. (see instructions) 28.00 IME payment adjustment factor. (see instructions) 29.00 IME payment sadjustment factor. (see instructions) 20.00 IME payments adjustment amount (see instructions) 20.00 IME add-on adjustment amount (see instructions) 20.00 IME add-on adjustment amount (see instructions) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 22 and 28) 20.00 IME payment (sum of lines 24 see instructions) 20.00 IME payment (sum of li			sure			
20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Enter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adjustment (see instructions)       0.22.00         1ME payment adjustment - Managed Care (see instructions)       0.22.01         Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA       0.00         23.00       (f) (1) (iv) (C).       0.00         24.00       IME FTE Resident Count Over Cap (see instructions)       0.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)       0.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000         27.00       IME add-on adjustment factor. (see instructions)       0.000000         28.01       IME add-on adjustment amount (see instructions)       0.000000         29.00       Total IME payment (sum of lines 22 and 28)       0.29.00         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.00000         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.00000         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.000000         29.01		,				
21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  22.01 IME payment adjustment - Managed Care (see instructions)  1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.01 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  Allowable disproportionate share percentage (see instructions)  30.00 Allowable disproportionate share percentage (see instructions)  21.00 2.20 0  22.01 1ME payment (see instructions)  22.01 0.00 0.00 0.00 0.00 0.00 0.00 0.00		· · · · · · · · · · · · · · · · · · ·	•			
22.00 IME payment adjustment (see instructions)  1 IME payment adjustment - Managed Care (see instructions)  1 IME payment adjustment - Managed Care (see instructions)  2 IME payment adjustment - Managed Care (see instructions)  2 IME FTE Resident Count Over Cap (see instructions)  2 IME FTE Resident Count Over Cap (see instructions)  2 IME FTE Resident Count Over Cap (see instructions)  2 IME FTE Resident Count Over Cap (see instructions)  2 IME FTE Resident Count Over Cap (see instructions)  2 IME FTE Resident Count Over Cap (see instructions)  2 IME payment adjustment on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  3 IME payments adjustment factor. (see instructions)  3 IME payments adjustment factor. (see instructions)  3 IME add-on adjustment amount (see instructions)  3 IME add-on adjustment amount (see instructions)  4 IME add-on adjustment amount - Managed Care (see instructions)  5 IME payment (sum of lines 22 and 28)  5 IME payment (sum of lines 22 and 28)  6 IME payment - Managed Care (sum of lines 22.01 and 28.01)  7 IME payment - Managed Care (sum of lines 22.01 and 28.01)  8 IME payment - Managed Care (sum of lines 22.01 and 28.01)  8 IME payment - Managed Care (sum of lines 22.01 and 28.01)  9 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  10 IME payment - Managed Care (sum of lines 22.01 and 28.01)  11 IME payment - Managed Care (sum of lines 22.01 and 28.01)  12 IME payment - Managed Care (sum of lines 22.01 and 28.01)  13 IME payment - Managed Care (sum of lines		· · · · · · · · · · · · · · · · · · ·				
22. 01   IME payment adjustment - Managed Care (see instructions)   0   1ndi rect Medical Education Adjustment for the Add-on for § 422 of the MMA   23. 00   Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23. 00   (f) (1) (iv) (C)   .     0.00   24. 00   IME FTE Resident Count Over Cap (see instructions)   0.00   24. 00   25. 00   If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see   0.00   25. 00   instructions)   0.000000   26. 00   Resident to bed ratio (divide line 25 by line 4)   0.000000   27. 00   IME payments adjustment factor. (see instructions)   0.000000   27. 00   28. 00   IME add-on adjustment amount (see instructions)   0.000000   28. 00   29. 01   IME payment (sum of lines 22 and 28)   0.00   29. 01   Total IME payment (sum of lines 22 and 28)   0.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000					0	22. 00
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105   0.00   23.00   (f)(1)(iv)(c).	22. 01				0	22. 01
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.00 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.00 IME add-on adjustment amount - Managed Care (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 32.00 IME add-on adjustment amount (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions)	23. 00	Number of additional allopathic and osteopathic IME FTE reside		FR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  0.00 25.00 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  31.00 Allowable disproportionate share percentage (see instructions)  32.00 Sum of lines 30 and 31  33.00	24.00				0.00	24.00
26.00       Resident to bed ratio (divide line 25 by line 4)       0.000000       26.00         27.00       IME payments adjustment factor. (see instructions)       0.000000       27.00         28.00       IME add-on adjustment amount (see instructions)       0       28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0       28.01         29.00       Total IME payment (sum of lines 22 and 28)       0       29.00         29.01       Disproportionate Share Adjustment       0       29.01         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       3.59       30.00         31.00       Percentage of Medicaid patient days (see instructions)       32.49       31.00         32.00       Allowable disproportionate share percentage (see instructions)       18.98       33.00		If the amount on line 24 is greater than -O-, then enter the I	ower of line 23 or line	24 (see		
27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 04 31. 00  33. 00 Allowable disproportionate share percentage (see instructions)  34. 00  35. 00  36. 08  37. 00  38. 00  39. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00	26. 00				0. 000000	26. 00
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30.00 Sum of lines 30 and 31  30.00 Allowable disproportionate share percentage (see instructions)						
28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 49 31. 00  33. 00 Allowable disproportionate share percentage (see instructions)  33. 00 Allowable disproportionate share percentage (see instructions)		· · · · · · · · · · · · · · · · · · ·				
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 32.49 31.00 Percentage of Medicaid patient days (see instructions) 32.49 31.00 32.00 Sum of lines 30 and 31 36.08 32.00 Allowable disproportionate share percentage (see instructions) 18.98 33.00		· · · · · · · · · · · · · · · · · · ·				
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Sum of lines 30 and 31  33. 00 Allowable disproportionate share percentage (see instructions)  30. 00 Percentage of Medicaid patient days (see instructions)  31. 00 Percentage of Medicaid patient days (see instructions)  32. 00 Percentage of Medicaid patient days (see instructions)  33. 00 Percentage of Medicaid patient days (see instructions)  34. 00 Percentage of Medicaid patient days (see instructions)  35. 00 Percentage of Medicaid patient days (see instructions)  36. 08 Percentage of Medicaid patient days (see instructions)  37. 00 Percentage of Medicaid patient days (see instructions)  38. 00 Percentage of Medicaid patient days (see instructions)						
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Percentage of SSI recipient patient days (see instructions) 32.49 31.00 32.00 33.00 32.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.01	)		0	
31.00Percentage of Medicaid patient days (see instructions)32.4931.0032.00Sum of lines 30 and 3136.0832.0033.00Allowable disproportionate share percentage (see instructions)18.9833.00	30.00	Percentage of SSI recipient patient days to Medicare Part A pa	itient days (see instruc	tions)	3. 59	30. 00
32.00 Sum of Lines 30 and 31 36.08 32.00 33.00 Allowable disproportionate share percentage (see instructions) 18.98 33.00			3 (2.2.2. 2.2.2.2.	´		
34.00   Disproportionate share adjustment (see instructions)   194,959   34.00						
	34. 00	Disproportionate share adjustment (see instructions)			194, 959	34.00

Heal th	Financial Systems DUPONT H	OSPI TAL	In Li€	eu of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0150	Peri od: From 04/01/2018 To 03/31/2019	Worksheet E Part A	pared:
	<u> </u>	Title XVIII	Hospi tal Pri or to 10/1 1.00	PPS 0n/After 10/1 2.00	
	Uncompensated Care Adjustment				
35. 00 35. 01 35. 02	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, er instructions)	nter zero on this line) (s	0. 000000000 ee 1, 007, 408	0. 000000000	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35	5. 03)	505, 084 897, 525		35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I excludir 652, 682, 683, 684 and 685 (see instructions)		ugh 46)		40. 00
	1902/ 902/ 903/ 907 and 900 (900 more dott one)		Before 1/1	On/After 1/1	
41 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	692 694 an 695 (soo	1.00	1. 01	41.00
41. 00	instructions) Total ESRD Medicare covered and paid discharges excluding M	•			
42. 00 43. 00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)		0. 00 e 0		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		44. 00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line	*	0.00		46. 00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	, small rural hospitals	5, 690, 400 0		47. 00 48. 00
	only. (See That detrois)			Amount 1.00	
	Total payment for inpatient operating costs (see instruction Payment for inpatient program capital (from Wkst. L., Pt. In Exception payment for inpatient program capital (Wkst. L., Pt. In Exception payment for inpatient program capital (Wkst. L., Pt. In Incect graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment  Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)  Primary payer payments  Total amount payable for program beneficiaries (line 59 min Deductibles billed to program beneficiaries  Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)  Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratic SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)  HNPB payment adjustment amount (see instructions)  HNPB payment adjustment amount (see instructions)	and Pt. II, as applicable Pt. III, see instructions) line 49 see instructions) e 69) ntructions) . III, column 9, lines 30 t. IV, col. 11 line 200) nus line 60) or applicable to MS-DRGs (6). (For SCH see instructions) enstruction) onstruction)	through 35). see instructions)	5, 690, 400 436, 428 0 0 0 0 0 0 0 0 0 0 6, 126, 828 519, 184 7, 071 50, 626 32, 907 10, 218 5, 633, 480 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 67. 00 68. 00 70. 00 70. 50 70. 88 70. 89 70. 90 70. 92 70. 93

		0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 96
70 07	the corresponding federal year for the period prior to 10/1)	0	0	70 07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	U	0	70. 97
70. 98	Low Volume Payment-3		0	70. 98
70. 99	HAC adjustment amount (see instructions)		l o	1
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5, 617, 756	71.00
71. 01	Sequestration adjustment (see instructions)		112, 355	71. 01
71. 02	Demonstration payment adjustment amount after sequestration		0	
72.00	Interim payments		5, 330, 143	
73.00	Tentative settlement (for contractor use only)		0	
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		175, 258	74. 00
75. 00	Protested amounts (nonallowable cost report items) in accordance with		413, 848	75.00
73.00	CMS Pub. 15-2, chapter 1, §115.2		413, 040	75.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)			İ
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
	plus 2.04 (see instructions)			
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	
94. 00 95. 00	The rate used to calculate the time value of money (see instructions)		0.00	
96. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions)		0	
70.00	Trille value of money for capital related expenses (see firstructions)	Prior to 10/1	On/After 10/1	70.00
		1. 00	2. 00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
	HVBP adjustment factor (see instructions)	0. 000000000		
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
400.00	HRR Adjustment for HSP Bonus Payment	0.0000	0.0000	1400 00
	HRR adjustment factor (see instructions)	0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment		0	104.00
200 00	Is this the first year of the current 5-year demonstration period under the 21s	+		200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement	<u> </u>		1
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
	Medicare discharges (see instructions)			202. 00
203.00	Case-mix adjustment factor (see instructions)			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the	current 5-year demonst	tration	
	peri od)			
204 00				204 00
	Medicare target amount			
205.00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204)			205. 00
205.00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)			205. 00
205. 00 206. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement			205. 00 206. 00
205. 00 206. 00 207. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)			205. 00 206. 00 207. 00
205. 00 206. 00 207. 00 208. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)			205. 00 206. 00 207. 00 208. 00
205. 00 206. 00 207. 00 208. 00 209. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			205. 00 206. 00 207. 00 208. 00 209. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00
205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	ent)		204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00 218. 00

 
 Heal th Financial
 Systems
 DUPONT HODITION

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT
 Provider CCN: 15-0150

				'	0 03/31/2019	9/3/2019 3:51	
			Title	XVIII	Hospi tal	PPS	
	·	Wkst. E, Pt.	Amt. from	Period to		Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)	0.00	0.00	4.00	
1 00	DDC	0	1.00	2. 00	3. 00	4. 00	1 00
1.00	DRG amounts other than outlier payments	1. 00 1. 01	2, 095, 967	2, 095, 967	7	2 005 047	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2, 095, 967	2, 095, 96		2, 095, 967	1. 01
1. 02	DRG amounts other than outlier payments for	1. 02	2, 012, 743		2, 012, 743	2, 012, 743	1. 02
1.02	di scharges occurring on or after October 1	1.02	2,012,743		2,012,743	2,012,743	1.02
1. 03	DRG for Federal specific operating payment	1. 03	0			0	1. 03
	for Model 4 BPCI occurring prior to October		_			_	
	1						
1.04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2. 00	489, 206	185, 048	304, 158	489, 206	2. 00
0.01	instructions)	0.00		,			0.04
2. 01	Outlier payments for discharges for Model 4	2. 02	0	(	0	0	2. 01
3.00	BPCI Operating outlier reconciliation	2. 01	0	(	0	0	3. 00
4.00	Managed care simulated payments	3. 00	0			0	4. 00
4.00	Indirect Medical Education Adjustment	3.00	0		0	0	4.00
5. 00	Amount from Worksheet E, Part A, Line 21	21.00	0. 000000	0. 000000	0.00000		5. 00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	0		0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0		0	0	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	instructions)						
8.00	IME adjustment (see instructions)	28.00	0	(	0	0	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0		U	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	_	,	0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0			0	9. 01
7. 01	lines 6.01 and 8.01)	27.01		`		O	7.01
	Disproportionate Share Adjustment	l	ļ.				
10.00	Allowable disproportionate share percentage	33.00	0. 1898	0. 1898	0. 1898		10.00
	(see instructions)						
11. 00	Di sproporti onate share adjustment (see	34.00	194, 959	99, 454	95, 505	194, 959	11. 00
	instructions)						
11. 01	Uncompensated care payments	36.00	897, 525	505, 084	392, 441	897, 525	11. 01
12.00	Additional payment for high percentage of ESF Total ESRD additional payment (see	46.00				0	12.00
12. 00	instructions)	46.00	0	(	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	5, 690, 400	2, 885, 553	2, 804, 847	5, 690, 400	13. 00
14. 00	Hospital specific payments (completed by SCH		0, 070, 400	2,000,000	2,004,047	0, 070, 400	14. 00
11.00	and MDH, small rural hospitals only.) (see	10.00	Ĭ	· `	1	o l	11.00
	instructions)						
15.00	Total payment for inpatient operating costs	49. 00	5, 690, 400	2, 885, 553	2, 804, 847	5, 690, 400	15. 00
	(see instructions)						
16. 00	Payment for inpatient program capital (from	50.00	436, 428	265, 624	170, 804	436, 428	16. 00
	Wkst. L, Pt. I, if applicable)						
17. 00	Special add-on payments for new technologies	54. 00	0	(	0	0	
17. 01	Net organ acquisition cost						17. 01
17. 02	Credits received from manufacturers for	68. 00	0		0	0	17. 02
10 00	replaced devices for applicable MS-DRGs	02.00	0	(	0	_	10 00
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00			0 ار	0	18. 00
19 00	SUBTOTAL			3, 151, 177	2, 975, 651	6, 126, 828	19, 00
	1	ı	ı	3, 101, 17	2, 7, 5, 551	5, 125, 526	

Health Financial Systems	DUPONT HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider CO	F	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part A Exhibi Date/Time Pre 9/3/2019 3:51	pared:
		Title	: XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	330, 117	168, 447	161, 670	330, 117	20. 00
20 01 Model 4 PDCL Capital DDC athor than outlier	1 01	0	(	) 0	l	20 01

			Title	XVIII	Hospi tal	PPS	
	·	Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	330, 117	168, 447	161, 670	330, 117	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	
21. 00	Capital DRG outlier payments	2.00	81, 288	84, 409	-3, 121	81, 288	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0758	0. 0758	0. 0758		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	25, 023	12, 768	12, 255	25, 023	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	436, 428	265, 624	170, 804	436, 428	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-12, 470	-16, 774	4, 304	-12, 470	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-3, 254	-839	-2, 415	-3, 254	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1. 00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		0	0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	DUPONT HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0150	Peri od: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared:

		10 03/31/2019	9/3/2019 3: 51	
-		Title XVIII Hospital	PPS	
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1	
1.00	Medical and other services (see instructions)	+:>	1, 260	
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)	9, 756, 535	1
3. 00 4. 00	OPPS payments Outlier payment (see instructions)		8, 408, 382 118, 367	•
4. 00	Outlier reconciliation amount (see instructions)		0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)	0.000	1
6.00	Line 2 times line 5		0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7. 00
8.00	Transitional corridor payment (see instructions)		0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200	0	
10. 00	Organ acquisitions		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		1, 260	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
12. 00	Reasonable charges Ancillary service charges		12, 146	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)	12, 140	1
14. 00	Total reasonable charges (sum of lines 12 and 13)	1110 07)	12, 146	1
	Customary charges		.=,	
15.00	Aggregate amount actually collected from patients liable for patients and actually collected from patients liable for patients.	payment for services on a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for	r payment for services on a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e	e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	•
18.00	Total customary charges (see instructions)	Ly if line 10 avecade line 11) (con	12, 146	•
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	ry if line 18 exceeds line II) (see	10, 886	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds line 18) (see	0	20. 00
20.00	instructions)	Ty TT TTHE TT EXCEEDES TTHE TOTAL (SEE		20.00
21.00	Lesser of cost or charges (see instructions)		1, 260	21. 00
22. 00	Interns and residents (see instructions)		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		8, 526, 749	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	-)	7 205	1 25 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	·	7, 385 1, 470, 266	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		7, 050, 358	1
27.00	instructions)	or as the sam or Times 22 and 20] (see	7,000,000	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 50)	0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)		7, 050, 358	1
31. 00	Primary payer payments		1, 256	1
32. 00	Subtotal (line 30 minus line 31)	CTC)	7, 049, 102	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	JES)	0	33. 00
34. 00	Allowable bad debts (see instructions)		188, 459	ł
35. 00	Adjusted reimbursable bad debts (see instructions)		122, 498	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	138, 343	1
37.00	Subtotal (see instructions)	•	7, 171, 600	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R		30	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)	_	39. 50
39. 97	Demonstration payment adjustment amount before sequestration		0	•
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instructions)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)		7, 171, 570	1
40. 01	Sequestration adjustment (see instructions)		143, 431	1
40. 02	Demonstration payment adjustment amount after sequestration		0	1
41.00	Interim payments		7, 031, 111	41.00
42.00	Tentative settlement (for contractors use only)		0	42. 00
43.00	Balance due provider/program (see instructions)		-2, 972	1
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2			
90 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)		0	90. 00
90. 00 91. 00	Outlier reconciliation adjustment amount (see instructions)		0	
91.00	The rate used to calculate the Time Value of Money		0.00	1
93. 00	Time Value of Money (see instructions)		0.00	1
	Total (sum of lines 91 and 93)		0	•

Provider CCN: 15-0150

					9/3/2019 3:51	pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	⁻t 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		5, 330, 14	3	6, 907, 305	1. 00
2.00	Interim payments payable on individual bills, either			0	123, 806	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			0	1 0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER			0		3. 01
3. 02				0		3. 02
3. 04				0		3. 04
3. 05				0		3. 05
3.03	Provider to Program			0	0	3. 03
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	7.BOGG TIMELTY OF THE OTHER IN			0	0	3. 51
3. 52				o	l ol	3. 52
3. 53				o	l ol	3. 53
3.54				Ö	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 330, 14	3	7, 031, 111	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		<b>-</b>			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	1 0	5. 01
5. 01	TENTATIVE TO PROVIDER			0		5. 01
5. 02				0		5. 02
5.05	Provider to Program			0	0	3. 03
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				Ö	0	5. 51
5. 52				o	l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o	l ol	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		175, 25	8	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	2, 972	6. 02
7. 00	Total Medicare program liability (see instructions)		5, 505, 40		7, 028, 139	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems DUPONT HO	SPI TAL	In Lie	u of Form CMS-	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0150	Peri od: From 04/01/2018	Worksheet E-	I
			To 03/31/2019		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wks		e 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
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	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	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	ns)		32. 00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: Worksheet E-3 From 04/01/2018 Part VII To 03/31/2019 Date/Time Prepared:

		-	o 03/31/2019	Date/Time Prep 9/3/2019 3:51	pared:
		Title XIX	Hospi tal	PPS	рш
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			360, 279	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	360, 279	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	360, 279	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges		2 2 4 420		0.00
8.00	Routine service charges		3, 264, 439	2 000 174	8. 00
9. 00 10. 00	Ancillary service charges		3, 196, 828	2, 988, 174	9.00
11. 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10. 00 11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		6, 461, 267	2, 988, 174	
12.00	CUSTOMARY CHARGES		0, 401, 207	2, 700, 174	12.00
13. 00	Amount actually collected from patients liable for payment for s	services on a charge	O	0	13. 00
13.00	basis	ser vices on a charge	Ĭ	O	13.00
14.00	Amounts that would have been realized from patients liable for p	payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42			_	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	, ,	0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		6, 461, 267	2, 988, 174	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	6, 461, 267	2, 627, 895	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)		_	_	
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruc		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	360, 279	21. 00
22. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co Other than outlier payments	ompleted for PPS provide	ers.	0	22. 00
	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	U	24. 00
	Capital exception payments (see instructions)				25. 00
	Routine and Ancillary service other pass through costs		Ö	0	26. 00
	Subtotal (sum of lines 22 through 26)		ol	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		o	360, 279	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	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)		0	360, 279	31.00
32.00	Deducti bl es		0	0	32.00
33. 00	Coinsurance		0	0	33. 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 and 3	33)	0	360, 279	36. 00
37. 00	ELIMINATE SETTLEMENT		0	-360, 279	
	Subtotal (line 36 ± line 37)		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0	0	39. 00
40.00			0	0	
41. 00 42. 00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	with CMS Dub 15 2	0	0	42. 00 43. 00
43.00	chapter 1, §115.2	WITH CIND FUD 19-2,	"	U	43.00
	1		' '	ı	ı

Health Financial Systems

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

N: 15-0150 | Peri od: From 04/01/2018 To 03/31/2019 | Date/Ti me Prepared:

onl y)			'	0 03/31/2019	9/3/2019 3: 51	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	352, 928	1	-	0	1
2. 00 3. 00	Temporary i nvestments Notes receivable			-	1	
4.00	Accounts receivable	40, 705, 392	1		0	
5. 00	Other recei vabl e	0		o o	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	-3, 280, 744	1 C	0	0	6. 00
7.00	Inventory	3, 753, 298	1	0	0	
8.00	Prepai d expenses	1, 553, 612	1	0	0	
9. 00 10. 00	Other current assets Due from other funds	-600, 640			0	
11. 00	Total current assets (sum of lines 1-10)	42, 483, 846		-	l	1
	FIXED ASSETS	12/ 100/ 010	1	,		1
12.00	Land	1, 060, 000	C	0	0	12. 00
13. 00	Land improvements	629, 378	1			1
14.00	Accumulated depreciation	-409, 436	1	1	1	
15.00	Buildings	63, 596, 706	1	,	0	
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-15, 018, 093 10, 382, 498	1	1	0	
18. 00	Accumulated depreciation	-1, 092, 176	1	1	Ö	
19. 00	Fi xed equi pment	2, 329, 546	1	0	0	
20.00	Accumulated depreciation	-2, 534, 461	ı  c	0	0	
21. 00	Automobiles and trucks	24, 168	•	1	0	
22. 00	Accumulated depreciation	-13, 091		,	0	
23. 00 24. 00	Major movable equipment Accumulated depreciation	42, 591, 650 -29, 436, 711	1		0	
25. 00	Mi nor equi pment depreci abl e	8, 195, 241	1	0	0	
26. 00	Accumulated depreciation	-6, 241, 535	1	1	ő	
27. 00	HIT designated Assets	C	) c	0	0	27. 00
28. 00	Accumulated depreciation	C	C	1	0	
29. 00	Mi nor equi pment-nondepreci abl e	74.000.00		-	1	
30. 00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	74, 063, 684	1 <u> </u> C	0	0	30.00
31. 00	Investments			0	0	31.00
32. 00	Deposits on Leases	d	o c	-	l	
33.00	Due from owners/officers	C	o c	0	0	33. 00
34. 00	Other assets	5, 944, 505	1	1	0	
35. 00	Total other assets (sum of lines 31-34)	5, 944, 505	1		0	1
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	122, 492, 035	5  C	)  0	0	36. 00
37. 00	Accounts payable	4, 563, 214	1 0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	4, 004, 087	1	-	Ō	
39. 00	Payroll taxes payable	390, 550	o c	0	0	
40. 00	Notes and Loans payable (short term)	792, 704	1	0	0	
41.00	Deferred income		C	0	0	
42. 00 43. 00	Accelerated payments Due to other funds	-336, 313, 168	) S	0	0	42. 00 43. 00
44. 00	Other current liabilities	1, 640, 690	1	o o	l .	
45.00	Total current liabilities (sum of lines 37 thru 44)	-324, 921, 923		0	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	C	C	-	1	
47. 00 48. 00	Notes payable	711, 440		-		
48.00	Unsecured Loans Other Long term Liabilities	48, 609, 279		-	l	
50. 00	Total long term liabilities (sum of lines 46 thru 49)	49, 320, 719	1		l	
51.00	Total liabilities (sum of lines 45 and 50)	-275, 601, 204	1	0	l	
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	398, 093, 239	1			52. 00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		C	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EQ 00	replacement, and expansion	200 000 000	,	_	_	F0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	398, 093, 239 122, 492, 035	1		0	
00.00	[59]	122, 492, 030	1			55. 55
		•	•	T.	•	•

Provider CCN: 15-0150

					То	03/31/2019	Date/Time F 9/3/2019 3:		
		General	Fund	Speci al	Pur	pose Fund	Endowment Fu		PIII
				·					
4 00		1.00	2.00	3. 00		4. 00	5. 00		4 00
1.00	Fund balances at beginning of period		367, 646, 755			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		30, 444, 732			0			2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	398, 091, 487		0	U		0	3. 00 4. 00
5.00	Additions (credit adjustments) (specify)				0			0	5. 00
6. 00					0			0	6. 00
7. 00					0			0	7. 00
8. 00					0			0	8. 00
9. 00					0			0	9. 00
10.00	Total additions (sum of line 4-9)		0			0		-	10.00
11. 00	Subtotal (line 3 plus line 10)		398, 091, 487			0			11. 00
12.00	Deductions (debit adjustments) (specify)	0			0			0	12.00
13.00		O			0			0	13.00
14.00		0			0			0	14.00
15.00		0			0			0	15.00
16.00		0			0			0	16.00
17. 00		0			0			0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0			18. 00
19. 00	Fund balance at end of period per balance		398, 091, 487			0			19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund					
		Eridowiiicht Tana	TTUTTE	Turiu					
		6.00	7. 00	8. 00					
1.00	Fund balances at beginning of period	0			0				1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)								2.00
3.00	Total (sum of line 1 and line 2)	0			0				3.00
4.00	Additions (credit adjustments) (specify)		0						4. 00
5.00			0						5. 00
6.00			0						6. 00
7.00			0						7. 00
8.00			0						8. 00
9.00	T-t-1 -dditi (6 li 4 0)		0						9.00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)				0				10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)		0		U			- 1	12. 00
13. 00	debit adjustments) (specify)		0					- 1	13. 00
14. 00			0					- 1	14. 00
15. 00			0						15. 00
16. 00			0					ı	16. 00
17. 00		1	ol						17. 00
18. 00	Total deductions (sum of lines 12-17)	o			0				18. 00
19. 00	Fund balance at end of period per balance	0			0				19.00
	sheet (line 11 minus line 18)								

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0150

			03/31/2019	9/3/2019 3:51	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	40, 099, 32!	5	40, 099, 325	1.00
2.00	SUBPROVI DER - I PF			0	2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY			0	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	40, 099, 32	5	40, 099, 325	10. 00
	Intensive Care Type Inpatient Hospital Services	1	_T		
11. 00	INTENSIVE CARE UNIT	2, 936, 369		2, 936, 369	11.00
11. 01	NEONATAL INTENSIVE CARE UNIT	28, 413, 389	7	28, 413, 389	11. 01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14. 00 15. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)	21 240 75		21 240 750	
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15)	31, 349, 758		31, 349, 758	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	71, 449, 08		71, 449, 083	17. 00
18. 00	Ancillary services	174, 914, 514		594, 579, 258	18.00
19. 00	Outpatient services	5, 576, 92		45, 063, 944	
20. 00	RURAL HEALTH CLINIC	1 ' '	0	43, 003, 744	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21.00
22. 00	HOME HEALTH AGENCY	`			22.00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC	· ·			24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26.00
27. 00	OTHER (SPECIFY)		o	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	251, 940, 520	459, 151, 765		28. 00
	G-3, line 1)			, ,	
	PART II - OPERATING EXPENSES	•			
29.00	Operating expenses (per Wkst. A, column 3, line 200)		126, 813, 953		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32. 00
33.00					33. 00
34.00					34.00
35. 00					35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00					39. 00
40.00					40. 00
41. 00					41.00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r	126, 813, 953		43. 00
	to Wkst. G-3, line 4)	I			

111 41-	Figure in Contains	NI TAI	1 - 11 -	£ F CMC (	2552 40
	Financial Systems DUPONT HOSE MENT OF REVENUES AND EXPENSES	Provider CCN: 15-0150	Peri od:	u of Form CMS-2 Worksheet G-3	
	LENT OF REVENUES THIS ENTEROLS	Trevitaer son. Is cres	From 04/01/2018 To 03/31/2019		pared:
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			711, 092, 285	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	ts		554, 901, 133	
3.00	Net patient revenues (line 1 minus line 2)			156, 191, 152	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			126, 813, 953	
5. 00	Net income from service to patients (line 3 minus line 4)			29, 377, 199	5. 00
	OTHER I NCOME		1		
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	1			0	14. 00 15. 00
	Revenue from rental of living quarters	han nationta		0	16.00
	Revenue from sale of medical and surgical supplies to other t Revenue from sale of drugs to other than patients	nan patrents		0	17. 00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
				0	20.00
20. 00 21. 00				0	20.00
22. 00	Rental of hospital space			0	21.00
23. 00	· · ·			0	23. 00
24. 00	Governmental appropriations OTHER MISCELLANEOUS REVENUE			1, 067, 533	
25. 00	Total other income (sum of lines 6-24)			1, 067, 533	
	Total (line 5 plus line 25)			30, 444, 732	
	OTHER EXPENSES (SPECIFY)			30, 444, 732	26.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
	Net income (or loss) for the period (line 26 minus line 28)			30, 444, 732	
27.00	The tribonic (or 1033) for the period (fille 20 illinus fille 20)		I	30, 444, 732	27.00

	Financial Systems DUPONT H	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	LATION OF CAPITAL PAYMENT	Provider CCN: 15-0150	Peri od: From 04/01/2018 To 03/31/2019		
		Title XVIII	Hospi tal	PPS	- Piii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
4 00	CAPITAL FEDERAL AMOUNT			000 447	1 4 00
1.00	Capital DRG other than outlier			330, 117	•
1. 01	Model 4 BPCI Capital DRG other than outlier			0 81, 288	1. 01 2. 00
2.00   Capital DRG outlier payments 2.01   Model 4 BPCI Capital DRG outlier payments					2.00
3. 00					
4. 00		. reporting period (see inst	.ructrons)	47. 15 0. 00	
5.00					5.00
6.00	3 (31 )				6.00
	On Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patient days (Worksheet E	, part A line	3. 59	7. 00
8.00	Percentage of Medicaid patient days to total days (see ins	structions)		32. 49	8.00
9.00	Sum of lines 7 and 8			36. 08	9.00
10.00	Allowable disproportionate share percentage (see instructi	ons)		7. 58	10.00
11.00	Disproportionate share adjustment (see instructions)			25, 023	11.00
12.00	Total prospective capital payments (see instructions)			436, 428	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions	5)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumst	ances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	0.00
6.00	Percentage adjustment for extraordinary circumstances (see			0.00	
7.00	Adjustment to capital minimum payment level for extraordin	nary circumstances (line 2 x	(line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9. 00 10. 00	Current year capital payments (from Part I, line 12, as ap		loca lina ()	0	
10.00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over			0	
11. 00	Worksheet L, Part III, line 14)		- 11)		10.00
	Not consider all the statements of the statement of the s	navments (Line II) nills lin		0	
12. 00	Net comparison of capital minimum payment level to capital				l 13. 00
12. 00 13. 00	Current year exception payment (if line 12 is positive, er	nter the amount on this line		-	
12. 00	Current year exception payment (if line 12 is positive, er Carryover of accumulated capital minimum payment level over	nter the amount on this line		0	
12. 00 13. 00	Current year exception payment (if line 12 is positive, er Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line)	nter the amount on this line er capital payment for the f		-	14. 00
12. 00 13. 00 14. 00	Current year exception payment (if line 12 is positive, er Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	nter the amount on this line or capital payment for the f instructions)		0	14. 00 15. 00