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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 DUKES MEMORIAL HOSPITAL (15-1318) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. (Signed) Officer or Administrator of Provider(s) SR VICE PRESIDENT REVENUE MANAGEMENT Title Of/31/2017 Date PART 111 - SETTLEMENT SUMMARY 1.00 Subprovider - IPF 0 132, 129 - 1, 530, 823 0 1, 20 2, 20 0, 30.00 Subprovider - IRF 0 - 2, 586 0 0, 0, 2, 50, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0							
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provio	ler CCN: 1		Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/30/20	ime Pre	parec
	1.00	2.00		3.00			4.00	57 307 20	517 5.4	
	Hospital and Hospital Health Care Co									
00	Street: 275 WEST 12TH STREET	PO Box:	7. 0	4/070						1.
00	City: PERU	State: IN Component Name	CCN	e: 46970 CBSA	Provi der	zy: MIAMI Date	Davime	ent Syst	om (D	2.
		component name	Number	Number	Type	Certified	1 2	, 0, or		
					51		V	XVIII		1
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00	Hospital and Hospital-Based Componen		151010	00015	1	07/01/1966	N		Р	
00 00	Hospital Subprovider - IPF	DUKES MEMORIAL HOSPITAL	151318	99915	1	0770171966	N	0	P	3. 4.
00	Subprovider - IRF						1			5.
00	Subprovider - (Other)						Í .			6.
00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL	15Z318	99915		12/01/2003	N	0	N	7.
		SB								
00 00	Swing Beds - NF									8.
00	Hospi tal -Based SNF Hospi tal -Based NF									10.
00	Hospi tal -Based OLTC						1			11.
00	Hospital-Based HHA						1			12.
00	Separately Certified ASC						1			13.
00	Hospi tal -Based Hospi ce									14.
00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									15.
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis						1			18.
00	Other									19.
						From:		То		-
00	Cost Departing Deried (mm (dd (uuu))					1.00		2. (20
00 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/2	J16	12/31/	/2016	20.
00	Inpatient PPS Information					4				21.
00	Does this facility qualify and is it	currently receiving pay	/ments foi	di sprop	ortionate	N				22.
	share hospital adjustment, in accord	ance with 42 CFR §412.10)6? In co	olumn 1,	enter "Y"					
	for yes or "N" for no. Is this facil	ity subject to 42 CFR Se	ection §4	2.106(c)	(2) (Pi ckl	e				
01	amendment hospital?) In column 2, en Did this hospital receive interim un			s cost r	oporting	N		N		22.
01	period? Enter in column 1, "Y" for y					IN IN		IN IN		22.
	reporting period occurring prior to									
	for no for the portion of the cost r									
	(see instructions)									
02	Is this a newly merged hospital that determined at cost report settlement					N		N	Í.	22.
	or "N" for no, for the portion of th	. ,			5	5				
	in column 2, "Y" for yes or "N" for					n				
	or after October 1.			5						
03	Did this hospital receive a geograph							N	I	22.
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for									
	prior to October 1. Enter in column	no for the portion of th								
		2 "V" for ves or "N" fo								
			or no for	the port	ion of th	e				
	cost reporting period occurring on o hospital contain at least 100 but no	r after October 1. (see	or no for instructi	the port ons) Doe	ion of th s this					
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for n	or no for instructi s counted no.	the port ons) Doe in accor	ion of the s this dance with	h				
00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for n dicaid days on lines 24	or no for instructi s counted no. and/or 25	the port ons) Doe in accor below?	ion of th s this dance with In column	h	3	N	I	23.
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	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for i dicaid days on lines 24 f census days, or 3 if o is cost reporting perior iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state	or no for instructi s counted no. and/or 24 late of di d differen "Y" for tre In-S aid Medi ays elig unp da 0 2.	the port ons) Doe in accord scharge. t from ti yes or " tate 0 caid 9 i bl e Me aid pai ys 00	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00	ledi cai IMO day	id 0 ys Mec c	ther di cai d days 5.00	23.
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for n dicaid days on lines 24 f census days, or 3 if o is cost reporting period iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state umn 2,	or no for instructi s counted no. and/or 24 late of di d differen "Y" for tre In-S aid Medi ays elig unp da 0 2.	the port ons) Doe in accord scharge. t from ti yes or " tate 0 caid 9 i bl e Me aid pai ys 00	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00	ledi cai IMO day	id 0 ys Mec c	ther di cai d days 5.00	_
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for n' dicaid days on lines 24 f census days, or 3 if d is cost reporting period iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state umn 2, olumn 3,	or no for instructi s counted no. and/or 24 late of di d differen "Y" for tre In-S aid Medi ays elig unp da 0 2.	the port ons) Doe in accord scharge. t from ti yes or " tate 0 caid 9 i bl e Me aid pai ys 00	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00	ledi cai IMO day	id 0 ys Mec c	ther di cai d days 5.00	_
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for r dicaid days on lines 24 f census days, or 3 if o is cost reporting period iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state umn 2, olumn 3, d days in column	or no for instructi s counted no. and/or 24 late of di d differen "Y" for tre In-S aid Medi ays elig unp da 0 2.	the port ons) Doe in accord scharge. t from ti yes or " tate 0 caid 9 i bl e Me aid pai ys 00	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00	ledi cai IMO day	id 0 ys Mec c	ther di cai d days 5.00	_
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for i dicaid days on lines 24 f census days, or 3 if o is cost reporting period iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	or no for instructi s counted no. and/or 24 late of di d differen "Y" for tre In-S aid Medi ays elig unp da 0 2.	the port ons) Doe in accord scharge. t from ti yes or " tate 0 caid 9 i bl e Me aid pai ys 00	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00	ledi cai IMO day	id 0 ys Mec c	ther di cai d days 5.00	_
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in RF, enter th	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for n dicaid days on lines 24 f census days, or 3 if o is cost reporting period iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state	or no for instructi s counted no. and/or 24 late of di d differen "Y" for tre In-S aid Medi ays elig unp da 0 2.	the port ons) Doe in accord scharge. t from ti yes or " tate 0 caid 9 i bl e Me aid pai ys 00	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00	ledi cai IMO day	id 0 ys Mec c	ther di cai d days 5.00	_
00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per Medicaid eligible unpaid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in Medicaid paid days in column 1 f this provider is an IRF, enter th Medicaid paid days in column 1, the	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for n' dicaid days on lines 24 f census days, or 3 if d is cost reporting period iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state	or no for instructi s counted no. and/or 29 late of di d differen - "Y" for tte In-S aid Medi ays elig unp da 0 2. 0	the port ons) Doe in accord scharge. t from t yes or " tate 0 caid 9 ible Me aid pai ys 00 0	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00 0	ledi cai IMO day	i d ys C 0	ther di cai d days 5.00	24.
00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per Medicaid eligible unpaid days in colum Medicaid eligible unpaid days in colum out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid eligible unpaid days in column 1 f this provider is an IRF, enter th Medicaid eligible unpaid days in column 1, the	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for r dicaid days on lines 24 f census days, or 3 if o is cost reporting period iod? In column 2, enter In-Sta Medica paid d 1.00 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state umn 2,	or no for instructi s counted no. and/or 29 late of di d differen - "Y" for tte In-S aid Medi ays elig unp da 0 2. 0	the port ons) Doe in accord scharge. t from t yes or " tate 0 caid 9 ible Me aid pai ys 00 0	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00 0	ledi cai IMO day	i d ys C 0	ther di cai d days 5.00	24.
00	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per Medicaid eligible unpaid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in Medicaid paid days in column 1 f this provider is an IRF, enter th Medicaid paid days in column 1, the	r after October 1. (see t more than 499 beds (as "Y" for yes or "N" for r dicaid days on lines 24 f census days, or 3 if o is cost reporting period iod? In column 2, enter In-State umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state umn 2, 3, out-of-state	or no for instructi s counted no. and/or 29 late of di d differen - "Y" for tte In-S aid Medi ays elig unp da 0 2. 0	the port ons) Doe in accord scharge. t from t yes or " tate 0 caid 9 ible Me aid pai ys 00 0	ion of the s this dance with In column Is the he method N" for no ut-of State dicaid I d days 3.00	h Out-of M State H Medicaid eligible unpaid 4.00 0	ledi cai IMO day	i d ys C 0	ther di cai d days 5.00	24.

JSPI I.	Financial Systems DUKES AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL HOSPITAL Provider CC		eriod: rom 01/01/		u of For Workshe Part I		
					o 12/31/		Date/Ti		
					Urban/Rur	al S		Geogr	
. 00	Enter your standard geographic classification (not wa	ide) sta	atus at the beg	inning of the	1.00	2	2.0)0	26.0
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ige) sta	atus at the end	of the cost		2			27.
. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.
					Begi nni r	ng:	Endi		_
. 00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00		2.0	0	36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	s MDH status		0			37.
. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N				37.
. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
					Y/N		Y/		-
. 00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	or low volume	1.00 N		2. C		39.
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ente juiremen or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)					
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. I	Enter "Y" for y		N		N		40.
					-	V 1.00	XVIII 2.00	XI X 3.00	-
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	nt for (di sproporti onat	e share in ac	cordance	N	N	N	45.
. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					Ν	N	N	46.
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47. 48.
00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	Ν			56.
. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or h of th' '", comp	r "N" for no in nis cost report plete Worksheet	column 1. lf ing period?	column 1 Enter "Y"				57.
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	ursemei	nt for physicia	ns' services	as	Ν			58.
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		Ν			59.
00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				ctions)	Ν			60.
		Y/N	IME	Direct GME	IME		Direct	GME	
		1.00	2.00	3.00	4.00		5.0	00	1
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N				0.00	1	0.00	61.
	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0. 00	0.0	o				61.
02	ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care		0.00	0.0	o				61.
02	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.0					L 1
03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.0	Ĭ				61.
04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	o				61.
	current cost reporting period.(see instructions). Enter the difference between the baseline primary		0.00	0.0	d				61.

IOSPI TA	L AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA	Provider CC		Period: From 01/01/2016	Worksheet S-2 Part I	
						o 12/31/2016		
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
ι	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00				61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
s f c r u	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
1.20 C F r i 3	of the FTEs in line 61.05, speci- program specialty, if any, and t residents for each expanded prog- nstructions) Enter in column 1, enter in column 2, the program c 8, the IME FTE unweighted count 4, direct GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0.00	61.
							1.00	
	ACA Provisions Affecting the Hea							
	Enter the number of FTE resident your hospital received HRSA PCRE			d in this cost	reporting per	iod for which	0.00	62.
2.01 E	Enter the number of FTE resident Juring in this cost reporting pe Teaching Hospitals that Claim Re	s that rotated from a riod of HRSA THC prog	a Teachi gram. (s	see instruction		your hospital	0.00	62.
3.00 🖡	Has your facility trained reside 'Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co	instructions)		N	63.
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
4.00 E i r s r	Section 5504 of the ACA Base Yea beriod that begins on or after J Enter in column 1, if line 63 is n the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	uly 1, 2009 and befor yes, or your facilit ber of unweighted nor tations occurring in number of unweightee ur hospital. Enter in	<u>re June</u> ty trair n-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	Inis base year	-		64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
i t S a F F F r t c u r r v v v v v v v v v v v v v v v v v	Enter in column 1, if line 63 s yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care orogram 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				0. 00	0.00	0. 000000	05.

Heal th	Financial Systems		MEMORIAL HOSPITAL			eu of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	NTA Provider		eriod: rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/30/2017 5:4	pared: 4 pm
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settin	1.00 ngsEffective fo	2.00 pr cost report	3.00 ing periods	
66.00	<u>beginning on or after July 1, 20</u> Enter in column 1 the number of FTEs attributable to rotations o	10 unweighted non-primar ccurring in all nonpr	ry care resident rovider settings.	0.00			66.00
	Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	al. Enter in column 3 _column 2)). (see ins	3 the ratio of structions)				
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.0	0. 000000	67.00
					1.0	0 2.00 3.00	
	Inpatient Psychiatric Facility P	PS			1.0	0 2.00 3.00	
70.00	Is this facility an Inpatient Ps		IPF), or does it con	tain an IPF subp	provider? N		70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	DO4? Enter "Y" for llity train resident)(D)? Enter "Y" for	yes or "N" for r s in a new teach yes or "N" for r	no. (see ni ng no.	0	71.00
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		v (IRF), or does it	contain an IRF	N		75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	oproved GME teaching ember 15, 2004? Ente new teaching progra for no. Column 3: I	program in the r "Y" for yes or m in accordance f column 2 is Y,	most "N" for with 42	0	76.00
						1.00	
	Long Term Care Hospital PPS					1	
	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				period? Enter	N N	80.00 81.00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded unit) unde			N	85. 00 86. 00
87.00	Is this hospital a "subclause (I for yes or "N" for no.)(1)(B)(iv)(II)?		N	87.00
					V 1.00	XI X 2.00	
00.00	Title V and XIX Services	and/or VIV innationt	bospital convious?	Entor "V" for	N	Y	90.00
	Does this facility have title V yes or "N" for no in the applica	ble column.	•				
91.00	ls this hospital reimbursed for full or in part? Enter "Y" for y				N	N	91.00
92.00	Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certifica			N	92.00
93.00	instructions) Enter "Y" for yes Does this facility operate an IC "Y" for yes or "N" for no in the	F/IID facility for pu		nd XIX? Enter	N	Ν	93.00
94.00	Does title V or XIX reduce capit applicable column.		or yes, and "N" for	no in the	N	Ν	94.00

	L HOSPITAL	ON 45 4040					2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	JN: 15-1318	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti		
				2010	5/30/20	17 5:4	
			V 1.00		XI > 2. 0		_
95.00 ffline 94 is "Y", enter the reduction percentage in the app	olicable colum	n.	0.00		0.0		95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N		Ν		96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable colum	n.	0.00		0.0	0	97.00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		hod of paymer	nt N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst	ructions) If	st N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							108.00
	Physi cal 1.00	Occupationa 2.00	1 Speed 3.00		Respira 4.0		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y		N		109.00
				-	1.0	0	-
10.00 Did this hospital participate in the Rural Community Hospita		on project (4	10A Demo)fo	r	N		110. 00
the current cost reporting period? Enter "Y" for yes or "N"	TOT NO.						
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	
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" percer psychiatric, rehabilitation and long term hospitals provider	If column 2 nt for long te	is "E", enter rm care (incl	in column udes	N		0	115. 0
Pub.15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insur			"N" for	N N			116.0
no. 18.00 s the malpractice insurance a claims-made or occurrence pol				1			
claim-made. Enter 2 if the policy is occurrence.		in the poincy	15	1			118.0
	-				Insura	ance	118.0
	-	Premi ums	Losse		Insura	ance	118.00
				s	I nsura 3. 0		118.0
		Premi ums	Losse	s		0	
18.01 List amounts of malpractice premiums and paid losses:		Premi ums	Losse 2.00 41 17 1.00	s 1 3, 114		0	
 18.01 List amounts of malpractice premiums and paid losses: 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. 		Premi ums 1.00 12,1 than the	2.00 41 17	s 1 3, 114	3.0	0	- - - 118. 0.
 18.01 List amounts of malpractice premiums and paid losses: 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. 19.00 DO NOT USE THIS LINE 	dule listing co d Harmless prov n column 1, "Y ualifies for th	Premiums 1.00 12,1 than the ost centers vision in ACA " for yes or he Outpatient	Losse 2.00 41 17 1.00 N N	s 1 3, 114	3.0	0 (0 <u>118.0</u> 118.0 119.0
 18. 01 List amounts of malpractice premiums and paid losses: 18. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment 2, "Y" for yes or "N" for no. 21. 00 Did this facility incur and report costs for high cost impla 	dule listing co d Harmless provin column 1, "Y Jalifies for ti hts? (see inst	Premiums 1.00 12,1 than the ost centers vision in ACP " for yes or he Outpatient ructions)	Losse 2.00 41 17 1.00 N N	s 1 3, 114	3.0	0 (118.0 118.0 119.0 120.0
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 18. 01 List amounts of malpractice premiums and paid losses: 18. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schect and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? 21. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 	dule listing co d Harmless provin n column 1, "Y Jalifies for ti nts? (see inst antable device: Enter "Y" for ne Worksheet A	Premiums 1.00 12,1 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	Losse	s 1 3, 114	3.0	0 (118.0 118.0 119.0 120.0 121.0 122.0
 18. 01 List amounts of malpractice premiums and paid losses: 18. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? 21. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 22. 00 Des the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes (mm/dd/yyyy) below. 	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst antable device: Enter "Y" for ne Worksheet A pr yes and "N"	Premiums 1.00 12,1 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If	Losse 2.00 41 17 1.00 N N N Y N N	s 1 3, 114	3.0	0 (118. 0 118. 0 118. 0 120. 00 121. 00 122. 00
 18. 01 List amounts of malpractice premiums and paid losses: 18. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheor and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21. 00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2 	dule listing control of the devices of the worksheet A the devices of the devices	Premiums 1.00 12,1 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date	Losse 2.00 41 17 1.00 N N N Y N N	s 1 3, 114	3.0	0 (0 118. 0 118. 0 119. 0 120. 0 121. 0 122. 0 125. 0 126. 0
 18. 01 List amounts of malpractice premiums and paid losses: 18. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? 21. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing control of the devices of the devices of the worksheet A control of the certification of the certific	Premiums 1.00 12,1 than the ost centers vision in ACP " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	Losse 2.00 41 17 1.00 N N N Y N N	s 1 3, 114	3.0	0 (118.0 118.0 118.0 119.0 120.0 121.0 122.0 125.0 126.0 127.0
 18. 01 List amounts of malpractice premiums and paid losses: 18. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 21. 00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 27. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst- antable device: Enter "Y" for ne Worksheet A por yes and "N" nter the certif 2. ter the certif 2.	Premiums 1.00 12,1 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	Losse 2.00 41 17 1.00 N N Y N N	s 1 3, 114	3.0	0 (118. 0 118. 0 118. 0 119. 0 120. 0 121. 0 122. 0 125. 0 126. 0 127. 0 128. 0
 118.01 List amounts of malpractice premiums and paid losses: 118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implat patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 	dule listing control of the devices	Premiums 1.00 12,1 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date i	Losse 2.00 41 17 1.00 N N Y N N	s 1 3, 114	3.0	0 (118. 07 118. 07 118. 07 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00
 118.01 List amounts of malpractice premiums and paid losses: 118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schee and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. 127.00 Dif this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for th nts? (see inst- antable device: Enter "Y" for ne Worksheet A bor yes and "N" nter the certific ter the certific en the certific enter the certific enter the certific enter the certific enter the certific enter the certific	Premiums 1.00 12,1 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date i tification	Losse 2.00 41 17 1.00 N N Y N N	s 1 3, 114	3.0	0 (118. 00 118. 00 118. 02 118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	DUKES MEMORI.	Provider CCN	N: 15-1318	Peri od:		u of Form CMS- Worksheet S-:	
					/01/2016 2/31/2016	Part I Date/Time Pro 5/30/2017 5:-	
12 00 f this is a Madisara cartified ath	en trancolont contan en	ton the contific	anti an data		1. 00	2.00	133.0
3.00 If this is a Medicare certified oth in column 1 and termination date, i			cation date				133.0
4.00 If this is an organ procurement org and termination date, if applicable	anization (OPO), enter t		n column 1				134.0
All Providers 10.00 Are there any related organization	an home office costs as	dofined in CNC I	Dub 1E 1		Y	440000	140.0
chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	" for no in column 1. If	yes, and home of	office cost	s	Ŷ	449008	140. 0
1.00	2. (Í		3.00		
If this facility is part of a chain				name and	address	of the	
home office and enter the home offi 1.00 Name: CHS/COMMUNITY HEALTH SYSTEMS I NC.				tor's Num	nber: 5228	0	141. 0
2.00 Street: 4000 MERIDIAN BLVD	PO Box:						142.0
3.00 City: FRANKLIN	State: TI	N	Zip Code	ə:	3706	7	143.0
						1.00	-
4.00 Are provider based physicians' cost	s included in Worksheet	A?				1.00 Y	144.0
	s moradou in norksheet						1 1 4.0
					1.00	2.00	
5.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for no in ude Medicare utilization	column 1. If co	olumn 1 is		Y		145. C
6.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	changed from the previo column 1. (See CMS Pub.			f	N		146. C
						1.00	-
7.00 Was there a change in the statistic						N	147.0
8.00 Was there a change in the order of						Ν	148.0
9.00 Was there a change to the simplifie	d cost finding method? E	nter "Y" for yes Part A	<u>s or "N" fo</u> Part B		tle V	N Title XIX	149.0
		1,00	2.00		3.00	4.00	-
Does this facility contain a provid	ler that qualifies for ar						
or charges? Enter "Y" for yes or "N	l" for no for each compor			(See 42			
5.00Hospital 6.00Subprovider - IPF		N N	N N		N N	N N	155. C
7.00 Subprovider - TRF		N	N		N	N	157.0
8. 00 SUBPROVI DER							158.0
9. 00 SNF		N	N		Ν	Ν	159.0
0.00 HOME HEALTH AGENCY		N	N		Ν	Ν	160. 0
1.00 CMHC			N		N	N	161. C
Multicampus						1.00	
5.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	pus hospital that has on	e or more campus	ses in diff	erent CBS	SAs?	Ν	165. 0
	Name	County		ip Code	CBSA	FTE/Campus	_
6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	0	1.00	2.00	3.00	4.00	<u>5.00</u> 0.0	0166. C
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
						1.00	-
Health Information Technology (HIT)				nt Act			
7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI	is "Y") and is a meanin	ngful user (line), enter	the	Y	167. 0 0168. 0
8.01 If this provider is a CAH and is no	t a meaningful user, doe	s this provider			shi p		168. 0
exception under §413.70(a)(6)(ii)? 9.00 f this provider is a meaningful us							0169.0

Health Financial Systems D	DUKES MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATI	ON DATA	Provider CCN: 15-1318	Period: From 01/01/2016	Worksheet S-2 Part I	2
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date period respectively (mm/dd/yyyy)	and ending dat	e for the reporting	01/01/2016	03/30/2016	170.00
			1.00	0.00	-
			1.00	2.00	
171.00 f line 167 is "Y", does this provider have any section 1876 Medicare cost plans reported on Wks "Y" for yes and "N" for no in column 1. If colur 1876 Medicare days in column 2. (see instruction	st. S-3, Pt. I, mn 1 is yes, en	line 2, col. 6? Enter	n	C	171.00

OSPI T	Financial Systems DUKES MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016	u of Form CMS- Worksheet S- Part II Date/Time Pro 5/30/2017 5:	2 epared
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ro	choncoc Entr		2.00	-
	mm/dd/yyyy format.	TOT ALL NO LE	esponses. Ente	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in co	olumn 2. (see				_
			Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare P	rogram2 lf	1.00	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members or of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		1			
. 00 . 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, ilable in	N			4. C
. 00	those on the filed financial statements? If yes, submit reco					0.0
			•	Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If yoo in th		s N		
. 00	the legal operator of the program?	TT yes, is ti		5 11		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in:	structions.		Ν		7.0
. 00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	and/or renewed	Ū.	Ν		8.0
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9.0
0. 00	program in the current cost report? If yes, see instruction: Was an approved Intern and Resident GME program initiated of		the current	N		10.0
0.00	cost reporting period? If yes, see instructions.	I Tellewed III I	the current	IN		10.0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11. (
				-	Y/N 1.00	
2 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes,	see instruct	tions		Y	12.0
	If line 12 is yes, did the provider's bad debt collection pr period? If yes, submit copy.			ost reporting	N	13. (
4.00	If line 12 is yes, were patient deductibles and/or co-payment Bed Complement	nts waived? If	fyes, see ins	structions.	Ν	14. (
5.00	Did total beds available change from the prior cost reportin	<u> </u>	yes, see inst ^t A	tructions. Par	N t B	15. (
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	_
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Ν		N		16.0
7. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	04/06/2017	Y	04/06/2017	17. (
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					10
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Ν		N		18.0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

HOSPI T	Financial Systems DUKES MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provider C	CN: 15-1318	Peri od: From 01/01/2016 To 12/31/2016		Prepared:
		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	PT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see				N	22.00
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	ars made dur	ing the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases entere If yes, see instructions	d into during	this cost re	eporting period?	Ν	24.00
5.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	?lfyes, see	Ν	25.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reporti	ng period? I	f yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	ົyes, submit	Ν	27.00
8. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit en	tered into dur	ing the cost	t reporting	N	28.00
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service F	Reserve Fund)	Ν	29.0
80. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	s, see	Ν	30. 00
81. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	s, see	N	31.00
2.00	Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ontractual	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	Ν	33.00
4 00	Provider-Based Physicians Are services furnished at the provider facility under an ar	rangement with	nrovi der-ha	ased physicians?	Y	34.0
	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	0			Y	35.0
	physicians during the cost reporting period? If yes, see in					33.0
				Y/N	Date	
	Home Office Costs			1.00	2.00	
36, 00	Were home office costs claimed on the cost report?			Y		36. 00
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the	home office?			37.00
8.00	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			Ê N		38.0
89. 00	If line 36 is yes, did the provider render services to othe see instructions.			s, N		39.0
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	N		40.00
		1.	00	2.	00	
1. 00	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,	KUZI WA		TSI GA		41.00
12.00	respecti vel y.	COMMUNITY HEAL	TH SYSTEMS,			42.00
	preparer.	INC 615-465-3416		KUZI WA TSI GA@CI		43.0

Heal th	Financial Systems DUKES ME	IORI /	AL HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1318	Period: From 01/01/2016	Worksheet S-2 Part II	
				To 12/31/2016		
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position		MANAGER			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 cos	t				43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	DUKES MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Prep 5/30/2017 5:44	pared: 4 pm
						I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	<u>Visits / Trips</u> Title V	
	component	Line Number	No. of Deus	Avai I abl e	or the floor of	in the v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	21	7, 6	69, 192. 00	0	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider						2.00 3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		21	7,68	69, 192. 00	0	7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	4	1, 4	13, 008. 00	0	8.00
9.00	CORONARY CARE UNI T	51.00	4	1, 40	13,000.00	0	9,00
10.00	BURN I NTENSI VE CARE UNI T						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)	101.00	25	9, 1	50 82, 200. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	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)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00 30.00	Ambulance Trips						29.00 30.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30.00
31.00			0		0		31.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		U		32.00
32.01	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: Worksheet S-3 From 01/01/2016 Part I To 12/31/2016 Date/Time Prost 5/30/2017 5.4		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the particulations of UD proceeding and block bedge)	1, 542	42	2, 88		10.00	1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	297	0				2.00
2.00	HMO IPF Subprovider	297	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	150	0	15	50		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 692	42	3, 03	33		7.00
8.00	INTENSIVE CARE UNIT	366	7	54	12		8.00
9.00	CORONARY CARE UNI T						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		37	32			13.00
14.00	Total (see instructions)	2, 058	86	3, 89	0.00	193.27	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE	0	0		0		24.00
24.10 25.00	HOSPICE (non-distinct part)	0	0		0		24.10 25.00
25.00	CMHC – CMHC RURAL HEALTH CLINIC						25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
20.25	Total (sum of lines 14-26)	0	0		0.00		20.25
28.00	Observation Bed Days		0	79		175.27	28.00
29.00	Ambul ance Trips	0	0	1.	.0		29.00
30.00	Employee discount days (see instruction)	U.S.			0		30.00
31.00	Employee discount days (see first detroit)				0		31.00
32.00	Labor & delivery days (see instructions)	0	0		0		32.00
32.00	Total ancillary labor & delivery room	0	0		0		32.00
52.01	outpatient days (see instructions)				-		
33 00	LTCH non-covered days	0					33.00

iospi t	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016		
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5	38 198	1, 113	1.0
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0 0 0		2.0 3.0 4.0 5.0
5.00 7.00 8.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						6. 0 7. 0 8. 0
 0.00 0.00 1.00 2.00 	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						9.0 10.0 11.0 12.0
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 20. 00 21. 00 22. 00 23. 00 24. 00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE UNCEL (Second distinct ment)	0.00	O	5	38 198	1, 113	13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 20. 0 21. 0 22. 0 23. 0 24. 0
4. 10 5. 00 6. 00 6. 25 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 2. 01	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00					24. 25. (26. (26. 27. (28. (29. (30. (31. (32. (32. (

)SPI T.	AL WAGE INDEX INFORMATION			Provider CC	F	Period: From 01/01/2016 To 12/31/2016		pared
		Worksheet A Line Number	Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see	200.00	11, 626, 483	0	11, 626, 483	3 0.00	0.00	1.(
00	instructions)		0		~		0.00	
00	Non-physician anesthetist Part A		0	0	C	0.00	0.00	2.0
00	Non-physician anesthetist Part		0	0	C	0.00	0.00	3.
00	B Physician-Part A -		0	0	C	0.00	0.00	4.
	Administrative		0	Ĵ				
01 00	Physicians - Part A - Teaching		0	-	C			
00	Physician and Non Physician-Part B		0	0	Ĺ	0.00	0.00	5.
00	Non-physician-Part B for		0	0	C	0.00	0.00	6.
	hospital-based RHC and FQHC services							
00	Interns & residents (in an	21.00	0	0	C	0.00	0.00	7.
01	approved program) Contracted interns and		0	0	C	0.00	0. 00	7.
01	residents (in an approved		0	0	C	0.00	0.00	/.
00	programs)		0				0.00	
00	Home office and/or related organization personnel		0	0	Ĺ	0.00	0.00	8.
00	SNF	44.00	0	-	C	0.00		
0. 00	Excluded area salaries (see instructions)		199, 018	70, 092	269, 110	0.00	0.00	10.
	OTHER WAGES & RELATED COSTS							
. 00	Contract Labor: Direct Patient		0	0	C	0.00	0.00	11.
2.00	Care Contract Labor: Top Level		0	0	C	0.00	0.00	12.
	management and other							
	management and administrative services							
3. 00	Contract Labor: Physician-Part		0	0	C	0.00	0.00	13.
	A - Administrative Home office and/or related		0		C	0.00	0.00	14
1.00	orgainzation salaries and		0	0	Ĺ	0.00	0.00	14.
	wage-related costs		_					
l. 01 l. 02	Home office salaries Related organization salaries		0	-	C	0.00		
	Home office: Physician Part A		0	-	C	0.00		
00	- Administrative		0	0	C	0.00	0.00	14
5. 00	Home office and Contract Physicians Part A - Teaching		0	0	Ĺ	0.00	0.00	10.
	WAGE-RELATED COSTS			1		1		
. 00	Wage-related costs (core) (see instructions)		0	0	C)		17.
3. 00	Wage-related costs (other)		0	0	C)		18.
9. 00	(see instructions) Excluded areas		0	0	0			19.
). 00	Non-physician anesthetist Part		0	-	C			20.
	A		_					
. 00	Non-physician anesthetist Part		0	0	C)		21.
2.00	Physician Part A -		0	0	C	þ		22.
2. 01	Administrative Physician Part A - Teaching		0		C.			22.
3.00	Physician Part B		0	0	C			23.
	Wage-related costs (RHC/FQHC)		0	0	C)		24.
5. 00	Interns & residents (in an approved program)		0	0	C)		25.
. 50	Home office wage-related		0	0	C)		25.
5. 51	Related orgainzation		0	0	C			25.
52	wage-related Home office: Physician Part A - Administrative -		0	0	C			25.
	wage-rel ated							
5. 53	Home office & Contract Physicians Part A - Teaching -		0	0	C			25.
	wage-related							
	OVERHEAD COSTS - DIRECT SALARI E							
o. 00	Employee Benefits Department Administrative & General	4.00 5.00	104, 416 1, 720, 729					

Heal th	Financial Systems		DUKES MEMORIA	AL HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2016 Fo 12/31/2016		pared:	
		Worksheet A		Reclassi fi cati			Average Hourly		
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷		
				(from	(col.2 ± col.		col. 5)		
				Worksheet A-6)		col. 4			
	1	1.00	2.00	3.00	4.00	5.00	6.00		
28.00	Administrative & General under contract (see inst.)		0	0		0.00	0.00	28.00	
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00	
30.00	Operation of Plant	7.00	233, 885	615	234, 50	0.00	0.00	30.00	
31.00	Laundry & Linen Service	8.00	0	0	(0.00	0.00	31.00	
32.00	Housekeepi ng	9.00	207, 772	0	207, 77	2 0.00	0.00	32.00	
33.00	Housekeeping under contract (see instructions)		0	0		0.00	0.00	33.00	
34.00	Dietary	10.00	200, 078	-83, 133	116, 94	5 0.00	0.00	34.00	
35.00	Dietary under contract (see instructions)		0	0	(0.00	0.00	35.00	
36.00	Cafeteri a	11.00	0	83, 133	83, 13	3 0.00	0.00	36.00	
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00	
38.00	Nursing Administration	13.00	293, 664	-82, 568	211, 09	6 0.00	0.00	38.00	
39.00	Central Services and Supply	14.00	70, 813	0	70, 81	3 0.00	0.00	39.00	
40.00	Pharmacy	15.00	405, 134	0	405, 13	4 0.00	0.00	40.00	
41.00	Medi cal Records & Medi cal Records Li brary	16.00	100, 777	67, 991	168, 76	3 0.00	0.00	41.00	
42.00	Social Service	17.00	0	0	(0.00	0.00	42.00	
43.00	Other General Service	18.00	0	0	(0.00	0.00	43.00	

Heal th	Financial Systems		DUKES MEMORI	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2016	Worksheet S-3 Part III	
						To 12/31/2016		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		11, 626, 483	0	11, 626, 48	3 0.00	0.00	1.00
	instructions)							
2.00	Excluded area salaries (see		199, 018	70, 092	269, 11	0.00	0.00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		11, 427, 465	-70, 092	11, 357, 37	3 0.00	0.00	3.00
	minus line 2)							
4.00	Subtotal other wages & related		0	0		0 0.00	0.00	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		0	0		0.00	0.00	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		11, 427, 465	-70, 092	11, 357, 37	3 0.00	0.00	6.00
7.00	Total overhead cost (see		3, 337, 268	-70, 092	3, 267, 17	6 0.00	0.00	7.00
	instructions)							

Heal th	Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE RELATED COSTS		Provider C	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016		
	·					Amount	
						Reported	
						1.00	
	PART I V - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST					154 010	
1.00	401K Employer Contributions					156, 918	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrib					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins					0	4.00
F 00	PLAN ADMINISTRATIVE COSTS (Paid to External	urgani zati on)				0	F 00
5.00	401K/TSA Plan Administration fees Legal /Accounting/Management Fees-Pension Pla					0	5.00
6.00 7.00						0	6.00 7.00
7.00	Employee Managed Care Program Administration HEALTH AND INSURANCE COST	1 Fees				0	7.00
8.00	Health Insurance (Purchased or Self Funded)					1, 431, 600	8.00
8.00 8.01	Health Insurance (Self Funded without a Thir	d Darty Administr	cator)			1, 431, 600	8.00 8.01
8.01	Health Insurance (Self Funded with a Third F					0	
8.02 8.03	Heal th Insurance (Purchased)	ally Auministrate)))			0	8.02 8.03
8.03 9.00	Prescription Drug Plan					0	
9.00 10.00	Dental, Hearing and Vision Plan					12, 574	
11.00	Life Insurance (If employee is owner or bene	ficiary					10.00
12.00	Accident Insurance (If employee is owner or					7, 9 01 54	
13.00	Disability Insurance (If employee is owner of						12.00
14.00	Long-Term Care Insurance (If employee is owner of		ر) ا			7, 300	
15.00	'Workers' Compensation Insurance	ier of benefiterary	()			334, 276	
16.00	Retirement Health Care Cost (Only current ye	ear not the extra	ordinary acc	rual require	d by FASB 106	034, 270	
10.00	Non cumulative portion)		lor ar har y dee		Ju by 1710b 100.	0	10.00
	TAXES						
17.00	FICA-Employers Portion Only					574, 465	17.00
18.00	Medicare Taxes - Employers Portion Only					134, 351	
19.00	Unemployment Insurance						19.00
20.00	State or Federal Unemployment Taxes					37, 790	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost F	Reported on I	ines 1 throu	igh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23))				2, 697, 355	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					13, 250	25.00

Heal th	Financial Systems DUKES MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS	-2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-1318	Peri od:	Worksheet S-	10
				From 01/01/2016		
				To 12/31/2016	Date/Time Pr 5/30/2017 5:	
					5/ 50/ 2017 5.	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	divided by li	ne 202 colum	ו 8)	0. 16339	3 1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				7, 384, 62	9 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplement		from Medicai	1?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments 1	from Medicaid			1, 242, 29	
6.00	Medi cai d charges				37, 421, 52	
7.00	Medicaid cost (line 1 times line 6)	<i></i>	C 1 1		6, 114, 41	
8.00	Difference between net revenue and costs for Medicaid progra	am (line / mir	nus sum of li	nes 2 and 5; if		0 8.00
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions)</pre>	for oach lir	20)			_
9.00	Net revenue from stand-al one CHIP					0 9.00
10,00	Stand-al one CHIP charges					0 10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)					0 11.00
12.00	Difference between net revenue and costs for stand-al one CHI	P (line 11 mi	nus line 9 [.]	f < zero then		0 12.00
12:00	enter zero)	(1110 11 111	1140 11110 77			
	Other state or local government indigent care program (see i	nstructions f	for each line)		
13.00	Net revenue from state or local indigent care program (Not i	ncluded on li	nes 2, 5 or	7)	150, 98	9 13.00
14.00	Charges for patients covered under state or local indigent of	care program ((Not included	in lines 6 or	800, 71	9 14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line				130, 83	
16.00	Difference between net revenue and costs for state or local	indigent care	e program (li	ne 15 minus line		0 16.00
	13; if < zero then enter zero)					_
17.00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to	, funding char	city caro			0 17.00
18.00	Government grants, appropriations or transfers for support of	5	5			0 18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and Ic			s (sum of lines		0 19.00
17.00	8, 12 and 16)	Sear Thangent		3 (3011 01 111103		0 17.00
			Uni nsured	Insured	Total (col.	1
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instruction		209, 5			
21.00	Cost of patients approved for charity care (line 1 times lin	ne 20)	34, 2			
22.00	Partial payment by patients approved for charity care			0 0		0 22.00
23.00	Cost of charity care (line 21 minus line 22)		34, 2	41 4, 397	38, 63	8 23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for pati	ant dava have	and a longth	f atou limit	1.00	24.00
24.00	imposed on patients covered by Medicaid or other indigent ca		ond a rength o	Stay ITMIL		24.00
25.00	If line 24 is "yes," charges for patient days beyond an inc		roaram's Lena	th of stay limit		0 25.00
26.00	Total bad debt expense for the entire hospital complex (see			th of Stay film t	4, 971, 17	
27.00	Medicare bad debts for the entire hospital complex (see inst		*		873, 34	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense		us line 27)		4, 097, 82	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt			e 28)	669, 55	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	, panar (rind		/	708, 19	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	s line 30)				4 31.00

Health Financial Systems	DUKES MEMORIAL				u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1318	Peri od:	Worksheet A	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 5:4	
Cost Center Description	Sal ari es	Other		Reclassificati	Reclassified Trial Balance	
			+ col. 2)	ons (See A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS	l – – – – – – – – – – – – – – – – – – –		1		I	-
1.00 00100 CAP REL COSTS-BLDG & FIXT		730, 853			1, 129, 534	1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	104 414	1, 568, 553				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00570 ADMITTING	104, 416 0	50, 997 0		3 1, 458, 535 0 1, 629, 126		
5. 02 00590 ADMINISTRATIVE AND GENERAL	1, 720, 729	6, 834, 090				5.02
7. 00 00700 OPERATION OF PLANT	233, 885	1, 315, 004				•
8.00 00800 LAUNDRY & LINEN SERVICE	0	87, 084			87, 084	8.00
9. 00 00900 HOUSEKEEPI NG	207, 772	65, 058	272, 83	0 0	272, 830	9.00
10. 00 01000 DI ETARY	200, 078	162, 777	362, 85		201, 475	10.00
11. 00 01100 CAFETERI A	0	0		0 159, 892	159, 892	
13.00 01300 NURSING ADMINISTRATION	293, 664	151, 345				
14.00 01400 CENTRAL SERVICES & SUPPLY	70, 813	378, 923			197, 059	•
15.00 01500 PHARMACY	405, 134	1, 106, 979				•
16.00 01600 MEDICAL RECORDS & LIBRARY	100, 777	258, 606	359, 38	3 69, 175	428, 558	16.00
30. 00 03000 ADULTS & PEDIATRICS	1, 390, 359	860, 030	2, 250, 38	9 -131, 457	2, 118, 932	30.00
31. 00 03100 INTENSIVE CARE UNIT	286, 750	36, 421				
43. 00 04300 NURSERY	200, 730	0	1	0 120, 288		
ANCI LLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	437, 325	1, 529, 917	1, 967, 24	2 -637, 553	1, 329, 689	50.00
51.00 05100 RECOVERY ROOM	240, 242	45, 274	285, 51	6 -1, 488	284, 028	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	105, 426			105, 426	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	571, 550	263, 572				
54. 01 05401 ULTRASOUND	67, 393	12,032			0	54.01
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	75, 549	105, 729				56.00 57.00
58. 00 05800 MRI	53, 537 49, 725	138, 451 98, 055			0	57.00
60. 00 06000 LABORATORY	655, 250	766, 921			-	60.00
65. 00 06500 RESPI RATORY THERAPY	343,060	72, 965				
66. 00 06600 PHYSI CAL THERAPY	1, 641	477, 770				•
67.00 06700 OCCUPATI ONAL THERAPY	0	132, 592			132, 592	•
68.00 06800 SPEECH PATHOLOGY	0	15, 525	15, 52	5 0	15, 525	68.00
69. 00 06900 ELECTROCARDI OLOGY	288, 126	41, 210	329, 33	6 -1, 488	327, 848	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 233, 148		•
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 586, 333		•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0.10	0 848, 922		
76. 00 03610 SLEEP LAB OUTPATI ENT SERVICE COST CENTERS	52,004	17, 183	69, 18	7 -929	68, 258	76.00
90. 00 09000 CLINIC	250, 861	49, 261	300, 12	2 -3, 025	297, 097	90.00
91. 00 09100 EMERGENCY	3, 326, 825	908, 732				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0,020,020	700, 702	1,200,00	2,100	1, 200, 10,	92.00
OTHER REIMBURSABLE COST CENTERS	I		1		1	
95. 00 09500 AMBULANCE SERVICES	198, 403	157, 717	356, 12	0 -4, 269	351, 851	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	11, 625, 868	18, 545, 052	30, 170, 92	0 -149, 183	30, 021, 737	118.00
NONREI MBURSABLE COST CENTERS			1	a -	-	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15 204		0 0		190.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 OTHER NRCC	615	15, 394		_		192.00
194. 00 07950 0THER_NRCC 194. 01 07951 MARKETI NG	0	0		0 0 0 164,601	0 164, 601	194.00
194. 02 07952 SENI OR CI RCLE	0	54		4 0		194.01
194. 03 07953 FREE MEALS	0	04 0		0 0		194.02
200.00 TOTAL (SUM OF LINES 118-199)	11, 626, 483	18, 560, 500	30, 186, 98			
		.,,			,,,,	

Health Financial Systems	DUKES MEMORI			u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CCN: 15-13	318 Period: From 01/01/2016	Worksheet A
			To 12/31/2016	Date/Time Prepared:
Cost Center Description	Adjustments	Net Expenses		5/30/2017 5:44 pm
		For Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS-BLDG & FIXT	236, 890			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P	-263, 720			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-2,073			4.00
5. 01 00570 ADMI TTI NG	0			5. 01
5. 02 00590 ADMINISTRATIVE AND GENERAL	-695, 346			5. 02
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	-22, 541 633	1, 529, 597 87, 717		7.00 8.00
9. 00 00900 HOUSEKEEPING	033			9.00
10. 00 01000 DI ETARY	0	201, 475		10.00
11. 00 01100 CAFETERIA	-61, 798			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-120			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	197, 059		14.00
15. 00 01500 PHARMACY	0	600, 436		15.00
16. 00 01600 MEDICAL RECORDS & LI BRARY	-13,602			16.00
INPATIENT ROUTINE SERVICE COST CENTERS	10,002	111, 700		10.00
30. 00 03000 ADULTS & PEDI ATRI CS	-408, 240	1, 710, 692		30.00
31. 00 03100 I NTENSI VE CARE UNI T	00,210			31.00
43. 00 04300 NURSERY	0			43.00
ANCI LLARY SERVI CE COST CENTERS	-			
50. 00 05000 OPERATI NG ROOM	-401, 295	928, 394		50.00
51.00 05100 RECOVERY ROOM	0	1		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			52.00
53.00 05300 ANESTHESI OLOGY	-105, 426	О		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	-299	1		54.00
54. 01 05401 ULTRASOUND	0	0		54.01
56. 00 05600 RADI OI SOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
60. 00 06000 LABORATORY	0	1, 355, 737		60.00
65. 00 06500 RESPI RATORY THERAPY	0	407, 293		65.00
66. 00 06600 PHYSI CAL THERAPY	0	478, 642		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	132, 592		67.00
68.00 06800 SPEECH PATHOLOGY	0	15, 525		68.00
69. 00 06900 ELECTROCARDI OLOGY	-3, 013	324, 835		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	233, 148		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	586, 333		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			73.00
76.00 03610 SLEEP LAB	0	68, 258		76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0			90.00
91.00 09100 EMERGENCY	-57, 478	4, 175, 929		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART				92.00
OTHER REIMBURSABLE COST CENTERS		054.054		
95. 00 09500 AMBULANCE SERVICES	0	351, 851		95.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	-1, 797, 428	28 224 200		110.00
	-1, 191, 428	28, 224, 309		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	-		190.00
192.00 19200 PHISICIANS PRIVATE OFFICES	0			192.00
194. 01 07951 MARKETI NG	0	-		194.00
194. 02 07952 SENI OR CIRCLE	0	54		194.01
194. 03 07953 FREE MEALS	0	0		194.02
200.00 TOTAL (SUM OF LINES 118-199)	-1, 797, 428	-		200.00
	., , , , , , , , , , , , , , , , , , ,	20,007,000		1200.00

	Financial Systems		DUKES MEMORIA			u of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provider CCN: 15-13	Period: From 01/01/2016 To 12/31/2016	
		Increases				5/30/2017 5:44 pm
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 460, 023		1.00
	TOTALS		0	1, 460, 023		
	B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	31, 228		1.00
	PATI ENT		+			
	TOTALS		0	31, 228		
1 00	C - RECLASS RENT AND LEASES CAP REL COSTS-MVBLE EQUIP	2.00	0	2/ 7 075		1.00
1.00 2.00	PHYSICIANS' PRIVATE OFFICES	2.00 192.00	0	367, 975 591		1.00
2.00	PHISICIANS PRIVATE OFFICES	0.00	0	0		3.00
4.00		0.00	0	0		4.00
4.00 5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	o	0		8.00
9.00		0.00	o	Ő		9.00
10.00		0.00	o	õ		10.00
11.00		0.00	o	Ō		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	o	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	o	0		17.00
18.00		0.00	О	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		o	368, 566		
	D - RECLASS OTHER CAPITAL COS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51, 329		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	347, 352		2.00
3.00	CAP REL COSTS-MVBLE EQUIP		0	<u> </u>		3.00
	TOTALS		0	427, 020		
	E - RECLASS MARKETING DEPT					
1.00	MARKETING	1 <u>94.</u> 01	7 <u>0, 7</u> 07	<u> </u>		1.00
	TOTALS		70, 707	93, 894		
	F - RECLASS CNO COSTS	10.00	4 (7 400			
1.00	NURSING ADMINISTRATION		167, 189	<u>0</u>		1.00
	TOTALS		167, 189	0		
4 00	G - RECLASS MEDICAL SUPPLIES	71.00		001 000		
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	201, 920		1.00
2.00	IMPL. DEV. CHARGED TO	72.00	0	586, 333		2.00
2.00	PATIENTS	72.00	0	560, 555		2.00
	TOTALS	+		788, 253		
	H - RECLASS COST OF DRUGS/IV	SOLUTIONS	Ч	760, 255		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	848, 922		1.00
1.00	TOTALS		— — — o	848, 922		1.00
	I - RECLASS LABOR AND DELIVER	Υ Υ		010,722		
1.00	NURSERY	43.00	102, 048	18, 240		1.00
	TOTALS		102, 048	18, 240		
	J - RECLASS NURSING ADMIN COS	STS				
1.00	ADMI NI STRATI VE AND GENERAL	5.02	181, 766	135, 630		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	67, 991	6, 273		2.00
	TOTALS		249, 757	141,903		
	K - RECLASS MISC DEPARTMENTS					
1.00	ADMI TTI NG	5.01	484, 288	1, 144, 838		1.00
	TOTALS		484, 288	1, 144, 838		
	L - RECLASS OTHER RADIOLOGY					
1.00	RADI OLOGY-DI AGNOSTI C	54.00	246, 204	352, 779		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00	L	0.00	0	<u>0</u>		4.00
	TOTALS		246, 204	352, 779		
	M - RECLASS DIETARY COSTS TO	CAFETERI A				
1.00	CAFETERI A	11.00	83, 133	7 <u>6, 7</u> 59		1.00
	TOTALS		83, 133	76, 759		
	N - RECLASS PHYSICIAN PRACTIC					
1.00	OPERATION OF PLANT		615	1 <u>5, 3</u> 94		1.00
	TOTALS	ļ ļ	615	15, 394		
500.00	Grand Total: Increases	<u> </u>	1, 403, 941	5, 767, 819		500.00

ASSI	inancial Systems IFICATIONS			Provider (CCN: 15-1318	Period:	Worksheet A-6
						From 01/01/2016 To 12/31/2016	Date/Time Prepa
		Decreases					5/30/2017 5:44
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	:	
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS				I.	1	
	ADMI NI STRATI VE AND GENERAL	5.02	0	<u>1,460,023</u>		Q	
	TOTALS		0	1, 460, 023			
	B - RECLASS OXYGEN COSTS CENTRAL SERVICES & SUPPLY	14.00	0	31, 228		0	
- H	TOTALS	14.00	0	3 <u>1, 220</u> 31, 228		4	
- H	C - RECLASS RENT AND LEASES		9	51, 220	I		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 488	1	0	
	ADMI NI STRATI VE AND GENERAL	5.02	0	20, 675		0	
	OPERATION OF PLANT	7.00	0	12, 760		o	
[DI ETARY	10.00	0	1, 488		0	
	NURSING ADMINISTRATION	13.00	0	2, 259		0	
	CENTRAL SERVICES & SUPPLY	14.00	0	5, 090		0	
	PHARMACY	15.00	0	62, 755		0	
	MEDI CAL RECORDS & LI BRARY	16.00	0	5, 089		0	
	ADULTS & PEDIATRICS	30.00	0	11, 169		0	
	INTENSIVE CARE UNIT	31.00	0	769		0	
	DPERATING ROOM RECOVERY ROOM	50.00 51.00	U	65, 659 1, 488		0	
	RADI OLOGY-DI AGNOSTI C	54.00		1, 488 88, 593		0	
	MRI	58.00	0	1, 488		0	
	LABORATORY	60.00	0	66, 434		0	
	RESPI RATORY THERAPY	65.00	0	8, 732		0	
	PHYSICAL THERAPY	66.00	0	769		0	
	ELECTROCARDI OLOGY	69.00	o	1, 488		0	
	SLEEP LAB	76.00	0	929		0	
0 0	CLINIC	90.00	0	3, 025		0	
0	EMERGENCY	91.00	0	2, 150		0	
0 /	AMBULANCE_SERVICES	95.00	0	4, 269		o	
- H	TOTALS		0	368, 566			
	D - RECLASS OTHER CAPITAL COST				1		
	ADMI NI STRATI VE AND GENERAL	5.02	0	427, 020			
		0.00	0	0		3	
		0.00	0	0		2	
- F	TOTALS E - RECLASS MARKETING DEPT		0	427, 020			
	ADMINI STRATI VE AND GENERAL	5.02	70, 707	93, 894		0	
	TOTALS		70,707	<u>93, 894</u>			
- F	F - RECLASS CNO COSTS	I	10,101	,0,0,1			
	ADMI NI STRATI VE AND GENERAL	5.02	167, 189	0		0	
	TOTALS		167, 189	0			
C	G - RECLASS MEDICAL SUPPLIES	· · · ·	· · · ·				
0	CENTRAL SERVICES & SUPPLY	14.00	0	216, 359		0	
	OPERATING_ROOM	50.00	0	571, 894		0	
	TOTALS		0	788, 253			
	H - RECLASS COST OF DRUGS/IV S				1		
- H	PHARMACY		0	848, 922		Q	
ļ	TOTALS		0	848, 922			
H	I - RECLASS LABOR AND DELIVERY		100.040	40.010			
	ADULTS & PEDIATRICS	<u>30.</u> 00	102,048	1 <u>8, 2</u> 40		Q	
- H	TOTALS	c	102, 048	18, 240			
	J - RECLASS NURSING ADMIN COST NURSING ADMINISTRATION	13.00	249, 757	141, 903		0	
ľ	NORSTING ADMINISTRATION	0.00	247, /3/	141, 903		0	
	TOTALS		249, 757	141,903		벽	
- H	K - RECLASS MISC DEPARTMENTS		247,101	141, 703	I		
	ADMI NI STRATI VE AND GENERAL	5.02	484, 288	1, 144, 838		0	
	TOTALS		484, 288	1, 144, 838		7	
- H	L - RECLASS OTHER RADIOLOGY			,, 000			
	JLTRASOUND	54.01	67, 393	12, 032		0	
	RADI OI SOTOPE	56.00	75, 549	105, 729		0	
	CT SCAN	57.00	53, 537	138, 451		o	
	MRI	58.00	49, 725	9 <u>6, 5</u> 67		o	
	TOTALS		246, 204	352, 779			
	M - RECLASS DIETARY COSTS TO C						
	DI ETARY	10.00	83, 133	7 <u>6, 7</u> 59		0	
	TOTALS		83, 133	76, 759			
- 6	N – RECLASS PHYSICIAN PRACTICE						
			/10	15, 394	1	0	
[PHYSICIANS' PRIVATE OFFICES	192.00	<u>615</u>	<u>15, 394</u> 15, 394		9	ļ

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
	ILLIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-1318		Period: From 01/01/2016 To 12/31/2016		Worksheet A-7 Part I	pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances 1.00	2.00	3.00		4.00	Retirements 5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		2.00	3.00		4.00	5.00	
1.00	Land	193, 225	0		0	0	0	1.00
2.00	Land Improvements	938, 654	38, 015		0	38, 015	0	2.00
2.00	Buildings and Fixtures	30, 735, 968	4, 201, 359		0	4, 201, 359	-	3.00
3.00 4.00	Building Improvements	16, 741, 423	4, 201, 339 3, 405, 237		0	4, 201, 339 3, 405, 237	592, 177	4.00
4.00 5.00	Fixed Equipment	10, 741, 423	3, 405, 237		0	3, 403, 237	592, 177	4.00 5.00
5.00 6.00	Movable Equipment	0	0		0	0	0	6.00
7.00	HIT designated Assets	2, 441, 970	2, 306, 519		0	2, 306, 519	0	7.00
8.00	Subtotal (sum of lines 1-7)	51, 051, 240	2, 308, 319 9, 951, 130		0	2, 308, 319 9, 951, 130	927, 890	8.00
8.00 9.00	Reconciling I tems	51,051,240	9,901,130		0	9, 901, 130	927, 890	9.00
9.00 10.00	Total (line 8 minus line 9)	51, 051, 240	9, 951, 130		0	9, 951, 130	-	
10.00		Endi ng Bal ance	Fully		0	9, 951, 130	927, 890	10.00
		Ending barance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		7.00					
1.00	Land	193, 225	0					1.00
2.00	Land Improvements	976, 669	0					2.00
3.00	Buildings and Fixtures	34, 601, 614	0					3.00
4.00	Building Improvements	19, 554, 483	0					4.00
5.00	Fixed Equipment	17, 334, 403	0					5.00
6.00	Movable Equipment	0	0					6.00
7.00	HIT designated Assets	4, 748, 489	0					7.00
8.00	Subtotal (sum of lines 1-7)	60, 074, 480	0					8.00
9.00	Reconciling Items	00,074,400	0					9.00
10.00	Total (line 8 minus line 9)	60, 074, 480	0					10.00
10.00		00,074,400	0	1				10.00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1318	Period:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		pared:
		·				5/30/2017 5:4	
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	8, 382			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 645	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	12, 027	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	722, 471	730, 853				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 564, 908	1, 568, 553				2.00
3.00	Total (sum of lines 1-2)	2, 287, 379	2, 299, 406	1			3.00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552-			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-1318		Period: From 01/01/2016 To 12/31/2016			
	COM	COMPUTATION OF RATIOS			OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance		
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00		
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 0 0	0		0 1.000000 0 0.000000 0 1.000000	0	1.00 2.00 3.00	
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CE		r .	Γ				
1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	0	Ű		0 247, 387 0 -332, 635 0 -85, 248		1.00 2.00 3.00	
	0	SL	IMMARY OF CAPI		424, 203	3.00	
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CE		F1 000	247.05	2 700 474	1 0// 101	1 00	
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	12, 237 1, 920			2 722, 471 0 1, 564, 908		1.00 2.00	
3.00 Total (sum of lines 1-2)	14, 157					3.00	

Heal th Finance			DUKES MEMORIA	AL HOSPITAL Provider CCN: 15-1318	In Lie Period:	u of Form CMS-2 Worksheet A-8	2552-10
					From 01/01/2016 To 12/31/2016	Date/Time Prep 5/30/2017 5:44	
				Expense Classification of To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	4.00	Wkst. A-7 Ref. 5.00	
	tment income - CAP REL -BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
	tment income - CAP REL -MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	tment income - other ter 2)		0		0.00	0	3.00
4.00 Trade,	quantity, and time unts (chapter 8)		0		0.00	0	4.00
5.00 Refund	ds and rebates of ses (chapter 8)		0		0.00	0	5.00
6.00 Rental	of provider space by		0		0.00	0	6.00
7.00 Teleph	iers (chapter 8) none services (pay ons excluded) (chapter	А	-32, 390	ADMINISTRATIVE AND GENERAL	5. 02	0	7.00
8.00 Tel evi	sion and radio service	А	-3, 645	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00 Parkir	ter 21) ng lot (chapter 21) der-based physician tmont	A-8-2	0 -997, 052		0.00	0 0	
11.00 Sale o	of scrap, waste, etc.	А	-299	RADI OLOGY-DI AGNOSTI C	54.00	0	11.00
12.00 Relate	ter 23) ed organization actions (chapter 10)	A-8-1	-276, 819			0	12. 00
13.00 Laundi	ry and linen service	P	0		0.00		13.00
15.00 Rental	eria-employees and guests of quarters to employee	В	-61, 798 0	CAFETERI A	11.00 0.00	0 0	14. 00 15. 00
suppl i	of medical and surgical ies to other than		0		0.00	0	16. 00
	of drugs to other than		0		0.00	0	17.00
	of medical records and	В	-13, 602	MEDICAL RECORDS & LIBRARY	16.00	0	18. 00
	ng school (tuition, fees,		0		0.00	0	19. 00
20. 00 Vendi r	, etc.) ng machi nes	В	-1, 944	ADMI NI STRATI VE AND GENERAL	5.02		
i ntere charge	e from imposition of est, finance or penalty es (chapter 21)		0		0.00		
overpa	est expense on Medicare ayments and borrowings to		0		0.00	0	22. 00
23.00 Adjust thera	Medicare overpayments tment for respiratory by costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00 Adj ust therap	ation (chapter 14) tment for physical by costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utiliz physic	ation (chapter 14) zation review - cians' compensation		0	*** Cost Center Deleted ***	* 114.00		25.00
26.00 Depred	ter 21) ciation - CAP REL	А	239, 005	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depred	-BLDG & FIXT ciation - CAP REL	А	-326, 430	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-pł	-MVBLE EQUIP nysician Anesthetist		0	*** Cost Center Deleted ***			28.00
30.00 Adjust thera	cians' assistant tment for occupational oy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29. 00 30. 00
30. 99 Hospi (ation (chapter 14) ce (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00 Adjust pathol	uctions) tment for speech logy costs in excess of	A-8-3		SPEECH PATHOLOGY	68.00		31. 00
32.00 CAH HI	ation (chapter 14) IT Adjustment for ciation and Interest		0		0.00	0	32.00
33.00 RENTAL	L INCOME ING REVENUE	B B		CAP REL COSTS-BLDG & FIXT NURSING ADMINISTRATION	1.00 13.00		33. 00 35. 00

Health Financial Systems			DUKES MEMORIA	AL HOSPI TAL	In Lieu of Form CMS-2552-10			
ADJUST	ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 01/01/2016 To 12/31/2016		narod	
					10 12/31/2016	Date/Time Prepared: 5/30/2017 5:44 pm		
				Expense Classification or	Worksheet A		- <u>-</u>	
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Pacic/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.		
	cost center bescription	1.00	2.00	3.00	4,00	5.00		
36.00	FI TNESS REVENUE	B		ADMI NI STRATI VE AND GENERAL	4.00		36.00	
37.00	OTHER MISC REVENUE - HOSPITAL	В		ADMINI STRATI VE AND GENERAL	5.02		37.00	
37.00	PATIENT PHONES BENEFITS COST	A		EMPLOYEE BENEFITS DEPARTMEN			38.00	
40.00	PATIENT PHONES DEPRECIATION	A		CAP REL COSTS-MVBLE EQUIP	2.00		40.00	
40.00	COST	A	-0, 203	CAP REL CUSTS-MUBLE EQUIP	2.00	9	40.00	
41.00	PATIENT TV SERVICE COST	А	-22 541	OPERATION OF PLANT	7.00	0	41.00	
42.00	NON-ALLOWABLE LOBBYING EXPENSE	A		ADMINI STRATI VE AND GENERAL	5. 02		42.00	
43.00	MARKETING EXPENSE	A		ADMI NI STRATI VE AND GENERAL	5.02		43.00	
44.00	PENALTIES	A		ADMINI STRATI VE AND GENERAL	5.02		44.00	
44.00	LOBBYING EXPENSE IN	A		ADMI NI STRATI VE AND GENERAL	5.02		44.00	
44.01	ASSOCIATION DUES	~	1, 240		5.02	,	44.01	
45.00	CHARI TABLE CONTRI BUTI ONS	А	-20,655	ADMINISTRATIVE AND GENERAL	5.02	0	45.00	
45.01	PHYSI CLAN RECRULTING	А		ADMI NI STRATI VE AND GENERAL	5.02		45.01	
45.05	LEGAL FEES	А	-9, 189	ADMI NI STRATI VE AND GENERAL	5.02	0	45.05	
45.07	MEALS AND ENTERTAINMENT	А		ADMI NI STRATI VE AND GENERAL	5.02		45.07	
50.00	TOTAL (sum of lines 1 thru 49)		-1, 797, 428				50.00	
	(Transfer to Worksheet A,							
	column 6, line 200.)							

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

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

Heal th	Financial Systems	DUKES MEMOR	I AL HOSPI TAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016		nared
					5/30/2017 5:4	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	2.00	3.00	4,00	5 5.00	
	A. COSTS INCURRED AND ADJUST					
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED 0	RGANIZATIONS OR	CLATMED	
1.00		CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	12, 237	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	1, 920	0	2.00
3.00	5. 02	ADMINISTRATIVE AND GENERAL	PASI OPERATING COSTS	181, 984	0	3.00
3.02		ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA	95, 363	0	3.02
3.04		CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING AND F		0	3.04
4.00		CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM		0	4.00
4.01		ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST			4.01
4.02			MALPRACTICE ALLOCATIONS (PER		684, 188	4.02
4.05		LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (F	2 102, 149	101, 516	4.05
4.06		ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	235, 496	4.06
4.07		ADMINISTRATIVE AND GENERAL	401K FEES	0	7,688	4.07
4.08			AUDIT FEES	0	22, 642	4.08
4.09			CORPORATE OVERHEAD FEES	0	516, 909	4.09
4.10		ADMINISTRATIVE AND GENERAL	PPSI FEES	0	21, 650	4.10
4.11			PASI COLLECTION FEES	0	166, 561	4.11
4.12			EBOS FEES	0	3, 310	4.12
4.13		ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE		21, 810	4.13
5.00	TOTALS (sum of lines 1-4).			1, 504, 951	1, 781, 770	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			
					1		
Symbol (1)	Name	Percentage of	Name	Percentage of	1		
		Ownershi p		Ownershi p			
1.00	2.00	3.00	4.00	5.00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00 B	0.00 COMMUNITY HEALTH SYTEMS	100.00	6.00
7.00 B	0. 00 PASI	100.00	7.00
8.00 B	0.00 HOSPI TAL LAUNDRY SERVI CE	100.00	8.00
9.00	0.00	0.00	9.00
10.00	0.00	0.00	10.00
100.00 G. Other (financial or			100.00
non-financial) specify:			

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

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

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

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

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

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FF	ROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1318	Period: From 01/01/2016	Worksheet A-8-1
OTTEL COSTS				Date/Time Prepared:

			5/30/2017 5:44	4 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	12, 237			1.00
2.00	1, 920			2.00
3.00	181, 984			3.00
3.02	95, 363			3. 02
3.04	5, 114			3.04
4.00	70, 640			4.00
4.01	850, 289			4.01
4.02	-498, 933			4.02
4.05	633			4.05
4.06	-235, 496			4.06
4.07	-7, 688			4.07
4.08	-22, 642			4.08
4.09	-516, 909			4.09
4.10	-21, 650			4.10
4.11	-166, 561			4.11
4.12	-3, 310			4.12
4.13	-21, 810			4.13
5.00	-276, 819			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which here not here posted to Worksheet A, columns 1, and/or 2, the amounts decrease cost. For related organization or home office cost which

has no	t been posted to Worksheet A,	columns 1 and/or 2,	the amount	allowable s	should be	indicated	in column 4	4 of this part.	
	Rel ated Organization(s)								
	and/or Home Office								
	Type of Business								
	6. 00								
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S)	AND/OR HOME	OFFICE:					

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

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

reriibui	Sement under title Aviii.								
6.00	HOSPITAL MANAGEMENT	6.00	ō						
7.00	DEBT COLLECTION	7.00	0						
8.00	LAUNDRY SERVICE	8.00	0						
9.00		9.00	0						
10.00		10.00	0						
100.00		100.00	0						
(1) 1150	(1) Use the following symbols to indicate interrelationship to related organizations:								

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Heal th	Financial Syste	ems	DUKES MEMORI	AL I	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC				Provider CCN: 15-1318		Peri od: Worksheet A-8 From 01/01/2016 To 12/31/2016 Date/Time Pre 5/30/2017 5:4		B-2
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component		Provider Component		Physician/Prov ider Component	·
	1.00	2.00	3.00	2 00		5.00	6.00	Hours 7.00	
1.00		ADMI NI STRATI VE AND GENERAL	21,600		4.00	<u> </u>			1.00
2.00		ADULTS & PEDIATRICS	408, 240		408, 240	(-	-	2.00
3.00		OPERATING ROOM	400, 240		400, 240	(-	0	3.00
4.00		ANESTHESI OLOGY	105, 426		105, 426	(-	0	4.00
5.00		ELECTROCARDI OLOGY	3, 013		3, 013	(-	0	5.00
6.00		EMERGENCY	2, 515, 463		57, 478	2, 457, 98	°	0	6.00
7.00		AMBULANCE SERVICES	2, 313, 403		37,470	2, 437, 98		0	7.00
8.00	0.00		2,013		0	2,013		0	8.00
9.00	0.00		0		0	(0	9.00
10.00	0.00		0		0			0	10.00
200.00	0.00		3, 457, 850		997, 052	2, 460, 798		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 6	Percent of	Cost of		Physician Cost	200.00
	WRSt. A LINC #	I denti fi er				Memberships &		of Malpractice	
				onac	Limit	Conti nui ng	Share of col.	Insurance	
					2	Education	12	i nour anoo	
	1.00	2.00	8.00		9.00	12.00	13.00	14.00	
1.00	5. 02	ADMINISTRATIVE AND GENERAL	0		0	(0 0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0		0	(0 0	0	2.00
3.00	50.00	OPERATING ROOM	0		0	(0 0	0	3.00
4.00	53.00	ANESTHESI OLOGY	0		0	(0 0	0	4.00
5.00	69.00	ELECTROCARDI OLOGY	0		0	(0 0	0	5.00
6.00	91.00	EMERGENCY	0		0	(0 0	0	6.00
7.00	95.00	AMBULANCE SERVICES	0		0	(0 0	0	7.00
8.00	0.00		0		0	(0 0	0	8.00
9.00	0.00		0		0	(0 0	0	9.00
10.00	0.00		0		0	(0 0	0	10.00
200.00			0		0	(0 0	0	200.00
	Wkst. A Line #		Provi der	Adj	usted RCE	RCE	Adjustment		
		I denti fi er	Component		Limit	Di sal I owance			
			Share of col.						
			14						
	1.00	2.00	15.00		16.00	17.00	18.00		
1.00		ADMI NI STRATI VE AND GENERAL	0		0		21,600		1.00
2.00		ADULTS & PEDIATRICS	0		0	(2.00
3.00		OPERATING ROOM	0		0	(3.00
4.00		ANESTHESI OLOGY	0		0	(4.00
5.00		ELECTROCARDI OLOGY	0		0	(-,		5.00
6.00			0		0	(6.00
7.00		AMBULANCE SERVICES	0		0	(°		7.00
8.00	0.00		0		0	(-		8.00
9.00	0.00		0		0	(°,		9.00
10.00	0.00		0		0	(10.00
200.00			0		0	(997, 052		200.00

	IABLE COST DETERMINATION FOR THERAPY SERVICES I DE SUPPLIERS	FURNI SHED BY	Provider CC	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016		pared:
					Physical Therapy		4 pm
						1.00	
	PART I – GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			52	
2.00 3.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	or or theranis	t was on provid	dor sito (si	e instructions)	780 0	
4.00	Number of unduplicated days in which therapy					0	
	nor therapist was on provider site (see instr	ructions)					
5.00	Number of unduplicated offsite visits - super			,	h th	0	
5.00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther					0	6.00
	instructions)	aprot nuo not	procent during		5))) (000		
7.00	Standard travel expense rate					0.00	
3.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stant	s Ai des	5. 19 Trai nees	8.00
		1.00	2.00	3.00	4.00	5. 00	
9.00	Total hours worked	0.00	3, 449. 00	3, 179		0.00	
10.00	AHSEA (see instructions)	0.00	70.00		. 50 17. 50	0.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	35.00	35.00	25	. 25		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0 0	0		0 0		12.0 ⁴ 13.00
13.00	Number of miles driven (provider site)	0	0		0		13.00
			1				
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					241, 430	
16.00	Assistants (column 3, line 9 times column 3,					160, 540	
17.00	Subtotal allowance amount (sum of lines 14 ar others)	nd 15 for respi	ratory therapy	or lines 14	4-16 for all	401, 970	17.00
18.00	Aides (column 4, line 9 times column 4, line	10)				64, 033	18.00
19.00	Trainees (column 5, line 9 times column 5, li					0	
20. 00	Total allowance amount (sum of lines 17-19 fo					466, 003	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete					11110 20	
21.00	Weighted average rate excluding aides and tra			m of columns	s 1 and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine					0	22.00
23.00	Total salary equivalency (see instructions)					466, 003	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPL	JTATION - PE	ROVI DER SITE		-
24 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for al	II others)		0	
27.00	Standard travel expense (line 7 times line 3	for respirator	y therapy or su	um of lines	3 and 4 for all	0	27.00
28. 00	others) Total standard travel allowance and standard	travel expense	at the provide	er site (su	n of lines 26 and	0	28.00
	27)	•				-	
	Optional Travel Allowance and Optional Travel					0	
29.00 30.00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		u z, iine 12)			0	
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for al	II others)		0	
32.00	Optional travel expense (line 8 times columns				by or sum of	0	32.00
22 00	columns 1-3, line 13 for all others)	ovpopco (Liss	20)			0	22 00
33.00 34.00	Standard travel allowance and standard travel Optional travel allowance and standard travel			d 31)		0	
35.00	Optional travel allowance and optional travel					0	
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPUT	TATION - SEF	RVICES OUTSIDE PRO	OVIDER SITE	-
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	
38.00	Subtotal (sum of lines 36 and 37)					0	
39.00	Standard travel expense (line 7 times the sum		d 6)			0	39.00
40. 00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0		2. line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times column		,			0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	
43.00	Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - C		,	a of the fel	Lowing three line	0	43.00
		insite service	s, comprete one		rowing three the	53 44, 40,	
	or 46, as appropriate.						
	or 46, as appropriate. Standard travel allowance and standard travel Optional travel allowance and standard travel						44. 0 45. 0

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I	DUKES MEMORIAL	Provider C	CN: 15-1318	In Lie Period:	u of Form CMS-2 Worksheet A-8	
	E SUPPLIERS				From 01/01/2016 To 12/31/2016	Parts I-VI	pared:
					Physical Therapy		
						1.00	
6.00	Optional travel allowance and optional travel						46.00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4. 00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	0.00	1.00	0.00	
7.00	Overtime hours worked during reporting	0.00	0.00	0.0	0 0.00	0.00	47.00
	period (if column 5, line 47, is zero or						
	equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each						
	column of line 56)						
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	0 0.00		48.0
9.00	Total overtime (including base and overtime	0.00	0.00	0.0	0 0.00		49.0
	allowance) (multiply line 47 times line 48)						
0 00	CALCULATION OF LIMIT Percentage of overtime hours by category	0.00	0.00	0.0	0 0.00	0.00	50.0
0. 00	(divide the hours in each column on line 47	0.00	0.00	0.0	0.00	0.00	50.0
	by the total overtime worked - column 5,						
	line 47)						
1.00	Allocation of provider's standard work year	0.00	0.00	0.0	0 0.00	0.00	51.0
	for one full-time employee times the						
	percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE			<u> </u>		<u> </u>	
2.00	Adjusted hourly salary equivalency amount	70.00	50.50	17.5	0 0.00		52.0
	(see instructions)						
3.00	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
4 00	52)		0				
4.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.0
5.00	Portion of overtime already included in	0	0		0 0		55.0
	hourly computation at the AHSEA (multiply						
	line 47 times line 52)						
6.00	Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.0
	if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EVCESS COST /				1.00	
7.00	Salary equivalency amount (from line 23)	ND LACESS COST A				466, 003	57. C
8.00	Travel allowance and expense - provider site	(from lines 33,	34, or 35))			00,000	
9.00	Travel allowance and expense - Offsite servic)		0	59.0
0.00	Overtime allowance (from column 5, line 56)					0	
1.00	Equipment cost (see instructions)					0	
2.00	Supplies (see instructions)					0	
03.00 04.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	vour recorde)				466, 003	63.C
4.00 5.00	Excess over limitation (line 64 minus line 63	,	enter zero)				65.0
5.00	LINE 33 CALCULATION	i – Ti negative,	enter zero)			0	05.0
00.00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		0	100. 0
00. 01	Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 a	nd 4 for all	others	0	100. C
00.02	Line 33 = line 28 = sum of lines 26 and 27					0	100. 0
04 00	LINE 34 CALCULATION		<u> </u>			0	101 0
	Line 27 = line 7 times line 3 for respiratory				others		101.0 101.0
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	Sum of Times 29	and 30 TOF a	IT others			101.0
01.02	LINE 35 CALCULATION					0	101.0
02.00	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others		0	102. C
	Line $32 = 1$ ine 8 times columns 1 and 2, line				mns 1-3, line		102. C
02.01							1
	13 for all others Line 35 = sum of lines 31 and 32						102. (

					To 12/31/2016 Occupational Therapy	Date/Time Prep 5/30/2017 5:44 Cost	
					-	1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides	c) (coo instruct	tions)		T	0	1.00
2.00	Line 1 multiplied by 15 hours per week	s) (see mistruc	tions)			0	2.00
3.00	Number of unduplicated days in which supervis					0	3.00
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		on provider si	te but neither	⁻ supervi sor	0	4.00
5.00	Number of unduplicated offsite visits - super		apists (see ins	structions)		0	5.00
6.00	Number of unduplicated offsite visits - there					0	6.00
	assistant and on which supervisor and/or the instructions)	apist was not	present during	the visit(s))	(see		
7.00	Standard travel expense rate					0.00	
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1, 278. 00	854.00		0.00	
10.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0.00 35.00	70.00 35.00	50.50 25.25		0.00	10.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0	(12.00
12.00	Number of travel hours (offsite)	0	0	-			12.00
13.00	Number of miles driven (provider site)	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	(13.01
	1					1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					89, 460	1
16.00	Assistants (column 3, line 9 times column 3,					43, 127	
17.00	Subtotal allowance amount (sum of lines 14 an others)	nd 15 for respi	ratory therapy	or lines 14-1	6 for all	132, 587	17.00
18.00	Aides (column 4, line 9 times column 4, line					0	
19.00 20.00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 fo		thoropy or line	ac 17 and 19 f	For all others)	0 132, 587	19.00 20.00
20.00	If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on I	ines 21 and 2	22 and enter on	line 23	
21.00	Weighted average rate excluding aides and tra		divided by sur	n of columns 1	1 and 2, line 9	0.00	21.00
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)				
22.00 23.00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	ees (line 2 time	es line 21)			0 132, 587	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	L EXPENSE COMPU	JTATION - PRON	/IDER SITE		
24.00	Standard Travel Allowance					0	24 00
25.00	Assistants (line 3 times column 2, line 11)					0	1
26.00	Subtotal (line 24 for respiratory therapy or					0	1
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or su	um of lines 3	and 4 for all	0	27.00
28.00	Total standard travel allowance and standard	travel expense	at the provide	er site (sum d	of lines 26 and	0	28.00
	27) Optional Travel Allowance and Optional Travel	Exnense					
29.00	Therapists (column 2, line 10 times the sum of		d 2, line 12)			0	29.00
30.00	Assistants (column 3, line 10 times column 3,			1 - + h `		0	
31.00 32.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns				or sum of	0	31.00 32.00
	columns 1-3, line 13 for all others)						
33.00 34.00	Standard travel allowance and standard travel Optional travel allowance and standard travel			4 31)		0	33.00 34.00
35.00	Optional travel allowance and optional travel					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPUT	TATION - SERVI	CES OUTSIDE PRO	VIDER SITE	-
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00 39.00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur	n of lines 5 and	d 6)			0	
57.00	Optional Travel Allowance and Optional Travel						37.00
40.00	Therapists (sum of columns 1 and 2, line 12.0		2, line 10)			0	
44 5-	Assistants (column 3, line 12.01 times column	n 3, line 10)				0	41.00 42.00
41.00	Subtotal (sum of lines 40 and 41)						1
41.00 42.00 43.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur					0	43.00
42.00				of the follo	wing three line	0	43.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provider C	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016	Worksheet A-8 Parts I-VI Date/Time Prep 5/30/2017 5:4	pared:
					Occupati onal Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel					0	45.00
6.00	Optional travel allowance and optional travel		of lines 42 an			0	46.00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	<u>Total</u> 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0. (0.00	0.00	47.00
	Overtime rate (see instructions)	0.00	0.00				48.00
	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.0	0.00		49.00
	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50.00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	70.00	50.50	0.0	0.00		52.00
	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53.00
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	0	0		0 0	0	56.00
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63)	(from lines 33 es (from lines your records)	, 34, or 35)) 44, 45, or 46)		132, 587 0 0 0 0 132, 587 0 0	58.00 59.00 60.00 61.00 62.00 63.00 64.00
	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	9		II others			100.00
00. 01 00. 02	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	therapy or su	m of lines 3 a	ind 4 for all	others	0	100. 01 100. 02
01. 01 01. 02	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
02.00	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others	sum of lines 2 13 for respira	9 and 30 for a tory therapy c	ll others or sum of colu	umns 1-3, line		102. 00 102. 01

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CC	CN: 15-1318	Peri od: From 01/01/2016 To 12/31/2016	Worksheet A-8- Parts I-VI Date/Time Prep 5/30/2017 5:44	pared:
					Speech Pathology		•
						1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (coo instrue	tions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week		(TOHS)				2.00
3.00	Number of unduplicated days in which supervis	sor or therapis	t was on provi	der site (se	e instructions)	0	3.00
4.00	Number of unduplicated days in which therapy		on provider si	te but neith	ner supervisor	0	4.00
5.00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super		anists (see in	structions)		0	5.00
5.00	Number of unduplicated offsite visits - there				by therapy	0	6.00
	assistant and on which supervisor and/or the	rapist was not	present during	the visit(s	s)) (see		
7.00	instructions) Standard travel expense rate					5. 19	7.00
B. 00	Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants		Trai nees	
9.00	Total hours worked	1.00 0.00	2.00	3.00	4.00 00 0.00	5.00	9.00
10.00	AHSEA (see instructions)	0.00	69.99		00 0.00		10.00
11.00	Standard travel allowance (columns 1 and 2,	35.00	35.00	0.	00		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.0
10.01					0		10.0
						1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					15, 538	
16. 00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 ar	nd 15 for respi	ratory therapy	or lines 14	I-16 for all	15, 538	17.00
18.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19.00
20. 00	Total allowance amount (sum of lines 17-19 for					15, 538	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.					
21.00	Weighted average rate excluding aides and tra			m of columns	s 1 and 2, line 9	69.99	21 00
	for respiratory therapy or columns 1 thru 3, line 9 for all others)						
22.00	Weighted allowance excluding aides and traine	ees (line 2 tim					
22. 00 23. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions)		es line 21)			54, 592 54, 592	22.00
	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW		es line 21)	UTATION - PR	ROVIDER SITE	54, 592	22.00
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance		es line 21)	UTATION - PR	ROVIDER SITE	54, 592 54, 592	22. 00 23. 00
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW		es line 21)	JTATION - PR	ROVI DER SI TE	54, 592 54, 592 0	22. 00 23. 00 24. 00
23.00 24.00 25.00 26.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	ANCE AND TRAVE	es line 21) L EXPENSE COMP 4 and 25 for a	II others)		54, 592 54, 592 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00
23.00 24.00 25.00	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3)	ANCE AND TRAVE	es line 21) L EXPENSE COMP 4 and 25 for a	II others)		54, 592 54, 592 0 0	22. 00 23. 00 24. 00 25. 00 26. 00
23.00 24.00 25.00 26.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	ANCE AND TRAVE sum of lines 2 for respirator	es line 21) L EXPENSE COMPL 4 and 25 for a y therapy or s	ll others) um of lines	3 and 4 for all	54, 592 54, 592 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
23.00 24.00 25.00 26.00 27.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	ANCE AND TRAVE sum of lines 2 for respirator travel expense	es line 21) L EXPENSE COMPL 4 and 25 for a y therapy or s	ll others) um of lines	3 and 4 for all	54, 592 54, 592 0 0 0 0 0 0	22.00 23.00 24.00 25.00 26.00 27.00
23.00 24.00 25.00 26.00 27.00	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional Travel	ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense	es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid	ll others) um of lines	3 and 4 for all	54, 592 54, 592 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	ANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an	es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid	ll others) um of lines	3 and 4 for all	54, 592 54, 592 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a	II others) um of lines er site (sum II others)	3 and 4 for all n of lines 26 and	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 30. 00 31. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a	II others) um of lines er site (sum II others)	3 and 4 for all n of lines 26 and	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 30. 00 31. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	ANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 s 1 and 2, line	es line 21) L EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respire	II others) um of lines er site (sum II others)	3 and 4 for all n of lines 26 and	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)Standard travel allowance and standard travel optional travel allowance and standard travel	ANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an	II others) um of lines er site (sum II others) atory therap d 31)	3 and 4 for all n of lines 26 and	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times columns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and optional travel	ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all n of lines 26 and by or sum of	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times columns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and potional travelOptional travel allowance and optional travelOptional travel allowance and potional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAND	ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all n of lines 26 and by or sum of	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel expense (line 8 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 2, line 11)	ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all n of lines 26 and by or sum of	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelStandard travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)	ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all n of lines 26 and by or sum of	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel expense (line 8 times columns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)	ANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all n of lines 26 and by or sum of	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelStandard travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)	ANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all n of lines 26 and by or sum of	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
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23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times columns)Standard travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 12.01 times column	ANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum NCE AND TRAVEL	es line 21) <u>L EXPENSE COMP</u> 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all n of lines 26 and by or sum of	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 29. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 12.01 times columnSubtotal (sum of lines 40 and 41)	ANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum expense (sum NACE AND TRAVEL n of lines 5 an Expense 1 times column n 3, line 10)	es line 21) L EXPENSE COMPI 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10)	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all n of lines 26 and by or sum of	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)Standard travel allowance and standard travel optional travel allowance and standard travel Optional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard travel expense (line 7 times the sum of the su	ANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum expense (sum ince AND TRAVEL n of lines 5 an <u>Expense</u> D1 times column n 3, line 10) n of columns 1-	es line 21) L EXPENSE COMPI 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	II others) um of lines er site (sun ll others) atory therap d 31) d 32) TATION - SEF	3 and 4 for all n of lines 26 and by or sum of RVICES OUTSIDE PRO	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 	Total salary equivalency (see instructions)PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)Standard travel allowance and standard travel optional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelStandard travel allowance and standard travelOptional travel allowance and standard travelDytional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard travel expenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 12.01 times columnSubtotal (sum of lines 40 and 41)Optional travel expense (line 8 times the sum	ANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL n of lines 5 an Expense 1 times column n 3, line 10) n of columns 1- offsite Service	es line 21) L EXPENSE COMPI 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01) s; Complete on	II others) um of lines er site (sum II others) atory therap d 31) d 32) TATION - SEF	3 and 4 for all n of lines 26 and by or sum of RVICES OUTSIDE PRO	54, 592 54, 592 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I	DUKES MEMORIAL	HOSPITAL Provider CO	°N: 15_1318	Period:	u of Form CMS-2 Worksheet A-8	
	E SUPPLIERS			51. 13 1310	From 01/01/2016 To 12/31/2016	Parts I-VI	pared:
					Speech Pathology		•
						1.00	
6.00	Optional travel allowance and optional travel						46.0
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	0.00	1.00	0.00	
7.00	Overtime hours worked during reporting	0.00	0.00	0. C	0.00	0.00	47.0
	period (if column 5, line 47, is zero or						
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each column of line 56)						
8. 00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
9.00	Total overtime (including base and overtime	0.00	0.00				49.0
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category	0.00	0.00	0. C	0.00	0.00	50.0
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5,						
1.00	line 47) Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51 (
1.00	for one full-time employee times the	0.00	0.00	0.0	0.00	0.00	51.0
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE						
2.00	Adjusted hourly salary equivalency amount	69. 99	0.00	0. C	0.00		52.0
	(see instructions)	_	-		_		
3.00	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
4.00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54.
4.00	line 49 or line 53)	0	0		0 0		54.1
5.00	Portion of overtime already included in	0	0		0 0		55.0
	hourly computation at the AHSEA (multiply						
	line 47 times line 52)						
6. 00	Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56. (
	if negative enter zero) (Enter in column 5						
	the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT				
7.00	Salary equivalency amount (from line 23)	(6 1) 00				54, 592	
8.00 9.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service			`		0	
9.00 0.00	Overtime allowance (from column 5, line 56)		4, 45, 01 40)		0	
1.00	Equipment cost (see instructions)					0	
2.00	Supplies (see instructions)					0	
3.00	Total allowance (sum of lines 57-62)					54, 592	
4.00	Total cost of outside supplier services (from	your records)				0	64.
5.00	Excess over limitation (line 64 minus line 63	- if negative,	enter zero)			0	65.
	LINE 33 CALCULATION						
	Line 26 = line 24 for respiratory therapy or						100.
	Line 27 = line 7 times line 3 for respiratory	therapy or sum	or lines 3 a	nd 4 for all	others		100. 100.
00.02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					0	100.0
01 00	Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 a	nd 4 for all	others	0	101.0
	Line 31 = line 29 for respiratory therapy or				other 5		101.
	Line $34 = sum of lines 27 and 31$						101. (
	LINE 35 CALCULATION						1
~~ ~~	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others			102. (
02.00		10.0		r sum of colu	mns 1_3 line	0	102. (
	Line 32 = line 8 times columns 1 and 2, line	13 for respirate	ory therapy o	i suil oi coru	iiii 3 1-3, TTHE	0	102.
)2. 01	Line 32 = line 8 times columns 1 and 2, line 13 for all others Line 35 = sum of lines 31 and 32	13 for respirate	ory therapy o				102.

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-1318	Period: From 01/01/2016	Worksheet B Part I	
					To 12/31/2016	Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/30/2017 5:4	4 pm
				LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	
		for Cost Allocation			BENEFI TS DEPARTMENT		
		(from Wkst A			DEFARTMENT		
		<u>col. 7)</u>	1.00	0.00	1.00	5.04	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5. 01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 366, 424	1, 366, 424				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 701, 147		1, 701, 14	7		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 611, 875				4 700 700	4.00
5. 01 5. 02	00570 ADMI TTI NG 00590 ADMI NI STRATI VE AND GENERAL	1, 629, 126				1, 730, 799 0	
5.02 7.00	00700 OPERATION OF PLANT	4, 308, 235 1, 529, 597				0	5.02 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	87,717				0	
9.00	00900 HOUSEKEEPI NG	272, 830				0	
10.00	01000 DI ETARY	201, 475				0	
11.00	01100 CAFETERIA	98, 094				0	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	218, 159 197, 059				0	13.00 14.00
15.00	01500 PHARMACY	600, 436				0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	414, 956		34, 30		0	16.00
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 740 (00	007 770		1 100 (5)	01.007	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 710, 692 322, 402				81, 207 12, 807	
43.00	04300 NURSERY	120, 288				4, 150	
101.00	ANCI LLARY SERVICE COST CENTERS	120/200	0,220	0,02	11,100	1,100	101 00
50.00	05000 OPERATING ROOM	928, 394	104, 644			212, 342	
51.00	05100 RECOVERY ROOM	284,028		9, 41		37, 175	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		0 0	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 345, 213	Ű	92, 00	0	368, 303	
54.01	05401 ULTRASOUND	0	0	,2,00	0 0	0	
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00		0	0	24 70	0 0	0	58.00
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	1, 355, 737 407, 293				242, 393 21, 364	60.00 65.00
66.00	06600 PHYSI CAL THERAPY	478, 642	17, 335			29, 021	66.00
67.00	06700 OCCUPATI ONAL THERAPY	132, 592				9, 573	
68.00	06800 SPEECH PATHOLOGY	15, 525	228			635	
69.00	06900 ELECTROCARDI OLOGY	324,835		10, 71		57, 880	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	233, 148 586, 333			0 0	59, 891 51, 085	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	848, 922	0		0 0	250, 312	
	03610 SLEEP LAB	68, 258	12, 237	15, 29	7 7, 373		76.00
	OUTPATIENT SERVICE COST CENTERS		[
90.00		297,097				6, 058	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 175, 929	50, 690	63, 36	6 471, 667	217, 296	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVI CES	351, 851	20, 413	25, 51	8 28, 129	62, 539	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	28, 224, 309	1, 273, 422	1, 591, 86	1, 623, 547	1, 730, 799	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 582		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	591	87, 420		2 0		192.00
194.00	07950 OTHER NRCC	0	0		0 0	0	194.00
	07951 MARKETI NG	164, 601	0		0 10, 025		194. 01
	07952 SENI OR CI RCLE	54			0 0		194.02
194.03 200.00	07953 FREE MEALS Cross Foot Adjustments	0	0		0 0	0	194. 03 200. 00
200.00			0		0 0	0	200.00
202.00		28, 389, 555	1, 366, 424	1, 701, 14	7 1, 633, 572	1, 730, 799	

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/30/2017 5:4	
Cost Center Description	Subtotal	ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	
	5A. 01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS		1				
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 00590 ADMI NI STRATI VE AND GENERAL	4, 632, 108					5.02
7.00 00700 OPERATION OF PLANT	2, 472, 668					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	123, 437					8.00
9.00 00900 HOUSEKEEPI NG	331, 859				441, 293	9.00
10. 00 01000 DI ETARY	292, 717				17, 449	10.00
11. 00 01100 CAFETERI A	157, 834				11, 207	
13.00 01300 NURSING ADMINISTRATION	262, 034			04 0	3, 259	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	280, 283		110, 69		17, 104	
15. 00 01500 PHARMACY	692,038	134, 930			7, 984	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	500, 628	97, 610	93, 39	02 0	14, 430	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 487, 056	484, 914	775, 19	80, 006	119, 781	30.00
31.00 03100 INTENSIVE CARE UNIT	435, 257	84, 864	89, 83	4, 905	13, 881	31.00
43. 00 04300 NURSERY	150, 658	29, 375	17, 77	/4 0	2, 746	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 438, 196	280, 412	356, 14	33, 442	55, 029	50.00
51.00 05100 RECOVERY ROOM	372, 214	72, 572	25, 63	37 0	3, 961	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	C	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 995, 061	388, 987	250, 48	39 22, 773	38, 704	54.00
54. 01 05401 ULTRASOUND	C	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	C	0		0 0	0	56.00
57.00 05700 CT SCAN	C	0		0 0	0	57.00
58. 00 05800 MRI	C	0		0 0	0	58.00
60. 00 06000 LABORATORY	1, 757, 241	342, 618	100, 14	8 329	15, 474	60.00
65. 00 06500 RESPI RATORY THERAPY	505, 716	98, 602	42, 98	38 0	6, 642	65.00
66. 00 06600 PHYSI CAL THERAPY	546, 901	106, 632	58, 99	97 0	9, 116	66.00
67.00 06700 OCCUPATI ONAL THERAPY	154, 928	30, 207	19, 30	05 0	2, 983	67.00
68.00 06800 SPEECH PATHOLOGY	16, 673	3, 251	77	7 0	120	68.00
69. 00 06900 ELECTROCARDI OLOGY	442,850	86, 345	29, 16	09 0	4, 507	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	293, 039	57, 135		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	637, 418	124, 281		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 099, 234	214, 323		0 0	0	73.00
76.00 03610 SLEEP LAB	109, 933	21, 434	41, 64	6 5, 046	6, 435	76.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	356, 621	69, 532	27, 07	/3 0	4, 183	90.00
91. 00 09100 EMERGENCY	4, 978, 948	970, 771	172, 51	7 55, 032	26, 656	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	488, 450	95, 236	69, 47	/3 0	10, 734	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	28, 012, 000	4, 558, 494	2, 638, 25	201, 533	392, 385	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 582	1, 088	18, 99	99 0	2, 936	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	197, 293	38, 467	297, 52	26 0	45, 972	192.00
194.0007950 OTHER NRCC	C	0		0 0	0	194.00
194. 01 07951 MARKETI NG	174, 626	34, 048		0 0		194.01
194. 02 07952 SENI OR CI RCLE	54	11		0 0		194. 02
194.0307953 FREE MEALS	C	0		0 0	0	194. 03
200.00 Cross Foot Adjustments	C					200. 00
201.00 Negative Cost Centers	C	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	28, 389, 555	4, 632, 108	2, 954, 77	201, 533	441, 293	202.00

COST ALLOCATION - CENERAL SERVICE COSTS Provider COL 15-1318		Financial Systems	DUKES MEMORIAL				u of Form CMS-	2552-10	
CHIERDAL SERVICE COST CENTERS 10.00 11.00 13.00 14.00 15.00 1.00 00200 (AP REL COST SERVICES ALL ARCH REAL 0.00 CAPA DURAVEE BLERENT IN CAPACITY AND ALL EQUIP ALL 0.00 CAPA DURAVEE BLERENT IN CAPACITY AND ALL EQUIP ALL 0.00 CAPA DURAVEE BLERENT IN CAPACITY AND ALL EQUIP ALL 0.00 CAPA DURAVEE BLERENT IN CAPACITY AND ALL EQUIP ALL 0.00 CAPA DURAVEE BLERENT IN CAPACITY AND ALL EQUIP ALL 0.00 CAPA DURAVEE BLERENT IN CAPACITY AND ALL EQUIP ALL 0.00 CAPACITY AND ALL EQUIP ALL IN CAPACITY AND ALL EQUIP ALL 0.00 CAPACITY AND ALL EQUIP ALL IN CAPACITY AND ALL EQUIP ALL IN CAPACITY AND AL	COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C			Date/Time Pre		
CRNPRAL SERVICE COST CENTERS 1.00 000100 CAP REL COSTS-BLOG & FLYT 1.00 2.00 00200 CAP REL COSTS-BLOG & FLYT 2.00 5.01 00270 CAP REL COSTS-BUNCH F COULP 2.00 5.01 00270 CAP REL COSTS-BUNCH F COULP 5.01 5.01 00270 CAP REL COSTS-BUNCH F COST CENTERS 5.01 6.00 006800 LANINGY & LINEN SERVICE 9.00 0.00 006800 CAPIREL COSTS-BUNCH F COST CENTERS 8.00 1.00 01300 CAPIREL COSTS-BUNCH F COST CENTERS 3.00 1.00 01300 CAPIREL CASTS-BUNCH F COST CENTERS 3.72 A3 44.699 1.3.23 9.09, 7.00 1.00 1.00 01300 CAPIREL CASTS BUNCH F COST CENTERS 3.01 1.00 1.		Cost Center Description	DI ETARY			N SERVICES &	PHARMACY		
1.00 00100 CAP REL COSTS-BLOG & FIXT 1.00 2.00 00200 CAP REL COSTS-BLOG & FIXT 1.00 2.00 00200 CAP REL COSTS-BLOG & FIXT 0.00 2.00 00200 CAP REL COSTS-BLOG & FIXT 0.00 2.00 00200 CAP REL COSTS-BLOG & FIXT 0.00 2.00 00200 CAPRIEL 0.00 1.00 0100 CAFTERIA 0.00 0.00 1.00 0100 CAFTERIA 0.00 1.00 1.00 0100 CAFTERIA 0.00 0.100 1.00 1.00 0100 CAFTERIA 0.00 1.00 1.00 1.00 0100 CAFTERIA 1.100 1.00 1.00 1.00 0100 CAFTERIA 0.00 1.00 1.00 1.00 0100 CHENALK 0.01 1.00 1.00 <td></td> <td></td> <td>10.00</td> <td>11.00</td> <td>13.00</td> <td>14.00</td> <td>15.00</td> <td></td>			10.00	11.00	13.00	14.00	15.00		
2: 00 0200 CAP REL COSTS-MUBLE SOLVE 00 0200 CAP REL COSTS-MUBLE SOLVE 00 0570 ABMI TING 0: 00 0570 ABMI TI	1 00				1			1 1 00	
11.00 01100 CAFETERIA 10 022,248 11.00 13.00 01300 CENTRAL SERVICES & SUPPLY 0 4,92 0 466,922 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 9,369 0 3.73 909,730 15.00 15.00 01500 MENDIAL RECORDS & LIBRARY 0 9,369 0 466,922 13.00 0 01.00 01400 IEXTROUTER SERVICE COST CENTERS 337,243 8,016 13.23 24,724 0 0.00 0 0 0 43.00 0 000 0 43.00 0 0.00 0 <td< td=""><td>2.00 4.00 5.01 5.02 7.00 8.00</td><td>00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE</td><td></td><td></td><td></td><td></td><td></td><td>2.00 4.00 5.01 5.02 7.00 8.00</td></td<>	2.00 4.00 5.01 5.02 7.00 8.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						2.00 4.00 5.01 5.02 7.00 8.00	
13. 00 01300 NURSI NG ADMINISTRATION 0 2,578 340,055 11.00 13.00 14. 00 01400 CHRIAL SERVICES & SUPPLY 0 8,192 0 666,922 999,730 15.00 15. 00 01500 PHIABMACY 0 8,369 0 13.724 999,730 15.00 0 0.00 </td <td></td> <td></td> <td>480, 170</td> <td></td> <td></td> <td></td> <td></td> <td></td>			480, 170						
14.00 01400 (ENTRAL SERVICES & SUPPLY 0 4,192 0 466,922 14,000 15.00 01500 (HARMACY 0 8,916 0 445 00 10.00 03000 (ADUTS & PEDI ATRICS 337,243 44,46,99 61,233 24,724 0 30.00 10.00 03000 (INTENSI VE CABE UNI T 43,896 8,168 113,629 2,869 0 31.00 43.00 04300 (INTERSI VE CABE UNI T 43,896 8,168 13,629 2,869 0 43.00 ACULLARY SERVICE COST CENTERS 0 15,005 20,786 94,101 0 50.00 00000 (RECOVERY ROM 0 6,790 11,419 4,880 51.00 53.00 53.00 05300 NESTHESI OLOGY 0 0 0 0 54.00 54.00 54.00 54.00 55.00 55.00 55.00 55.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 57.00 57.00 57.00 57.00 57.00 57.00 57.			0						
15.00 01500 PHARMACY 0 9.369 0 13.734 909.730 15.00 10.00 10000 10000 10000 10000 10000 10.00 10.00 10.00 10000 20000 20000 24.59 0 16.00 10.00 031000 INPATIENT ENDERVICE COST CENTERS 337.243 44.699 61.233 24.724 0 30.00 30.00 031000 INTERVICE COST CENTERS 0 0 43.00 0 43.00 30.00 05100 PERVICE COST CENTERS 0 0 0 0 0 50.00 51.00 DSTOD PERVINEN ROMA 0 0 0 0 0 0 0 50.00 52.00 DSTOD PELVERY ROMA 0 0 0 0 0 0 0 50.00 50.00 53.00 DSTOD REATING READIAND 0 0 0 0 0 0 50.00 50.00 54.00 DSA00 RADI OLSCHARMACY 0 0 0 0 50.00 50.00 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0						
16:00 01-600 MEDICAL RECORDS & LIBRARY 0 8.916 0 6.45 0 16:00 10:00 03000 APULTS & PEDIATRIC COST CENTERS 337, 243 44, 699 61, 233 24, 724 0 0 0 0 30:00 0			Ŭ						
INPATIENT NOUTINE SERVICE COST CENTERS									
30.00 03000 ADULTS & PEDIATRICS 337, 243 44, 690 61, 233 24, 724 0 30.00 43.00 04300 NURSENY 0 0 4850 0 4850 0 43.00 43.00 05000 NURSENY 0 15.805 20.766 94.101 50.00 50.00 05000 OPECOVERY ROOM 0 67.900 11.419 4.788 0 51.00 51.00 05300 RECOVERY ROOM 0 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53.00 54.01 05400 RADI OLOGY-OLAGNOSTI C 0 30.193 38.868 23.489 0 54.00 55.00 0500 RADI OLOGY-OLAGNOSTI C 0 0 0 0 0 0 0 54.00 56.00 0500 RADI OLOGY-OLAGNOSTOPE 0 0 0 0 0 0 0 56.00 56.00 56.00 56.00 56.00 <td>16.00</td> <td></td> <td>0</td> <td>8, 916</td> <td></td> <td>0 645</td> <td>0</td> <td>16.00</td>	16.00		0	8, 916		0 645	0	16.00	
13.100 03100 INTERSIVE CARE UNIT 43.906 8,168 13.629 2,869 0 31.00 34.00 04300 NRSERVICE COST CENTERS 0 0 48.50 0 0 50.00 05000 DPERATING ROM 0 15.805 20.786 94.101 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 50.00 52.00 051.00 ABST RESINCE NORT 0 0 0 0 51.00 52.00 52.00 52.00 0 53.00 53.00 53.00 53.00 53.00 53.00 54.01 54.01 0 0 0 0 0 54.01 57.00 65.00 66.00 66.00 66.00	20.00		227 242	44 600	41.00	2 24 724	0	20.00	
43.00 DAGO_NURSERY O 4.850 O O 43.00 ANCILLARY SERVICE COST CENTERS 0 15.805 20.786 94.101 50.00 50.00 51.00 05000 RECVERY ROM 0 67.790 11.419 47.788 51.00 51.00 51.00 50.00 52.00 50.00 50.00				-					
ANCILLARY SERVICE COST CENTERS				-					
50:00 OSDOQ OPERATING ROOM 0 15,805 20,786 94,101 0 50.0 50.0 51:00 OSDOQ RECOVERY ROM 0 6,790 11,419 4,788 51.0 52.00 52:00 DSJOQ ANESTHESI OLGY 0 0 0 0 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 54.01 54.01 54.01 54.01 54.01 54.01 54.00 54.00 54.00 56.00	40.00		ч Ч	0	4,00	0	0	45.00	
51:00 05100 RECOVERY ROOM 0 6,790 11,419 4,788 0 51.00 52:00 05200 DELVERY ROOM & LABOR ROOM 0 0 0 0 52.00 53:00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54:00 05400 RANDOLLOGY-DI ARROSTI C 0 0 0 0 53.00 54:01 05401 ULTRASOUDA 0 0 0 0 54.01 56:00 05600 RAI 0 0 0 0 0 55.00 57:00 05700 CT SCAN 0 0 0 0 55.00 00:00 000 CABOR ATDRY 0 33.441 31,144 86.138 66.00 05:00 06500 RESPI RATORY THERAPY 0 98 0 2.065 66.00 06:00 0 0 0 0 0 0 67.00 06:00 0 0.00 0 0 0 0 72.00 0:00 0.00 0 0 </td <td>50.00</td> <td></td> <td>0</td> <td>15, 805</td> <td>20, 78</td> <td>6 94, 101</td> <td>0</td> <td>50.00</td>	50.00		0	15, 805	20, 78	6 94, 101	0	50.00	
53:00 NESTHESTICOOGY 0 0 0 53:00 ASESTHESTOLOGY 50:00 54:00 55:00 0 0 0 0 0 0 55:00 55:00 55:00 56:00 0 0 0 0 0 0 56:00 50:00 57:00 57:00 57:00 57:00 56:00 0 58:00 0 0 0 0 0 0 0 58:00 0 58:00 0 58:00 0 58:00 0 58:00 0	51.00		0						
54.00 05401 RADIOLOGY-DIAGNOSTIC 0 30, 193 38, 868 23, 489 0 54.00 54.01 05400 INTASSOUND 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 0	0	52.00	
54.01 05401 ULTRASQUIND 0	53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00	
66.00 05600 RADIO I SOTOPE 0 0 0 0 0 0 0 57.00 057.00 057.00 057.00 057.00 057.00 0 0 0 0 0 0 0 0 0 57.00 0 57.00 0 0 0 0 0 57.00 0 0 0 0 0 0 0 57.00 0 0 0 0 0 0 57.00 0 <			0	30, 193	38, 86	8 23, 489			
57.00 05700 CT SCAN 0 0 0 0 57.00 05800 MRI 0 0 0 0 0 57.00 058.00 MRI 0			0	0					
58.00 05800 NRI 0 0 0 0 0 58.00 60.00 06000 LABORATORY 0 33.441 31,144 86,138 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 12.223 0 8.057 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 98 0 2.065 0 66.00 67.00 06700 0 0 0 0 0 67.00 68.00 066800 SPEECH PATHOLOCY 0 0 0 0 68.00 69.00 06800 SPEECH PATHOLOCY 0 16.041 1.285 6 69.00 71.00 07100 MEUCALSPRIJES CHARGED TO PATIENTS 0 0 10 90.71.00 72.00 72.00 72.00 73.00 90.00 72.00 73.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.			0	0		-			
60.00 06000 LABORATORY 0 33,441 31,144 86,138 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 12,223 0 8,057 65.00 66.00 06600 PHYSICAL THERAPY 0 98 0 2,065 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06600 PEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 16.041 0 1,285 6 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.79 0 5,714 0 90.00 90.00 90.00 90.00 90.00 92.00 9000 90.00			0	0					
65.00 06500 RESPIRATORY THERAPY 0 12,223 0 8,057 0 65.00 66.00 06600 PHYSICAL THERAPY 0 98 0 2,065 0 66.00 67.00 05070 0CCUPATIONAL THERAPY 0 0 0 0 0 66.00 68.00 06900 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 069000 ELCTROCARDIOLOGY 0 16,041 0 1,285 6 69.00 71.00 OT100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 123,406 0 72.00 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 0 0 0 0 909,730 73.00 06.00 03610 SLEEP LAB 0 1,614 0 1,064 0 76.00 0.00 09000 CLINIC 23,927 57,142 158,126 15,496 91.00 90.00 92.00 092000 BBERGARLE COST CENTERS 90.00 11,691 0 13,085 95.00 SUPECI			0	0	01.14	-	0		
66.00 06600 PHYSI CAL THERAPY 0 98 0 2,065 0 66.00 67.00 0CCUPATI ONAL THERAPY 0			0				-		
67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 67.00 68.00 06800 SPECT PATHOLOGY 0			0				-		
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 16.041 0 1,285 0 69.00 71.00 OTOCAL SUPPLIES CHARGED TO PATIENTS 0 0 044,907 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 9090,730 73.00 76.00 03010 SLEEP LAB 0 1,614 0 1,064 0 76.00 001PATIENT SERVICE COST CENTERS 0 7,479 0 5,714 0 90.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DI STINCT PART 23,927 57,142 158,126 15,496 91.00 92.00 9200 085ERVATION BEDS (NON-DI STINCT PART 92.00 09500 AMBULANCES SERVICES 0 11,691 0 13,085 0 92.00 95.00 MONREI MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 40			0		1		-		
69.00 06900 ELECTROCARDIOLOGY 0 16.041 0 1.285 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 44,907 0 71.00 72.00 07300 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 123,406 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 9099,730 73.00 03610 SLEEP LAB 0 1,614 0 1,064 0 76.00 0000 CLIN C 0 7,479 0 5,714 0 90.00 91.00 92.00 09200 DBUS (NON-DI STINCT PART 23,927 57,142 158,126 15,496 92.00 95.00 OBSOL AMBULANCE SERVI CES 0 11,691 0 13,085 0 95.00 SPECI AL PURPOSE COST CENTERS 118.00 NOREL MBURSABLE COST CENTERS 90.00 190.00 190.00 190.00 192.00 192.00 192.00			0			-			
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 44,907 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 123,406 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 909,730 73.00 76.00 O3610 SLEEP LAB 0 1,614 0 1,064 0 76.00 00 09000 CLINIC 0 7,479 0 5,714 0 90.00 90.00 91.00 90.00 91.00 92.00 0 92.00 0500/ ABULANCE SERVICE 0 1,691 0 13,085 91.00 92.00 95.00 950.00 950.00 950.00 950.00 950.00 11,691 0 13,085 95.00 95.00 95.00 95.00 95.00 95.00 95.00 118.00 118.00 10.000 13,085 0 118.00 190.001 190.001 190.00 192.00 192.00 192.00 192.00 192.00 194.01 194.01 194.01 194.01			0	-		-			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 123,406 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 909,730 73.00 76.00 OS610 SLEEP LAB 0 1,614 0 1,064 0 00000 CLINIC 0 7,479 0 5,714 0 90.00 90.00 09000 CLINIC 0 7,479 0 5,714 0 90.00 91.00 09100 EMERGENCY 23,927 57,142 158,126 15,496 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 23,927 57,142 158,126 15,496 95.00 95.00 OPSDOI AMBULANCE SERVICES 0 11,691 0 13,085 95.00 95.00 SPECIAL PURPOSE COST CENTERS 118.00 NONREI MBURSABLE COST CENTERS 91.00 92.00 93 0 192.00 190.00 <td></td> <td></td> <td>0</td> <td>-</td> <td></td> <td></td> <td>0</td> <td></td>			0	-			0		
76.00 03610 SLEEP LAB 0 1,614 0 1,064 0 76.00 OUTPATIENT SERVICE COST CENTERS 0 7,479 0 5,714 0 90.00 90.00 90.00 09100 EMRGENCY 23,927 57,142 158,126 15,496 0 92.00 92.00 09500 AMBULANCE SERVICES 0 11,691 0 13,085 0 92.00 92.00 95.00 AMBULANCE SERVICES 0 11,691 0 13,085 0 92.00 92.00 95.00 AMBULANCE SERVICES 0 11,691 0 13,085 0 95.00 95.00 OSOOI AMBULANCE SERVICES 0 11,691 0 13,085 0 95.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 405,066 270,439 340,055 465,567 909,730 188.00 190.00 190000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192.00 192.00 192.00 192.00 192.00 192.00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 123, 406	0	72.00	
OUTPATI ENT SERVICE COST CENTERS O 7,479 O 5,714 O 90.00 90.00 90.00 CLINIC 90.00 13,085 0 95.00 95.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 <td>73.00</td> <td>07300 DRUGS CHARGED TO PATIENTS</td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>909, 730</td> <td>73.00</td>	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	909, 730	73.00	
90.00 09000 CLINIC 0 7,479 0 5,714 0 90.00 91.00 90.00 91.00 90.00 EMERGENCY 23,927 57,142 158,126 15,496 0 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART 92.00 91.00 92.00 00 SPECIAL PURPOSE COST CENTERS 92.00 92.00 95.00 95.00 09500 AMBULANCE SERVICES 0 11,691 0 13,085 0 95.00 95.00 95.00 95.00 95.00 10.00 13,085 0 95.00 96.00 97.00 18.00 95.00 97.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	76.00		0	1, 614		0 1,064	0	76.00	
91.00 09100 EMERGENCY 23,927 57,142 158,126 15,496 0 91.00 92.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART 0 118,012 0 13,085 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 11,691 0 13,085 0 95.00 SPECIAL PURPOSE COST CENTERS 0 11,691 0 13,085 0 95.00 NONREI MBURSABLE COST CENTERS 0 11,691 0 0 0 0 180.00 19			1 1		1	T			
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 92.00 0THER REIMBURSABLE COST CENTERS 0 11,691 0 13,085 0 95.00 95.00 AMBULANCE SERVICES 0 11,691 0 13,085 0 95.00 SPECIAL PURPOSE COST CENTERS 5PECIAL PURPOSE COST CENTERS 500 340,055 465,567 909,730 118.00 NONREI MBURSABLE COST CENTERS 500 0 0 0 0 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 190.00 192.00 192.00 192.00 192.00 192.00 0 0 0 190.00 190.00 192.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00			-	-	1				
OTHER REI MBURSABLE COST CENTERS 95.00 OPSOO AMBULANCE SERVICES 0 11,691 0 13,085 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 405,066 270,439 340,055 465,567 909,730 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 PHYSICI ANS' PRI VATE OFFICES 75,104 59 0 93 0 192.00 190.00 75,104 59 0 190.00 190.00 75,104 59 0 190.00 190.00 75,104 59 0 190.00 192.00 75,104 59 0 192.00 192.00 0 0 192.00 <th colspan<="" td=""><td></td><td></td><td>23, 927</td><td>57, 142</td><td>158, 12</td><td>15, 496</td><td>0</td><td></td></th>	<td></td> <td></td> <td>23, 927</td> <td>57, 142</td> <td>158, 12</td> <td>15, 496</td> <td>0</td> <td></td>			23, 927	57, 142	158, 12	15, 496	0	
95.00 09500 AMBULANCE SERVICES 0 11,691 0 13,085 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 405,066 270,439 340,055 465,567 909,730 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 19200 PHYSI CI ANS' PRI VATE OFFICES 75,104 59 0 93 192.00 194.00 07950 OTHER NRCC 0 0 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.01 194.02 0 0 0 0 194.00 194.01 194.02 0 194.01 194.02 0 194.02 0 194.02 0 194.02 0 194.02 0 194.02 0 194.02 0 194.02 0 194.02 194.02 0 194.02 194.02 <	92.00							92.00	
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 405,066 270,439 340,055 465,567 909,730 118.00 NONREI MBURSABLE COST CENTERS 118.00 0 0 0 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 192.00 194.01 192.00 192.00 192.00 0 0 0 192.00 194.00 0 0 0 192.00 194.00 0 194.00 0 0 0 194.00 194.00 194.00 194.00 194.00 194.02 0 194.01 194.02 0 194.02 194.02 194.02 0 194.02 0 194.02 0 194.02 194.02 194.02 194.02 0 0 0 0 194.02 0 194.02 0 194.02 194.02 194.02 194.02 0 0 0 0 0 0 0 194.02 194.02	05 00			11 (01		0 12 005	0		
118.00 SUBTOTALS (SUM OF LINES 1-117) 405,066 270,439 340,055 465,567 909,730 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 0 0 0 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 192.00 194.01 192.00 194.00 0 0 0 192.00 194.00 0 0 0 194.00 194.00 194.00 194.00 194.00 194.02 194.02 194.02 194.02 194.02 0 0 0 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 0 0 0 0 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 </td <td>95.00</td> <td></td> <td>0</td> <td>11, 091</td> <td></td> <td>0 13,065</td> <td>0</td> <td>95.00</td>	95.00		0	11, 091		0 13,065	0	95.00	
NORREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 75, 104 59 0 93 0 192.00 194.00 07950 OTHER NRCC 0 0 0 0 194.00 194.01 07951 MARKETI NG 0 1, 850 0 1, 262 0 194.01 194.02 07952 SENIOR CI RCLE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 194.03 194.03 201.00 Negative Cost Centers 0 0 0 0 194.03	118 00		405 066	270 439	340.05	5 465 567	909 730	118 00	
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 75, 104 59 0 93 0 192.00 194.00 07950 OTHER NRCC 0 0 0 0 0 194.00 194.01 07950 OTHER NRCC 0 0 0 0 194.00 194.02 07952 SENI OR CI RCLE 0 1,850 0 1,262 194.01 194.02 07952 SENI OR CI RCLE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.03 200.00 Cross Foot Adj ustments 200.00 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 201.00	110.00		403,000	270, 437	340,00	405, 507	707,730	110.00	
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 75, 104 59 0 93 0 192.00 194.00 07950 OTHER NRCC 0 0 0 0 194.00 194.01 07951 MARKETI NG 0 1,850 0 1,262 0 194.01 194.02 07952 SENI OR CI RCLE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 0 0 0 201.00	190.00		0	0		0 0	0	190.00	
194.00 07950 OTHER NRCC 0 0 0 0 194.00 194.01 07951 MARKETING 0 1,850 0 1,262 0 194.01 194.02 07952 SENIOR CIRCLE 0 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 200.00 0 0 201.00			75, 104	59					
194.01 07951 MARKETI NG 0 1,850 0 1,262 0 194.01 194.02 07952 SENI OR CI RCLE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.03 200.00 Cross Foot Adjustments 0 0 0 0 201.00			0	0		0 0			
194.02 07952 SENIOR CIRCLE 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.03 200.00 Cross Foot Adjustments 201.00 0 0 0 0 201.00			0	1, 850		0 1, 262			
200.00 Cross Foot Adjustments 200.00			0	0		0 0			
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>			0	0		0 0	0		
202.00 [101AL (sum lines 118-201) 480,170 272,348 340,055 466,922 909,730 202.00			0	0		0 0			
	202.00	0 AL (sum lines 118-201)	480, 170	272, 348	340, 05	5 466, 922	909, 730	202.00	

COST ALL	LOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1318	Period:	Worksheet B
0001 7122					From 01/01/2016 To 12/31/2016	Part I Date/Time Prepared: 5/30/2017 5:44 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		
		16.00	24.00	25.00	26.00	
	ENERAL SERVICE COST CENTERS					
	0100 CAP REL COSTS-BLDG & FIXT					1.00
	0200 CAP REL COSTS-MVBLE EQUIP					2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT					4.00
	0570 ADMI TTI NG					5.01
	0590 ADMINI STRATI VE AND GENERAL					5. 02
	0700 OPERATION OF PLANT					7.00
	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING					8.00
	1000 DI ETARY					10.00
	1100 CAFETERI A					11.00
	1300 NURSI NG ADMI NI STRATI ON					13.00
	1400 CENTRAL SERVICES & SUPPLY					14.00
15.00 0	1500 PHARMACY					15.00
16.00 0	1600 MEDICAL RECORDS & LIBRARY	715, 621				16.00
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS	33, 577	4, 448, 428		0 4, 448, 428	30.00
	3100 I NTENSI VE CARE UNI T	5, 295	702, 601		0 702, 601	31.00
	4300 NURSERY	1, 716	207, 119		0 207, 119	43.00
	NCI LLARY SERVICE COST CENTERS	07.700		1		
	5000 OPERATING ROOM	87, 798	2, 381, 715		0 2, 381, 715	50.00
	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM	15, 371	512, 752 0	1	0 512, 752 0 0	51.00 52.00
	5300 ANESTHESI OLOGY	0	0		0 0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	152, 263	2, 940, 827		0 2, 940, 827	54.00
	5401 ULTRASOUND	0	2, 710, 027		0 0	54.01
	5600 RADI OI SOTOPE	0	0	1	0 0	56.00
57.00 0	5700 CT SCAN	0	C)	0 0	57.00
58.00 0	5800 MRI	0	C		0 0	58.00
	6000 LABORATORY	100, 223	2, 466, 756		0 2, 466, 756	60.00
	6500 RESPI RATORY THERAPY	8, 834	683, 062		0 683, 062	65.00
1	6600 PHYSI CAL THERAPY	11, 999	735, 808		0 735, 808	66.00
	6700 OCCUPATIONAL THERAPY	3, 958	211, 381		0 211, 381	67.00
	6800 SPEECH PATHOLOGY	263	21, 084	1	0 21,084	68.00
	6900 ELECTROCARDIOLOGY 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 932 24, 764	604, 129 419, 845		0 604, 129 0 419, 845	69.00 71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	24, 704	906, 227		0 906, 227	72.00
	7300 DRUGS CHARGED TO PATIENTS	103, 498	2, 326, 785		0 2, 326, 785	73.00
	3610 SLEEP LAB	2, 799	189, 971		0 189, 971	76.00
	UTPATIENT SERVICE COST CENTERS			1		
90.00 0	9000 CLI NI C	2, 505	473, 107		0 473, 107	90.00
	9100 EMERGENCY	89, 846	6, 548, 461		0 6, 548, 461	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
	THER REIMBURSABLE COST CENTERS			1		
	9500 AMBULANCE SERVICES	25, 858	714, 527		0 714, 527	95.00
	PECIAL PURPOSE COST CENTERS	745 (04	07 404 505		0 07 404 505	
118.00	SUBTOTALS (SUM OF LINES 1-117)	715, 621	27, 494, 585		0 27, 494, 585	118.00
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28, 605		0 28, 605	190. 00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSICIANS' PRIVATE OFFICES	0	654, 514	1	0 654, 514	190.00
	7950 OTHER NRCC	0	054, 514	1	0 0 0	192.00
	7951 MARKETI NG	0	211, 786		0 211, 786	194.00
	7952 SENI OR CI RCLE	0	65		0 65	194.02
	7953 FREE MEALS	0	0		0 0	194. 03
		1	0			200.00
200.00	Cross Foot Adjustments		0		0	200.00
200. 00 201. 00	Negative Cost Centers	о	0		0 0	200.00

Health Financial Sy	stems	DUKES MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPIT			Provider CC	CN: 15-1318	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/30/2017 5:4	pared:
			CAPI TAL REL	ATED COSTS			
Cost Co	enter Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	ICE COST CENTERS _ COSTS-BLDG & FIXT						1.00
	_ COSTS-BEDG & TTXT						2.00
	E BENEFITS DEPARTMENT	0	9, 643	12, 05	54 21, 697	21, 697	4.00
5. 01 00570 ADMI TTI	NG	0	14, 672	18, 34		912	5. 01
	STRATIVE AND GENERAL	0	69, 567	86, 96		2, 223	5.02
7.00 00700 OPERAT		0	404, 355	505, 46		442	7.00
	/ & LINEN SERVICE	0	15, 875	19, 84		0	8.00
9.00 00900 HOUSEKI		0	13, 143	16, 42		391	9.00
10. 00 01000 DI ETAR 11. 00 01100 CAFETEI		0	33, 182 21, 312	41, 48 26, 64		220 157	10.00 11.00
	G ADMI NI STRATI ON	0	6, 198	7,74		397	13.00
	_ SERVICES & SUPPLY	0	32, 525	40, 65		133	14.00
15.00 01500 PHARMA	CY	0	15, 183	18, 98		763	15.00
	_ RECORDS & LI BRARY	0	27, 441	34, 30	03 61, 744	318	16.00
	UTINE SERVICE COST CENTERS						
	& PEDIATRICS	0	227, 772	284, 73		2, 426	30.00
31.00 03100 I NTENS 43.00 04300 NURSER	VE CARE UNIT	0	26, 396 5, 223	32, 99 6, 52		540 192	31.00 43.00
	RVICE COST CENTERS	<u> </u>	5,225	0, 52	11,752	172	43.00
50.00 05000 OPERAT		0	104, 644	130, 81	13 235, 457	823	50.00
51.00 05100 RECOVER		0	7, 533	9, 41		452	51.00
	RY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTH		0	0		0 0	0	53.00
	DGY-DI AGNOSTI C	0	73, 600	92, 00		1, 540	54.00
54.01 05401 ULTRAS		0	0		0 0	0	54.01 56.00
57.00 05700 CT SCAL		0	0			0	57.00
58.00 05800 MRI	•	0	0		0 0	0	58.00
60.00 06000 LABORA	FORY	0	29, 426	36, 78	66, 211	1, 234	60.00
65.00 06500 RESPI R/	ATORY THERAPY	0	12, 631	15, 79	90 28, 421	646	65.00
66. 00 06600 PHYSI C/		0	17, 335	21, 67		3	66.00
	FIONAL THERAPY	0	5, 672	7, 09		0	67.00
68.00 06800 SPEECH		0	228		35 513	0	68.00
69.00 06900 ELECTRO	_ SUPPLIES CHARGED TO PATIENT	0	8, 571	10, 71	14 19, 285 0 0	543 0	69.00 71.00
	DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03610 SLEEP I	_AB	0	12, 237	15, 29	97 27, 534	98	76.00
	ERVICE COST CENTERS	-					
90.00 09000 CLINIC 91.00 09100 EMERGEI		0	7, 955	9, 94 63, 36		472	90.00
	ATION BEDS (NON-DISTINCT PART	0	50, 690	03, 30	56 114, 056	6, 265	91.00 92.00
	RSABLE COST CENTERS	I			<u>Ч</u>		72.00
95.00 09500 AMBULA		0	20, 413	25, 51	18 45, 931	374	95.00
	OSE COST CENTERS						
	ALS (SUM OF LINES 1-117)	0	1, 273, 422	1, 591, 86	65 2, 865, 287	21, 564	118.00
	BLE COST CENTERS		5 500				100.00
	FLOWER, COFFEE SHOP & CANTEEN ANS' PRIVATE OFFICES	0	5, 582	109, 28	0 5, 582		190.00
194. 00 07950 OTHER 1		0	87, 420 0	109, 28	32 196, 702 0 0		192.00 194.00
194. 01 07951 MARKET		0	0		0 0		194.00
194. 02 07952 SENI OR		0	0		0 0		194. 02
194.0307953 FREE MI	EALS	0	0		0 0	0	194. 03
	Foot Adjustments				0		200. 00
	ve Cost Centers		0	1 701 4			201.00
202.00 TOTAL	(sum lines 118-201)	0	1, 366, 424	1, 701, 14	47 3, 067, 571	21, 697	1202. UU

Heal th	Financial Systems	DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre	
	Cost Center Description	ADMI TTI NG	ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	5/30/2017 5: 4 HOUSEKEEPI NG	4 pm
		5.01	5. 02	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS			•	-		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG	33, 924	ļ				5.01
5.02	00590 ADMINISTRATIVE AND GENERAL	C	158, 754				5.02
7.00	00700 OPERATION OF PLANT	C	16, 522	926, 78	8		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	C	825				8.00
9.00	00900 HOUSEKEEPI NG	C	2, 217			46, 210	9.00
10.00	01000 DI ETARY	C	1, 956			1, 827	10.00
11.00	01100 CAFETERI A	C	1, 055			1, 174	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	C	1, 751	6, 61		341	13.00
	01400 CENTRAL SERVICES & SUPPLY	C	.,			1, 791	14.00
	01500 PHARMACY	C	.,			836	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	C	3, 345	29, 29	3 0	1, 511	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 505				40.540	
	03000 ADULTS & PEDIATRICS	1, 595				12, 542	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	252				1, 454	31.00
43.00		82	1,007	5, 57	5 0	288	43.00
E0 00	ANCI LLARY SERVI CE COST CENTERS	4, 170	9, 610	111, 70	8 8, 876	5, 762	50.00
	05100 RECOVERY ROOM	4, 170		8, 04		5, 782	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	/ 30			0 0	415	52.00
53.00	05300 ANESTHESI OLOGY				0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 166	, s	78, 56	-	4, 053	54.00
54.00	05401 ULTRASOUND	, 100			0 0,044	4,000	54.00
56.00	05600 RADI OI SOTOPE				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	4,760	11, 742	31, 41	2 87	1, 620	60.00
65.00	06500 RESPI RATORY THERAPY	420				696	65.00
66.00	06600 PHYSI CAL THERAPY	570		18, 50		955	66.00
67.00	06700 OCCUPATIONAL THERAPY	188	1,035	6, 05	5 0	312	67.00
68.00	06800 SPEECH PATHOLOGY	12	111	24	4 0	13	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 137	2, 959	9, 14	9 0	472	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 176	1, 958		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,003	4, 259		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 916	7, 345		0 0	0	73.00
76.00	03610 SLEEP LAB	133	735	13, 06	3 1, 339	674	76.00
	OUTPATIENT SERVICE COST CENTERS	1	1	1			
90.00	09000 CLINIC	119				438	90.00
91.00	09100 EMERGENCY	4, 267	33, 278	54, 11	1 14, 607	2, 791	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	1.000	0.0(4	04.70		4 404	05 00
95.00	09500 AMBULANCE SERVICES	1, 228	3, 264	21, 79	1 0	1, 124	95.00
110 00	SPECIAL PURPOSE COST CENTERS	22.024	154 000	007 50	0 E2 402	41 000	110 00
118.00		33, 924	156, 232	827, 50	8 53, 492	41, 089	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	37	5, 95	9 0	500	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES		1, 318				190.00
	07950 OTHER NRCC		, 1, 310	73, 32			192.00
	07951 MARKETI NG		1, 167				194.00
	07952 SENI OR CI RCLE				0 0		194.01
	07953 FREE MEALS				0 0		194.02
200.00						0	200.00
201.00		0	0		0 0	0	201.00
202.00		33, 924	158, 754	926, 78	8 53, 492		202.00
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ALLOCATION OF CAPITAL RELATED COSTS Provider CON 15-1318 Provider CON 15-131 Provider CON 15-131 Provider CON 15-1318 Provider CON 15-1		Financial Systems	DUKES MEMORIAL				u of Form CMS-	2552-10
DIFERRY CAFETERIA WIM NISH ON DUPLY MIRSH NG WIM NISH ON DUPLY CAFETERIA WIM NISH ON DUPLY PURAWAY 00 00000 (AP RL COSTS-RUCA & LIXI COSTS RUCA & LIXI COUDER DUPLY 11.00 13.00 14.00 15.00 1.00 001001 (AP RL COSTS-RUCA & LIXI COSTS RUCA & LIXI COSTS RU	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	Fi	rom 01/01/2016	Part II Date/Time Pre	pared:
Element Stervice Construction 1.00 00000 CAP REL<00STS-MUELE GUIP 1.00 2.00 00000 CAP REL<00STS-MUELE GUIP 2.00 3.00 00000 CAP REL<00STS-MUELE GUIP 5.01 5.01 00000 CAMITIN STRATUE AND GENERAL 5.01 5.00 00000 LAINDRY AL INER SERVICE 9.00 9.00 00000 DOBSTREEPING 9.00 10.00 01000 DESTREE SERVICE 9.00 10.00 01000 DESTREE SERVICE 0 1.22,820 10.00 01000 DESTREE SERVICE 0 1.22,820 0 1.00 10.00 01000 DESTREE SERVICE 0 1.22,824 0 1.66 0 6.00 10.00 01000 DESTREE SERVICE 0 2.333 0 1.64 0 1.00 1.00 1.00 1.00 0 3.09 0 3.00 0 3.00 0 3.00 0 3.00 0		Cost Center Description	DI ETARY	CAFETERI A		SERVICES &		
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2.00 00200 [CAP FFL COSTS-UNRE FOUP 2.00 CAP FFL COSTS-UNRE FOUP 4.00 0400 (DAP FFL COSTS-UNRE F OUP 2 BLEFT S DEPARTMENT S DEPARTM								
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57.00 OTS CON CT SCAN O O O O S7.00 S8.97 S7.00 S6.00	54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
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69.00 06900 ELECTROCARDIOLOGY 0 4,305 0 310 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 10,851 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 29.821 72.00 73.00 07300 RUGS CHARGED TO PATIENTS 0 0 0 62,427 73.00 76.00 03610 SLEEP LAB 0 433 0 257 0 76.00 001700 BMERGENCY 5,685 15,335 11,039 3,744 0 91.00 92.00 D9200 DBEDS (NON-DI STINCT PART 5,685 15,335 11,039 3,162 0 92.00 92.00 D9500 AMBULANCE SERVICES 0 3,138 0 3,162 0 92.00 92.00 D9500 AMBULANCE SERVICES 0 3,138 0 3,162 0 100.00 190.00 190.00			0			-	0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 10,851 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 29,821 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 29,821 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 433 0 257 0 76.00 001701 ENT SERVICE COST CENTERS 0 2,007 0 1,381 0 90.00 91.00 09000 CLINIC 0 2,007 0 1,381 0 90.00 92.00 DSSOQ AMBURADE SERVICES 0 3,138 0 3,162 0 92.00 950.01 MURLANCE SERVICES 0 3,138 0 3,162 0 95.00 950.01 MURLANCE SERVICES 0 3,138 0 3,162 0 95.00 9100.00 IFT, FLOWER, COFFEE SHOP & CANTEEN			0			-		1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 29, 821 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 62, 427 73.00 76.00 03610 SLEEP LAB 0 433 0 257 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 2,007 0 1,381 0 90.00 90.00 91.00 90.00 91.00 92.00 0SERVATION BEDS (NON-DISTINCT PART 92.00 0SERVATION BEDS (NON-DISTINCT PART 92.00 3,142 0 91.00 92.00 0SERVATION BEDS (NON-DISTINCT PART 95.00 3,138 0 3,162 0 95.00 9500 AMBULANCE SERVICES 0 3,138 0 3,162 0 95.00 95.00 95.00 95.00 95.00 118.00 NONREI MBURSABLE COST CENTERS 118.00 1000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 192.00 192.00 1			0					1
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 62,427 73.00 76.00 03610 SLEEP LAB 0 433 0 257 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 433 0 257 0 76.00 90.00 09000 CLINIC 0 2,007 0 1,381 0 90.00 91.00 09000 CLINIC 5,685 15,335 11,039 3,744 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92.00 95.00			0					1
76.00 03610 SLEEP LAB 0 433 0 257 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 2,007 0 1,381 0 90.00 90.00 0 1,381 0 90.00 90.00 0 1,381 0 90.00 91.00 90.00 0 1,381 0 90.00 92.00 005ERVATION BEDS (NON-DISTINCT PART 0 1,335 11,039 3,744 0 92.00 92.00 03.138 0 3,162 92.00 92.00 92.00 0050C AMBULANCE SERVICES 0 3,138 0 3,162 95.00			-					
OUTPATIENT SERVICE COST CENTERS O <t< td=""><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td></td><td></td></t<>			-			-		
90.00 09000 CLINIC 0 2,007 0 1,381 0 90.00 91.00 09100 EMERGENCY 5,685 15,335 11,039 3,744 0 91.00 92.00 09200 (DBSERVATION BEDS (NON-DISTINCT PART) 5,685 15,335 11,039 3,744 0 92.00 07500 (AMBULANCE SERVICES 0 3,138 0 3,162 0 95.00 09500 (AMBULANCE SERVICES 0 3,138 0 3,162 0 95.00 95.00 SUBTOTALS (SUM OF LINES 1-117) 96,243 72,578 23,743 112,499 62,427 118.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 96,243 72,578 23,743 112,499 62,427 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 17,844 16 0 22 0 192.00 194.00 07950 OTHER NRCC	70.00			100		207	0	/ 0. 00
91.00 09100 EMERGENCY 5,685 15,335 11,039 3,744 0 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART 0 01 0 92.00 92.00 OTHER REI MBURSABLE COST CENTERS 0 3,138 0 3,162 0 92.00 SPECI AL PURPOSE COST CENTERS 0 3,138 0 3,162 0 95.00 NONREI MBURSABLE COST CENTERS 0 0,23,733 112,499 62,427 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 17,844 16 0 22 0 192.00 194.00 07950 OTHER NRCC 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 0 0 0 194.03 0	90.00		0	2,007	0	1, 381	0	90.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92.00 OTHER REI MBURSABLE COST CENTERS 92.00 95.00 09500 AMBULANCE SERVI CES 0 3,138 0 3,162 0 SPECIAL PURPOSE COST CENTERS 0 3,138 0 3,162 0 95.00 NONREI MBULANCE SERVI CES 0 3,138 0 3,162 0 95.00 NONREI MUROSE COST CENTERS							0	
OTHER REIMBURSABLE COST CENTERS 95.00 OPSOO AMBULANCE SERVI CES O 3, 138 O 3, 162 O 50.00 SPECIAL PURPOSE COST CENTERS 95.00 3, 138 O 3, 162 O 95.00 SPECIAL PURPOSE COST CENTERS 95.00 3, 138 O 3, 162 O 95.00 SPECIAL PURPOSE COST CENTERS 95.00 3, 138 O 3, 162 O 95.00 300 3, 162 O 3, 162 O 95.00 300	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 96,243 72,578 23,743 112,499 62,427 118.00 NONREL MBURSABLE COST CENTERS 0 0 0 0 190.00 19200 FIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 19200 PHYSI CLANS' PRI VATE OFFI CES 17,844 16 0 222 0 192.00 19200 0 19200 0 0 192.00 19200 0 192.00 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 17,844 16 0 222 0 192.00 194.00 07950 OTHER NRCC 0 0 0 194.01 0144.01 0144.01 194.02 07952 SENI OR CI RCLE 0 0 0 0 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.02 194.03 200.00 0 0 194.03 200.00			· ·					
118.00 SUBTOTALS (SUM OF LINES 1-117) 96,243 72,578 23,743 112,499 62,427 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 17,844 16 0 22 0 192.00 194.00 07950 OTHER NRCC 0 0 0 0 194.00 194.01 07951 MARKETI NG 0 497 0 305 0 194.02 194.02 07952 SENI OR CI RCLE 00 0 0 0 194.02 194.02 07953 FREE MEALS 0 0 0 0 194.02 194.02 07953 FREE MEALS 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.03 200.00 Cross Foot Adjustments	95.00		0	3, 138	0	3, 162	0	95.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 17,844 16 0 22 0 192.00 194.00 07950 OTHER NRCC 0 0 0 0 194.00 194.01 07951 MARKETI NG 0 497 0 305 0 194.02 194.02 07952 SENI OR CL RCLE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 194.03 201.00 Negative Cost Centers 0 0 0 0 201.00								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 17,844 16 0 22 0 192.00 194.00 07950 OTHER NRCC 0 0 0 0 194.00 194.01 07951 MARKETING 0 497 0 305 0 194.02 194.02 07952 SENI OR CI RCLE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	118.00		96, 243	72, 578	23, 743	112, 499	62, 427	118.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 17,844 16 0 22 0 192.00 194.00 07950 OTHER NRCC 0 0 0 0 194.00 194.01 07950 MARKETI NG 0 497 0 305 0 194.01 194.02 07952 SENI OR CLECE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.03 200.00 Cross Foot Adjustments								
194.00 07950 OTHER NRCC 0 0 0 194.00 194.01 07951 MARKETING 0 497 0 305 0 194.01 194.02 07952 SENI OR CIRCLE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.03 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0			0		
194.01 07951 MARKETING 0 497 0 305 0 194.01 194.02 07952 SENI OR CIRCLE 0 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.03 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			17, 844					
194.02 07952 SENI OR CIRCLE 0 0 0 194.02 194.03 07953 FREE MEALS 0 0 0 0 194.03 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0			-		
194.03 07953 FREE MEALS 0 0 0 194.03 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 200.00 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			s					
200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 201.00 0			-	0	0	0		
201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00			0	Ŭ	0	0	0	
				~		~	0	
			111 007	U 72 001		112 024		
	202.00		4, 007	13,091	1 23, 143	112,020	02,427	1202.00

	nancial Systems	DUKES MEMORIAL		CN: 15 1210		u of Form CMS-2552-1
ALLUCAII(ON OF CAPITAL RELATED COSTS		Provider C	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/30/2017 5:44 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		
		16.00	24.00	25.00	26.00	
GE	NERAL SERVICE COST CENTERS					
1.00 00	0100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00	D200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00	D400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00	D570 ADMI TTI NG					5.01
5.02 00	0590 ADMINISTRATIVE AND GENERAL					5. 02
7.00 00	0700 OPERATION OF PLANT					7.00
B. 00 0C	0800 LAUNDRY & LINEN SERVICE					8.00
9.00 00	0900 HOUSEKEEPI NG					9.00
10.00 01	1000 DI ETARY					10.00
	1100 CAFETERI A					11.00
	1300 NURSI NG ADMI NI STRATI ON					13.00
	1400 CENTRAL SERVICES & SUPPLY					14.00
	1500 PHARMACY					15.00
	1600 MEDICAL RECORDS & LIBRARY	98, 760				16.00
	IPATIENT ROUTINE SERVICE COST CENTERS	1		1		
	3000 ADULTS & PEDIATRICS	4,634	917, 075	1	0 917,075	30.00
	3100 INTENSIVE CARE UNIT	731	109, 025		0 109,025	31.00
		237	19, 472	2	0 19, 472	43.00
	ICI LLARY SERVI CE COST CENTERS	10 110	414 055		0 414 055	FO. 00
	5000 OPERATING ROOM 5100 RECOVERY ROOM	12, 118	416, 955	1	0 416, 955 0 34, 972	50.00 51.00
	5200 DELIVERY ROOM & LABOR ROOM	2, 121	34, 972		0 34, 972 0 0	51.00
	5300 ANESTHESI OLOGY	0	0		0 0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	21,006	313, 806		0 313, 806	54.00
	5401 ULTRASOUND	21,000	010,000		0 0	54.0
	5600 RADI OI SOTOPE	0	0		0 0	56.00
	5700 CT SCAN	0	0		0 0	57.00
	5800 MRI	0	C		0 0	58.00
	5000 LABORATORY	13, 833	162, 863	3	0 162, 863	60.00
	5500 RESPI RATORY THERAPY	1, 219	53, 492	2	0 53, 492	65.00
66.00 06	5600 PHYSI CAL THERAPY	1, 656	64, 873	3	0 64, 873	66.00
67.00 06	5700 OCCUPATI ONAL THERAPY	546	20, 899		0 20, 899	67.00
68.00 06	5800 SPEECH PATHOLOGY	36	929		0 929	68.00
	5900 ELECTROCARDI OLOGY	3, 303	41, 463	3	0 41, 463	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 418	17, 403		0 17,403	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	2, 915	37, 998		0 37, 998	72.00
	7300 DRUGS CHARGED TO PATIENTS	14, 285	88, 973		0 88, 973	73.00
	3610 SLEEP LAB	386	44, 652	2	0 44, 652	76.00
	JTPATIENT SERVICE COST CENTERS	0.44	00 507	,	0 00 507	
		346	33, 537		0 33, 537	90.00
	9100 EMERGENCY	12, 401	277, 579		0 277, 579	91.00
	2200 OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
	THER REIMBURSABLE COST CENTERS	3, 569	83, 581	1	0 83, 581	95.00
	PECIAL PURPOSE COST CENTERS	3, 309	03, 301		0 03, 301	93.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	98, 760	2, 739, 547	/	0 2, 739, 547	118.00
	DNREI MBURSABLE COST CENTERS	70,700	2,107,017	1	2,107,017	
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 885	5	0 11, 885	190. 00
	2200 PHYSICIANS' PRIVATE OFFICES	0	314, 037		0 314,037	192.00
	7950 OTHER NRCC	0	014,007		0 0	192.00
	7951 MARKETI NG	0	2, 102		0 2, 102	194. 0
	7952 SENI OR CI RCLE	0	2, 102		0 2,102	194. 02
	7953 FREE MEALS	0	0		0 0	194. 03
194, 03/07		, V	0	1	-	
	Cross Foot Adjustments		0		0 01	200 00
194. 03 07 200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers	0	0		0 0	200. 00 201. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	DUKES MEMORI	AL HOSPITAL Provider CO	N. 15 1010	In Lie Period:	u of Form CMS-2	2552-10
CUST A	LLUCATION - STATISTICAL BASIS		Provider CC	F	rom 01/01/2016	Worksheet B-1	
				T	o 12/31/2016	Date/Time Pre 5/30/2017 5:4	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	Reconciliation	
			(SQUARE FEE T)	BENEFITS	(GROSS CHAR		
				DEPARTMENT	GES)		
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5.01	5A. 02	
1 00	GENERAL SERVICE COST CENTERS	107 520					1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	197, 538	196, 731				1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 394		11, 522, 067			4.00
5.01	00570 ADMI TTI NG	2, 121		484, 288			5.01
5.02 7.00	00590 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	10, 057 58, 456		1, 180, 311 234, 500		-4, 632, 108 0	5.02 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 295		234, 300	0 0	0	
9.00	00900 HOUSEKEEPI NG	1, 900	1, 900	207, 772	0	0	9.00
10.00	01000 DI ETARY	4, 797		116, 945		0	10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	3, 081 896		83, 133 211, 096		0	11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	4, 702		70, 813		0	14.00
15.00	01500 PHARMACY	2, 195		405, 134		0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	3, 967	3, 967	168, 768	0	0	16.00
30.00	03000 ADULTS & PEDIATRICS	32, 928	32, 928	1, 288, 311	7, 894, 946	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	3, 816		286, 750		0	
43.00	04300 NURSERY	755	755	102, 048	403, 493	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	15, 128	15, 128	437, 325	20, 643, 822	0	50.00
51.00	05100 RECOVERY ROOM	1, 089		240, 242		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	017 754	0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	10, 640	10, 640	817, 754	35, 811, 944	0	54.00 54.01
56.00	05600 RADI OI SOTOPE	0	0	C	0 0	0	56.00
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58.00		0	0	(55.050	0	0	58.00
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	4, 254 1, 826		655, 250 343, 060		0	60.00 65.00
66. 00	06600 PHYSI CAL THERAPY	2, 506		1, 641		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	820		C		0	67.00
68.00	06800 SPEECH PATHOLOGY	33		C	61, 740	0	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1,239	1, 239 0	288, 126		0	69.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		4, 966, 451	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	24, 335, 190	0	73.00
76.00	03610 SLEEP LAB	1, 769	1, 769	52, 004	658, 008	0	76.00
90.00	OUTPATIENT SERVICE COST CENTERS	1, 150	1, 150	250, 861	589,000	0	90.00
	09100 EMERGENCY	7, 328					
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05 00		2.051	2.051	100 403	4 000 014	0	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	2,951	2, 951	198, 403	6, 080, 014	0	95.00
118.00		184, 093	184, 093	11, 451, 360	168, 273, 212	-4, 632, 108	118.00
	NONREI MBURSABLE COST CENTERS				1		1.05
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	807		C			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 OTHER NRCC	12,638	12, 638 0		0		192.00 194.00
	07951 MARKETI NG	0	0	70, 707	0		194.00
194.02	07952 SENIOR CIRCLE	0	0	C	0	0	194.02
	07953 FREE MEALS	0	0	C	0	0	194.03
200.00 201.00							200.00
201.00		1, 366, 424	1, 701, 147	1, 633, 572	1, 730, 799		201.00
	Part I)						
203.00		6. 917272	8. 647071	0. 141778			203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			21, 697	33, 924		204.00
005 00				0.001883	0. 000202		205.00
205.00							

	Financial Systems LLOCATION - STATISTICAL BASIS	DUKES MEMORI	AL HOSPITAL Provider C	CN: 15 1210 5	In Lie Period:	u of Form CMS- Worksheet B-1	
CUST	LLUCATION - STATISTICAL DASIS		Provider C	F	rom 01/01/2016 o 12/31/2016		epared:
	Cost Center Description	ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEE T)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEE T)	DIETARY	
	1	5.02	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1	1		1		1.00
2.00 4.00 5.01 5.02 7.00 8.00	00200 CAP REL COSTS-BUBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	23, 757, 447 2, 472, 668 123, 437	125, 510				1.00 2.00 4.00 5.01 5.02 7.00 8.00
9.00 10.00 11.00 13.00	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	331, 859 292, 717 157, 834 262, 034	1, 900 4, 797 3, 081		121, 315	13, 586 0	9.00 10.00 11.00
15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	280, 283 692, 038 500, 628	2, 195	c	-,		15.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	2, 487, 056 435, 257 150, 658	3, 816	4, 139	3, 816	1, 242	31.00
50. 00 51. 00 52. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 438, 196 372, 214 0	1, 089	c c	1, 089	0	51.00
53.00 54.00 54.01	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0 1, 995, 061 0	-	0 19, 215 0		0	53.00 54.00
56.00 57.00 58.00 60.00 65.00	05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06500 RESPI RATORY THERAPY	0 0 1, 757, 241 505, 716		C C 278	0 0 4, 254		57.00 58.00 60.00
66.00 67.00 68.00 69.00 71.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	546, 901 154, 928 16, 673 442, 850 293, 039	2, 506 820 33 1, 239			0 0 0	66.00 67.00 68.00 69.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03610 SLEEP LAB OUTPATIENT SERVICE COST CENTERS	637, 418 1, 099, 234 109, 933	0	-	-	0 0 0	73.00
91.00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	356, 621 4, 978, 948					90.00 91.00 92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	488, 450	2, 951	C	2, 951	0	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	23, 379, 892	112, 065	170, 049	107, 870	11, 461	118.00
192.00 194.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 07950 OTHER NRCC	5, 582 197, 293 0	12, 638 0	c		2, 125 0	190.00 192.00 194.00
194.02		174, 626 54 0	C			0	194. 01 194. 02 194. 03 200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 632, 108					202. 00
203.00 204.00		0. 194975 158, 754					
205.00		0. 006682	7. 384177	0. 314568	0. 380909	8. 397394	205.00

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2016	Worksheet B-1	
				To 12/31/2016	Date/Time Pre	pared:
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/30/2017 5:4 MEDI CAL	4 pm
cost center bescription	(FTES)	ADMI NI STRATI ON		(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LI BRARY	
			(COSTED REQ U)		(GROSS CHAR	
	11.00	LARIES) 13.00	14.00	15.00	<u>GES)</u> 16.00	
GENERAL SERVICE COST CENTERS				I		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5. 01 00570 ADMITTING						5.01
5. 02 00590 ADMINI STRATI VE 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 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERIA	13, 837	7				11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	131		5			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	213					14.00
	476				1/0 070 010	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	453	3 C	2,941	0	168, 273, 212	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	2,271	1, 288, 311	112, 766	6 0	7, 894, 946	30.00
31. 00 03100 I NTENSI VE CARE UNI T	415				1, 245, 080	•
43. 00 04300 NURSERY	C	102, 048	3 (0 0	403, 493	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	803	437, 325	429, 195	5 0	20, 643, 822	50.00
51. 00 05100 RECOVERY ROOM	345				3, 614, 120	
52.00 05200 DELIVERY ROOM & LABOR ROOM	C			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	C	-		-	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	1, 534				35, 811, 944	54.00 54.01
56. 00 05600 RADI 0I SOTOPE		-			0	56.00
57. 00 05700 CT SCAN		-			0	57.00
58. 00 05800 MRI	C			0 0	0	58.00
60. 00 06000 LABORATORY	1, 699				23, 565, 332	•
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	621				2, 077, 029 2, 821, 377	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY			9,420		930, 672	
68. 00 06800 SPEECH PATHOLOGY	C			0 0	61, 740	
69. 00 06900 ELECTROCARDI OLOGY	815	5 C	5, 859	9 0	5, 627, 028	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	C				5, 822, 600	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		-			4, 966, 451 24, 335, 190	•
76. 00 03610 SLEEP LAB	82				658, 008	•
OUTPATIENT SERVICE COST CENTERS				-1 -1	,	
90. 00 09000 CLINIC	380	-				
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,903	3, 326, 825	5 70, 678	3 0	21, 125, 366	91.00
OTHER REIMBURSABLE COST CENTERS		1	1			92.00
95. 00 09500 AMBULANCE SERVICES	594	C	59, 681	0	6, 080, 014	95.00
SPECIAL PURPOSE COST CENTERS	10.74	7 454 505			4/0 070 040	
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	13,740	7, 154, 505	2, 123, 457	848, 922	168, 273, 212	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	3		423			192.00
194.00 07950 OTHER NRCC	C			0		194.00
194. 01 07951 MARKETI NG	94		0,100			194.01
194. 02 07952 SENI OR CI RCLE 194. 03 07953 FREE MEALS						194. 02 194. 03
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	272, 348	340, 055	466, 922	909, 730	715, 621	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	19. 682590	0. 047530	0. 219249	1. 071630	0.004253	203 00
203.00 [Offit Cost multiplier (wkst. B, Part I) 204.00 [Cost to be allocated (per Wkst. B,	73, 091					203.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	5. 282287	0. 003319	0. 052979	0. 073537	0. 000587	205.00
11)	I	I	I	1 I		I

Heal th I	- inancial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1318	Period: From 01/01/2016	Worksheet C Part I	
					To 12/31/2016		pared: 4 pm
			Title	e XVIII	Hospi tal	Cost	- p
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	1	1	1			-
	03000 ADULTS & PEDI ATRI CS	4, 448, 428		4, 448, 42		-	
	03100 I NTENSI VE CARE UNI T	702, 601		702, 60			
	04300 NURSERY	207, 119		207, 11	9 0	0	43.00
	NCI LLARY SERVICE COST CENTERS	0.004.745		0.004.74	-		
	D5000 OPERATING ROOM	2, 381, 715		2, 381, 7		-	
	D5100 RECOVERY ROOM	512, 752		512, 75		, s	
	D5200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
	05300 ANESTHESI OLOGY	0			0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	2, 940, 827		2, 940, 82	0	0	
	05401 ULTRASOUND	0			0 0	0	
	05600 RADI OI SOTOPE	0			0 0	0	
	05700 CT SCAN	0			0 0	0	
	05800 MRI	0			0 0	0	
	06000 LABORATORY	2, 466, 756		2, 466, 75		0	
	06500 RESPI RATORY THERAPY	683, 062				0	
	06600 PHYSI CAL THERAPY	735, 808	0	735, 80		0	
	06700 OCCUPATI ONAL THERAPY	211, 381	0	211, 38		0	
	06800 SPEECH PATHOLOGY	21,084		21, 08		0	
	06900 ELECTROCARDI OLOGY	604, 129		604, 12		0	07.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	419, 845		419, 84		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	906, 227		906, 22		0	
	07300 DRUGS CHARGED TO PATIENTS	2, 326, 785		2, 326, 78		0	
	03610 SLEEP LAB	189, 971		189, 97	0	0	76.00
	DUTPATIENT SERVICE COST CENTERS	472 107	1	470.10	-	0	
	D9100 EMERGENCY	473, 107		473, 10		-	
		6, 548, 461		6, 548, 46		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	926, 614		926, 61	4	0	92.00
	09500 AMBULANCE SERVICES	714, 527	i	714, 52	27 0	0	95.00
200.00	Subtotal (see instructions)	28, 421, 199			· · · · · · · · · · · · · · · · · · ·	-	200.00
200.00	Less Observation Beds	926, 614		926, 6			200.00
201.00	Total (see instructions)	27, 494, 585					201.00
202.00		21,474,000	I U	'l ∠/, 474, 30	0	0	202.00

ealth Financial Systems	DUKES MEMORIA	Provider C	N. 15 1210	Peri od:	Worksheet C	2552-1
UMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	JN. 10-1310	From 01/01/2016	Part I	
				To 12/31/2016	Date/Time Pre	
					5/30/2017 5:4	14 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Inpatient	Charges Outpatient	Total (col	6 Cost or Other	TEFRA	
cost center bescription	Inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
			+ cor. 7)	Ratio	Ratio	
	6.00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 658, 584		5, 658, 58	34		30. 0
31. 00 03100 INTENSIVE CARE UNIT	1, 245, 080		1, 245, 08	30		31.0
3. 00 04300 NURSERY	403, 493		403, 49	93		43.0
ANCILLARY SERVICE COST CENTERS						
0. 00 05000 OPERATI NG ROOM	4, 949, 416	15, 694, 406	20, 643, 82	0. 115372	0.00000	50.0
1.00 05100 RECOVERY ROOM	682, 913	2, 931, 207	3, 614, 12	0. 141875	0.00000	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.00000	
3. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 764, 068	31, 047, 876	35, 811, 94		0.00000	
54. 01 05401 ULTRASOUND	0	0		0 0.000000	0.00000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0.000000	0.00000	
57. 00 05700 CT SCAN	0	0		0 0.000000	0.00000	
58. 00 05800 MRI	0	0		0 0.000000	0.00000	
0. 00 06000 LABORATORY	5, 218, 554	18, 346, 778			0.00000	
5. 00 06500 RESPI RATORY THERAPY	1, 499, 608	577, 421			0.00000	
6.00 06600 PHYSI CAL THERAPY	626, 946	2, 194, 431			0.00000	
57.00 06700 OCCUPATI ONAL THERAPY	460, 453	470, 219			0.00000	
08.00 06800 SPEECH PATHOLOGY	16, 832	44, 908			0.00000	
9.00 06900 ELECTROCARDI OLOGY	1, 467, 396	4, 159, 632			0.00000	
11.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	2, 475, 194	3, 347, 406			0.00000	
22.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 758, 192	2, 208, 259			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 866, 301	11, 468, 889			0. 000000 0. 000000	
76. 00 03610 SLEEP LAB OUTPATI ENT SERVI CE COST CENTERS	18, 795	639, 213	658, 00	0. 288706	0.00000	76.0
20. 00 09000 CLINIC	6,065	582, 935	589.00	0, 803238	0, 000000	90.0
21. 00 09100 EMERGENCY	2, 231, 951	18, 893, 415			0.000000	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	441,089	1, 795, 273			0.000000	
OTHER REIMBURSABLE COST CENTERS	441,089	1, 790, 273	2,230,30	0.414340	0.00000	72.0
25. 00 09500 AMBULANCE SERVICES	0	6, 080, 014	6, 080, 01	0, 117521	0, 000000	95 0
200.00 Subtotal (see instructions)	47, 790, 930	120, 482, 282			0.00000	200.0
201.00 Less Observation Beds	47,770,730	120, 402, 202	100, 273, 2	-		200.0
202.00 Total (see instructions)	47, 790, 930	120, 482, 282	168, 273, 2 ²			201.0

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1318	Peri od:	Worksheet C	
			From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/30/2017 5:4	
		Title XVIII	Hospi tal	Cost	
Cost Center Description P	PS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	I				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 01 05401 ULTRASOUND	0. 000000				54.01
56. 00 05600 RADI 0I SOTOPE	0.000000				56.00
57.00 05700 CT SCAN	0.000000				57.00
58. 00 05800 MRI	0.000000				58.00
60. 00 06000 LABORATORY	0.000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				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. 000000				69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00 03610 SLEEP LAB	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0. 000000				95.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

	nancial Systems	DUKES MEMORI				u of Form CMS-	2002-1
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1318	Period: From 01/01/2016	Worksheet C Part I	
					To 12/31/2016		pared:
						5/30/2017 5:4	4 pm
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	PATIENT ROUTINE SERVICE COST CENTERS	1	l	1			
	000 ADULTS & PEDIATRICS	4, 448, 428		4, 448, 4			
	100 INTENSIVE CARE UNIT	702, 601		702, 6			
	300 NURSERY	207, 119		207, 1	19 0	207, 119	43.00
	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM	2, 381, 715		2, 381, 7			
	100 RECOVERY ROOM	512, 752		512, 7	52 0	512, 752	
	200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
	300 ANESTHESI OLOGY	0			0 0	0	53.0
54.00 054	400 RADI OLOGY-DI AGNOSTI C	2, 940, 827		2, 940, 8	27 0	2, 940, 827	54.00
54.01 054	401 ULTRASOUND	0			0 0	0	54. 0 ²
56.00 056	600 RADI OI SOTOPE	0			0 0	0	56.00
57.00 057	700 CT SCAN	0			0 0	0	57.00
58.00 058	800 MRI	0			0 0	0	58.00
60.00 060	000 LABORATORY	2, 466, 756		2, 466, 7	56 0	2, 466, 756	60.00
65.00 065	500 RESPI RATORY THERAPY	683,062	l o	683, 0	62 0	683, 062	65.0
66.00 066	600 PHYSI CAL THERAPY	735,808	c c	735, 8	08 0	735, 808	66.00
67.00 067	700 OCCUPATI ONAL THERAPY	211, 381	l a	211, 3	81 0	211, 381	67.00
	800 SPEECH PATHOLOGY	21,084	l d	21,0		21, 084	
	900 ELECTROCARDI OLOGY	604, 129		604, 1		604, 129	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	419, 845		419, 8		419, 845	
	200 I MPL. DEV. CHARGED TO PATIENTS	906, 227		906, 2		906, 227	
	300 DRUGS CHARGED TO PATIENTS	2, 326, 785		2, 326, 7			
	610 SLEEP LAB	189, 971		189, 9			
	TPATIENT SERVICE COST CENTERS	107,771		107,7	, 1	107,771	/ 0. 00
	000 CLINIC	473, 107		473, 1	07 0	473, 107	90.00
	100 EMERGENCY	6, 548, 461		6, 548, 4			
	200 OBSERVATION BEDS (NON-DISTINCT PART	926, 614		926, 6		926, 614	
	HER REIMBURSABLE COST CENTERS	720,014		,20,0		720, 014	/2.00
	500 AMBULANCE SERVICES	714, 527		714, 5	27 0	714, 527	95.00
200.00	Subtotal (see instructions)	28, 421, 199					
200.00	Less Observation Beds	926, 614		926, 6		926, 614	
201.00	Total (see instructions)	27, 494, 585					
202.00		27, 474, 303	1 0	μ <i>ΖΙ</i> , 474, Ο	00	27, 474, 303	1202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	DUKES MEMORIA	Provider C	NV 15 1210	Period:	u of Form CMS- Worksheet C	2002-1
JUMPUTATION OF RATIO OF CUSTS TO CHARGES		Provider Co	JN. 10-1310	From 01/01/2016	Part I	
				To 12/31/2016	Date/Time Pre	
					5/30/2017 5:4	14 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpatient	Total (col	6 Cost or Other	TEFRA	
cost center bescription	Inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
			+ cor. 7)	Ratio	Ratio	
	6.00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 658, 584		5, 658, 58	34		30. 0
31. 00 03100 INTENSIVE CARE UNIT	1, 245, 080		1, 245, 08	30		31.0
43. 00 04300 NURSERY	403, 493		403, 49	93		43.0
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	4, 949, 416	15, 694, 406	20, 643, 82	0. 115372	0.00000	50.0
51.00 05100 RECOVERY ROOM	682, 913	2, 931, 207	3, 614, 12	0. 141875	0.00000	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.00000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 764, 068	31, 047, 876	35, 811, 94		0.00000	
54. 01 05401 ULTRASOUND	0	0		0 0. 000000	0.00000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0. 000000	0.00000	
57. 00 05700 CT SCAN	0	0		0 0. 000000	0.00000	
58. 00 05800 MRI	0	0		0 0. 000000	0.00000	
50. 00 06000 LABORATORY	5, 218, 554	18, 346, 778			0.00000	
55. 00 06500 RESPI RATORY THERAPY	1, 499, 608	577, 421			0.00000	
66. 00 06600 PHYSI CAL THERAPY	626, 946	2, 194, 431			0.00000	
57.00 06700 OCCUPATI ONAL THERAPY	460, 453	470, 219			0.00000	
58.00 06800 SPEECH PATHOLOGY	16, 832	44, 908			0.00000	
59. 00 06900 ELECTROCARDI OLOGY	1, 467, 396	4, 159, 632			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 475, 194	3, 347, 406			0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	2, 758, 192	2, 208, 259			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 866, 301	11, 468, 889			0.00000	
76.00 03610 SLEEP LAB	18, 795	639, 213	658, 00	0. 288706	0.00000) 76. C
OUTPATIENT SERVICE COST CENTERS	(500.0		0.00000	
20.00 09000 CLINIC	6,065	582, 935			0.00000	
91.00 09100 EMERGENCY	2, 231, 951	18, 893, 415			0.00000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	441, 089	1, 795, 273	2, 236, 30	0. 414340	0.00000	92.0
		(000 014	(000 0	0 117501	0,000000	
95.00 09500 AMBULANCE SERVICES	0	6, 080, 014			0. 000000	
200.00 Subtotal (see instructions)	47, 790, 930	120, 482, 282	168, 273, 2 ⁻	12		200.0
201.00 Less Observation Beds	47 700 000	100 400 000	140 070 0	10		
202.00 Total (see instructions)	47, 790, 930	120, 482, 282	168, 273, 2 ⁻	12		202.0

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1318 Porid: From 01/01/2016 To 12/31/2016 Worksheet C Part 1 To 12/31/2016 Cost Center Description PPS Inpatient Ratio Title XIX Hospital PPS 0.00 03000 ADULTS & PEDIATRICS 11.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 30.00 31.	Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
Cost Center Description PPS Inpatient Ratio PPS Inpatient Ratio PPS Inpatient Ratio PPS Inpatient Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.00 03000 ADULTS & PEDIATRICS 31.00 31.00 03000 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 0.00 05000 OPERATING ROOM 0.115372 51.00 05100 RECOVERY ROOM 0.141875 52.00 05200 DELIVERY ROOM 0.000000 53.00 05300 ANESTHESI OLGY 0.000000 54.00 05400 RADULTS & LABOR ROOM 0.000000 54.00 05400 TURENOND 0.000000 54.01 05300 ARESTHESI OLGY 0.000000 54.00 05400 RADULTS & LABOR ROOM 0.000000 54.00 05400 RADULOSTOPE 0.000000 55.00 05500 ARESTRAND 0.000000 56.00 06600 RESPI RATORY 0.104677 66.00 06600 RESPI RATORY THERAPY 0.227127 67.00 0.000000 58.00 66.00 066000 RESPI RA	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/30/2017 5:44	pared: 4 pm
Ratio 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 43.00 04300 NURSERY 43.00 ANCULARY SERVICE COST CENTERS 50.00 50.00 05000 PERATING ROM 0.111372 51.00 05100 RECOVERY ROM 0.141875 50.00 05200 DELIVERY ROM 0.000000 52.00 05200 ANESTHESI OLOGY 0.000000 54.00 05400 RADI OLOCY-DIAGNOSTI C 0.082119 54.00 05400 RADI OLOCY-DIAGNOSTI C 0.082119 54.00 05400 RADI OLSTOPE 0.000000 54.01 05600 RESPI RATORY THERAPY 0.32865 60.00 06000 LABDRATORY 0.104677 60.00 06000 RESPI RATORY THERAPY 0.280727 60.00 06000 RESPI RATORY THERAPY 0.280727 60.00 06000 RESPI RATORY THERAPY 0.280727 60.00 06000 LABDRATORY 0.104577 60.00 06000 RESPI RATORY THERAPY 0.280797 70.00 07000 CUPATIONAL THE			Title XIX	Hospi tal	PPS	
30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 03100 INTENSIVE CARE UNIT 31. 00 31. 00 04300 INTENSIVE CARE UNIT 43. 00 ANCILLARY SERVICE COST CENTERS 43. 00 ANCILLARY SERVICE 60. 00 ANCILLARY SERVICE 51. 00 50. 00 5000 (PERATING ROM 0. 115372 51. 00 05100 (RECOVERY ROM & LABOR ROM 0. 000000 52. 00 5200 (DELVENY ROM & LABOR ROM 0. 000000 54. 00 05400 (RADIOLOGY DI AGNOSTIC 0. 082119 54. 01 05401 (ULTRASOUND 0. 000000 54. 01 50. 00 5500 (T SCAN 0. 000000 55. 00 50. 00 05500 (RESPI RATORY 0. 104677 60. 00 60. 00 06500 (RESPI RATORY 0. 280797 67. 00 61. 00 06500 (RESPI RATORY 0. 280797 67. 00 62. 00 06500 RESPI RATORY 0. 280797 67. 00 63. 00 06500 SECCH PATHOLOGY 0. 314497 71. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.72716 71. 00	Cost Center Description	Ratio				
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43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 5000 0FEATING ROM 0.115372 50.00 5100 RECOVERY ROOM 0.141875 50.00 51.00 05100 RECOVERY ROOM 0.000000 52.00 52.00 5200 DELI-VERY ROOM & LABOR ROOM 0.000000 53.00 54.00 05400 RADIOLOGY - JI AGNOSTI C 0.082119 54.01 54.01 01500 RESTRISSIONDE 0.000000 54.01 55.00 05600 RADIOLSTOPE 0.000000 54.01 56.00 05600 RESTRIATORY 0.000000 56.00 57.00 05700 CT SCAN 0.000000 57.00 50.00 05600 RESTRATORY 0.104677 66.00 60.00 06000 PHYSICAL THERAPY 0.260797 66.00 61.00 06000 SPEECH PATHOLOCY 0.314197 67.00 62.00 06000 SPEECH PATHOLOCY 0.314197 67.00 63.00 06000 SPEECH PATHOLOCY 0.314197 67.00 64.00 06000 SPEECH PATHOLOCY 0.314197 67.00 65.00 </td <td>30. 00 03000 ADULTS & PEDI ATRI CS</td> <td></td> <td></td> <td></td> <td></td> <td>30.00</td>	30. 00 03000 ADULTS & PEDI ATRI CS					30.00
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54.00 05400 RADI OLOGY - DI AGNOSTI C 0.082119 54.00 54.01 05401 ULTRASOUND 0.000000 54.01 56.00 05600 RADI OLOGY - DI AGNOSTI C 0.000000 54.01 57.00 05600 RADI OLOGY - DI AGNOSTI C 0.000000 57.00 58.00 05700 CT SCAN 0.000000 58.00 60.00 D6800 MRI 0.000000 58.00 60.00 06500 RADRATORY 0.104677 60.00 60.00 06600 PHYSI CAL THERAPY 0.260797 66.00 67.00 0C700 OCUPATI ONAL THERAPY 0.227127 67.00 68.00 06800 SPECH PATHOLOGY 0.341497 68.00 69.00 06800 SPECH PATHOLOGY 0.107362 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.092104 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.182470 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.995614 73.00 74.00 09000 <td< td=""><td>52.00 05200 DELIVERY ROOM & LABOR ROOM</td><td>0.000000</td><td></td><td></td><td></td><td>52.00</td></td<>	52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000				52.00
54.01 05401 ULTRASOUND 0.000000 54.01 56.00 RADI 01 SOTOPE 0.000000 55.00 57.00 05700 CT SCAN 0.000000 58.00 60.00 05800 MRI 0.000000 58.00 60.00 06000 LABORATORY 0.104677 60.00 65.00 06500 RESPI RATORY THERAPY 0.28865 65.00 66.00 06600 PHSI CAL THERAPY 0.20077 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.227127 67.00 68.00 06800 SPEECH PATHOLOGY 0.341497 68.00 69.00 ELECTROCARDI OLOGY 0.341497 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.072106 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.182470 72.00 73.00 07300 DRUS CHARGED TO PATI ENTS 0.288706 76.00 0017DATI ENT SERVICE COST CENTERS 0.288706 76.00 73.00 90.00 09000 CLI NI C 0.803238 90.00	53.00 05300 ANESTHESI OLOGY	0.000000				53.00
56.00 05600 RADI 01 SOTOPE 0.000000 57.00 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MRI 0.000000 58.00 60.00 0.6000 LABORATORY 0.104677 60.00 65.00 06500 RESPI RATORY THERAPY 0.328865 65.00 66.00 06600 PHYSI CAL THERAPY 0.227127 66.00 67.00 05700 OCCUPATI ONAL THERAPY 0.227127 67.00 68.00 06800 SPEECH PATHOLOGY 0.341497 68.00 69.00 06900 ELECTROCARDI 0LOGY 0.107362 71.00 71.00 O7100 MEDL CAL SUPPLIES CHARGED TO PATI ENTS 0.182470 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.288706 73.00 70.00 OPSOOL CLINIC 0.803238 73.00 73.00 70.00 DUTPATI ENT SERVICE COST CENTERS 0.309981 91.00 92.00 91.00 D92000 DBSERVATI ON BEDS (NON-D	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 082119				54.00
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58.00 05800 MRI 0.00000 58.00 60.00 06000 LABORATORY 0.104677 60.00 65.00 06500 RESPI RATORY THERAPY 0.28865 66.00 66.00 06600 PHYSI CAL THERAPY 0.2201727 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.227127 67.00 68.00 06800 SPEECH PATHOLOGY 0.341497 68.00 69.00 06900 ELECTROCARDI OLOGY 0.107362 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.182470 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.182470 73.00 74.00 09000 CLIN C 0.803238 76.00 90.00 09000 CLIN C 0.803238 90.00 91.00 09100 EMERGENCY 0.309981 91.00 92.00 OPSEOR AMBULANCE SERVICES 0.117521 95.00 95.00 OPSEOR AMBULANCE SERVICIES 0.117521 95.00 90.00 Subtotal (see instructions) 200.00	56. 00 05600 RADI OI SOTOPE	0.000000				56.00
60.00 06000 LABORATORY 0.104677 60.00 65.00 06500 RESPI RATORY THERAPY 0.328865 65.00 66.00 06600 PHYSI CAL THERAPY 0.260797 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.227127 67.00 68.00 06800 SPEECH PATHOLOGY 0.341497 68.00 69.00 66000 ELECTROCARDI OLOGY 0.107362 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.182470 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.195614 73.00 73.00 03610 SLEEP LAB 0.288706 76.00 00100 OP0000 CLINIC 0.803238 90.00 90.00 090000 CLINIC 0.309981 91.00 92.00 OP2000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.414340 92.00 92.00 OP400 ENVICES 0.117521 95.00 95.00 O9500 AMBULANCE SERVICES 0.117521 95.00 90.000 O1400 ENVICA	57.00 05700 CT SCAN	0. 000000				57.00
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73.00 07300 DRUGS CHARGED TO PATIENTS 0.095614 73.00 76.00 03610 SLEEP LAB 0.288706 76.00 0UTPATIENT SERVICE COST CENTERS 0.803238 90.00 91.00 09000 CLINIC 0.803238 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.414340 91.00 95.00 09500 AMBULANCE SERVICES 0.117521 95.00 200.00 Subtotal (see instructions) 0.117521 95.00 201.00 Less Observation Beds 201.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 072106				71.00
76.00 03610 SLEEP LAB 0.288706 76.00 OUTPATI ENT SERVICE COST CENTERS 0000 0000 CLINIC 0.803238 90.00 90.00 91.00 91.00 91.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 90.00 200.00 201.00 200.00 201.00 <td>72.00 07200 IMPL. DEV. CHARGED TO PATIENTS</td> <td>0. 182470</td> <td></td> <td></td> <td></td> <td>72.00</td>	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 182470				72.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.803238 90.00 91.00 09100 EMERGENCY 0.309981 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.414340 92.00 0THER REIMBURSABLE COST CENTERS 0.117521 95.00 95.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00						
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95.00 09500 AMBULANCE SERVICES 0.117521 95.00 200.00 Subtotal (see instructions) 200.00 200.00 200.00 200.00 201.00 Less Observation Beds 201.00 201.00 201.00 201.00		0. 414340				92.00
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201.00 Less Observation Beds 201.00		0. 117521				
202.00 Total (see instructions) 202.00						
	202.00 Total (see instructions)					202.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	TIOS NET OF	Provider C	CN: 15-1318	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICALD ONLY				From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	norod.
				To 12/31/2016	5/30/2017 5:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	st Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)		-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1	- 1	L	
50. 00 05000 OPERATI NG ROOM	2, 381, 715				0	
51.00 05100 RECOVERY ROOM	512, 752	34, 972	477,78	30 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0)	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 940, 827	313, 806	2, 627, 02	21 0	0	54.00
54. 01 05401 ULTRASOUND	0	0)	0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	2, 466, 756				0	60.00
65. 00 06500 RESPI RATORY THERAPY	683, 062				0	65.00
66. 00 06600 PHYSI CAL THERAPY	735, 808				0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	211, 381				0	67.00
68.00 06800 SPEECH PATHOLOGY	21, 084				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	604, 129				0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	419, 845				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	906, 227				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 326, 785				0	73.00
76.00 03610 SLEEP LAB	189, 971	44, 652	145, 31	19 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	473, 107			70 0	0	90.00
91. 00 09100 EMERGENCY	6, 548, 461			32 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	926, 614	191, 028	735, 58	36 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	714, 527					95.00
200.00 Subtotal (sum of lines 50 thru 199)	23, 063, 051					200. 00
201.00 Less Observation Beds	926, 614					201.00
202.00 Total (line 200 minus line 201)	22, 136, 437	1, 693, 975	20, 442, 40	62 0	0	202.00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Prepared: 5/30/2017 5:44 pm
			e XIX	Hospi tal	PPS
Cost Center Description		Total Charges	Outpati ent		
		(Worksheet C,			
	Operating Cost			6	
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM	2, 381, 715	20, 643, 822			50.00
51.00 05100 RECOVERY ROOM	512, 752	3, 614, 120	0. 1418	75	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	00	52.00
53.00 05300 ANESTHESI OLOGY	0	0	0.0000	00	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 940, 827	35, 811, 944	0. 0821	19	54.00
54. 01 05401 ULTRASOUND	0	0	0.0000	00	54.01
56. 00 05600 RADI 0I SOTOPE	0	0	0.0000	00	56.00
57.00 05700 CT SCAN	0	0	0.0000	00	57.00
58. 00 05800 MRI	0	0	0.0000	00	58.00
60. 00 06000 LABORATORY	2, 466, 756	23, 565, 332	0. 1046	77	60.00
65. 00 06500 RESPI RATORY THERAPY	683, 062	2,077,029	0. 3288	65	65.00
66.00 06600 PHYSI CAL THERAPY	735, 808	2, 821, 377			66.00
67.00 06700 OCCUPATIONAL THERAPY	211, 381	930, 672			67.00
68. 00 06800 SPEECH PATHOLOGY	21, 084	61, 740			68.00
69. 00 06900 ELECTROCARDI OLOGY	604, 129				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	419, 845	5, 822, 600			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	906, 227	4, 966, 451			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 326, 785	24, 335, 190			73.00
76. 00 03610 SLEEP LAB	189, 971	658,008			76.00
OUTPATIENT SERVICE COST CENTERS	1077771		012007		
90. 00 09000 CLINIC	473, 107	589,000	0.8032	38	90.00
91. 00 09100 EMERGENCY	6, 548, 461	21, 125, 366			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	926, 614	2, 236, 362			92.00
OTHER REI MBURSABLE COST CENTERS	720,014	2,200,302	0. + 143		72.00
95. 00 09500 AMBULANCE SERVICES	714, 527	6, 080, 014	0. 1175	21	95.00
200.00 Subtotal (sum of lines 50 thru 199)	23, 063, 051	160, 966, 055			200.00
201.00 Less Observation Beds	926, 614	100, 900, 000			200.00
202.00 Total (line 200 minus line 201)	22, 136, 437	0			201.00
	22, 130, 437	100, 200, 000	I	1	1202.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	416, 955	20, 643, 822	0. 02019	1, 744, 620	35, 238	50.00
51.00 05100 RECOVERY ROOM	34, 972	3, 614, 120	0.00967	239, 072	2, 313	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	-	0.0000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	313, 806	35, 811, 944	0.00876	1, 628, 947	14, 274	54.00
54. 01 05401 ULTRASOUND	0	0	0.0000	0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0	0	0.0000	0 0	0	56.00
57.00 05700 CT SCAN	0	0	0.0000	0 0	0	57.00
58. 00 05800 MRI	0	0	0.0000	0 0	0	58.00
60. 00 06000 LABORATORY	162, 863	23, 565, 332	0. 00691	1 2, 092, 057	14, 458	60.00
65. 00 06500 RESPI RATORY THERAPY	53, 492	2, 077, 029	0. 02575	907, 898	23, 382	65.00
66. 00 06600 PHYSI CAL THERAPY	64, 873	2, 821, 377	0. 02299	322, 378	7, 412	66.00
67.00 06700 OCCUPATI ONAL THERAPY	20, 899	930, 672	0. 02245	6 288, 492	6, 478	67.00
68.00 06800 SPEECH PATHOLOGY	929	61, 740	0. 01504	13, 979	210	68.00
69.00 06900 ELECTROCARDI OLOGY	41, 463	5, 627, 028	0.00736	818, 244	6, 030	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17,403	5, 822, 600	0.00298	1, 245, 738	3, 724	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	37, 998	4, 966, 451	0.00765	1, 299, 808	9, 945	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	88, 973	24, 335, 190	0.00365	6, 856, 092	25,066	73.00
76.00 03610 SLEEP LAB	44,652					76.00
OUTPATIENT SERVICE COST CENTERS						
90, 00 09000 CLINIC	33, 537	589,000	0.05693	39 0	0	90.00
91.00 09100 EMERGENCY	277, 579				164	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	191,028				335	92.00
OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	, , , ,				
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1, 801, 422	154, 886, 041		17, 483, 140	149, 667	200. 00

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 4 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description		Nursing School	Allied Healt		Total Cost	
	Anestheti st	-		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0	0	54.00
54.01 05401 ULTRASOUND	0	l o)	0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	c c		0 0	0	56.00
57.00 05700 CT SCAN	0	l a		0 0	0	57.00
58. 00 05800 MRI	0	l d		0 0	0	58.00
60. 00 06000 LABORATORY	0			0 0	0	60,00
65. 00 06500 RESPI RATORY THERAPY	0			0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0			0 0	0	66,00
67.00 06700 OCCUPATIONAL 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
76. 00 03610 SLEEP LAB	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS				<u> </u>		10100
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0			0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1	<u> </u>	0	12.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	c c		0 0	0	200.00
	-	-	1	-	-	

PAPPORT ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CON: 15-1318 Period: To 12/31/2016 Vorksheet D Part IV Date/Time Prepared: 5/30/2017 5: 44 pm Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and 4) Total Total Charges (col. 5 + col. 7) Untpatient To 12/31/2016 Untpatient Part IV Date/Time Prepared: 5/30/2017 Inpatient Cost Charges (col. 5 + col. 7) Inpatient To 12/31/2016 Inpatient Cost Charges (col. 6 + col. 7) Inpatient To 10 col 7) Inpatient Cost Charges (col. 6 + col. 7) Inpatient Cocs Cost Cost Cost Cost Cost Cost Cost Cos	Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Interview To 12/31/2016 Date/Time Prepared: 50/2017 Date/Time Prepared: 50/2017 To 111e XVIIII Hospital Cost Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and 4) Total Outpatient Form R, colspan="2">Cost Inpatient Program Charges (col. 6 + col. 7) ANCILLARY SERVICE COST CENTERS 0.00 05000 0PERTING ROM 6.00 7.00 8.00 9.00 10.00 50.00 05000 0PERTING ROM 6.00 0 20,643,822 0.000000 0.000000 1.744,620 50.00 50.00 05000 RECOVERY ROM & LABOR ROM 0 0 20,643,822 0.000000 0.000000 0.52.00 50.00 05000 RESTHESI 0.0GY 0 0 0.000000 0.000000 0.52.00 50.00 05000 RADIOLOGY-DI AGNOSTI C 0 35,811,944 0.000000 0.000000 0.54.00 50.000000 60.000000 60.000000 60.000000 60.0000000 60.0000000		RVICE OTHER PASS	S Provider C			Worksheet D	
ANCI LLARY SERVICE COST CENTERS Total Cost (sum of cost (sum of cost (sum of cost (sum of cost st (sum of cost st st (sum of	THROUGH COSTS						narad
Cost Center Description Total Outpatient Cost (sum of 4) Total (suppatient Cost (sum of 4) Total (suppatient Cost (sum of 4) Total (suppatient (sol (sign)) Hospital (sol (sign)) Cost (sol (sign)) ANCI LLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 50.00 05000 (DPERATI NG ROM (sol (sol (sol (sol (sol (sol (sol (sol					10 12/31/2010	5/30/2017 5:4	4 pm
ANCI LLARY SERVICE COST CENTERS Outpatient cost (sum (from Wkst, c) Part I, col. to Charges (col. 5 + col. Ratio of Cost (col. 6 + col. Program Charges ANCI LLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 50.00 05000 [PERATI NG ROM 0 220,643,822 0.000000 0.000000 239,072 51.00 51.00 05000 [PERATI NG ROM 0 3,614,120 0.000000 0.000000 239,072 51.00 52.00 05300 [ANESTHESI OLOGY 0 0 0.000000 0.000000 0 53.00 54.00 05400 [RADI ULCY-DI AGNOSTI C 0 35,811,944 0.000000 0.000000 0 54.01 56.00 05600 [RADI ULTRASOUND 0 0 0.000000 0.000000 54.01 56.00 05600 [RADI OLSCY-DI AGNOSTI C 0 0 0.000000 0.000000 55.00 57.00 05700 CT SCAN 0 0 0.000000 0.000000 56.00 66.00 06600 [RESPI RATORY 0 23,565,332			Title	XVIII	Hospi tal		
ANCI LLARY SERVICE COST CENTERS Cost (sum of col 2, 3 and 4) Part I, col. 8) Col. 5 + col. 7) to Charges (col . 6 + col. 7) Charges (col . 6 + col. 7) ANCI LLARY SERVICE COST CENTERS 0 0.000 8.00 9.00 10.00 S0.00 05000 OPERATI NG. ROOM 0 23, 613, 822 0.000000 0.000000 239, 072 51.00 50.00 05100 RCOYERY ROM 0 3, 614, 120 0.000000 0.000000 239, 072 51.00 54.00 05400 RAUSILLARY SERVICE 0 0 0.000000 0.000000 0 53.00 54.00 05400 RAUSILLARY 0 0.000000 0.000000 0 53.00 54.00 05400 RAUSILLARY 0 0 0.000000 0.000000 0 53.00 54.00 05600 RAUI INARSOUND 0 0 0.000000 0 54.00 54.00 05700 CT SCAN 0 0 0.000000 0 0.000000 54.00	Cost Center Description		Total Charges				
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$						Program	
4) 7) 6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 0 0.00000 0.000000 1.744,620 50.00 50.00 05200 DPERATI NG ROOM 0 3,614,120 0.000000 0.000000 239,072 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.000000 0.000000 0.000000 0 53.00 54.00 O5400 RADI LVERY ROOM & LABOR ROOM 0 0.000000 0.000000 0 53.00 54.00 O5400 RADI DUGY-DI AGNOSTI C 0 35,811,944 0.000000 0.000000 0 54.01 56.00 O5600 RADI DI SOTOPE 0 0 0.000000 0.000000 0 57.00 57.00 0 0.000000 0.000000 0 58.00 65.00 57.00 0.500/RATORY 0 23,565,332 0.000000 0.000000 2.092,057 60.00 66.00 66.00 66.00 66.00 66.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>Charges</td><td></td></t<>						Charges	
ANCI LLARY SERVI CE COST CENTERS 6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVI CE COST CENTERS 0 0.000000 0.000000 1.744,620 50.00 51.00 05000 (DELCARY ROM & LABOR ROM 0 3.614,120 0.000000 0.000000 239,072 51.00 52.00 05300 ANESTHESI OLOGY 0 0.000000 0.000000 0 53.00 54.00 05400 RADI OLOGY - JI AGNOSTI C 0 35,811,944 0.000000 0.000000 0 54.00 56.00 05600 RDI OL SOTOPE 0 0 0.000000 0.000000 0 56.00 57.00 05700 CT SCAN 0 0 0.000000 0.000000 0 57.00 58.00 05600 RADI OLSOTOPE 0 0 0.000000 0.000000 0 56.00 50.00 05600 RADI OLSOTOPE 0 0 0.000000 0.000000 0 56.00 50.00 05600 RSPI RATORY 0 23,565,332 0.000000 0.000000			8)	7)	•		
ANCI LLARY SERVICE COST CENTERS							
50.00 05000 0PERATI NG ROOM 0 20, 643, 822 0.000000 0.000000 1, 744, 620 50.00 51.00 05100 RECOVERY ROOM & LABOR ROOM 0 3, 614, 120 0.000000 0.000000 239, 072 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.000000 0.000000 0 53.00 54.00 05400 RADI OLGGY-DI AGNOSTI C 0 35, 811, 944 0.000000 0.000000 0 54.01 56.00 05600 RADI OLGGY-DI AGNOSTI C 0 0.000000 0.000000 0 56.00 57.00 05700 CT SCAN 0 0 0.000000 0.000000 0 56.00 50.00 06000 LABORATORY 0 23, 565, 332 0.000000 0.000000 0 58.00 60.00 06000 LABORATORY 0 2, 821, 377 0.000000 0.000000 2, 822, 337 66.00 61.00 06500 RESPI RATORY THERAPY 0 2, 821, 377 0.000000 0.000000 2, 23, 238, 66.00 0.0000000 13, 979 68		6.00	7.00	8.00	9.00	10.00	
51.00 05100 RECOVERY ROOM 0 3, 614, 120 0.000000 0.000000 239, 072 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 0.000000 52.00 53.00 OS200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 0.000000 53.00 54.00 O5400 RADI OLOGY -DI AGNOSTI C 0 35, 811, 944 0.000000 0.000000 0 54.00 54.01 O5401 DLTRASQUND 0 0 0.000000 0.000000 0 56.00 55.00 O5500 RADI OLOGY -DI AGNOSTI C 0 0 0.000000 0.000000 0 56.00 56.00 O5600 RADI OLOGY -DI AGNOSTI C 0 0 0.000000 0.000000 0 56.00 56.00 O5600 RTSPI RATORY 0 23, 565, 332 0.000000 0.000000 2, 992, 057 60.00 65.00 O6500 RESPI RATORY THERAPY 0 2, 821, 377 0.000000 0.000000 23, 378 66.00 60.00 O6600 <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>		-					
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 0.000000 0 52.00 53.00 OS300 ANESTHESI OLOGY 0 0 0.000000 0.000000 1,628,947 54.00 54.01 O5401 ULTRASOUND 0 0 0.000000 0.000000 0 54.01 56.00 O5500 (RADI OLGGY-DI AGNOSTI C 0 0 0.000000 0.000000 0 56.00 0 0.5700 (CT SCAN 0 0 0.000000 0.000000 0 58.00 60.00 06000 LABORATORY 0 0 0.000000 0.000000 2.097,898 65.00 65.00 06500 RESPI RATORY THERAPY 0 2,077,029 0.000000 0.000000 2.988,892 67.00 64.00 06600 PHYSI CAL THERAPY 0 2,81,377 0.000000 0.000000 2.884,92 67.00 68.00 06800 SPEECH PATHOLOGY 0 61,740 0.000000 0.000000 13,979 86.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5,822,600 0.0000000<		0					
53.00 05300 ANESTHESI OLOGY 0 0 0.000000 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 35,811,944 0.000000 0.000000 1,628,947 54.01 56.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0.000000 0.000000 0 56.00 56.00 05600 RADI OLSOTOPE 0 0 0.000000 0.000000 56.00 57.00 05700 CT SCAN 0 0 0.000000 0.000000 57.00 58.00 06800 MRI 0 0 0.000000 0.000000 2.092,057 60.00 65.00 06500 RESPI RATORY THERAPY 0 2,871,377 0.000000 0.000000 2.292,057 60.00 66.00 06600 PHYSI CAL THERAPY 0 2,821,377 0.000000 0.000000 2.292,378 66.00 67.00 06200 ELECTROCARDI OLOGY 0 61,740 0.000000 0.000000 1.329,88 72.00 69.00 06900 ELECTROCARDI OLOGY		0					
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 35, 811, 944 0.000000 0.000000 1, 628, 947 54.00 54.01 05401 ULTRASOUND 0 0 0.000000 0.000000 0 54.01 56.00 RADI OL SOTOPE 0 0 0.000000 0.000000 0 56.00 57.00 05700 CT SCAN 0 0 0.000000 0.000000 0 57.00 58.00 05800 MRI 0 0 0.000000 0.000000 2,092,057 60.00 60.00 LABORATORY 0 2,077,029 0.000000 0.000000 322,378 66.00 65.00 06600 PHYSI CAL THERAPY 0 930,672 0.000000 0.000000 13,979 68.00 68.00 06600 EECH PATHOLOGY 0 61,740 0.000000 0.000000 1,245,738 71.00 71.00 07100 MEICAL SUPPLIES CHARGED TO PATI ENT 0 5.822,600 0.000000 0.000000 1,245,738 71.00 73.00 O7200 IMPL. DEV. CHARGED TO PATI		0					
54. 01 05401 ULTRASOUND 0 0 0 0.000000 0.000000 0 54. 01 55. 00 05600 RADI 0I SOTOPE 0 0 0.000000 0.000000 0 56. 00 57. 00 05700 CT SCAN 0 0 0.000000 0.000000 0 57. 00 58. 00 05800 MRI 0 0 0.000000 0.000000 0 58. 00 60. 00 06000 LABORATORY 0 23, 565, 332 0.000000 0.000000 2, 092, 057 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 2, 821, 377 0.000000 0.000000 223, 238 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 2, 821, 377 0.000000 0.000000 228, 238 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 61, 740 0.000000 0.000000 13, 979 68. 00 69. 00 06900 ELECTROCARDI 0LOGY 0 5, 822, 600 0.000000 0.000000 1, 245, 738 71. 00 72. 0		0	-				
56.00 05600 RADI 0I SOTOPE 0 0 0.000000 0.000000 0 56.00 57.00 05700 CT SCAN 0 0 0.000000 0.000000 0 57.00 58.00 05800 MRI 0 0 0.000000 0.000000 2,092,057 60.00 60.00 LABORATORY 0 2,077,029 0.000000 0.000000 907,898 65.00 65.00 06500 RESPI RATORY THERAPY 0 2,821,377 0.000000 0.000000 288,492 67.00 66.00 06600 PHYSI CAL THERAPY 0 930,672 0.000000 0.000000 288,492 67.00 68.00 06800 SPEECH PATHOLOGY 0 61,740 0.000000 0.000000 13,979 88.00 69.00 06900 ELECTROCADI OLOGY 0 5,627,028 0.000000 0.000000 1,245,738 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 4,966,451 0.000000 0.000000 1,245,738 71.00 73.00 07300 <td></td> <td>0</td> <td>35, 811, 944</td> <td></td> <td></td> <td></td> <td></td>		0	35, 811, 944				
57.00 05700 CT SCAN 0 0 0.000000 0.000000 0 57.00 58.00 05800 MRI 0 0 0.000000 0.000000 0 58.00 60.00 06000 LABORATORY 0 23,565,332 0.000000 0.000000 2,092,057 60.00 65.00 06500 RESPI RATORY THERAPY 0 2,077,029 0.000000 0.000000 322,378 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 2,821,377 0.000000 0.000000 288,492 67.00 68.00 06800 SPEECH PATHOLOGY 0 61,740 0.000000 0.000000 13,979 68.00 69.00 06900 ELECTROCARDI OLOGY 0 5,627,028 0.000000 0.000000 1,245,738 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5,822,600 0.000000 1,245,738 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 4,966,451 0.000000 0.000000 1,299,808 72.00 76.00		0	0			-	
58.00 05800 MRI 0 0 0.000000 0.000000 0.000000 2,092,057 60.00 60.00 06000 LABORATORY 0 23,565,332 0.000000 0.000000 2,092,057 60.00 65.00 06500 RESPI RATORY THERAPY 0 2,077,029 0.000000 0.000000 907,898 65.00 66.00 06600 PHYSI CAL THERAPY 0 2,821,377 0.000000 0.000000 288,492 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0 61,740 0.000000 0.000000 288,492 67.00 68.00 06800 SPEECH PATHOLOGY 0 61,740 0.000000 0.000000 13,979 68.00 69.00 06900 ELECTROCARDI OLOGY 0 5,627,028 0.000000 0.000000 1,245,738 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 5,822,600 0.000000 0.000000 1,245,738 72.00 73.00 07300 DRGS CHARGED TO PATI ENTS 0 24,335,190 0.000000 0.000000		0	0			u u u u u u u u u u u u u u u u u u u	
60.00 06000 LABORATORY 0 23, 565, 332 0.000000 0.000000 2, 092, 057 60.00 65.00 06500 RESPI RATORY THERAPY 0 2, 077, 029 0.000000 0.000000 907, 898 65.00 66.00 06600 PHYSI CAL THERAPY 0 2, 821, 377 0.000000 0.000000 288, 492 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0 930, 672 0.000000 0.000000 288, 492 67.00 68.00 06800 SPEECH PATHOLOGY 0 61,740 0.000000 0.000000 13,979 68.00 69.00 06900 ELECTROCARDI OLOGY 0 5, 627, 028 0.000000 0.000000 1,245, 738 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5, 822, 600 0.000000 0.000000 1,245, 738 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 4,966,451 0.000000 0.000000 6,856,092 73.00 76.00 03610 SLEEP LAB 0 658,008 0.000000 0.000000 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td>		0	0			-	
65.00 06500 RESPI RATORY THERAPY 0 2,077,029 0.000000 0.000000 907,898 65.00 66.00 06600 PHYSI CAL THERAPY 0 2,821,377 0.000000 0.000000 322,378 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 930,672 0.000000 0.000000 288,492 67.00 68.00 06800 SPEECH PATHOLOGY 0 61,740 0.000000 0.000000 13,979 68.00 69.00 06900 ELECTROCARDI OLOGY 0 5,627,028 0.000000 0.000000 1,245,738 71.00 71.00 MDI CAL SUPPLIES CHARGED TO PATI ENT 0 5,822,600 0.000000 0.000000 1,245,738 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 4,966,451 0.000000 0.000000 1,299,808 72.00 73.00 03610 SLEP LAB 0 658,008 0.000000 0.000000 9,398 76.00 00 09000 CLINIC 0 589,000 0.000000 0.000000 9,990 90.00		0	0			-	
66.00 06600 PHYSI CAL THERAPY 0 2, 821, 377 0.000000 322, 378 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 930, 672 0.000000 0.000000 288, 492 67.00 68.00 06800 SPEECH PATHOLOGY 0 61, 740 0.000000 0.000000 13, 979 68.00 69.00 06900 ELECTROCARDI OLOGY 0 5, 627, 028 0.000000 0.000000 1, 245, 738 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5, 822, 600 0.000000 0.000000 1, 245, 738 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 24, 335, 190 0.000000 0.000000 6, 856, 092 73.00 76.00 03610 SLEEP LAB 0 658, 008 0.000000 0.000000 9, 398 76.00 90.00 09000 CLINIC 0 589, 000 0.000000 0.000000 9, 90.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 2, 236, 362 0.000000 0.000000 92.00 <		0					
67.00 06700 0CCUPATI ONAL THERAPY 0 930, 672 0.000000 0.000000 288, 492 67.00 68.00 06800 SPEECH PATHOLOGY 0 61, 740 0.000000 0.000000 13, 979 68.00 69.00 06900 ELECTROCARDI OLOGY 0 5, 627, 028 0.000000 0.000000 13, 979 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 5, 822, 600 0.000000 0.000000 1, 245, 738 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 4, 966, 451 0.000000 0.000000 6, 856, 092 73.00 73.00 03610 SLEEP LAB 0 658, 008 0.000000 0.000000 9, 398 76.00 0 09000 CLI NI C 0 589, 000 0.000000 0.000000 9, 309, 90.00 90.00 90.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 2, 236, 362 0.000000 0.000000 12, 497 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 2, 236,		0					
68.00 06800 SPEECH PATHOLOGY 0 61,740 0.000000 13,979 68.00 69.00 06900 ELECTROCARDI OLOGY 0 5,627,028 0.000000 0.000000 818,244 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5,822,600 0.000000 0.000000 1,245,738 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 4,966,451 0.000000 0.000000 1,299,808 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 24,335,190 0.000000 0.000000 6,856,092 73.00 76.00 03610 SLEEP LAB 0 658,008 0.000000 0.000000 9,398 76.00 017401 DVTPATI ENT SERVICE COST CENTERS 0 21,125,366 0.000000 0.000000 90.00 90.00 90.00 09000 CLINIC 0 589,000 0.000000 0.000000 12,497 91.00 91.00 09200 DBERVATI ON BEDS (NON-DI STINCT PART 0 2,236,362 0.000000 0.000000 12		0					
69.00 06900 ELECTROCARDI OLOGY 0 5, 627, 028 0.000000 0.000000 818, 244 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 5, 822, 600 0.000000 0.000000 1, 245, 738 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 4, 966, 451 0.000000 0.000000 1, 299, 808 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 24, 335, 190 0.000000 0.000000 6, 856, 092 73.00 76.00 03610 SLEEP LAB 0 658, 008 0.000000 0.000000 9, 398 76.00 0 09000 CLI NI C 0 589,000 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 0 21, 125, 366 0.000000 0.000000 12, 497 91.00 92.00 052RVATI ON BEDS (NON-DI STI NCT PART 0 2, 236, 362 0.000000 0.000000 3, 920 92.00 0 09500 AMBULANCE SERVI CES 95.00 95.00 95.00 95.00 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 5,822,600 0.000000 0.000000 1,245,738 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 4,966,451 0.000000 0.000000 1,299,808 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 24,335,190 0.000000 0.000000 6,856,092 73.00 76.00 03610 SLEEP LAB 0 658,008 0.000000 0.000000 9,398 76.00 0 09000 CLI NI C 0 589,000 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 0 21,125,366 0.000000 0.000000 12,497 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 2,236,362 0.000000 0.000000 3,920 92.00 0 09500 AMBULANCE SERVICES 95.00 95.00 95.00 95.00		0					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 4,966,451 0.000000 0.000000 1,299,808 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 24,335,190 0.000000 0.000000 6,856,092 73.00 76.00 03610 SLEEP LAB 0 658,008 0.000000 0.000000 9,398 76.00 00 09000 CLINIC 0 589,000 0.000000 0.000000 90.00 90.00 09100 EMERGENCY 0 21,125,366 0.000000 0.000000 12,497 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 2,236,362 0.000000 0.000000 3,920 92.00 0THER REIMBURSABLE COST CENTERS 0 09500 AMBULANCE SERVICES 95.00 95.00 95.00	69. 00 06900 ELECTROCARDI OLOGY	0	5, 627, 028	0.00000	0 0.000000	818, 244	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 24, 335, 190 0.000000 0.000000 6, 856, 092 73.00 76.00 03610 SLEEP LAB 0 658,008 0.000000 0.000000 9, 398 76.00 00TPATIENT SERVICE COST CENTERS 0 589,000 0.000000 0.000000 9, 398 76.00 90.00 09000 CLINIC 0 589,000 0.000000 0.000000 90.00 91.00 09100 EMERGENCY 0 21, 125, 366 0.000000 0.000000 12, 497 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 2, 236, 362 0.000000 0.000000 3, 920 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0	5, 822, 600				71.00
76.00 03610 SLEEP LAB 0 658,008 0.000000 0.000000 9,398 76.00 0UTPATI ENT SERVICE COST CENTERS 0 589,000 0.000000 0.000000 0.000000 90.00 90.00 09100 EMERGENCY 0 589,000 0.000000 0.000000 12,497 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0 2,236,362 0.000000 0.000000 3,920 92.00 OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 966, 451	0.00000	0.000000	1, 299, 808	72.00
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 0.00000 0.000000 0.000000 0.000000 90.00 91.00 91.00 92.00 92.00 92.00 0.000000 0.000000 3,920 92.00 92.00 95.00 09500 AMBULANCE_SERVICES 95.00 95.00 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	24, 335, 190	0.00000	0.000000	6, 856, 092	73.00
90.00 09000 CLINIC 0 589,000 0.000000 0.000000 0 90.00 91.00 91.00 92.00 92.00 0.000000 0.000000 3,920 92.00 92.00 95.00 0.9500 AMBULANCE SERVICES 95.00 9		0	658, 008	0.00000	0.000000	9, 398	76.00
91.00 09100 EMERGENCY 0 21, 125, 366 0.000000 0.000000 12, 497 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 2, 236, 362 0.000000 0.000000 3, 920 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00							
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 2, 236, 362 0. 000000 3, 920 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00		0					
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00		0					91.00
95.00 09500 AMBULANCE SERVICES 95.00		0	2, 236, 362	0.00000	0 0.00000	3, 920	92.00
		r					
200.00 Total (lines 50-199) 0 154, 886, 041 17, 483, 140 [200.00							
	200.00 Total (lines 50-199)	0	154, 886, 041			17, 483, 140	200. 00

Health Financial Systems	DUKES MEMORIAL	. HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 <u>x col. 10</u>) 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Throug Costs (col. <u>x col. 12)</u> 13.00	h		
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.01 05401 RADI OLOGY 54.00 05400 RADI OLOGY 56.00 05500 RESPI RATORY 58.00 06500 RESPI RATORY 66.00 04500 RESPI RATORY 66.00 06600 PHYSI CAL 67.00 06600 PHYSI CAL 68.00 06800 SPECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 69.00 06				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 76.\ 00\\ \end{array}$
OUTPATIENT SERVICE COST CENTERS]
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	0 0 0	0 0 0		0 0 0		90.00 91.00 92.00
95. 00 09500 AMBULANCE SERVICES 200. 00 Total (lines 50-199)	0	0		0		95. 00 200. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
				10 12/31/2010	5/30/2017 5:4	
		Title	× XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(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. 115372				0	
51.00 05100 RECOVERY ROOM	0. 141875		799, 45	6 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			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. 082119		11, 547, 39	6 0	0	54.00
54. 01 05401 ULTRASOUND	0. 000000			0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000			0 0	0	56.00
57.00 05700 CT SCAN	0. 000000			0 0	0	57.00
58. 00 05800 MRI	0. 000000			0 0	0	58.00
60. 00 06000 LABORATORY	0. 104677		7, 243, 65		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 328865		230, 21		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 260797		621, 02	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 227127		92, 17		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 341497		3, 70		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 107362		1, 879, 42	7 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 072106	0	703, 11	6 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 182470		662, 81	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 095614		4, 291, 82	0 0	0	73.00
76.00 03610 SLEEP LAB	0. 288706	0	221, 76	6 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 803238	0			0	
91.00 09100 EMERGENCY	0. 309981	0	5, 860, 61	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 414340	0	856, 51	6 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		1	1			
95. 00 09500 AMBULANCE SERVICES	0. 117521			0		95.00
200.00 Subtotal (see instructions)		0	39, 037, 35	4 0	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	39, 037, 35	4 0	0	202.00

Health Financial Systems	DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-1318	Period: From 01/01/2016	Worksheet D Part V	
				To 12/31/2016		epared:
					5/30/2017 5:4	
			XVIII	Hospi tal	Cost	
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				-
50. 00 05000 OPERATING ROOM	459, 764	C				50.00
51. 00 05100 RECOVERY ROOM	113, 423		1			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	113, 423		1			52.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	948, 261	, s				54.00
	948, 201					54.00
54. 01 05401 ULTRASOUND	0					
56. 00 05600 RADI OI SOTOPE	0					56.00
57. 00 05700 CT SCAN	0					57.00
58. 00 05800 MRI	750.044					58.00
60. 00 06000 LABORATORY	758, 244					60.00
65. 00 06500 RESPI RATORY THERAPY	75, 709					65.00
66. 00 06600 PHYSI CAL THERAPY	161, 960					66.00
67.00 06700 OCCUPATI ONAL THERAPY	20, 935					67.00
68.00 06800 SPEECH PATHOLOGY	1, 266					68.00
69. 00 06900 ELECTROCARDI OLOGY	201, 779					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	50, 699					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	120, 944					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	410, 358					73.00
76.00 03610 SLEEP LAB	64, 025	0				76.00
OUTPATIENT SERVICE COST CENTERS		1	1			
90. 00 09000 CLINIC	31,003					90.00
91.00 09100 EMERGENCY	1, 816, 681					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	354, 889	C				92.00
OTHER REI MBURSABLE COST CENTERS	-	1				05 63
95. 00 09500 AMBULANCE SERVICES	0	-				95.00
200.00 Subtotal (see instructions)	5, 589, 940		1			200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	F 500 0.0	_				
202.00 Net Charges (line 200 +/- line 201)	5, 589, 940	0	1			202.00

Health Financial Systems	DUKES MEMORIA			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
		Component		From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
		component	JUN: 15-2318	10 12/31/2010	5/30/2017 5:4	4 pm
		Title	XVIII	Swing Beds - SNF		<u> </u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coi ns	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 05000 OPERATI NG ROOM	0. 115372	0		0 0	-	
51.00 05100 RECOVERY ROOM	0. 141875	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 082119	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 104677	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 328865	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 260797	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 227127	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 341497	0	1	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 107362	0	1	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 072106	0	1	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 182470	0	1	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 095614	0	1	0 0	0	73.00
76.00 03610 SLEEP LAB	0. 288706	0	1	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 803238	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 309981	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 414340	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			_			
95. 00 09500 AMBULANCE SERVICES	0. 117521			0		95.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0	l	201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1318	Peri od:	Worksheet D	
		Component	CCN: 15-Z318	From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
		component	CCN. 13-2316	10 12/31/2010	5/30/2017 5:4	
		Title	e XVIII	Swing Beds - SNF		
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				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	0				54.00
54. 01 05401 ULTRASOUND	0	0				54.01
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0)			58.00
60. 00 06000 LABORATORY	0	C				60,00
65. 00 06500 RESPI RATORY THERAPY	0	C)			65.00
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C				67.00
68.00 06800 SPEECH PATHOLOGY	0	C				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C				73.00
76.00 03610 SLEEP LAB	0	0)			76.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	C	•			90.00
91. 00 09100 EMERGENCY	0	C				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0				92.00
OTHER REI MBURSABLE COST CENTERS			1			1 05 00
95. 00 09500 AMBULANCE SERVICES	0	_				95.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
0nl y Charges 202.00 Net Charges (line 200 +/- line 201)	0	C				202.00
202.00 INEL CHAIGES (ITTHE 200 +/ - ITTHE 201)	0	0	'			1202.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAN	PITAL COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/30/2017 5:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost		,	
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	917, 075	35, 907	881, 16	3, 681	239.38	30.00
31.00 INTENSIVE CARE UNIT	109, 025		109, 02	5 542	201.15	31.00
43.00 NURSERY	19, 472		19, 47	2 324	60.10	43.00
200.00 Total (lines 30-199)	1, 045, 572		1, 009, 66	5 4, 547		200.00
Cost Center Description	Inpati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	42		•			30.00
31.00 INTENSIVE CARE UNIT	7	1, 408				31.00
43.00 NURSERY	37					43.00
200.00 Total (lines 30-199)	86	13, 686				200. 00

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 5/30/2017 5:4	pared: 4 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	416, 955	20, 643, 822			2, 151	50.00
51.00 05100 RECOVERY ROOM	34, 972	3, 614, 120			131	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	313, 806	35, 811, 944	0.00876	46, 832	410	54.00
54. 01 05401 ULTRASOUND	0	0	0.0000	0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.0000	0 0	0	56.00
57.00 05700 CT SCAN	0	0	0.0000	0 0	0	57.00
58.00 05800 MRI	0	0	0.0000	0 0	0	58.00
60.00 06000 LABORATORY	162, 863	23, 565, 332	0.0069	1 79, 310	548	60.00
65. 00 06500 RESPI RATORY THERAPY	53, 492	2, 077, 029	0. 02575	48, 811	1, 257	65.00
66. 00 06600 PHYSI CAL THERAPY	64, 873	2, 821, 377	0. 02299	7, 295	168	66.00
67.00 06700 OCCUPATI ONAL THERAPY	20, 899	930, 672	0. 02245	2, 885	65	67.00
68.00 06800 SPEECH PATHOLOGY	929	61, 740	0.01504	408	6	68.00
69.00 06900 ELECTROCARDI OLOGY	41, 463	5, 627, 028	0.00736	9 19, 686	145	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 403	5, 822, 600	0.00298	30, 252	90	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	37, 998				166	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	88, 973	24, 335, 190	0.0036	146, 411	535	73.00
76.00 03610 SLEEP LAB	44,652				0	76.00
OUTPATIENT SERVICE COST CENTERS						
90, 00 09000 CLINIC	33, 537	589,000	0.05693	39 0	0	90.00
91.00 09100 EMERGENCY	277, 579	21, 125, 366	0.01314	36, 968	486	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	191,028				131	92.00
OTHER REIMBURSABLE COST CENTERS		, , , ,				
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1, 801, 422	154, 886, 041		562, 142	6, 289	200. 00

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C		Period:	Worksheet D	
				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/30/2017 5:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
	-	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				^	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				- 1		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0)	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.		Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	3, 681			2 0		30.00
31.00 03100 INTENSIVE CARE UNIT	542			7 0		31.00
43.00 04300 NURSERY	324			7 0		43.00
200.00 Total (lines 30-199)	4, 547		8	6 0		200. 00

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider C	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016		pared: 4 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st	-		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01 05401 ULTRASOUND	0	l o		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	c c		0 0	0	56.00
57.00 05700 CT SCAN	0	l a		0 0	0	57.00
58. 00 05800 MRI	0	l d		0 0	0	58.00
60. 00 06000 LABORATORY	0			0 0	0	60,00
65. 00 06500 RESPI RATORY THERAPY	0			0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0			0 0	0	66,00
67.00 06700 OCCUPATIONAL 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
76. 00 03610 SLEEP LAB	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	-	-		-		
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0			0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · ·			<u> </u>		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	C		0 0	0	200.00
			•			

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2016	Part IV	
				To 12/31/2016	Date/Time Pre 5/30/2017 5:4	pared: 1 nm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	-	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		-	1	- F		
50. 00 05000 OPERATI NG ROOM	0					
51.00 05100 RECOVERY ROOM	0	3, 614, 120				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000			52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	35, 811, 944				54.00
54. 01 05401 ULTRASOUND	0	0	0.00000	0. 000000	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.00000	0. 000000	0	56.00
57.00 05700 CT SCAN	0	0	0.00000	0. 000000	0	57.00
58. 00 05800 MRI	0	0	0.00000	0. 000000	0	58.00
60. 00 06000 LABORATORY	0	23, 565, 332	0.00000	0. 000000	79, 310	60.00
65. 00 06500 RESPI RATORY THERAPY	0	2, 077, 029	0.00000	0. 000000	48, 811	65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 821, 377	0.00000	0. 000000	7, 295	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	930, 672	0.00000	0. 000000	2, 885	67.00
68.00 06800 SPEECH PATHOLOGY	0	61, 740	0.00000	0. 000000	408	68.00
69.00 06900 ELECTROCARDI OLOGY	0	5, 627, 028	0.00000	0. 000000	19, 686	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 822, 600	0.00000	0. 000000	30, 252	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	4, 966, 451	0.00000	0. 000000	21, 717	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	24, 335, 190	0.00000	0. 000000	146, 411	73.00
76.00 03610 SLEEP LAB	0	658, 008	0.00000	0. 000000	0	76.00
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLI NI C	0	589,000	0.00000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	21, 125, 366	0.00000	0. 000000	36, 968	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 236, 362	0.00000	0. 000000	1, 531	92.00
OTHER REIMBURSABLE COST CENTERS			•	•		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	154, 886, 041			562, 142	200. 00
					-	

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-25	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Throug Costs (col. <u>x col. 12)</u> 13.00	h		
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.01 05401 RADI OLOGY 54.00 05400 RADI OLOGY 56.00 05500 RESPI RATORY 65.00 06500 RESPI RATORY 65.00 06600 PHYSI CAL 66.00 06600 PHYSI CAL 67.00 06700 OCUPATI ONAL 68.00 06800 SPECH 69.00 06900 ELECTROCARDI OLOGY 69.00 069000				0 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 56.00 57.00 58.00 60.00 65.00 66.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	0 0 0	0 0 0		0 0 0		90. 00 91. 00 92. 00
95. 00 09500 AMBULANCE SERVICES 200. 00 Total (lines 50-199)	0	0		0		95.00 200.00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narad
				10 12/31/2010	5/30/2017 5:4	
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		-				
50.00 05000 OPERATING ROOM	0. 115372				0	
51.00 05100 RECOVERY ROOM	0. 141875		68, 07	4 13, 782	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 082119	0	764, 04	6 256, 750	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 104677	0	608, 69	3 274, 427	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 328865	l o	15, 79	3 10, 321	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 260797	l o	38, 65	3 16,048	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 227127	0	3, 86		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 341497	0	5, 36		0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 107362	0	97, 04		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 072106	0	116, 77		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 182470	0	18, 70		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 095614				0	73.00
76.00 03610 SLEEP LAB	0. 288706				0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 803238	0	8, 67	3 656	0	90.00
91. 00 09100 EMERGENCY	0, 309981	0			0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 414340	0	62, 37	9 30, 279	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 117521	0	189, 07	3		95.00
200.00 Subtotal (see instructions)		0	3, 331, 01	6 1, 298, 554	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	3, 331, 01	6 1, 298, 554	0	202.00

Heal th	Financial Systems	DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pr 5/30/2017 5:	
				e XIX	Hospi tal	PPS	
			sts				
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins.	Cost Reimbursed Services Not Subject To Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	1			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	37,662	9, 498				50.00
	05100 RECOVERY ROOM	9, 658	1, 955				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	62, 743	21, 084				54.00
	05401 ULTRASOUND	0	0				54.01
	05600 RADI OI SOTOPE	0	0				56.00
	05700 CT SCAN	0	0				57.00
	05800 MRI	0	0				58.00
	06000 LABORATORY	63, 716					60.00
	06500 RESPI RATORY THERAPY	5, 194					65.00
	06600 PHYSI CAL THERAPY	10, 081	4, 185				66.00
	06700 OCCUPATI ONAL THERAPY	878					67.00
	06800 SPEECH PATHOLOGY	1, 833					68.00
	06900 ELECTROCARDI OLOGY	10, 419					69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 420					71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 414					72.00
	07300 DRUGS CHARGED TO PATIENTS	16, 845					73.00
	03610 SLEEP LAB	9, 925	0				76.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	6, 966					90.00
	09100 EMERGENCY	247,014					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	25, 846	12, 546				92.00
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	22, 220					95.00
95.00 200.00	Subtotal (see instructions)	542, 834					200.00
200.00	Less PBP Clinic Lab. Services-Program	542, 834					200.00
201.00	Only Charges	0					201.00
202.00	Net Charges (line 200 +/- line 201)	542, 834	244, 264				202.00

	Financial Systems DUKES MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1318	Period: From 01/01/2016 To 12/31/2016		pare
		Title XVIII	Hospi tal	5/30/2017 5:44 Cost	4 pm
	Cost Center Description		nospi tui	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s. excluding newborn)		3, 831	1.
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		3, 681	2
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	44	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed davs)		2, 839	4
00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	150	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	un days) arter becenber	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)	in days) arter becember e	T OF the cost	0	
00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 542	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	oom davs)	150	10
	through December 31 of the cost reporting period (see instruc	tions)	5 1		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
00	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			0	15
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	f the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction			4, 448, 428	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	er 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	о	25
. 00	x line 20) Total swing-bed cost (see instructions)			174, 175	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 274, 253	
00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	d and abcomunition had		(015 070	
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	6, 815, 878 83, 220	
	Semi -private room charges (excluding swing bed charges)			6, 732, 658	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.627102	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			1, 891. 36 2, 371. 49	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li			0.00	35
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 4, 274, 253	36 37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	•			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			ł
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 161. 17	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		1, 790, 524 0	
. 00					

OMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1318	Period: From 01/01/2016	Worksheet D-1	
					To 12/31/2016		
			Title	xvi i	Hospi tal	5/30/2017 5:4 Cost	+4 pii
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	10
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00000	0	42
. 00	INTENSIVE CARE UNIT	702, 601	542	1, 296. 3	31 366	474, 449	43
. 00	CORONARY CARE UNI T						44
. 00	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	
. 00	Program inpatient ancillary service cost (Wks			```		2, 119, 502	
. 00	Total Program inpatient costs (sum of lines / PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructio	ins)		4, 384, 475	49
. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sun	of Parts I and	0	50
. 00	Pass through costs applicable to Program inpa	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	0	51
. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anesth	netist, and	0	
	medical education costs (line 49 minus line !	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ing cost and tar	-get amount (I	ine 56 minus	line 53)	0	57
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period e	ending 1996, u	pdated and co	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, upo	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				the amount by	0	61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	f the target		
. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	·					
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	e cost reporti	ng period (See	174, 176	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	neriod (See	0	65
. 00	instructions) (title XVIII only)						/ 00
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line é	64 plus line 6	5)(title XVII	l only). For	174, 176	66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	a costs through	December 21	f the cost re	porting ported	0	67
. 00	(line 12 x line 19)	e costs through	December 31 C		portring period	0	" "
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68
	(line 13 x line 20)					_	
. 00	Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
. 00	Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service co	5		. ,			71
. 00	Program routine service cost (line 9 x line		(1) · · ·	25)			72
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73
. 00	Capital -related cost allocated to inpatient	•			Part II. column		74
55	26, line 45)						``
. 00	Per diem capital-related costs (line 75 ÷ lin						76
. 00	Program capital -related costs (line 9 x line	,					77
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	· ·	ovider record	ls)			78
00	Total Program routine service costs for compa	• •			nus line 79)		80
00	Inpatient routine service cost per diem limi	tation		-	~		81
00	Inpatient routine service cost limitation (li						82
. 00	Reasonable inpatient routine service costs (5)				83
. 00 . 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84
. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	~ <i>,</i>				
. 00	Total observation bed days (see instructions)					798	
3. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		line 2)			1, 161. 17 926, 614	
$\cap \cap$							

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	917, 075	4, 448, 428	0. 20615	7 926, 614	191, 028	90.00
91.00 Nursing School cost	0	4, 448, 428	0.00000	0 926, 614	0	91.00
92.00 Allied health cost	0	4, 448, 428	0.00000	0 926, 614	0	92.00
93.00 All other Medical Education	0	4, 448, 428	0. 00000	0 926, 614	0	93.00

	Financial Systems DUKES MEMORIAL HOSPITAL In Lie TATION OF INPATIENT OPERATING COST Provider CCN: 15-1318 Period: From 01/01/2016	u of Form CMS-2 Worksheet D-1	2002
	To 12/31/2016	5/30/2017 5:4	
	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS	1.00	
00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 831	1
00 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 681 0	2 3
00 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	2, 883 150	4
00	reporting period	150	
00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7
00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8
00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	42	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13
	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0 324	14 15
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		16
. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20
	Total general inpatient routine service cost (see instructions)	4, 448, 428	
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22
. 00	x Line 18)	0	
. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	174, 175 4, 274, 253	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28
. 00	Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0.00 0.00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
	Private room cost differential adjustment (line 3 x line 35)	0.00	36
	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4, 274, 253	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 161. 17	20
	Program general inpatient routine service cost (line 9 x line 38)	48, 769	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40

JMPUI	TATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-1318	Period: From 01/01/2016	eu of Form CMS- Worksheet D-1	
					To 12/31/2016		
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	10
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	207, 119	324	639.2	26 37	23, 653	3 42.
. 00	INTENSIVE CARE UNIT	702, 601	542	1, 296.	31 7	9, 074	43
. 00	CORONARY CARE UNI T						44
. 00	BURN INTENSIVE CARE UNIT						45
							46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
						1.00	
. 00	Program inpatient ancillary service cost (Wks			201		79, 455	
. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	i through 48)(s	see instructio	ns)		160, 951	49
. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sur	n of Parts I and	13, 686	50
. 00	Pass through costs applicable to Program inpa	atient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	6, 289	51
. 00	and IV) Total Program excludable cost (sum of lines {	50 and 51				19, 975	5 52
3. 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anestł	netist, and	140, 976	
	medical education costs (line 49 minus line 5						
~~	TARGET AMOUNT AND LIMIT COMPUTATION						1 = 4
. 00 . 00						0.00	
. 00	0					0.00	
. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ending 1996, u	pdated and co	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost report upo	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				the amount by	0	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see i	nstructions)				0	1 4 2
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST		seronoy				
. 00	5 1	ts through Decem	mber 31 of the	cost reporti	ng period (See	0	64
	instructions) (title XVIII only)	to often Decembe	n 21 of the o	aat manamtin	noniad (Cas		
5. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	IS after Decembe	er si or the c	σει τεροτιτής	j period (see	0	65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line é	64 plus line 6	5)(title XVII	I only). For	0	66
	CAH (see instructions)						
. 00	5	e costs through	December 31 o	f the cost re	eporting period	0	67
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost rep	orting period	C	68
	(line 13 x line 20)					-	
0. 00	Total title V or XIX swing-bed NF inpatient					0) 69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				1		70
. 00	Adjusted general inpatient routine service co	3					71
. 00	Program routine service cost (line 9 x line 7			,			72
. 00	Medically necessary private room cost applica	0	•	ne 35)			73
. 00	Total Program general inpatient routine servi	•		arkahaat D)ast II. aalumn		74
. 00	Capital-related cost allocated to inpatient r 26, line 45)	outine service	CUSIS (ITOM W	UIKSHEEL B, H	arri, column	1	75
. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)				1	76
. 00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minus		'			ł	78
. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· · ·		,	nus line 70)	1	80
. 00	Inpatient routine service cost per diem limit					1	81
. 00	Inpatient routine service cost limitation (li)			1	82
. 00	Reasonable inpatient routine service costs (s		5)				83
. 00	Program inpatient ancillary services (see ins					l	84
b. 00 b. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum					1	85
. 50	PART IV - COMPUTATION OF OBSERVATION BED PASS		g				
. 00	Total observation bed days (see instructions))				798	
3.00	Adjusted general inpatient routine cost per o		line 2)			1, 161. 17 926, 614	
	Observation bed cost (line 87 x line 88) (see						

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: 4 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				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	917, 075	4, 448, 428	0. 20615	7 926, 614	191, 028	90.00
91.00 Nursing School cost	0	4, 448, 428	0.00000	0 926, 614	0	91.00
92.00 Allied health cost	0	4, 448, 428	0.00000	0 926, 614	0	92.00
93.00 All other Medical Education	0	4, 448, 428	0.00000	0 926, 614	0	93.00

leal th Financial Systems DUKES NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	<u>S MEMORIAL HOSPITAL</u> Provider C	CN. 1E 1210		eu of Form CMS-2 Worksheet D-3	
NPATTENT ANGILLARY SERVICE CUST APPORTIONMENT	Provi der C	CN: 15-1318	Period: From 01/01/2016		i
			To 12/31/2016		
	Title	e XVIII	Hospi tal	Cost	4 pili
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
		5	Charges	(col. 1 x col.	
			Ŭ	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			2, 769, 188		30.0
31. 00 03100 I NTENSI VE CARE UNI T			990, 210		31.0
13. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS		1		1	
50. 00 05000 OPERATI NG ROOM		0. 1153			
51.00 05100 RECOVERY ROOM		0. 1418			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
53. 00 05300 ANESTHESI OLOGY		0.0000		Ŭ	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0.0821			
54. 01 05401 ULTRASOUND		0.0000			
56. 00 05600 RADI OI SOTOPE		0.0000			1
57. 00 05700 CT SCAN		0.0000			1
58.00 05800 MRI		0.0000		, o	
50. 00 06000 LABORATORY		0. 1046			
55. 00 06500 RESPIRATORY THERAPY		0.3288			
56.00 06600 PHYSI CAL THERAPY		0.2607			
57.00 06700 OCCUPATIONAL THERAPY		0. 2271			
58. 00 06800 SPEECH PATHOLOGY 59. 00 06900 ELECTROCARDI OLOGY		0. 3414			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1073			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS					
73.00 07200 TMPL. DEV. CHARGED TO PATIENTS		0. 1824			
76.00 03610 SLEEP LAB		0. 0958			
OUTPATIENT SERVICE COST CENTERS		0.2007	9, 390	2,713	1 /0.0
20. 00 09000 CLINIC		0.8032	38 0	0	90.0
21. 00 09100 EMERGENCY		0. 3099			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4143			
OTHER REIMBURSABLE COST CENTERS		0.4145	3, 720	1,024	72.0
25. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50-94 and 96-98)			17, 483, 140	2, 119, 502	
201.00 Less PBP Clinic Laboratory Services-Program or	nly charges (line 61)		17, 403, 140	2, 117, 302	200.0
202.00 Net Charges (line 200 minus line 201)			17, 483, 140		201.0

Health Financial Systems DUKES MEN	IORI AL HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
	C		From 01/01/2016		
	Component	CCN: 15-Z318	To 12/31/2016	Date/Time Pre 5/30/2017 5:4	
	Title	e XVIII	Swing Beds - SNI		- piii
Cost Center Description	, intro	Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
		J	Charges	(col. 1 x col.	
			Ŭ	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			120, 406		30.00
31. 00 03100 I NTENSI VE CARE UNI T			C		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 11537	'2 C	0	50.00
51.00 05100 RECOVERY ROOM		0. 1418	'5 C	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
53. 00 05300 ANESTHESI OLOGY		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08212		504	54.00
54. 01 05401 ULTRASOUND		0.0000		0	54.01
56. 00 05600 RADI OI SOTOPE		0.0000		0	56.00
57.00 05700 CT SCAN		0.0000		0	
58. 00 05800 MRI		0.0000		0	
60. 00 06000 LABORATORY		0. 10467			
65. 00 06500 RESPI RATORY THERAPY		0. 32886			
66. 00 06600 PHYSI CAL THERAPY		0. 26079			
67.00 06700 OCCUPATI ONAL THERAPY		0. 22712			
68.00 06800 SPEECH PATHOLOGY		0. 34149		-	
69. 00 06900 ELECTROCARDI OLOGY		0. 10736			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.07210			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18247			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 0956			
76.00 03610 SLEEP LAB		0. 28870	06 C	0	76.00
OUTPATIENT SERVICE COST CENTERS		1		1	
90. 00 09000 CLINIC		0.80323			
91. 00 09100 EMERGENCY		0. 30998			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 41434	0 C	0	92.00
OTHER REIMBURSABLE COST CENTERS		1			
95.00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			423, 864		200.00
201.00 Less PBP Clinic Laboratory Services-Program only of	charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		I	423, 864	1	202.00

Health Financial Systems DUKES MEMORIAL		ON 15 1010		eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	UN: 15-1318	Period: From 01/01/2016	Worksheet D-3	5
			To 12/31/2016		
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1	04.450	1	1
30. 00 03000 ADULTS & PEDIATRICS			96, 150		30.0
31. 00 03100 I NTENSI VE CARE UNI T			19,029		31.0
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS			43, 792	2	43.0
50. 00 05000 OPERATING ROOM		0. 1153	72 106, 486	12, 286	50.0
51. 00 05100 RECOVERY ROOM		0. 1153			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 1418			
53. 00 05300 ANESTHESI OLOGY		0.0000		-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0821		-	
54. 01 05401 ULTRASOUND		0.00021			
56. 00 05600 RADI OI SOTOPE		0.0000		-	
57. 00 05700 CT SCAN		0.0000		· · · · · · · · · · · · · · · · · · ·	
58. 00 05800 MRI		0.0000		-	
60. 00 06000 LABORATORY		0. 1046			
65. 00 06500 RESPI RATORY THERAPY		0. 3288			
66. 00 06600 PHYSI CAL THERAPY		0. 2607			
67.00 06700 OCCUPATI ONAL THERAPY		0. 2271			
68.00 06800 SPEECH PATHOLOGY		0.3414	97 408	139	68.0
69. 00 06900 ELECTROCARDI OLOGY		0. 1073	62 19, 686	2, 114	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0721	06 30, 252	2, 181	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1824	70 21, 717	3, 963	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 0956	14 146, 411	13, 999	73.0
76.00 03610 SLEEP LAB		0. 2887	06 C	0 0	76.0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.8032			
91. 00 09100 EMERGENCY		0. 3099			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4143	40 1, 531	634	92.0
OTHER REIMBURSABLE COST CENTERS		1			
95. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50-94 and 96-98)			562, 142		
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0	·	201.0
202.00 Net Charges (line 200 minus line 201)		1	562, 142	2	202.0

ALCUL	Financial Systems DUKES MEMORIAL F ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Peri od:	u of Form CMS-2 Worksheet E	N
			From 01/01/2016 To 12/31/2016	Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2017 5:44 Cost	4 pm
			lioopi tui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			5, 589, 940	
2.00	Medical and other services reimbursed under OPPS (see instruct	i ons)		0	
. 00 . 00	PPS payments Outlier payment (see instructions)			0	3.0 4.0
. 00 . 00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
. 00	Line 2 times line 5			0	6.0
. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. I	V col 13 line 200		0	
0.00	Organ acquisitions	V, COL. 13, THIC 200		0	
1.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 589, 940	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES				-
2.00	Reasonable charges Ancillary service charges			0	12.0
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	
4.00	Total reasonable charges (sum of lines 12 and 13)			0	14.0
F 00	Customary charges				1 15 0
5.00 6.00	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0	
0.00	had such payment been made in accordance with 42 CFR §413.13(e		in a chargebasi s	0	10.0
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	17.0
8.00	Total customary charges (see instructions)			0	18.0
9.00	Excess of customary charges over reasonable cost (complete onl instructions)	y if line 18 exceeds li	ne 11) (see	0	19. C
0. 00	Excess of reasonable cost over customary charges (complete on	vifline 11 exceeds li	ne 18) (see	0	20.0
	instructions)	-			
1.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		5, 645, 839	
2.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	ructions)		0	22.0 23.0
4. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
5.00	Deductibles and coinsurance (for CAH, see instructions)			50, 988	
26.00 27.00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			6, 373, 082 -778, 231	26.0 27.0
.7.00	instructions)	a sum of times 22		-770,231	27.0
8.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
0.00 1.00	Subtotal (sum of lines 27 through 29) Primary payer payments			-778, 231 1, 045	
2.00	Subtotal (line 30 minus line 31)			-779, 276	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
4.00 5.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			1, 298, 822	
6.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		844, 234 1, 126, 165	1
7.00	Subtotal (see instructions)			64, 958	
	MSP-LCC reconciliation amount from PS&R			0	38.0
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.0
9.50	Pioneer ACO demonstration payment adjustment (see instructions			0	39.5
9. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	ctions)	0	39.9
9.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.9
0.00	Subtotal (see instructions)			64, 958	
0.01	Sequestration adjustment (see instructions)			1, 299	
1.00	Interim payments Tentative settlement (for contractors use only)			1, 594, 482 0	
3.00	Balance due provider/program (see instructions)			-1, 530, 823	
	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub. 15-2,	chapter 1,	0	44. C
4.00	§115. 2				
4.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90 0
4.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0 0	
4.00 0.00 1.00 2.00	Original outlier amount (see instructions)			-	91. 0 92. 0

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1318	Period: From 01/01/2016 To 12/31/2016		
		Title		Hospi tal	Cost	
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		3, 751, 50	67 0	1, 594, 482 0	1. (2. (
00	services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02 03 04 05				0 0 0	000000000000000000000000000000000000000	3. (3. (3. (3. (
00	Provider to Program	<u> </u>		0		
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0 0	0 0 0 0 0	3. 3. 3. 3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		3, 751, 5	57	1, 594, 482	4.
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					0.
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.0
03				0	0	5.
F 0	Provider to Program	1		0		
50 51	TENTATI VE TO PROGRAM			0	0	5. 5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		132, 12		0	6.
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		3, 883, 6	0	1, 530, 823 63, 659	6. 7.
			<u> </u>	Contractor Number	NPR Date (Mo/Day/Yr)	/.
		0)	1.00	2.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C		Period: From 01/01/2016 To 12/31/2016		pared
				Swing Beds - SNI		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider	1.00	259, 59		0	1.0
. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
01	Program to Provider					1
. 01 . 02	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
04				0	0	
05				0	0	3.
	Provider to Program	11		1	1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	
52 53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		259, 59	6	0	4.
	TO BE COMPLETED BY CONTRACTOR			_	1	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
~ -	Program to Provider			al		
01 02	TENTATI VE TO PROVI DER			0	0	
02				0	0	
	Provider to Program					1 .
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtatal (sum of lines E 01 E 40 minute sum of lin			0	0	
7 9 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on			U	0	5. 6.
DU D1	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	
02	SETTLEMENT TO PROGRAM		24, 58	0	0	
00	Total Medicare program liability (see instructions)		235, 01		0	
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	C)	1.00	2.00	8.

Heal th	Financial Systems DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
CALCUL				Worksheet E-1			
			From 01/01/2016 To 12/31/2016		hared		
			10 12/31/2010	5/30/2017 5: 4			
	Title XVIII Hospital						
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	e 14	1, 113	1.00			
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8		1, 908	2.00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	297 3, 425	3.00 4.00				
4.00							
5.00					5.00		
6.00	5 5				6.00		
7.00					7.00		
0 00	line 168			0	0.00		
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00		
9.00					9.00		
10.00					10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			0	30.00		
	30.00 Initial/interim HIT payment adjustment (see instructions)						
31.00	Other Adjustment (specify)			0	31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)	0	32.00		

Health Financial Systems					eu of Form CMS-2552-		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING	BEDS	Provider CCN: 15-1318	Peri od:	Worksheet E-2		
			Component CCN: 15-Z318	From 01/01/2016 To 12/31/2016	Date/Time Pre	narod	
			component con. 13-2310	10 12/31/2010	5/30/2017 5:4		
			Title XVIII	Swing Beds - SNF			
				Part A	Part B		
				1.00	2.00		
	COMPUTATION OF NET COST OF COVERED SERVICE			1			
1.00	Inpatient routine services - swing bed-SNF	. ,		175, 918	0	1.00	
2.00	Inpatient routine services - swing bed-NF					2.00	
3.00	Ancillary services (from Wkst. D-3, col. 3			63, 888	0	3.00	
	Part V, cols. 6 and 7, line 202, for Part						
4.00	Per diem cost for interns and residents no	t in approved teachi	ng program (see		0.00	4.00	
F 00	instructions)			150	0		
5.00	Program days			150	0	5.00	
6.00	Interns and residents not in approved teac				0	6.00	
7.00	Utilization review - physician compensatio		nod only	0	0	7.00	
8.00	Subtotal (sum of lines 1 through 3 plus li	nes 6 and 7)		239, 806	0		
9.00	Primary payer payments (see instructions)			0	0		
10.00	Subtotal (line 8 minus line 9)			239, 806	0		
11.00	Deductibles billed to program patients (ex professional services)	clude amounts applic	able to physician	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)			239, 806	0	12.00	
13.00	Coinsurance billed to program patients (fr for physician professional services)	om provider records)	(excl ude coi nsurance	0	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)				0	14.00	
15.00	Subtotal (enter the lesser of line 12 minu	s line 13, or line 1	4)	239, 806	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPEC	IFY)		0	0	16.00	
16.50	Pioneer ACO demonstration payment adjustme	nt (see instructions	5)	0	0	16.50	
16.55	410A RURAL DEMONSTRATION PROJECT			0		16.5	
17.00	Allowable bad debts (see instructions)			0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instr	uctions)		0	0	17.0	
18.00	Allowable bad debts for dual eligible bene	ficiaries (see instr	ructions)	0	0	18.00	
19.00	Total (see instructions)			239, 806	0	19.0	
19.01	Sequestration adjustment (see instructions)		4, 796	0	19.0 [°]	
20.00	Interim payments			259, 596	0	20.00	
21.00	Tentative settlement (for contractor use c	nl y)		0	0	21.00	
22.00	Balance due provider/program (line 19 minu	s lines 19.01, 20, a	ind 21)	-24, 586	0	22.00	
23.00	Protested amounts (nonallowable cost repor	t items) in accordan	ice with CMS Pub. 15-2,	0	0	23.00	
	chapter 1, §115.2						

	Financial Systems DUKES MEMORIAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Period: From 01/01/2016	Worksheet E-3 Part V	
			To 12/31/2016	Date/Time Pre	pared
			10 12/01/2010	5/30/2017 5:4	
		Title XVIII	Hospi tal	Cost	
				1.00	
1.00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - CUST	REIMBURSEMENT	4 204 475	1 1 0
2.00	Inpatient services Nursing and Allied Health Managed Care payment (see instruct	tions)		4, 384, 475 0	
2.00 3.00	Organ acquisition	LI OIIS)		0	
4.00	Subtotal (sum of lines 1 through 3)			4, 384, 475	
5.00	Primary payer payments			4, 304, 473	
5.00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 428, 320	
	COMPUTATION OF LESSER OF COST OR CHARGES			.,,	
	Reasonabl e charges				1
7.00	Routine service charges			0	7.0
3.00	Ancillary service charges			0	8.0
9.00	Organ acquisition charges, net of revenue			0	9.0
10.00	Total reasonable charges			0	10.0
	Customary charges				
1.00	Aggregate amount actually collected from patients liable for			0	
2.00	Amounts that would have been realized from patients liable f		n a charge basis	0	12.0
	had such payment been made in accordance with 42 CFR 413.13((e)		0,00000	10
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
4.00 5.00	Total customary charges (see instructions)	anly if line 14 evenede li	no () (coo	0	
5.00	Excess of customary charges over reasonable cost (complete c instructions)	only II IIne 14 exceeds II	ne o) (see	0	15.0
6.00	Excess of reasonable cost over customary charges (complete c	only if line 6 exceeds lin	e 14) (see	0	16.0
10.00	instructions)		0 11) (300	Ū	10.0
17.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E	E-4, line 49)		0	18.0
9.00	Cost of covered services (sum of lines 6, 17 and 18)			4, 428, 320	
0.00	Deductibles (exclude professional component)			494, 480	
1. 00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			3, 933, 840	
3.00				0	
4.00	Subtotal (line 22 minus line 23)			3, 933, 840	
5.00 6.00	Allowable bad debts (exclude bad debts for professional serv	/ices) (see instructions)		44, 792 29, 115	
6.00 7.00	Adjusted reimbursable bad debts (see instructions)	structions)			
8.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (sum of lines 24 and 25, or line 26)			25, 488 3, 962, 955	
9.00	MSP			3, 902, 955	
9.50	Pioneer ACO demonstration payment adjustment (see instruction	ans)		0	
9.99	Recovery of Accel erated Depreciation	5157		0	
0.00	Subtotal (see instructions)			3, 962, 955	
0.01	Sequestration adjustment (see instructions)			79, 259	
	Interim payments			3, 751, 567	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 31,	and 32)		132, 129	33.0
34.00	Protested amounts (nonallowable cost report items) in accord		chapter 1,	528, 559	
57.00	§115. 2	achoo writh omo rub. 13-2,		520, 557	

MCRI F32 - 10. 5. 160. 2

	Financial Systems DUKES MEMORIA E SHEET (If you are nonproprietary and do not maintain	Provider C		Period: From 01/01/2016	u of Form CMS-: Worksheet G	
na-t Iy)	ype accounting records, complete the General Fund column			Tom 01/01/2010	Date/Time Pre 5/30/2017 5:4	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-184, 407		0 0	0	1.
00	Temporary investments	0		0 0	0	
00	Notes receivable	0		0 0	0	3.
00	Accounts receivable	13, 517, 672		- -	0	
00	Other receivable	0		-	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	2, 218, 967- 991, 327-		- -	0	
00	Prepaid expenses	274, 676			0	
00	Other current assets	248, 129		0 0	0	
. 00	Due from other funds	0		0 0	0	10
00	Total current assets (sum of lines 1-10)	12, 628, 430	(0 0	0	11
	FI XED_ASSETS		r .	-1 -1	-	
. 00	Land	500, 000			0	
00	Land improvements Accumulated depreciation	218, 645 -95, 916			0	
	Buildings	10, 468, 696			0	
	Accumulated depreciation	-2, 833, 804			0	
. 00	Leasehold improvements	8, 971, 989			0	
00	Accumulated depreciation	-1, 996, 441		0 0	0	18
	Fixed equipment	1, 789, 071		0 0	0	19
	Accumulated depreciation	-753, 388	(-	0	
	Automobiles and trucks	544, 256		-	0	
	Accumulated depreciation	-451, 394	(0	
	Major movable equipment Accumulated depreciation	6, 334, 549 -4, 866, 641			0	
	Minor equipment depreciable	2, 894, 565		-	0	
	Accumulated depreciation	-2, 094, 875		5	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	28
. 00	Mi nor equi pment-nondepreci abl e	0			0	29
. 00	Total fixed assets (sum of lines 12-29)	18, 629, 312	(0 0	0	30
~~	OTHER ASSETS					1 21
	Investments Deposits on Leases	0			0	
. 00	Due from owners/officers			-	0	
. 00	Other assets	4, 517, 894		-	0	
. 00	Total other assets (sum of lines 31-34)	4, 517, 894		0 0	0	
. 00	Total assets (sum of lines 11, 30, and 35)	35, 775, 636	(0 0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	1, 204, 186			0	
. 00	Salaries, wages, and fees payable	911, 175			0	
00	Payroll taxes payable Notes and Loans payable (short term)	80, 495		0	0	
	Deferred income				0	
. 00	Accel erated payments	0				42
. 00	Due to other funds	-12, 991, 319		0 0	0	43
. 00	Other current liabilities	419, 344		0 0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	-10, 376, 119	(0 0	0	45
~ ~	LONG TERM LI ABI LI TI ES		1			÷.,
	Mortgage payable	0			0	
00	Notes payable Unsecured Loans	0			0	
. 00	Other long term liabilities	0			0	
	Total long term liabilities (sum of lines 46 thru 49)	0		-	0	
	Total liabilities (sum of lines 45 and 50)	-10, 376, 119		0 0	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	46, 151, 755				52
00	Specific purpose fund					53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56 57
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
		44 151 755	1	0 0	0	59
. 00	Total fund balances (sum of lines 52 thru 58)	46, 151, 755		0	0	1

Heal th	Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEM	STATEMENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet G-1 Date/Time Pre 5/30/2017 5:4	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00 39,912,860	3.00	4.00	5.00	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		6, 238, 893 6, 151, 753 46, 151, 753 0 46, 151, 753			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 46, 151, 753		0		18. 00 19. 00
		Endowment Fund	Pl ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	000000000000000000000000000000000000000	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	: 15-1318	Period: From 01/01/2016 To 12/31/2016	Worksheet G-2 Parts I & II Date/Time Pre 5/30/2017 5:4	pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
	·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		6, 062, 07	77	6, 062, 077	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		6, 062, 07	77	6, 062, 077	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		1, 245, 08	30	1, 245, 080	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 245, 08	30	1, 245, 080	16.0
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		7, 307, 15	57	7, 307, 157	17.00
18.00	Ancillary services		40, 483, 77	73 0	40, 483, 773	18.00
19.00	Outpatient services			0 120, 482, 282	120, 482, 282	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES			0 0	0	23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	47, 790, 93	30 120, 482, 282	168, 273, 212	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES	•				1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			30, 186, 983		29.0
30.00	ADD (SPECI FY)			0		30.00
31.00				0		31.00
32.00				0		32.0
33.00				0		33.0
34.00				0		34.00
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.0
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.0
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		30, 186, 983		43.0
	to Wkst. G-3, line 4)					

Heal th	Financial Systems DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1318	Peri od:	Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	hared
			10 12/31/2010	5/30/2017 5: 44	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			168, 273, 212	1.00
2.00	Less contractual allowances and discounts on patients' accourt	nts		131, 647, 411	2.00
3.00	Net patient revenues (line 1 minus line 2)			36, 625, 801	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		30, 186, 983	4.00
5.00	Net income from service to patients (line 3 minus line 4)			6, 438, 818	5.00
	OTHER INCOME				
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	n services		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	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER INCOME			-199, 925	24.00
25.00	Total other income (sum of lines 6-24)			-199, 925	25.00
	Total (line 5 plus line 25)			6, 238, 893	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			6, 238, 893	29.00