AND SETTLEMENT	T SUMMARY	Frovider CCN. 13-131	From 01/01/2017	Parts I-III Date/Time Prepared: 5/31/2018 11:21 am
PART I - COST	REPORT STATUS			37 317 2010 11. 21 dill
Provi der	1. [X] Electronically filed cost report		Date: 5/31/20	18 Time: 11:21 am
use only	2. [] Manually submitted cost report			
	3. [0] If this is an amended report enter the number 4. [F] Medicare Utilization. Enter "F" for full or "I		er resubmitted this co	ost report
Contractor use only	5. [1] Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for 9. [N] Final Report for	or this Provider CCN		

PART II - CERTIFICATION

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUKES MEMORIAL HOSPITAL (15-1318) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

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

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

VICE PRESIDENT REVENUE MANAGEMENT
Title

Date

Title XVIII Title V Part B Cost Center Description Part A HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 774, 206 -1, 707, 679 Hospi tal 0 0 1.00 Subprovider - IPF 0 2 00 2 00 C 0 3.00 Subprovider - IRF 0 0 0 3.00 Swing bed - SNF 0 0 5.00 65, 403 0 5.00 Swina bed - NF 0 6 00 0 6.00 200.00 Total 839, 609 -1, 707, 679 0 200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1318 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/31/2018 11:18 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 275 WEST 12TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: PERU Zip Code: 46970 County: MI AMI 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fied Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 DUKES MEMORIAL HOSPITAL 151318 99915 07/01/1966 Ν 0 3.00 Hospi tal 1 4.00 Subprovider - IPF 4.00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF DUKES MEMORIAL HOSPITAL 157318 99915 12/01/2003 N 0 N 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 21.00 Type of Control (see instructions) 21.00 4 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 | Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 Ν 23 00 3 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" "N" fo<u>r no</u>. used in the prior cost reporting period? In column 2 for yes or In-State Out-of Medi cai d 0ther In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

instructions)

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPI			L HOSPITAL Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/31/2018 11:	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	
			1. 00	2. 00	3. 00	4.00	5. 00	
	Enter the number of unweighted p surgery allopathic and/or osteop current cost reporting period. (s	athic FTEs in the ee instructions).						61. 04
1. 05	Enter the difference between the and/or general surgery FTEs and primary care and/or general surg 61.04 minus line 61.03). (see in	the current year's ery FTE counts (line						61. 05
1. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	ard that is being that are nonprimary						61.06
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Direct GME FTE Count	
	loc 11 575 1 11 11 11 11			1. 00	2. 00	3.00	4.00	
1. 10	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. Enter in colum FTE unweighted count.	of FTE residents uctions) Enter in in column 2, the the IME FTE				0. 00	0.00	61. 10
1. 20	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, Enter in column 2, the program c 3, the IME FTE unweighted count. the direct GME FTE unweighted co	ne number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0. 00	0.00	61. 20
							1.00	
	ACA Provisions Affecting the Hea	th Resources and Ser	vi ces A	dmi ni strati on	(HRSA)			
2. 00	Enter the number of FTE resident			in this cost	reporting per	riod for which	0.00	62.00
2. 01	your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe	s that rotated from a riod of HRSA THC proc	ı Teachi ıram. (s	ee instructio		your hospital	0.00	62. 01
3. 00	Teaching Hospitals that Claim Re Has your facility trained reside				ost reporting	period? Enter	N	63.00
	"Y" for yes or "N" for no in col	umn 1. If yes, comple	te line	s 64 through (
					Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	T				1. 00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after J	r FIE Residents in No ulv 1 2009 and befor	onprovid Se June	er Settings 30 2010	This base year	r is your cost r	reporting	
4. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit per of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	y train n-primar all non I non-pr n column	ed residents y care provider imary care 3 the ratio	O. C	0.00	0. 000000	64.00
	processing and the second seco	Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1 00		2 00	3.00	4 00	5.00	

2.00

4.00

3. 00

5.00

1.00

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi der		eriod: rom 01/01/2017	Worksheet S-2	
					o 12/31/2017	Date/Time Pre	
		Program Name	Program Code	Unwei ghted	Unwei ghted	5/31/2018 11: Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	nospi tai	4))	
/F. 00	le	1.00	2. 00	3. 00	4.00	5.00	45.00
65. 00	Enter in column 1, if line 63 is yes, or your facility			0. 0	0. 00	0. 000000	65.00
	trained residents in the base						
	year period, the program name associated with primary care						
	FTEs for each primary care						
	program in which you trained residents. Enter in column 2,						
	the program code. Enter in						
	column 3, the number of unweighted primary care FTE						
	residents attributable to						
	rotations occurring in all non-provider settings. Enter in						
	column 4, the number of						
	unweighted primary care resident FTEs that trained in						
	your hospital. Enter in column						
	5, the ratio of (column 3 divided by (column 3 + column						
	4)). (see instructions)						
				Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te 1.00	2.00	3.00	
	Section 5504 of the ACA Current		Nonprovider Settir				
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of		v care resident	0.0	0.00	0. 000000	 66. 00
	FTEs attributable to rotations of	occurring in all nonpr	ovider settings.				
	Enter in column 2 the number of FTEs that trained in your hospit						
	(column 1 divided by (column 1 +	column 2)). (see ins	tructions)				
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1.00	2.00	Si te 3.00	4.00	5. 00	
67. 00	Enter in column 1, the program	1.00	2.00	3. 00 0. 0	4.00	5. 00 0. 000000	67. 00
67. 00	name associated with each of	1.00	2.00	3. 00			67. 00
67. 00	name associated with each of your primary care programs in which you trained residents.	1.00	2.00	3. 00			67. 00
67. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program	1.00	2.00	3. 00			67. 00
67.00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary	1.00	2.00	3. 00			67. 00
67.00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable	1.00	2.00	3. 00			67. 00
67. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in	1.00	2.00	3. 00			67. 00
67. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of	1.00	2.00	3. 00			67. 00
67.00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in	1.00	2.00	3. 00			67. 00
67.00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care	1.00	2.00	3. 00			67. 00
67. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	1.00	2.00	3. 00			67. 00
67. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	1.00	2.00	3. 00			67. 00
67. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		2.00	3. 00		0. 000000	67. 00
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	PPS Sychiatric Facility (I		3.00	1.00	0. 000000	67. 00
70. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F Is this facility an Inpatient Psenter "Y" for yes or "N" for no	PPS Sychiatric Facility (I	PF), or does it con	3.00 0.00	1. 0	0 2.00 3.00	70. 00
70. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility FI s this facility an Inpatient PsEnter "Y" for yes or "N" for no If line 70 is yes: Column 1: Dicrecent cost report filed on or between the programs of the progr	PPS sychiatric Facility (I , , , , the facility have ar Juefore November 15, 20	PF), or does it con approved GME teach 04? Enter "Y" for	tain an IPF sub	1.00 provider? N the most	0. 000000	
70. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility FIs this facility an Inpatient Psenter "Y" for yes or "N" for no lif line 70 is yes: Column 1: Dic recent cost report filed on or by 42 CFR 412.424(d)(1)(iii)(c)) Co	PPS sychiatric Facility (I). I the facility have ar before November 15, 20	PF), or does it con approved GME teach 04? Enter "Y" for lity train resident	tain an IPF sub	1.00 provider? N the most no. (see hing	0 2.00 3.00	70. 00
70. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility FIs this facility an Inpatient Psenter "Y" for yes or "N" for no lf line 70 is yes: Column 1: Dic recent cost report filed on or 42 CFR 412.424(d)(1)(iii)(c)) Cc program in accordance with 42 CF Column 3: If column 2 is Y, indi	PPS Sychiatric Facility (I). If the facility have are Defore November 15, 20 Dlumn 2: Did this facility H2: 424 (d)(1)(iii)	PF), or does it con approved GME teach 04? Enter "Y" for lity train resident (D)? Enter "Y" for	tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for	1.00 provider? N the most no. (see ning no.	0 2.00 3.00	70. 00
70. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Fisthis facility an Inpatient Psychiatric Facility Fisthis facility an Inpatient Psychiatric Column 1: Dicrecent cost report filed on or the symmetry of the column 3: If column 2 is Y, indice instructions)	PPS Sychiatric Facility (1). I the facility have ar Defore November 15, 20 Dlumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program ye	PF), or does it con approved GME teach 04? Enter "Y" for lity train resident (D)? Enter "Y" for	tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for	1.00 provider? N the most no. (see ning no.	0 2.00 3.00	70. 00
70. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility FI Is this facility an Inpatient Psenter "Y" for yes or "N" for not all the program in accordance with 42 CFC Column 3: If column 2 is Y, indice instructions) Inpatient Rehabilitation Facility Is this facility an Inpatient Resident Psychiatric Facility Inpatient Rehabilitation Facility Inpatient Rehabilitation Facility Is this facility an Inpatient Resident Facility Inpatient Rehabilitation Facility Inpatient Rehabilitation Facility Is this facility an Inpatient Resident Facility Inpatient Rehabilitation Facility Inpatient Psychological Psychologica	PPS sychiatric Facility (I). If the facility have an Defore November 15, 20 Diumn 2: Did this faci R 412.424 (d)(1)(iii) Cate which program ye Expressions are properated to the program of the program	PF), or does it con approved GME teach 04? Enter "Y" for lity train resident (D)? Enter "Y" for ar began during thi	tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for s cost reportin	1.00 provider? N the most no. (see ning no.	0 2.00 3.00	70. 00
70. 00 71. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F Is this facility an Inpatient Psenter "Y" for yes or "N" for not 1f line 70 is yes: Column 1: Dic recent cost report filed on or the second of the secon	pps sychiatric Facility (I). In the facility have are before November 15, 20 Jumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program years	PF), or does it con approved GME teach 04? Enter "Y" for lity train resident (D)? Enter "Y" for ear began during thi	tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for s cost reportin	1.00 provider? N the most no. (see ning no. g period.	0 2.00 3.00	70. 00 71. 00 75. 00
70. 00 71. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Fisthis facility an Inpatient Psenter "Y" for yes or "N" for not 1 fline 70 is yes: Column 1: Dic recent cost report filed on or the 42 CFR 412.424(d)(1)(iii)(c)) Coprogram in accordance with 42 CFC Column 3: If column 2 is Y, indice instructions) Inpatient Rehabilitation Facilit Is this facility an Inpatient Resubprovider? Enter "Y" for yes If line 75 is yes: Column 1: Dic recent cost reporting period ence	PPS Sychiatric Facility (I). I the facility have ar pefore November 15, 20 olumn 2: Did this facific attempts which program years and "N" for no. If the facility have arting on or before November 100.	PF), or does it con approved GME teach 04? Enter "Y" for lity train resident (D)? Enter "Y" for ar began during thi (IRF), or does it approved GME teach	tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for s cost reportin contain an IRF ing program in r "Y" for yes o	1.0 provider? N the most no. (see hing no. g period. N the most r "N" for	0 2.00 3.00	70. 00 71. 00
70. 00 71. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Is this facility an Inpatient Psetter "Y" for yes or "N" for no lf line 70 is yes: Column 1: Dic recent cost report filed on or the 42 CFR 412. 424(d)(1)(iii)(c)) Coprogram in accordance with 42 CFC column 3: If column 2 is Y, indice instructions) Inpatient Rehabilitation Facilit Is this facility an Inpatient Resubprovider? Enter "Y" for yes If line 75 is yes: Column 1: Dic recent cost reporting period enco. Column 2: Did this facility	PPS Sychiatric Facility (ID) If the facility have an operation of this facility have an operation of the facility (ID) If the facility have and "N" for no. If the facility have an operating on or before Nove train residents in a	PF), or does it con approved GME teach 04? Enter "Y" for lity train resident (D)? Enter "Y" for ear began during this (IRF), or does it approved GME teach mber 15, 2004? Entenew teaching progra	tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for s cost reportin contain an IRF ing program in r "Y" for yes o m in accordance	the most no. (see ning no. g period.	0 2.00 3.00	70. 00 71. 00 75. 00
70. 00 71. 00	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Fisthis facility an Inpatient Psenter "Y" for yes or "N" for not 1 fline 70 is yes: Column 1: Dic recent cost report filed on or the 42 CFR 412.424(d)(1)(iii)(c)) Coprogram in accordance with 42 CFC Column 3: If column 2 is Y, indice instructions) Inpatient Rehabilitation Facilit Is this facility an Inpatient Resubprovider? Enter "Y" for yes If line 75 is yes: Column 1: Dic recent cost reporting period ence	pps sychiatric Facility (I b). If the facility have an pefore November 15, 20 plumn 2: Did this faci FR 412.424 (d)(1)(iii) cate which program ye ty PPS phabilitation Facility and "N" for no. If the facility have an ing on or before Nove train residents in a per "Y" for yes or "N"	PF), or does it con approved GME teach 04? Enter "Y" for lity train resident (D)? Enter "Y" for ear began during thim (IRF), or does it approved GME teach maker 15, 2004? Entenew teaching prografor no. Column 3: I	tain an IPF sub ing program in yes or "N" for s in a new teac yes or "N" for s cost reportin contain an IRF ing program in r "Y" for yes o m in accordance f column 2 is Y	the most no. (see ning no. g period.	0 2.00 3.00	70. 00 71. 00 75. 00

yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.					
108.00 Is this a rural hospital qualifying for an exception to the	N		108. 00		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Occupati onal	Speech		
	Respi ratory				
	3.00	4. 00			
109.00 If this hospital qualifies as a CAH or a cost provider, are	Υ	N	109.00		
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
	1.00				
110.00 Did this hospital participate in the Rural Community Hospita	N	110. 00			
Demonstration) for the current cost reporting period? Enter '					
complete Worksheet E, Part A, lines 200 through 218, and Wor					
complete not not not not be a first the second of the bagin zero, and not	L 2, 11	Loo till oug	<u>-</u> , us	(

appl i cabl e.

ealth Financial Systems DUKES MEMORIAL HOSPIT OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi	ider CCN: 15-1318	Peri od:	Lieu of Form CM Worksheet S	
OSFITAL AND HOSFITAL HEALTH CARE COMPLEX TUDINTITICATION DATA	ruer con. 15-1316	From 01/01/20 To 12/31/20	017 Part I	repare
		1.00		
11.00 If this facility qualifies as a CAH, did it participate in the Fronthealth Integration Project (FCHIP) demonstration for this cost reportant "Y" for yes or "N" for no in column 1. If the response to column 1 integration prong of the FCHIP demo in which this CAH is participate Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	rting period? Enter is Y, enter the ing in column 2.	1. 00 N	2.00	111.
		1	1.00 2.00 3.0	00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for is yes, enter the method used (A, B, or E only) in column 2. If column 3 either "93" percent for short term hospital or "98" percent for loopsychiatric, rehabilitation and long term hospitals providers) based Pub. 15-1, chapter 22, §2208. 1.	umn 2 is "E", enter ong term care (incl d on the definitior	in column udes	N O	
16.00 s this facility classified as a referral center? Enter "Y" for yes 17.00 s this facility legally-required to carry malpractice insurance? En no.		"N" for	N	116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter a claim-made. Enter 2 if the policy is occurrence.	ter 1 if the policy	/ is	1	118.
	Premi ums	Losses	Insurance	
	1. 00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	15, 1	97 21,	052	0 118.
		1. 00	2.00	
18.02 Are malpractice premiums and paid losses reported in a cost center of Administrative and General? If yes, submit supporting schedule list and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmles §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (see	ting cost centers ss provision in AC/ 1, "Y" for yes or for the Outpatient		N	118. 119. 120.
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable of	devices charged to	Y		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included.				122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes an	nd "N" for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the	certification date	e		126.
in column 1 and termination date, if applicable, in column 2. [7.00] If this is a Medicare certified heart transplant center, enter the clin column 1 and termination date, if applicable, in column 2.	certification date			127
in column I and termination date, if applicable, in column 2. 8.00 f this is a Medicare certified liver transplant center, enter the in column 1 and termination date, if applicable, in column 2.	certification date			128
9.00 f this is a Medicare certified lung transplant center, enter the cocolumn 1 and termination date, if applicable, in column 2.	ertification date i	n		129
0.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2.				130
1.00 If this is a Medicare certified intestinal transplant center, enter date in column 1 and termination date, if applicable, in column 2.				131
2.00 If this is a Medicare certified islet transplant center, enter the clin column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified other transplant center, enter the clinical properties.				132
in column 1 and termination date, if applicable, in column 2. 4.00 f this is an organ procurement organization (0P0), enter the 0P0 no				134
and termination date, if applicable, in column 2. All Providers				
40.00 Are there any related organization or home office costs as defined in chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and		Y	449008	140.

Health Financial Systems

DUKES MEMORIAL HOSPITAL

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-1318

Period:
From 01/01/2017 Part I

From 01/01/2017 Part I Date/Time Prepared: To 12/31/2017 5/31/2018 11:18 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: CHS/COMMUNITY HEALTH SYSTEMS, Contractor's Name: WPS Contractor's Number: 52280 141 00 LNC 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 Ci ty: FRANKLIN State: TN Zip Code: 37067 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 Υ 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146, 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title XIX Title V 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF Ν Ν Ν N 157 00 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY Ν Ν Ν Ν 160.00 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Ν 165.00 Enter "Y" for yes or "N" for no. FTE/Campus Name County Zip Code **CBSA** State | 0 1.00 2 00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 167.00|s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. Υ 168.00|f this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 1168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 09/01/2017 11/29/2017 170 00 period respectively (mm/dd/yyyy) 1. 00 2.00 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in 0 171. 00 Ν section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1318 Peri od: Worksheet S-2 From 01/01/2017 Part II Date/Time Prepared: 12/31/2017 5/31/2018 11:18 am Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1. 00 2. 00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 N 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 N 7 00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using $\overline{\text{the PS\&R Report onl y?}}$ 05/25/2018 05/25/2018 16.00 Υ 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Ν N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν N 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

N

19.00

N

19.00

cost report? If yes, see instructions.

information? If yes, see instructions.

If line 16 or 17 is yes, were adjustments made to PS&R

Report data for corrections of other PS&R Report

	Financial Systems DUKES MEMORI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	AL HOSPITAL Provider C	CCN: 15-1318	Period: From 01/01/2017 To 12/31/2017	u of Form CM Worksheet S Part II Date/Time F 5/31/2018 1	6-2 Prepared:						
		Descr	iption	Y/N	Y/N							
			0	1. 00	3. 00							
0. 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							
1. 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 (EXC Capital Related Cost	EPT CHILDRENS I	HOSPI TALS)									
	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost	N N	22. 00 23. 00						
4. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into during	this cost re	eporting period?	N	24. 00						
5. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	rting period?	? If yes, see	N	25. 00						
5. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? I	f yes, see	N	26. 00						
7. 00	instructions. Has the provider's capitalization policy changed during th	N	27. 00									
2 00	copy. Interest Expense		-:		N	20.00						
3. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.		· ·	. 0	N	28. 00						
	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	ructi ons		,	N	29. 00						
0.00	Has existing debt been replaced prior to its scheduled mat instructions.	,	,		N	30.00						
1. 00	Has debt been recalled before scheduled maturity without i instructions. Purchased Services	ssuance of new	debt? If yes	s, see	N	31.00						
	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through co	ontractual	N	32.00						
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If	N	33.00						
4. 00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	n provi der-ba	ased physicians?	Υ	34.00						
5. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based	Υ	35. 00						
	prival chairs during the cost reporting period: 11 yes, see i	nstructions.		Y/N	Date							
				1. 00	2. 00							
	Home Office Costs											
5. 00 7. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y Y		36. 00 37. 00						
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of					38. 00						
9. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			s, N		39. 00						
0. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.		40. 00									
	i nstructi ons.	1	00	2.	00							
	Cost Report Preparer Contact Information	1.		2.								
	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						
2. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEALTH SYSTEMS,										
3. 00	preparer. Enter the telephone number and email address of the cost	I NC 615-465-3416		KUZIWA TSIGA@C	preparer.							

Heal th	Financial Systems DUKES N	MEMORI A	AL HOSPITAL	In Lie	u of Form C	MS-2	552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIF	RE	Provider CCN:	Peri od:	Worksheet	S-2	
				From 01/01/2017 o 12/31/2017		Pren	ared.
				12,01,201,	5/31/2018		
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	on	MANAGER				41.00
	held by the cost report preparer in columns 1, 2, and	d 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the c	cost					43.00
	report preparer in columns 1 and 2, respectively.						
	report preparer in columns 1 and 2, respectively.						

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:
 Heal th Financial
 Systems
 DUKES

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1318

						To	12/31/2017	Date/Time P 5/31/2018 1		
								I/P Days / 0		i o aiii
								Visits / Tri		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V		
		Line Number			Avai I abl e					
1.00		1.00		2.00	3.00	_	4. 00	5. 00		
1. 00	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and	30. 00		21	7, 66	5	71, 952. 00		0	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2									
	for the portion of LDP room available beds)									
2. 00	HMO and other (see instructions)									2. 00
3. 00	HMO IPF Subprovider									3. 00
4. 00	HMO IRF Subprovider								l	4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF								0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF								o	6. 00
7. 00	Total Adults and Peds. (exclude observation			21	7, 66	5	71, 952. 00		0	7. 00
	beds) (see instructions)						·			
8.00	INTENSIVE CARE UNIT	31. 00		4	1, 46	0	13, 008. 00		0	8.00
9.00	CORONARY CARE UNIT									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11. 00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13. 00	NURSERY	43. 00							0	13.00
14. 00	Total (see instructions)			25	9, 12	5	84, 960. 00		0	14.00
15. 00	CAH visits								0	15. 00
16. 00	SUBPROVI DER - I PF									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 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)									22. 00 23. 00
24. 00	HOSPICE									24. 00
24. 00	HOSPICE (non-distinct part)	30. 00							l	24. 00
25. 00	CMHC - CMHC	30.00							l	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)	07.00		25					Ĭ	27. 00
28. 00	Observation Bed Days								o	28. 00
29. 00	Ambul ance Trips									29. 00
30.00	Employee discount days (see instruction)									30.00
31. 00	Employee discount days - IRF									31.00
32. 00	Labor & delivery days (see instructions)			0		0				32.00
32. 01	Total ancillary labor & delivery room									32. 01
	outpatient days (see instructions)									
33. 00	LTCH non-covered days									33.00
33. 01	LTCH site neutral days and discharges								-	33. 01

Provider CCN: 15-1318

						5/31/2018 11:	18 am
		I/P Days	o/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 556	47	2, 976)		1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)	324	504				2. 00
3.00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	104	0	106			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	104	Ö	100			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 660	47	3, 082			7. 00
7.00	beds) (see instructions)	1,000	''	0,002			7.00
8.00	INTENSIVE CARE UNIT	331	17	594			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		18	335	i		13. 00
14.00	Total (see instructions)	1, 991	82	4, 011	0.00	199. 05	14. 00
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVI DER - I PF						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 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						22. 00 23. 00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)	0	0	22			24. 00
25. 00	CMHC - CMHC	ď	ď	22			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00	0.00	
27. 00	Total (sum of lines 14-26)	ı .	Ĭ		0.00		1
28. 00	Observation Bed Days		o	643		.,,,,,,	28. 00
29. 00	Ambul ance Trips	o					29. 00
30.00	Employee discount days (see instruction)			C)		30.00
31.00	Employee discount days - IRF			C)		31.00
32.00	Labor & delivery days (see instructions)	o	o	C)		32. 00
32. 01	Total ancillary labor & delivery room		ļ	C)		32. 01
	outpatient days (see instructions)						
	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

Provider CCN: 15-1318 Peri od: Worksheet S-3 From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

						5/31/2018 11:	18 am
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	The second secon	Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(543	233	1, 113	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds)			0	0		2. 00
3. 00	HMO and other (see instructions) HMO IPF Subprovider			0	0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				O		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY		_				13. 00
14.00	Total (see instructions)	0. 00	(543	233	1, 113	14.00
15. 00	CAH visits						15.00
16. 00 17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF						16. 00 17. 00
18.00	SUBPROVI DER - TRF						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)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00 30. 00	Ambulance Trips						29. 00 30. 00
31.00	Employee discount days (see instruction) Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 00	Total ancillary labor & delivery room						32. 00
32.01	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
	·	•					

Provider CCN: 15-1318

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To

Instructions						To	o 12/31/2017	Date/Time Pre 5/31/2018 11:	
Mart 11 - 505_ DATA 1.00									
PART II				·				col . 5)	
MANABLES SAMABLES MANABLES		DADT II WACE DATA	1. 00	2.00				6.00	
2.00 Non-physic dian anesthetist Part 0 0 0 0 0 0 0 0 0		SALARI ES							
Mon-physic clan anestheritist Part	1.00		200. 00	13, 053, 992	2 0	13, 053, 992	414, 023. 00	31. 53	1. 00
4. 00 Physician-Part A - Administrative part A - Teaching physician-Part B For physician-Part	2.00	1		C	0	0	0.00	0. 00	2. 00
Admin strative	3. 00	Non-physician anesthetist Part		C	0	0	0.00	0.00	3. 00
Physicians = Part A = Teaching	4.00	-		C	0	0	0.00	0.00	4. 00
Physician-Part B		Physicians - Part A - Teaching		-					
hospital -based RKC and FORC Services		Physician-Part B							
1.00 Interms & residents (in an approved program) 0 0 0 0 0 0 0 0 0	6. 00	hospital-based RHC and FQHC		C	0	0	0.00	0.00	6. 00
7.01 Contracted interins and residuents (in an approved programs) 8.00 Home office and/or related programs) 8.00 Home office and/or related programs 9.00 Excluded area salaries (see 44.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00	1	21. 00	C	0	0	0.00	0.00	7. 00
programs) 0	7. 01			C	0	0	0. 00	0.00	7. 01
None of Fice and/or related organization personnel									
9.00 SkE duded area salaries (see instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient Contract Contract labor: Direct Patient Contract Cont	8. 00	Home office and/or related		C	0	0	0.00	0.00	8. 00
Instructions OTHER WAGES & RELATED COSTS		SNF	44. 00	260_458	0 -615	0 259 843			
11.00 Contract labor: Direct Patient 0 0 0 0 0 0 0 0 0		instructions)		200, 100		207,010		1 0.00	
12.00 Contract labor: Top level management and other management and other management and administrative services	11. 00	Contract Labor: Direct Patient		C	0	0	0.00	0.00	11. 00
management and admin istrative services	12. 00	Contract Labor: Top Level		C	0	0	0.00	0.00	12. 00
13.00 Contract I abor: Physician-Part 0 0 0 0 0.00 0.00 13. 14.00 Home office and/or related 0 0 0 0 0.00 0.00 14. 14.01 Home office and/or related 0 0 0 0 0.00 0.00 14. 15.00 Home office sal aries and wage-related costs Home office Physician Part A 0 0 0 0 0.00 0.00 14. 16.00 Home office and Contract 0 0 0 0 0.00 0.00 14. 17.00 Home office and Contract 0 0 0 0 0.00 0.00 15. 18.00 Wage-related costs (core) (see instructions) 0 0 0 0 0.00 16. 19.00 Evided areas 0 0 0 0 0 0 17. 18.00 Wage-related costs (other) 0 0 0 0 0 18. 19.00 Evided areas 0 0 0 0 0 18. 19.00 Evided areas 0 0 0 0 0 19. 19.00 Evided areas 0 0 0 0 0 0 19. 19.01 Evided areas 0 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 0 19.02 Evided areas 0 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0 0 19.01 Evided areas 0 0 0 0 0									
14.00 Home office and/or related or organization salaries and wage-related costs 0 0 0 0 0 0 0 0 0	13. 00	1		C	0	0	0.00	0.00	13. 00
orgainzation sallaries and wage-related costs 14.01 Home office salaries 0 0 0 0.00 0.00 14. 14.02 Related organization salaries 0 0 0 0 0.00 0.00 14. 15.00 Home office: Physician Part A 0 0 0 0.00 0.00 14. 16.00 Home office and Contract 0 0 0 0 0.00 0.00 16. 16.00 Home office and Contract 0 0 0 0 0.00 0.00 16. 17.00 Wage-related costs (core) (see instructions) 0 0 0 0 0 17. 18.00 Wage-related costs (other) 0 0 0 0 18. 19.00 Excluded areas 0 0 0 0 19. 20.00 Non-physician anesthetist Part 0 0 0 0 20. 21.00 Non-physician anesthetist Part 0 0 0 0 22. 22.00 Physician Part A - Teaching 0 0 0 0 22. 23.00 Physician Part B 0 0 0 22. 24.00 Wage-related costs (RRC/FOHC) 0 0 0 22. 25.50 Home office wage-related (core) 0 0 0 25. 25.51 Related organization 0 0 0 0 25. 26.00 Early Standard Related (core) 0 0 0 0 25. 26.00 Early Standard Related (core) 0 0 0 0 0 26.00 VERREAD COSTS - DIRECT SALARIES 0 0 112, 315 0 112, 315 3, 93.90 28.51 26.	14. 00			C	0	0	0. 00	0.00	14. 00
14. 01 Home office salaries 0 0 0 0 0.00 0.00 14. 14. 02 Related organization salaries 0 0 0 0 0.00 0.00 15. 15. 00 Home office Physician Part A 0 0 0 0 0.00 0.00 15. 16. 00 Home office ond Contract 0 0 0 0 0.00 0.00 16. 16. 00 Home office ond Contract 0 0 0 0 0.00 0.00 16. 17. 00 Wage-related CoSTS 0 0 0 0 0 0 0 18. 00 Wage-related costs (core) (see instructions) 0 0 0 0 0 0 18. 19. 00 Excluded areas 0 0 0 0 0 0 19. 19. 00 Excluded areas 0 0 0 0 0 0 0 19. 00 Non-physician anesthetist Part 0 0 0 0 0 0 19. 00 Non-physician anesthetist Part 0 0 0 0 0 19. 00 Non-physician anesthetist Part 0 0 0 0 0 19. 02. 04 0 0 0 0 0 0 19. 02. 04 0 0 0 0 0 0 19. 02. 04 0 0 0 0 0 0 19. 05 0 0 0 0 0 0 19. 05 0 0 0 0 0 0 19. 07 0 0 0 0 0 0 19. 08 0 0 0 0 0 19. 08 0 0 0 0 0 0 19. 08 0 0 0 0 0 0 19. 08 0 0 0 0 0 19. 08 0 0 0 0 0 19. 08 0 0 0 0 0 19. 08 0 0 0 0 0 19. 08 0 0 0 0 0 19. 08 0 0 0 19. 08 0 0 0 0 19. 08 0 0 0 19. 08 0 0 0 19. 08 0 0 0 19. 08 0 0 0 19. 08 0 0 0 1		orgainzation salaries and							
15.00 Home office: Physician Part A 0 0 0 0 0 0 0 0 0		Home office salaries		C	_	_		1	
16. 00 Home office and Contract		Home office: Physician Part A		C	1			1	
WAGE-RELATED COSTS Wage-related costs (core) (see instructions) 17. 17. 18	16. 00			C	0	0	0.00	0.00	16. 00
17. 00 Wage-related costs (core) (see instructions) 18. 00 Wage-related costs (other) 0 0 0 0 0 18. 00 Wage-related costs (other) 0 0 0 0 0 0 0 18. 00 0 0 0 0 0 0 0 0 0									1
18. 00 Wage-related costs (other) (see instructions) 18. 19. 00 Excluded areas 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00	Wage-related costs (core) (see		C	0	0			17. 00
19.00 Excluded areas	18. 00	Wage-related costs (other)		C	0	0			18. 00
A S S S S S S S S S	19. 00			C	0	0			19.00
B	20. 00	Non-physician anesthetist Part		C	0	0			20.00
Administrative Physician Part A - Teaching 0 0 0 0 22.	21. 00	Non-physician anesthetist Part		C	0	0			21. 00
22.01 Physician Part A - Teaching 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00	3		C	0	0			22. 00
24.00 Wage-related costs (RHC/FQHC) 25.00 Interns & residents (in an approved program) Home office wage-related (core) 25.51 Related organization Wage-related (core) Home office: Physician Part A - Administrative - Wage-related (core) Home office & Contract Physicians Part A - Teaching - Wage-related (core) 26.00 Employee Benefits Department 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Physician Part A - Teaching		C	0	0			22. 01
25. 00				C	0	0			23.00
approved program) Home office wage-related (core) 25. 51 Related organization wage-related (core) Home office: Physician Part A - Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) 25. 52 DVERNEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 112, 315 0 0 0 0 0 0 0 0 25. 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , ,		C	0	0			24. 00 25. 00
Core Core Related organization Core		approved program)		C	0	0			25. 50
wage-related (core) Home office: Physician Part A		(core)		ſ					25. 51
- Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department		wage-related (core)		0					25. 51
25. 53 Home office & Contract 0 0 0 0 0 25. Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 112, 315 0 112, 315 3, 939. 00 28. 51 26. 9	20. JZ	- Administrative -		C					25.52
wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 112,315 0 112,315 3,939.00 28.51 26.00	25. 53	Home office & Contract		C	0	0			25. 53
26.00 Employee Benefits Department 4.00 112,315 0 112,315 3,939.00 28.51 26.0		wage-related (core)							
	26, 00			112 315	0	112 315	3 939 00) 28 51	26 00

Provider CCN: 15-1318

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To

					''	0 12/31/2017	5/31/2018 11:	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0. 00	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00		0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	· ·	615	276, 944	,		30.00
31. 00	Laundry & Linen Service	8. 00		0	0	0.00		
32. 00	Housekeepi ng	9. 00	281, 480	0	281, 480	,		32.00
33. 00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34. 00	Di etary	10. 00	201, 885	-38, 254	163, 631	,		34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00		38, 254	38, 254			36. 00
37. 00	Maintenance of Personnel	12. 00		0	0	0.00		37.00
38. 00	Nursing Administration	13. 00	· ·					38. 00
39. 00	Central Services and Supply	14. 00	83, 570	0	83, 570	5, 331. 00	15. 68	39. 00
40.00	Pharmacy	15. 00	478, 025	0	478, 025	10, 790. 00	44. 30	40.00
41.00	Medical Records & Medical	16. 00	98, 541	0	98, 541	6, 251. 00	15. 76	41.00
	Records Library							
42.00	Social Service	17. 00		67, 991	67, 991			42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION DUKES MEMORIAL HOSPITAL

Provider CCN: 15-1318

		Worksheet A Line Number		Reclassificati on of Salaries	.,		Average Hourly 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		13, 053, 992	0	13, 053, 992	414, 023. 00	31. 53	1.00
	instructions)							
2.00	Excluded area salaries (see		260, 458	-615	259, 843	0. 00	0. 00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		12, 793, 534	615	12, 794, 149	414, 023. 00	30. 90	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	0. 00	0. 00	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		12, 793, 534			,	l .	
7. 00	Total overhead cost (see		3, 629, 223	615	3, 629, 838	72, 790. 00	49. 87	7. 00
	instructions)							

	To 12/31/2017	Date/Time Prep 5/31/2018 11:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	169, 936	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1, 539, 217	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	8, 611	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	9, 408	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	208	12. 00
	Disability Insurance (If employee is owner or beneficiary)	7, 253	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	317, 143	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	626, 854	17. 00
18. 00	Medicare Taxes - Employers Portion Only	146, 603	18. 00
19. 00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	32, 023	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22.00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	2, 857, 256	
24.00	Part B - Other than Core Related Cost	2,037,230	24.00
25 00	OTHER BENEFITS	0	25. 00
23.00	OTHER BENEFITO	١	25.00

Heal th	Financial Systems DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN	N: 15-1318	Peri od:	Worksheet S-10			
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/31/2018 11:			
			,		1. 00			
	Uncompensated and indigent care cost computation				1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by lin	e 202 column	n 8)	0. 166654	1.00		
	Medicaid (see instructions for each line)			,				
2.00	Net revenue from Medicaid				7, 384, 629	2. 00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 00		
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme			11 d'?	N 1 242 207	4.00		
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges	rrom medicald			1, 242, 297 37, 421, 527	5. 00 6. 00		
7. 00	Medicaid cost (line 1 times line 6)				6, 236, 447			
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minu	s sum of lir	nes 2 and 5: if	0, 200, 117			
	< zero then enter zero)	(_			
	Children's Health Insurance Program (CHIP) (see instructions	for each line)					
9.00	Net revenue from stand-alone CHIP				0			
10.00	Stand-alone CHIP charges				0			
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(lino 11 min	us lino O. i	f . zoro thon	0	11. 00 12. 00		
12.00	enter zero)	(TITIE IT IIIITI	us iiile 9, i	i < Zei o tileli	U	12.00		
	Other state or local government indigent care program (see in	structions fo	r each line)			1		
13.00	Net revenue from state or local indigent care program (Not in				150, 989	13. 00		
14.00	Charges for patients covered under state or local indigent ca	re program (N	ot included	in lines 6 or	800, 719	14. 00		
	10)	_						
15.00	State or local indigent care program cost (line 1 times line		71.	45 ' ''	133, 443			
16. 00	00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 13; if < zero then enter zero)							
	Grants, donations and total unreimbursed cost for Medicaid, C	HIP and state	/local indic	ent care program	ns (see			
	instructions for each line)			, , ,	·			
17. 00					0			
18.00	Government grants, appropriations or transfers for support of				0			
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and loc 8, 12 and 16)	al indigent c	are programs	s (sum of lines	0	19. 00		
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
			1. 00	2. 00	3. 00			
00.00	Uncompensated Care (see instructions for each line)		200 5		00/ 470	00.00		
20. 00	Charity care charges and uninsured discounts for the entire f (see instructions)	actifity	209, 56	26, 912	236, 473	20. 00		
21. 00	Cost of patients approved for charity care and uninsured disc	ounts (see	34, 92	24 26, 912	61, 836	21.00		
	instructions)		- 1, 1-		2.7.222			
22. 00	Payments received from patients for amounts previously writte	n off as		0 0	0	22. 00		
	charity care							
23. 00	Cost of charity care (line 21 minus line 22)		34, 92	24 26, 912	61, 836	23.00		
					1. 00			
24. 00	Does the amount on line 20 column 2, include charges for pati	ent days beyo	nd a Length	of stay limit	1.00	24. 00		
	imposed on patients covered by Medicaid or other indigent car		3	,				
25. 00	If line 24 is yes, enter the charges for patient days beyond stay limit	the indigent	care program	n's length of	0	25. 00		
26. 00	Total bad debt expense for the entire hospital complex (see i	nstructions)			4, 971, 174	26. 00		
27. 00	Medicare reimbursable bad debts for the entire hospital compl	,	uctions)		689, 160			
27. 01	Medicare allowable bad debts for the entire hospital complex	(see instruct	i ons)		1, 060, 247	1		
	Non-Medicare bad debt expense (see instructions)				3, 910, 927			
28. 00								
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 1,022,859 29							
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt e Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus		nstructi ons)		1, 022, 859 1, 084, 695 1, 084, 695	30.00		

Health Financial Systems	DUKES MEMORIAL	. HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				rom 01/01/2017	D 1 /T' D	
				To 12/31/2017	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	5/31/2018 11: Recl assi fi ed	10 alli
cost center bescription	Sararres	Other	+ col . 2)	ons (See A-6)	Trial Balance	
			+ COI. 2)	0113 (366 A-0)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT		942, 891	942, 891	417, 206	1, 360, 097	1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP		1, 451, 540			1, 847, 589	2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	112, 315	102, 027			1, 364, 916	4. 00
5. 01 00570 ADMI TTI NG	112, 319	102, 027	214, 342		852, 950	5. 01
5. 02 00590 ADMINISTRATIVE AND GENERAL	1, 661, 779	6, 889, 699			6, 227, 691	5. 02
7. 00 00700 OPERATION OF PLANT	276, 329	1, 447, 518			1, 822, 882	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	270, 327	81, 805	81, 805		81, 778	8. 00
9. 00 00900 HOUSEKEEPI NG	281, 480	99, 305			380, 646	9. 00
10. 00 01000 DI ETARY	201, 885	157, 190			284, 572	10. 00
11. 00 01100 CAFETERI A	201,000	137, 170	337, 675		72, 880	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	435, 299	54, 507	489, 806		254, 841	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	83, 570	235, 061	318, 631		212, 777	14. 00
15. 00 01500 PHARMACY	478, 025	1, 153, 971	1, 631, 996		692, 231	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY			339, 328			16. 00
	98, 541	240, 787			333, 422	
	0	0		74, 264	74, 264	17. 00
I NPATIENT ROUTI NE SERVI CE COST CENTERS	1 (00 1/5	1 025 004	2 712 071	124 745	2 577 224	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 688, 165	1, 025, 806			2, 577, 226	30.00
31. 00 03100 INTENSIVE CARE UNIT	373, 143	113, 226			484, 613	31.00
43. 00 04300 NURSERY	0	495	495	120, 288	120, 783	43. 00
ANCILLARY SERVICE COST CENTERS	4/0 221	1 472 274	1 022 405	1 (22 000	1 211 407	FO 00
50. 00 05000 OPERATING ROOM	460, 221	1, 473, 274			1, 311, 407	50.00
51. 00 05100 RECOVERY ROOM	265, 543	69, 929	335, 472	-1, 749	333, 723	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	89, 779			89, 779	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	878, 757	623, 169	1, 501, 926	-101, 964	1, 399, 962	54.00
54. 01 05401 ULTRASOUND	0	0	(0	54. 01
56. 00 05600 RADI 01 SOTOPE	0	0	(0	0	56. 00
57. 00 05700 CT SCAN	0	0	(0	0	57. 00
58. 00 05800 MRI	0	0	(0	0	58. 00
60. 00 06000 LABORATORY	757, 289	867, 538			1, 559, 854	60. 00
65. 00 06500 RESPI RATORY THERAPY	424, 660	103, 547			507, 605	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 275	460, 591	462, 866		461, 776	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	129, 366			129, 366	67. 00
68.00 06800 SPEECH PATHOLOGY	0	21, 522			21, 522	68. 00
69. 00 06900 ELECTROCARDI OLOGY	124, 274	25, 908	150, 182		146, 462	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(68, 873	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(592, 119	592, 119	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	(857, 631	857, 631	73.00
76. 00 03610 SLEEP LAB	66, 173	22, 188	88, 361	-998	87, 363	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	279, 888	43, 483			320, 071	
91. 00 09100 EMERGENCY	3, 843, 923	581, 211	4, 425, 134	-9, 013	4, 416, 121	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	259, 672	149, 753	409, 425	-32, 807	376, 618	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 053, 206	18, 657, 086	31, 710, 292	16, 118	31, 726, 410	118. 00
NONREI MBURSABLE COST CENTERS		· · · · · ·		<u>'</u>		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	(0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	786	15, 512	16, 298	-16, 118		192. 00
194. 00 07950 OTHER NRCC	0	0	(0		194. 00
194. 01 07951 MARKETI NG		n		ol ől		194. 01
194. 02 07952 SENI OR CI RCLE	l ol	43	43	1		194. 02
194. 03 07953 FREE MEALS	o	0		1		194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	13, 053, 992	18, 672, 641	31, 726, 633	sl ol	31, 726, 633	
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		-, -, -,	, , , , , , , , , , , , , , , , , , , ,	, 91	. , , 5	

Provider CCN: 15-1318

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/31/2018 11:18 am

				5/31/2018 11: 1	<u> 18 am</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	1	
		6. 00	7. 00		
	GENERAL SERVI CE COST CENTERS				1
1.00	00100 CAP REL COSTS-BLDG & FLXT	-309, 107			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	274, 073			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 097			4. 00
5.01	00570 ADMI TTI NG	-184, 043	668, 907	'	5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL	-448, 576	5, 779, 115		5. 02
7.00	00700 OPERATION OF PLANT	-23, 522	1, 799, 360		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	81, 778	3	8. 00
9.00	00900 HOUSEKEEPI NG	0	380, 646		9. 00
10.00	01000 DI ETARY	0			10.00
11. 00	01100 CAFETERI A	-62, 986	9, 894		11. 00
13.00	01300 NURSING ADMINISTRATION	-7, 517	•		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1		14. 00
15. 00	01500 PHARMACY	0			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-11, 599			16. 00
17. 00	01700 SOCIAL SERVICE	0			17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		77,207		17.00
30. 00	03000 ADULTS & PEDIATRICS	-296, 613	2, 280, 613		30.00
31. 00	03100 NTENSIVE CARE UNIT	-270,013			31.00
43. 00	04300 NURSERY	0		1	43.00
43.00		U	120, 763		43.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	401 475	889, 932		50.00
		-421, 475	1		
51.00	05100 RECOVERY ROOM	0	1		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	00.770			52.00
53. 00	05300 ANESTHESI OLOGY	-89, 779			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1 ' '	l .	54.00
54. 01	05401 ULTRASOUND	0	•		54. 01
56. 00	05600 RADI OI SOTOPE	0	•		56. 00
57. 00	05700 CT SCAN	0			57. 00
58. 00	05800 MRI	0	l .	1	58. 00
60.00	06000 LABORATORY	0			60.00
65. 00	06500 RESPI RATORY THERAPY	0			65. 00
66. 00	06600 PHYSI CAL THERAPY	0			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	129, 366		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	21, 522		68. 00
69.00	06900 ELECTROCARDI OLOGY	-2, 882	143, 580		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	68, 873	3	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	592, 119		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	857, 631		73. 00
76.00	03610 SLEEP LAB	0			76.00
	OUTPATIENT SERVICE COST CENTERS				
90. 00	09000 CLI NI C	0	320, 071		90.00
91. 00	09100 EMERGENCY	-148, 305			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1, 201, 212		92.00
, 2, 00	OTHER REIMBURSABLE COST CENTERS		I		72.00
95. 00	09500 AMBULANCE SERVICES	0	376, 618	3	95. 00
70.00	SPECIAL PURPOSE COST CENTERS		070,010	,	70.00
118. 00		-1, 734, 428	29, 991, 982		118. 00
110.00	NONREI MBURSABLE COST CENTERS	-1, 734, 420	27, 771, 702		1110.00
100 00		0) 0		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192. 00
	07950 OTHER NRCC	0			194. 00
	07951 MARKETI NG	0	_		194. 01
	07952 SENI OR CI RCLE	0	43	5	194. 02
	07953 FREE MEALS	0	0)	194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-1, 734, 428	29, 992, 205	b	200. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/31/2018 11:18 am Provider CCN: 15-1318

					5/31/2018 11:1	o ani
		Increases	6.1	0.11		
	Cost Center 2.00	Li ne #	Salary	Other 5 00		
	A - EMPLOYEE BENEFITS	3. 00	4. 00	5. 00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 152, 197		1. 00
00	TOTALS	- — °		1, 152, 197		00
	B - RECLASS OXYGEN COSTS	· '				
1.00		0.00	0	0		1. 00
	TOTALS		0	0		
	C - RECLASS RENT AND LEASES					
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	367, 665		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6.00
7. 00 8. 00		0.00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	o		13. 00
14. 00		0.00	Ö	Ö		14. 00
15. 00		0. 00	Ö	Ö		15. 00
16. 00		0.00	o	Ö		16. 00
17. 00		0.00	Ö	Ö		17. 00
18. 00		0.00	ő	Ö		18. 00
19. 00		0.00	ō	Ö		19. 00
20.00		0.00	Ö	0		20.00
21.00		0.00	О	0		21.00
22.00		0.00	О	0		22.00
23.00		0.00	0	0		23.00
	TOTALS		0	367, 665		
	D - RECLASS OTHER CAPITAL COSTS	S				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	59, 054		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	358, 152		2. 00
3.00	CAP REL COSTS-MVBLE EQUIP		0_	<u>28, 3</u> 84		3.00
	TOTALS		0	445, 590		
	F - RECLASS CNO COSTS					
1. 00	NURSING ADMINISTRATION	<u>13.</u> 00	15 <u>9, 1</u> 57	$ \frac{0}{0}$		1. 00
	TOTALS		159, 157	0		
	G - RECLASS MEDICAL SUPPLIES	74 00	ما	(0.070		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	68, 873		1. 00
2 00	PATI ENT	70.00		F00 110		2 00
2. 00	IMPL. DEV. CHARGED TO	72. 00	0	592, 119		2. 00
	PATI ENTS	+				
	H - RECLASS COST OF DRUGS/IV SO	OLLITI ONS	U _I	000, 772		
1.00	DRUGS CHARGED TO PATIENTS	73.00	ol	857, 631		1. 00
1.00	TOTALS	/0. 00	- — — "	857, 631		1. 00
	I - RECLASS LABOR AND DELIVERY		-1	221,7221		
1.00	NURSERY	43.00	102, 048	18, 240		1. 00
	TOTALS		102, 048	18, 240		
	J - RECLASS NURSING ADMIN COSTS	S				
1.00	ADMINISTRATIVE 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		<u>459, 3</u> 01	<u>393, 6</u> 49		1.00
	TOTALS		459, 301	393, 649		
	L - RECLASS OTHER RADIOLOGY					
1.00		0.00	0_	0		1. 00
	TOTALS		Ō	0		
4 60	M - RECLASS DIETARY COSTS TO CA		00 05 1	64 (6.1		4 0-
1. 00	CAFETERI A	<u>11.</u> 00	38, 254	34, 626		1. 00
	TOTALS	2 202 2	38, 254	34, 626		
1 00	N - RECLASS PHYSICIAN PRACTICES		/ a E l	45 004		1 00
1. 00	OPERATION OF PLANT		615	15, 394		1. 00
	TOTALS		615	15, 394		
1 00	P - CASE MANAGEMENT	17.00	(7,004	(070		1 00
1. 00	SOCI AL SERVI CE	1700	67, 991	$ \frac{6,273}{4,272}$		1. 00
	TOTALS		67, 991	6, 273		
1 00	Q - REPAIRS AND MAINTENANCE	7 00	0	04 44 4		1 00
1.00	OPERATION OF PLANT	7. 00	0	96, 464		1.00
2.00		0.00	0	0		2. 00 3. 00
3.00	I I	0. 00	O			

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am Provider CCN: 15-1318

						_
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
4.00		0.00	0	0	4.00)
5.00		0.00	0	0	5.00)
6.00		0.00	0	0	6.00)
7.00		0.00	0	0	7. 00)
8. 00		0.00	0	0	8.00)
9. 00		0.00	0	0	9.00)
10. 00		0.00	0	0	10.00)
11. 00		0.00	0	0	11.00)
12. 00		0.00	0	0	12.00)
13. 00		0.00	0	0	13.00)
14. 00		0.00	0	0	14.00)
15. 00		0.00	0	0	15. 00)
16. 00		0.00	0	0	16.00)
17. 00		0.00	0	0	17. 00)
18. 00		0.00	0	0	18.00)
Ī	TOTALS — — — — — —			96, 464		
500.00	Grand Total: Increases		1, 077, 123	4, 190, 624	500.00)

RECLASSI FI CATIONS

Provider CCN: 15-1318

Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Ti me Prepared:

5/31/2018 11:18 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - EMPLOYEE BENEFITS 1.00 ADMINISTRATIVE AND GENERAL 5.02 1, 152, 197 0 1.00 1, 152, 197 TOTALS B - RECLASS OXYGEN COSTS 1.00 0.00 0 0 1.00 TOTALS C - RECLASS RENT AND LEASES EMPLOYEE BENEFITS DEPARTMENT 1.00 4.00 0 1,623 10 1.00 2.00 ADMINISTRATIVE AND GENERAL 5.02 0 20, 677 0 2.00 3.00 OPERATION OF PLANT 7.00 0 13, 438 0 3.00 4 00 DI FTARY 10 00 0 0 4 00 1 623 5.00 NURSING ADMINISTRATION 13.00 0 2, 462 0 5.00 6.00 CENTRAL SERVICES & SUPPLY 14.00 o 12, 052 0 6.00 7.00 PHARMACY 15.00 0 81, 924 0 7.00 MEDICAL RECORDS & LIBRARY 0 5, 228 0 8 00 16.00 8 00 0 9.00 ADULTS & PEDIATRICS 30.00 0 11, 810 9.00 10.00 INTENSIVE CARE UNIT 31.00 o 839 0 10.00 11.00 OPERATING ROOM 50.00 0 30, 919 0 11.00 0 01 51.00 RECOVERY ROOM 12.00 1,623 12.00 13.00 RADI OLOGY-DI AGNOSTI C 54.00 0 88, 301 0 13.00 RADI OLOGY-DI AGNOSTI C o 0 14.00 54.00 1,623 14.00 0 0 LABORATORY 60.00 15.00 15.00 62,622 16.00 RESPIRATORY THERAPY 65.00 0 17, 251 0 16.00 PHYSICAL THERAPY 935 0 17.00 66.00 17.00 18. 00 ELECTROCARDI OLOGY 69.00 o 0 1,623 18.00 SLEEP LAB 19.00 76.00 0 998 0 19 00 20.00 CLINIC 90.00 0 3, 300 0 20.00 91.00 0 0 21.00 EMERGENCY 2, 346 21.00 AMBULANCE SERVICES 0 95.00 4, 339 0 22.00 22.00 23.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 109 0 23.00 0 367, 665 D - RECLASS OTHER CAPITAL COSTS 1.00 ADMINISTRATIVE AND GENERAL 0 12 1.00 5.02 445, 590 2.00 0.00 0 13 2.00 0 3.00 0.00 12 3.00 TOTALS 445, 590 F - RECLASS CNO COSTS 1.00 ADMINISTRATIVE AND GENERAL 5.02 159, 157 0 1.00 TOTALS 159. 157 G - RECLASS MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY 1.00 14.00 0 93, 505 0 1.00 2.00 OPERATING ROOM 50.00 0 567, 487 0 2.00 TOTALS ō 660, 992 H - RECLASS COST OF DRUGS/IV SOLUTIONS PHARMACY 1.00 15.00 857, 631 0 1.00 857, 631 TOTALS I - RECLASS LABOR AND DELIVERY 1.00 ADULTS & PEDIATRICS 30.00 102, 048 18, 240 0 1.00 18, 240 TOTALS 102, 048 J - RECLASS NURSING ADMIN COSTS NURSING ADMINISTRATION 1 00 13 00 249, 757 141, 903 0 1 00 2.00 0.00 0 2.00 TOTALS 249, 757 141, 903 K - RECLASS MISC DEPARTMENTS 1 00 ADMINISTRATIVE AND GENERAL 5. 02 459, 301 393, 649 1 00 0 **TOTALS** 459, 301 393, 649 L - RECLASS OTHER RADIOLOGY 1.00 0.00 0 0 1.00 0 TOTAL S 0 M - RECLASS DIETARY COSTS TO CAFETERIA 38, 254 1.00 DI ETARY 10.00 34, 626 0 1.00 38, 254 TOTALS 34,626 N - RECLASS PHYSICIAN PRACTICES COSTS 1.00 PHYSICIANS' PRIVATE OFFICES 192. 00 615 15, 394 0 1.00 TOTALS 615 15, 394 P - CASE MANAGEMENT 67, 991 1.00 MEDICAL RECORDS & LIBRARY 16. 00 6, 273 0 1.00 67, 991 6, 273 Q - REPAIRS AND MAINTENANCE ADMINISTRATIVE AND GENERAL 1.00 5.02 10, 612 0 1.00 2.00 LAUNDRY & LINEN SERVICE 8.00 0 27 0 2.00 3.00 HOUSEKEEPI NG 9.00 0 139 0 3.00 CENTRAL SERVICES & SUPPLY 14.00 0 297 4.00 4.00 0 PHARMACY 5.00 15.00 210 0 5.00

Health Financial Systems RECLASSIFICATIONS

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1318

Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am

						5/31/2018 11:	:18 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
6.00	MEDICAL RECORDS & LIBRARY	16. 00	0	678	0		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	4, 647	0		7. 00
8.00	INTENSIVE CARE UNIT	31.00	0	917	0		8. 00
9.00	OPERATING ROOM	50.00	0	23, 682	0		9. 00
10.00	RECOVERY ROOM	51.00	0	126	0		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	5, 665	0		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	6, 375	0		12. 00
13.00	LABORATORY	60.00	0	2, 351	0		13. 00
14.00	RESPIRATORY THERAPY	65.00	0	3, 351	0		14. 00
15.00	PHYSI CAL THERAPY	66.00	0	155	0		15. 00
16.00	ELECTROCARDI OLOGY	69. 00	0	2, 097	0		16. 00
17.00	EMERGENCY	91.00	0	6, 667	0		17. 00
18.00	AMBULANCE SERVICES	95. 00	0	28, 468	0		18. 00
	TOTALS		0	96, 464			
500.00	Grand Total: Decreases		1, 077, 123	4, 190, 624			500.00

Provider CCN: 15-1318

					o 12/31/2017	Date/lime Prep 5/31/2018 11:	
				Acqui si ti ons		070172010 11.	TO GIII
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	193, 225	0	C	0	0	1. 00
2.00	Land Improvements	976, 669	38, 015	C	38, 015		2. 00
3.00	Buildings and Fixtures	26, 135, 998	1, 516, 677	0	1, 516, 677		3. 00
4.00	Building Improvements	28, 020, 100	5, 951, 301	0	5, 951, 301	592, 177	
5.00	Fixed Equipment	0	0	C	0	0	5. 00
6.00	Movable Equipment	0	0	0	0	0	6. 00
7.00	HIT designated Assets	4, 748, 489	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	60, 074, 481	7, 505, 993	C	7, 505, 993		8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10. 00	Total (line 8 minus line 9)	60, 074, 481	7, 505, 993	C	7, 505, 993	927, 890	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
		6. 00	Assets				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		7. 00				
1. 00	Land	193, 225	0				1.00
2.00	Land Improvements	1, 014, 684	0			ļ	2.00
3.00	Buildings and Fixtures	27, 316, 962	0			ļ	3.00
4.00	Building Improvements	33, 379, 224	0			l	4.00
5.00	Fi xed Equi pment	33, 379, 224	0			ļ	5.00
6. 00	Movable Equipment		0				6.00
7. 00	HIT designated Assets	4, 748, 489	0				7.00
8. 00	Subtotal (sum of lines 1-7)	66, 652, 584	0				8.00
9.00	Reconciling Items	00, 032, 304	0			ļ	9.00
10. 00	Total (line 8 minus line 9)	66, 652, 584	0			ļ	10.00
10.00	Tiotal (Title o milias Title)	00, 032, 304	O _I	I		ļ	10.00

Health Financial Systems	DUKES MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-1318	Peri od:	Worksheet A-7	
				From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
					5/31/2018 11:	18 am
		Sl	UMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
				instructions)	instructions)	
	9. 00	10.00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMN	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00 Total (sum of lines 1-2)	0	0)	0 0	0	3. 00
	SUMMARY OF	F CAPITAL				
Cost Center Description		Total (1) (sum	ו			
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00 CAP REL COSTS-BLDG & FLXT	942, 891	942, 891				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	1, 451, 540	1, 451, 540)			2. 00
3.00 Total (sum of lines 1-2)	2, 394, 431	2, 394, 431				3. 00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1318 Period: Worksheet A-From 01/01/2017 Part III	pared:
To 12/31/2017 Date/Time Pr	
COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL	18 am
Cost Center Description Gross Assets Capitalized Gross Assets Ratio (see instructions) Insurance Cost Center Description Cost Center De	
1.00 2.00 3.00 4.00 5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1.00 CAP REL COSTS-BLDG & FIXT 53 0 53 0.530000	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 47 0.470000 0.470000	
3.00 Total (sum of lines 1-2) 100 0 100 1.000000	3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL	
Cost Center Description Taxes Other Total (sum of Depreciation Lease	
Capi tal -Rel ate col s. 5 d Costs through 7)	
6.00 7.00 8.00 9.00 10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 -332, 514 14, 98	
2.00 CAP REL COSTS-MVBLE EQUIP 0 0 178, 331 461, 04:	
3.00 Total (sum of lines 1-2) 0 0 -154, 183 476, 02	3. 00
SUMMARY OF CAPITAL	
Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (su	
instructions) instructions) Capital -Relate of cols. 9	
d Costs (see through 14)	
11. 00 12. 00 13. 00 14. 00 15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	
1.00 CAP REL COSTS-BLDG & FIXT 8, 427 59, 054 358, 152 942, 891 1, 050, 99	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 2,359 28,384 0 1,451,540 2,121,66	
3.00 Total (sum of lines 1-2) 10,786 87,438 358,152 2,394,431 3,172,65	3. 00

| Period: | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1318

				T.	o 12/31/2017	Date/Time Prep 5/31/2018 11:	pared:
				Expense Classification on			TO dill
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	Investment income - other		0		0. 00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	О	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	A	20 254	ADMINISTRATIVE AND GENERAL	5. 02	0	7. 00
7.00	stations excluded) (chapter	A	-27, 234	ADMINISTRATIVE AND GENERAL	5.02		7.00
8.00	21) Tel evi si on and radio service	А	-3, 576	CAP REL COSTS-MVBLE EQUIP	2.00	9	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-951, 874			o	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-197, 448			О	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-62, 986 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical	1	0		0. 00	0	
10.00	supplies to other than patients		O		0.00	J	10.00
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-11, 599	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20.00	books, etc.)		1 540	ADMINICTRATIVE AND CENEDAL	F 02		20.00
20. 00 21. 00	Vending machines Income from imposition of	В	-1, 542 0	ADMINISTRATIVE AND GENERAL	5. 02 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation		0	Cost Center Dereteu	114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL	А	-353, 501	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL	A	171, 051	CAP REL COSTS-MVBLE EQUIP	2.00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
20.00	therapy costs in excess of		O		07.00		- 3. 30
30. 99	Hospice (non-distinct) (see	А	-7, 180	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
				•	•	· '	

Peri od: From 01/01/2017 | WUI KSHE

				To	o 12/31/2017	Date/Time Prep 5/31/2018 11:	pared:
				Expense Classification on	Workshoot A	5/31/2018 11:	18 8111
				To/From Which the Amount is			
				TOTT OIL WITCH THE AMOUNT 13	to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	·	1.00	2.00	3.00	4. 00	5. 00	
33. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 00
	(3)						
33. 01	NON-ALLOWABLE MARKETING	A	-211, 534	ADMINISTRATIVE AND GENERAL	5. 02	0	33. 01
33. 02	POB DEPRECIATION	A	20, 987	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 02
33. 03	POB DEPRECIATION	A	· ·	CAP REL COSTS-MVBLE EQUIP	2. 00		33. 03
35. 00	TRAINING REVENUE	В	· ·	NURSING ADMINISTRATION	13. 00		35. 00
36.00	FI TNESS REVENUE	В		ADMINISTRATIVE AND GENERAL	5. 02		36. 00
37. 00	OTHER MISC REVENUE - HOSPITAL	В		ADMINISTRATIVE AND GENERAL	5. 02		07.00
38. 00	PATIENT PHONES BENEFITS COST	A		EMPLOYEE BENEFITS DEPARTMENT			38. 00
40.00	PATIENT PHONES DEPRECIATION	A	-5, 008	CAP REL COSTS-MVBLE EQUIP	2. 00	9	40. 00
	COST						
41. 00	PATIENT TV SERVICE COST	A	· ·	OPERATION OF PLANT	7.00	-	
42. 00	NON-ALLOWABLE LOBBYING EXPENSE		· ·	ADMINISTRATIVE AND GENERAL	5. 02		12.00
43.00	MARKETING EXPENSE	A	· ·	ADMINISTRATIVE AND GENERAL	5. 02		10.00
44. 00	PENALTIES	A		ADMINISTRATIVE AND GENERAL	5. 02		
44. 01	LOBBYING EXPENSE IN	A	-2, 344	ADMINISTRATIVE AND GENERAL	5. 02	9	44. 01
45.00	ASSOCIATION DUES		4 7/0	ADMINISTRATIVE AND SENEDAL	F 00		45.00
45. 00	CHARITABLE CONTRIBUTIONS	A	· ·	ADMINISTRATIVE AND GENERAL	5. 02		10.00
45. 01	PHYSICIAN RECRUITING	A	· ·	ADMINISTRATIVE AND GENERAL	5. 02		
45. 05	LEGAL FEES	A	· ·	ADMINISTRATIVE AND GENERAL	5. 02		
45. 07	MEALS AND ENTERTAINMENT	A		ADMINISTRATIVE AND GENERAL	5. 02	0	10.07
50. 00	TOTAL (sum of lines 1 thru 49)		-1, 734, 428				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

Description - all chapter references in this column pertain to CMS Pub. 15-1.
 Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1318 OFFICE COSTS

Period: Worksheet A-8-1 From 01/01/2017

12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 3.00 4.00 5.00 1.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS PASI CAPITAL COSTS - BLDG & PASI CAPITAL COSTS - MOVEABL 1.00 CAP REL COSTS-BLDG & FIXT 1.00 8, 427 1.00 2. 00 CAP REL COSTS-MVBLE EQUIP 0 2.00 2.359 2.00 5. 02 ADMINISTRATIVE AND GENERAL 0 PASI OPERATING COSTS 3.00 124, 089 3.00 3.02 5. 02 ADMINISTRATIVE AND GENERAL SHARED SERVICE CENTER ALLOCA 442, 580 0 3.02 3.04 1.00 CAP REL COSTS-BLDG & FIXT NEW CAPITAL - BUILDING AND F 14, 980 0 3.04 2. 00 CAP REL COSTS-MVBLE EQUIP NEW CAPITAL - MOVABLE EQUIPM 93. 383 0 4 00 4 00 5. 02 ADMINISTRATIVE AND GENERAL NON-CAPITAL HOME OFFICE COST 4.01 865, 918 0 4.01 4.02 5.02 ADMINISTRATIVE AND GENERAL MALPRACTICE ALLOCATIONS (PER 21, 052 134, 526 4.02 102, 149 4.05 8. OO LAUNDRY & LINEN SERVICE HOSPITAL LAUNDRY SERVICES (P 102.149 4.05 5. 02 ADMINISTRATIVE AND GENERAL MANAGEMENT FEES 4.06 284, 571 4.06 4.07 5.02 ADMINISTRATIVE AND GENERAL 401K FEES 6,816 4.07 4.08 5. 02 ADMINISTRATIVE AND GENERAL AUDIT FEES 0 19, 775 4.08 5. 02 ADMINISTRATIVE AND GENERAL CORPORATE OVERHEAD FEES 0 959 686 4 09 4 09 4.10 5. 02 ADMINISTRATIVE AND GENERAL PPSI FEES C 24,094 4.10 5. 01 ADMITTING PASI COLLECTION FEES 0 153, 415 4.11 4.11 5. 02 ADMINISTRATIVE AND GENERAL HIIM ALLOCATION 156, 725 4.12 4.12 5. 01 ADMITTING PASI LIEN UNIT COLLECTION FE 4.13 30, 628 4.13 5.00 TOTALS (sum of lines 1-4) 1,674,937 1, 872, 385 5.00 Transfer column 6, line 5 to Worksheet A-8, column 2,

* 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.

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

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

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

6. 00	В	0.00 COMMUNITY HEALTH SYTEMS 100.00	6. 00
7.00	В	0. 00 PASI 100. 00	7. 00
8.00	В	0.00 HOSPITAL LAUNDRY SERVICE 100.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider}.$
- 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.

line 12.

			5/31/2018 1:	
	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			4
1. 00	8, 427			1.00
2.00	2, 359			2. 00
3.00	124, 089			3. 00
3. 02	442, 580			3. 02
3. 04	14, 980			3. 04
4.00	93, 383			4. 00
4. 01	865, 918			4. 01
4. 02	-113, 474	0		4. 02
4.05	0	0		4. 05
4.06	-284, 571			4. 06
4.07	-6, 816			4. 07
4.08	-19, 775			4. 08
4.09	-959, 686			4. 09
4. 10	-24, 094			4. 10
4. 11	-153, 415			4. 11
4. 12	-156, 725			4. 12
4. 13	-30, 628			4. 13
5.00	-197, 448			5. 00

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

Related Organization(s)		
and/or Home Office		
		4
Type of Business		
		4
6. 00		
B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ci ilibui	Schieff ander title Aviii.	
6.00	HOSPITAL MANAGEMENT	6. 00
7.00	DEBT COLLECTION	7.00
8.00	LAUNDRY SERVICE	8.00
9.00		9.00
10.00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1318

West. A Line # Cost Center/Physician Identifier Remuneration Professional Component Component Component RCE Amount Physician Provider Component Physician Provider RCE Amount Physician Physician Provider RCE Amount Physician Phys							10 12/31/2017	/ Date/IIMe Pre 5/31/2018 11:	
		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCF Amount		
1.00							1102 711104111	ider Component	
1.00									
2.00		1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
3. 00	1.00	30.00	ADULTS & PEDIATRICS	289, 433	289, 433	0	C	0	1. 00
4. 00	2.00	50.00	OPERATING ROOM	421, 475	421, 475	0	l c	0	2. 00
1.00	3.00	53.00	ANESTHESI OLOGY	89, 779	89, 779	0	l c	0	3. 00
1.00	4.00	69. 00	ELECTROCARDI OLOGY	2, 882	2, 882	0		0	4. 00
Column C	5.00	91. 00	EMERGENCY				l c	ol o	5. 00
8,00 0,00	6.00	0.00		0				0	6. 00
9.00	7.00	0.00		0	0	0		0	7. 00
10.00	8.00	0.00		0	0	0	l c	0	8. 00
10.00	9.00	0.00		l o	0	0	l c	ol o	9. 00
Next				0	0	0		ol o	4
Wkst. A Line # Cost Center/Physician Identifier Limit Limit Cost of Limit Cost of Limit Cost of Component Share of col. Cost of Component Share of col. Cost of Component Share of col. Cost of Share of Cost of Shar				3, 195, 856	951, 874	2, 243, 982		0	4
Identifier		Wkst. A Line #	Cost Center/Physician					Physician Cost	
1.00						Memberships &	Component		
1.00					Limit	Continuing	Share of col.	Insurance	
1.00						Educati on	12		
2. 00		1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
3. 00	1.00			0	0	0	C	0	1. 00
4.00 69.00 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 5.00 6.00 7.00 8.00 91.00 EMERGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	50.00	OPERATING ROOM	0	0	0	C	0	2. 00
S	3.00			0	0	0	C	0	3. 00
6.00	4.00	69. 00	ELECTROCARDI OLOGY	0	0	0	C	0	4. 00
7. 00	5.00	91. 00	EMERGENCY	0	0	0	C	0	5. 00
8. 00	6.00			0	0	0	C	0	6. 00
9.00	7.00	0.00		0	0	0	C	0	7. 00
10.00	8.00	0.00		0	0	0	C	0	8. 00
Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. Limit Disallowance Disallow	9.00			0	0	0	C	0	9. 00
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14 Disallowance Disallowance Disallowance Adjustment Disallowance Dis	10.00	0.00		0	0	0	C	0	10.00
Identifier Component Share of col. 14	200.00			0		_	C	0	200.00
Share of col . 14		Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
1.00 2.00 15.00 16.00 17.00 18.00			I denti fi er		Limit	Di sal I owance			
1. 00 2. 00 15. 00 16. 00 17. 00 18. 00 1. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 289, 433 1. 00 2. 00 50. 00 OPERATI NG ROOM 0 0 0 421, 475 2. 00 3. 00 53. 00 ANESTHESI OLOGY 0 0 0 89, 779 3. 00 4. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 2, 882 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 148, 305 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 6. 00 8. 00 0. 00 0 0 0 0 9. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 9. 00									
1.00 30.00 ADULTS & PEDIATRICS 0 0 289, 433 1.00 2.00 50.00 OPERATING ROOM 0 0 0 421, 475 2.00 3.00 53.00 ANESTHESI OLOGY 0 0 0 89, 779 3.00 4.00 69.00 ELECTROCARDI OLOGY 0 0 0 2,882 4.00 5.00 91.00 EMERGENCY 0 0 0 148,305 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 9.00 9.00 0.00 0 0 0 0 9.00 10.00 0 0 0 0 0 0 10.00								1	
2. 00 50. 00 OPERATING ROOM 0 0 421, 475 2. 00 3. 00 53. 00 ANESTHESI OLOGY 0 0 0 89, 779 3. 00 4. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 2, 882 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 148, 305 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 10. 00									
3. 00 53. 00 ANESTHESI OLOGY 0 0 89,779 3. 00 4. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 2,882 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 148,305 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 10. 00				"	-	-		1	
4. 00 69. 00 ELECTROCARDI OLOGY 0 0 2, 882 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 148, 305 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 8. 00 0. 00 0 0 0 0 0 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 10. 00			MI	0	1	0			
5. 00 91. 00 EMERGENCY 0 0 148, 305 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 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 9. 00 10. 00 0 0 0 0 0 10. 00				0	0	0			4
6.00 0.00 7.00 0.00 8.00 0.00 9.00 0.00 10.00 0.00 0 0 </td <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td>				0	0	0			
7. 00 0. 00 8. 00 0. 00 9. 00 0. 00 10. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0			4
8.00 0.00 9.00 0.00 10.00 0.00				0	0	0	C)	4
9. 00 0. 00 0 0 0 9. 00 10. 00 0 10. 00 0 10. 00 10. 00				0	1	· ·	C)	
10.00 0.00 10.00 10.00				0	-	-	C)	
				0	-	-	0)	1
200. 00 0		0.00		0	-	-	C)	
	200.00	l	I	1 0	1 0	0	J 951, 874	H	200.00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL				In Lie	u of Form CMS-:	2552-10
REASONABLE COST DETERMINATION FOR THERAPY OUTSIDE SUPPLIERS	SERVICES FURNISHED BY	Provi der	CCN:	15-1318			Worksheet A-8 Parts I-VI Date/Time Pre 5/31/2018 11:	pared:
					Physi cal	Therapy	Cost	

					Ph	ysical Therapy	5/31/2018 11: Cost	18 am_
Part GRYPAN INFORMATION 1.00 1.01						,		
2.00		PART I - GENERAL INFORMATION					1.00	
Author of unduplicated days in which supervisor or therapists was on provider site (see instructions)			s) (see instruc	tions)				
Author of underlicated days in which therapy assistant wis on provider at the but neither supervisor 0		, , ,	sor or theranis	t was on provi	der site (see i	nstructions)		
Number of unduplicated offsite visits - supervisors or therapists (see instructions) 0 5.00								
Number of undupli casted offsite visits - thorapy assistants (include only visits made by through sais start and on which supervision and/or therapist was not present during the visits) (sae instructions)								
assistant and on which supervisor and/or therapist was not present during the visit(s)) (see sinstructions) 5 cm or continuous provisions 5 cm or contin						therany		
Standard travel expense rate	0.00						o l	0.00
Supervisors Supervisors Therapists Assistants Aides Trailness	7 00	1					0.00	7 00
Supervisors Therapists Assistants Aldes Trail nees		· ·						
1.00 AISFA (see Instructions) 0.00 4,696.84 4,095.50 3,588.45 0.00 9.00 10.00 10.00 10.00 11.00 AISFA (see Instructions) 17.00 10.00 10.00 17.00 1		, , , , , , , , , , , , , , , , , , , ,					Trai nees	
10.00 AMSEA (see Instructions) 0.00 70.00 50.50 17.50 0.00 10.	9 00	Total hours worked						9 00
cone-half of column 3, line 10, column 3, cone-half of column 3, line 10, cone-half of column 4, line 3, cone-half of column 4, line 9, line 5, cone-half of column 4, line 10, cone-half of column 4, line 9, lines column 1, line 10, cone-half of column 4, line 9, lines column 3, line 10, cone-half of column 4, line 9, lines column 3, line 10, cone-half of column 4, line 9, lines column 3, line 10, cone-half of column 4, line 9, lines column 4, line 10, cone-half of column 4, line 9, lines column 4, line 10, cone-half of column 4, line 9, lines column 4, line 10, cone-half of column 4, line 9, lines column 4, line 10, cone-half of column 4, line 9, lines column 4, line 10, cone-half of column 4, line 9, lines column 4, line 10, cone-half of column 4, line 9, lines column 4, line 10, cone-half of column 4, line 9, lines column 4, line 10, cone-half of column 4, line 9, lines 10, line 10, cone-half of column 4, line 9, lines 10, line 10, cone-half of column 4, line 9, lines 10, lines 10, line 10, cone-half of column 4, line 9, lines 10, lines 10, line 10, cone-half of lines 10, lines 2								
12.00 Number of travel hours (provider site) 0 0 0 0 12.01	11. 00	· ·	35. 00	35. 00	25. 25			11. 00
12.00 Number of travel hours (provider site)								
13.00 Number of miles driven (provider site)	12. 00		О	0	0			12. 00
13.01 Number of miles driven (offsite)		, , ,	o					
Part II - SALARY EQUIVALENCY COMPUTATION		1	0					
Part II - SALARY EQUIVALENCY COMPUTATION 0 14.00 14.00 15.00 16.00 15.00 16.00 15.00 16.00 15.00 16.00 16.00 15.00 16.00	13.01	Number of life at their (offsite)	<u> </u>		<u> </u>			13.01
14.00 Supervisors (column 1, line 9 times column 2, line 10) 328,779 15.00 16.00 Assistants (column 3, line 9 times column 3, line 10) 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 16.00 206,823 206,8		Part II SALARY FOLLIVALENCY COMPLITATION					1. 00	
15.00 Therapists (column 2, line 9 times column 3, line 91) 15.00 328,779 15.00 206,823 16.00 201	14. 00		line 10)				0	14. 00
17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 535,602 17.00	15. 00	Therapists (column 2, line 9 times column 2,	line 10)					
Others			,	ratory thorany	or lines 14 14	for all		
19.00 Trainees (column 5, line 9 times column 5, line 10) 19.00 20.00 Trainees (column 5, line 9 times column 5, line 10) 19.00 20.00 1f the sum of columns 1 and 2 for respiratory therapy or clumns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, lis greater than line 2, make no entries on lines 21 and 22 and enter on line 23 21.00 Weighted allowance arise excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 0.00 22.00 23.00 Total salary equivalency (see instructions) 598,400 23.00 25.00	17.00		id 15 for respi	гатогу тпегару	Of Titles 14-10	TOT ALL	555, 602	17.00
20.00 Total allowance amount (sum of lines 17-19 for respiratory therapy or clumes 1 and 18 for all others) 598,400 20.00 16 fthe sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathol ogy or occupational therapy, line 9, is greater than line 2. make no entries on lines 21 and 22 and enter on line 23 17-23 17-24 17-24 17-24 18-24 19-24 1		1						
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		I The state of the		therany or lin	es 17 and 18 fo	r all others)		
the amount from line 20_Otherwise complete lines 21-23. 1.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9	20.00							20.00
21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 0.00 21.00 For respiratory therapy or columns 1 thru 3, line 9 for all others) 0.00 22.00 23.00 23.00 23.00 24.00 25.00				no entries on	lines 21 and 22	and enter on	line 23	
For respiratory therapy or columns 1 thru 3, line 9 for all others) 0 22.00	21. 00			divided by su	m of columns 1	and 2, line 9	0.00	21. 00
23. 00 PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance Standard Travel Standard Travel Standard Travel Standard Standard Travel Sta		for respiratory therapy or columns 1 thru 3,	line 9 for all	others)		·		
PART III - \$TANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			ees (line 2 tim	es line 21)			-	
24. 00 Therapists (line 3 times column 2, line 11)	23.00		VANCE AND TRAVE	L EXPENSE COMP	UTATION - PROVI	DER SITE	370, 400	25.00
25.00 Assistants (line 4 times column 3, line 11) 0 25.00 27								
26.00 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 0 26.00								
Others Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27) Optional Travel Allowance and Optional Travel Expense Others Optional Travel Allowance and Optional Travel Expense Optional Travel Allowance and Optional Travel Expense Optional		1	sum of lines 2	4 and 25 for a	II others)			
28.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 071) Optional Travel Allowance and Optional Travel Expense 29.00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 0 29.00 30.00 Assistants (column 3, line 10 times column 3, line 12) 0 30.00 31.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 0 31.00 32.00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 0 32.00 33.00 Standard travel allowance and standard travel expense (line 28) 0 33.00 34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 0 34.00 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) 0 90 Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapi sts (line 5 times column 2, line 11) 0 36.00 37.00 Assistants (line 6 times column 3, line 11) 0 37.00 38.00 Subtotal (sum of lines 36 and 37) 0 38.00 39.00 Optional Travel Allowance and Optional Travel Expense 40.00 Therapi sts (sum of columns 1 and 2, line 12.01 times column 2, line 10) 40.00 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 42.00 Subtotal (sum of lines 40 and 41) 43.00 42.00 Subtotal (sum of lines 40 and 41) 43.00 43.00 Optional travel allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.	27. 00		for respirator	y therapy or s	um of lines 3 a	nd 4 for all	0	27. 00
27)	28. 00		travel expense	at the provid	er site (sum of	lines 26 and	0	28. 00
29.00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		27)	·					
30.00 Assistants (column 3, line 10 times column 3, line 12) 31.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 32.00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 32.00 Standard travel allowance and standard travel expense (line 28) 33.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) 39.00 Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	20 00			d 2 lino 12)			0	20 00
32.00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 33.00 Standard travel allowance and standard travel expense (line 28) 34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 2, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 32.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 38.00 39.00 Optional Travel Allowance and Optional Travel Expense 44.00 5tandard travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		1		u z, Title Iz)				
columns 1-3, line 13 for all others) 33.00 34.00 34.00 35.00 Optional travel allowance and standard travel expense (line 28) Optional travel allowance and optional travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 38.00 Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) Optional travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) Optional travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						_		
33.00 Standard travel allowance and standard travel expense (line 28) 34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) 39.00 Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 2, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00	32. 00		s 1 and 2, line	13 for respir	atory therapy o	r sum of	0	32. 00
35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 35.00 Standard Travel allowance and optional travel expense (sum of lines 31 and 32) 0 36.00 0 36.00 0 37.00 37.00 38.00 0 38.00 0 39.00 0 40.00 0 40.00 40.00 41.00 42.00 64.00 64.00 64.00 64.00 64.00	33. 00	1	expense (line	28)			0	33. 00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36. 00 Therapists (line 5 times column 2, line 11) 0 36. 00 37. 00 Assistants (line 6 times column 3, line 11) 0 37. 00 38. 00 Subtotal (sum of lines 36 and 37) 0 38. 00 Standard travel expense (line 7 times the sum of lines 5 and 6) 0 39. 00 Optional Travel Allowance and Optional Travel Expense 40. 00 Therapists (sum of columns 1 and 2, line 12. 01 times column 2, line 10) 0 40. 00 41. 00 Assistants (column 3, line 12. 01 times column 3, line 10) 0 41. 00 42. 00 Subtotal (sum of lines 40 and 41) 0 42. 00 Optional travel expense (line 8 times the sum of columns 1-3, line 13. 01) 0 43. 00 Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44. 00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44. 00								
Standard Travel Expense 36. 00 Therapists (line 5 times column 2, line 11)	35.00					ES OUTSLDE PRO		35.00
37.00 Assistants (line 6 times column 3, line 11) 0 37.00 38.00 Subtotal (sum of lines 36 and 37) 0 38.00 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) 0 39.00 Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 0 40.00 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 0 41.00 42.00 Subtotal (sum of lines 40 and 41) 0 42.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 43.00 Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00			WOL 7WD TWWEL	EXI ENGE COM C	TATTON SERVICE	ES COTOTAL TIME	WIDER SITE	
38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 38.00 39.00 40.00 40.00 41.00 42.00 52.00 53.00 54.00 54.00 54.00								
39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00		, , ,						
40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 0 40.00 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 0 41.00 42.00 Subtotal (sum of lines 40 and 41) 0 42.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 43.00 Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00			m of lines 5 an	d 6)				
41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 41.00 42.00 44.00 42.00	40.00			2 1: 10)			0	40.00
42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 42.00 43.00		1		2, 11 ne 10)				
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00			-,				0	42. 00
or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00	43. 00	Optional travel expense (line 8 times the sur	m of columns 1-	3, line 13.01)	o of the f-11	ina tha - 1		43. 00
44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00			DITSILE SERVICE	s, comprete on	e or the follow	ing three line	5 44, 45,	
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions) 0 45.00		Standard travel allowance and standard trave						
	45. 00	Optional travel allowance and standard trave	expense (sum	of lines 39 an	d 42 - see inst	ructions)	0	45.00

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provi der CCN: 15-1318 Peri od: Worksheet A-8-3 From 01/01/2017 Parts I-VI Date/Time Prepared: OUTSIDE SUPPLIERS 12/31/2017 5/31/2018 11:18 am Physical Therapy Cost 1.00 46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions) 0 46.00 Therapi sts Assi stants Ai des Total 3.00 2.00 5.00 PART V - OVERTIME COMPUTATION 47.00 Overtime hours worked during reporting 0.00 0.00 0.00 0.00 0.00 47.00 period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 48.00 Overtime rate (see instructions) 0.00 0.00 0.00 0.00 48.00 49.00 Total overtime (including base and overtime 0.00 0.00 0.00 0.00 49.00 allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 0.00 0.00 0.00 0.00 0 00 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 51.00 Allocation of provider's standard work year 0.00 0.00 0.00 0.00 0.00 for one full-time employee times the $% \left(1\right) =\left(1\right) \left(1\right) \left($ percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount 70.00 50.50 17.50 0.00 52.00 (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0 53.00 52) 54.00 Maximum overtime cost (enter the lesser of 0 54.00 0 C 0 line 49 or line 53) 55.00 Portion of overtime already included in C 0 55.00 hourly computation at the AHSEA (multiply line 47 times line 52) Overtime allowance (line 54 minus line 55 -0 56.00 56.00 0 0 if negative enter zero) (${\sf Enter}$ in ${\sf column}$ 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 AND EXCESS COST ADJUSTMENT		
57.00 Salary equivalency amount (from line 23)	598, 400	57. 00
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58. 00
59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	07.00
60.00 Overtime allowance (from column 5, line 56)	0	00.00
61.00 Equipment cost (see instructions)	0	000
62.00 Supplies (see instructions)	0	62. 00
63.00 Total allowance (sum of lines 57-62)	598, 400	63. 00
64.00 Total cost of outside supplier services (from your records)	0	64. 00
65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65. 00
LINE 33 CALCULATION		
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100. 00
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100. 01
100.02 Line 33 = line 28 = sum of lines 26 and 27	0	100. 02
LINE 34 CALCULATION		
101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101. 00
101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101. 01
101.02 Line 34 = sum of lines 27 and 31	0	101. 02
LINE 35 CALCULATION		
102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102. 00
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line	0	102. 01
13 for all others		
102.02 Line 35 = sum of lines 31 and 32	0	102. 02

	ı Financial Systems NABLE COST DETERMINATION FOR THERAPY SERVICES FUI	DUKES MEMORIAL	HOSPITAL Provider CCN	l· 15, 1210	Peri od:	worksheet A-8	
	DE SUPPLIERS	KINI SHED BY	Provider CCN	1: 15-1318	From 01/01/2017 To 12/31/2017	Parts I-VI Date/Time Pre 5/31/2018 11:	epared
					Occupati onal Therapy	Cost	
					тист ару	1.00	
	PART I - GENERAL INFORMATION						
. 00	Total number of weeks worked (excluding aides) Line 1 multiplied by 15 hours per week	(see instructi	i ons)			0	1
3. 00	Number of unduplicated days in which supervisor					0	3.
. 00	Number of unduplicated days in which therapy as nor therapist was on provider site (see instruc		n provider site	e but neithe	er supervisor	0	4.
. 00	Number of unduplicated offsite visits - supervi	sors or therap				0	5.
. 00	Number of unduplicated offsite visits - therapy assistant and on which supervisor and/or therapy					0	6.
	instructions)		adiring		, (555		
7. 00 3. 00	Standard travel expense rate Optional travel expense rate per mile					0. 00 0. 00	
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
9. 00	Total hours worked	1.00	2. 00 1, 278. 00	3. 00 854. 0	4. 00	5. 00	9.
10.00	AHSEA (see instructions)	0. 00	70.00	50. 5	0.00	l e	10.
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	35. 00	35. 00	25. 2	25		11.
	one-half of column 3, line 10)						
12. 00 12. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12.
13.00	Number of miles driven (provider site)	0	O		0		13.
3. 01	Number of miles driven (offsite)	0	0		0		13.
	D. J. LL. CALADY FOUNDALENCY CONDUCTATION					1. 00	
4. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1, l	ine 10)				0	14.
5.00	Therapists (column 2, line 9 times column 2, li					89, 460	
6. 00 7. 00	Assistants (column 3, line 9 times column 3, li Subtotal allowance amount (sum of lines 14 and		atory therapy o	or lines 14-	-16 for all	43, 127 132, 587	1
10.00	others)	•	3 13				
18. 00 19. 00	Aides (column 4, line 9 times column 4, line 10 Trainees (column 5, line 9 times column 5, line					0	1
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory t					132, 587	20.
	occupational therapy, line 9, is greater than I						
21. 00	the amount from line 20. Otherwise complete li Weighted average rate excluding aides and train		divided by sum	of columns	1 and 2 line 0	0.00	21.
	for respiratory therapy or columns 1 thru 3, li	ne 9 for all o	others)	Of COT units	Tana 2, Title 7		
2.00	Weighted allowance excluding aides and trainees Total salary equivalency (see instructions)	s (line 2 times	s line 21)			0 132, 587	
.0. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWAN	ICE AND TRAVEL	EXPENSE COMPUT	TATION - PRO	OVIDER SITE	102,007	20.
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.
25. 00	Assistants (line 4 times column 3, line 11)					0	25.
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or su Standard travel expense (line 7 times line 3 for				and 4 for all	0	1
	others)		. 3				
28. 00	Total standard travel allowance and standard tr 27)	ravei expense a	at the provide	r site (sum	of lines 26 and	0	28.
00.00	Optional Travel Allowance and Optional Travel E		2 1: 2 12)			0	3
29. 00 30. 00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l		2, TIME 12)			0	
31.00	Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1				, or our of	0	
32. 00	columns 1-3, line 13 for all others)	r and 2, Time	is for respira	tory therapy	Of Sull Of	0	32.
33.00	Standard travel allowance and standard travel e Optional travel allowance and standard travel e			31)		0	
	Optional travel allowance and optional travel e					0	1
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWAND Standard Travel Expense	E AND TRAVEL E	EXPENSE COMPUTA	ATION - SERV	ICES OUTSIDE PRO	OVI DER SITE	+
86. 00	Therapists (line 5 times column 2, line 11)					0	36.
7.00	Assistants (line 6 times column 3, line 11)					0	1
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of	of lines 5 and	6)			0	1
	Optional Travel Allowance and Optional Travel E Therapists (sum of columns 1 and 2, line 12.01		2 Line 10)			0	40.
10 00	Assistants (column 3, line 12.01 times column 3		z, iiile 10 <i>)</i>			0	1
40. 00 41. 00						1 0	42.
11. 00 12. 00	Subtotal (sum of lines 40 and 41)	of columns 1.2	lino 12 01\			0	
1. 00 2. 00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of Total Travel Allowance and Travel Expense - Off			of the foll	owing three line	0	

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	DUKES MEMORIA FURNISHED BY	Provi der Co		Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 5/31/2018 11:	-3 pared:
					Occupati onal Therapy	Cost	
						1. 00	
	Optional travel allowance and standard travel					0	
46. 00	Optional travel allowance and optional travel	expense (sum Therapists	of lines 42 an Assistants	d 43 - see in Aides	structions) Trainees	0 Total	46. 00
		1.00	2.00	3. 00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION						
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0. 00	0. 0	0.00	0.00	47. 00
48. 00	Overtime rate (see instructions)	0. 00	0.00				48. 00
49. 00	Total overtime (including base and overtime	0. 00	0. 00	0.0	0.00		49. 00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						1
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0. 00	0. 00	O. C	0.00	0.00	50. 00
51. 00	line 47) 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 (see instructions)	70. 00	50. 50	0.0	0.00		52. 00
53. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53. 00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56. 00
						1 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	AD JUSTMENT			1. 00	
	Salary equivalency amount (from line 23)	27.0200 0001	7.00001			132, 587	57. 00
62. 00 63. 00 64. 00	Excess over limitation (line 64 minus line 63	ces (from lines n your records)	44, 45, or 46)		0 0 0 0 0 132, 587 0	62. 00 63. 00 64. 00
100 00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	II others		0	100. 00
100.01	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	0	100. 01 100. 02
101.01	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				others	0	101. 00 101. 01 101. 02
100.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or						102. 00
	Line 32 = line 8 times columns 1 and 2, line	12 for rooming	tory thorans -	r cum of ool.	impo 1 2 lino	^	102. 01

Note Creation National Na					C	D-+I	5/31/2018 11:	18 am
Mail - Cellisteal Histograms (1988) 100					[Sp	eech Pathology	Cost	
Mail - Cellisteal Histograms (1988) 100							1. 00	
2.00 United Principle Description 2.00 Author of undeplicated days in which supervisor or therapist was on provider site (see Instructions) 3.00 Author of undeplicated days in which supervisor or therapist was on provider site but not their supervisor 4.00 4.								
Sumber of unduplicated days in which therapy assistant sets on provider site (see instructions)			s) (see instruct	ti ons)				
4.00 Subservice of unduplicated asys in which therapy assistant was on provider site but neither supervisor or or therapist season growder site but neither supervisor in provider site of control instructions) 5.00 6.00 Subservice of unduplicated offsite vikits - Therapy assistants (include only vikits name by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions) 5.10 7.00 6.00 Opticated travel expense rate 5.10 0.20 0.00 0.00 0.00 0.00 0.00 0.00 6.00 Opticated travel expense rate 5.10 0.20 0.00 0.00 0.00 0.00 0.00 0.00 6.00 Opticated travel expense rate 5.10 0.20 0.00 0.00 0.00 0.00 0.00 0.00 6.00 Opticated travel expense rate 5.10 0.00 2.20 0.00 0.00 0.00 0.00 0.00 6.00 Opticated travel expense rate 6.00 0.00 0.00 0.00 0.00 0.00 0.00 6.00 Opticated travel expense rate 6.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 6.00 Opticated travel expense rate 6.00 0.00		' '	sor or theranist	t was on nrovid	ter site (see i	nstructions)		
1.00 Number of undigit cards offs to supervisions of therapists (see instructions) 0.5							-	4.00
Manber of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistants (include only visits) (see Instructions)								
assistant and on which supervisor and/or theraplist was not present during the visit(s)) (see							-	5. 00
The structions The	6. 00						0	6.00
Standard travel expense rate per mile Supervisors Therapists Assistants Aides Trainees			rapisi was noi p	present during	the visit(s))	(See		
Supervi sors Therapists Assistants Aldex Train nees	7.00	1					5. 19	7. 00
1.00	8.00	Optional travel expense rate per mile						8. 00
1.00 MESTA (see Instructions) 0.00 222.00 0.00 0.00 0.00 0.00 0.00 1.00 1.00 1.00 MESTA (see Instructions) 0.00 0.00 0.00 0.00 1.00								
AMSEA (see Instructions) 0.00 69.99 0.00 0.00 0.00 1.100	9 00	Total hours worked						9 00
11.00								1
12.00 Number of travel hours (provider site) 0 0 0 0 0 12.00	11. 00	1	35. 00	35. 00				11. 00
12.00 Number of travel hours (provider site) 0 0 0 0 12.00								
12.01 Number of travel hours (offsite) 0 0 0 13.00 Number of miles driven (provider site) 0 0 0 0 13.00 Number of miles driven (offsite) 0 0 0 0 0 13.00 Number of miles driven (offsite) 0 0 0 0 0 13.00 Number of miles driven (offsite) 0 0 0 0 0 13.00 Number of miles driven (offsite) 0 0 0 0 0 13.00 Number of miles driven (offsite) 0 0 0 0 0 0 0 0 13.00 Number of miles driven (offsite) 0 0 0 0 0 0 0 0 0	12 00		0		0			12 00
13.00 Number of miles driven (provider site) 0 0 0 0 13.00				0	-			ı
Part II - SALARY EQUIVALENCY COMPUTATION 1.00			O	0				13. 00
Part II - SALARY EQUIVALENCY COMPUTATION 1, 00 9 times column 1, line 9 times column 2, line 10) 15,538 15,00 16,00 Assistants (column 2, line 9 times column 3, line 10) 0 16,00 Assistants (column 3, line 9 times column 3, line 10) 0 16,00 17,00 17,00 17,00 17,00 18,00 18,00 18,00 18,00 18,00 19,00 18,00	13. 01	Number of miles driven (offsite)	0	0	0			13. 01
Part II - SALARY EQUIVALENCY COMPUTATION 1, 00 9 times column 1, line 9 times column 2, line 10) 15,538 15,00 16,00 Assistants (column 2, line 9 times column 3, line 10) 0 16,00 Assistants (column 3, line 9 times column 3, line 10) 0 16,00 17,00 17,00 17,00 17,00 18,00 18,00 18,00 18,00 18,00 19,00 18,00							1.00	
14.00 Supervisors (Column 1, line 9 times column 2, line 10) 14.00 15.00 Therspits* (column 2, line 9 times column 3, line 10) 15.00 15.		Part II - SALARY FOULVALENCY COMPUTATION					1.00	
15.00 Therapists (column 2, line 9 times column 3, line 910 15.588 15.00 16.00 Assistants (column 3, line 9 times column 3, line 10) 17.00 17.	14. 00		line 10)				0	14. 00
17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others) 18.00 Aldes (colum 4, line 9 times column 4, line 10) 0 18.00 0 18.00 0 19.00 Tarlanees (column 5, line 9 times column 4, line 10) 19.00 Tarlanees (column 5, line 9 times column 4, line 10) 19.00 Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 15.538 15 the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or becaught in the amount from line 20. Otherwise complete lines 21-23. 21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 69.99 70 respiratory therapy or columns 1 thru 3, line 9 69.99 70 respiratory therapy or all others) 54,592 22.00 70 70 70 70 70 70 70	15.00						15, 538	15. 00
Others 18.00 Aldes (column 4, line 9 times column 4, line 10) 0 18.00 19.00 Trainees (column 5, line 9 times column 5, line 10) 0 19.00 Trainees (column 5, line 9 times column 5, line 10) 15.538 20.00 17.10 18.00 20.00 Trainees (column 5, line 9 times column 5, line 10) 15.538 20.00 20.0		1					0	16. 00
18.00 Aides (column 4, line 9 times column 4, line 10) 10.01 Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 15.38 lif the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the namount from line 20. Otherwise complete lines 21-23. 21.00 Weighted allowance excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 than 3, line 9 for all others) 22.00 Weighted allowance excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for all others) 22.00 Total salary equivalency (see instructions) 23.00 Total salary equivalence 24.00 Therapists (line 3 times column 3, line 11) 25.00 Assistants (line 4 times column 3, line 11) 26.00 Subtotal (line 2 for respiratory therapy or sum of lines 24 and 25 for all others) 27.00 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 28.00 Therapists (cloum 2, line 10 times line 3 for respiratory therapy or sum of lines 26 and others) 29.00 Therapists (column 3, line 10 times line 3 for respiratory therapy or sum of lines 26 and 27.00 poptional Travel Allowance and standard travel expense at the provider site (sum of lines 26 and 27.00 poptional Travel Allowance and standard travel expense (line 28) 30.00 Standard travel expense (line 8 times column 3, line 12) 30.00 Assistants (column 3, line 10 times the sum of columns 1 and 2, line 12) 30.00 Assistants (column 3, line 10 times column 3 and 2, line 13 for respiratory therapy or sum of 3.00 columns 1-3, line 10 times column 3, line 12 30.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 30.00 Optional travel allowance and standard travel expense (sum of lines 31 and 32) 30.00 Optional travel allowance and fortional travel expense (sum of lines 31 and 3	17. 00		nd 15 for respir	ratory therapy	or lines 14-16	for all	15, 538	17.00
19.00 Trai nees (column 5, line 9 times column 5, line 10) 19.00 19.00 10.00 10.01 10.00	18. 00	1	10)				0	18. 00
if the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. 21.00 Weighted allowance rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others) 22.00 Weighted allowance excluding aides and trainees (line 12 times line 21) 23.00 Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance 2 standard travel expense (line 3 times column 3, line 11) 24.00 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 25.00 Assistants (line 4 times column 3, line 11) 26.00 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 4 for all others) 27.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and others) 28.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and others) 29.00 Total standard travel allowance and optional Travel Expense 29.00 Therapists (column 2, line 10 times column 3, line 12) 30.00 Assistants (column 3, line 10 times column 3, line 12) 31.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 32.00 Optional travel expense (line 8 times column 3 line 12) 33.00 Standard travel allowance and standard travel expense (sum of lines 27 and 31) 34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 35.00 Optional travel allowance and optional travel expense (sum of lines 27 and 31) 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (cloum 6, line 10 times column 7, line 10) 38.00 Total ravel expense (line 7 times the sum of lines 5 and 6) 38.00 Therapists (line 6 ti		Trainees (column 5, line 9 times column 5, li	ne 10)				0	1
occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. 21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for all others) 22.00 Weighted allowance excluding aides and trainees (line 2 times line 21) 23.00 Total salary equivalency (see instructions) 24.00 Total salary equivalency (see instructions) 25.00 Assistants (line 4 times column 2, line 11) 26.00 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 27.00 Standard travel allowance and standard travel expense at the provider site (sum of lines 26 and others) 28.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and others) 29.00 Total standard travel allowance and optional Travel Expense Therapists (column 2, line 10 times column 3, line 12) 29.00 Total standard travel allowance and optional Travel expense (line 27 and 31) 29.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 30.00 Assistants (column 3, line 10 times column 3, line 12) 30.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 30.00 Subtotal (line 29 for respiratory therapy or sum of lines 27 and 31) 30.00 Subtotal (line 29 for respiratory therapy or sum of lines 27 and 31) 30.00 Subtotal (line 20 for respiratory therapy or sum of lines 27 and 31) 30.00 Subtotal (line 30 fines 31 date 30 da	20.00							20. 00
the amount from line 20. Otherwise complete lines 21-23. 10. OW leighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 69-99 for respiratory therapy or columns 1 thru 3, line 9 for all others) 10. OW leighted allowance excluding aides and trainees (line 2 times line 21) 54, 592 22. 00 for respiratory therapy or columns 1 travel expense (line 2 times line 21) 54, 592 25. 00 FART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE STANDARD AND OPTIONAL TRAVEL EXPENSE OUTSIDE PROVI								
21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 69, 99 21.00				io entries on i	THES 21 and 22	and enter on	TITIE 23	
22.00 Weighted allowance excluding aides and trainees (line 2 times line 21) 54,592 22.00	21.00			divided by sun	n of columns 1	and 2, line 9	69. 99	21.00
23. 00 Total salary equivalency (see instructions) 54,592 23. 00								
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			ees (line 2 time	es line 21)				•
Standard Travel Allowance Therapists (line 3 times column 2, line 11) 0.24.00 25.00 25.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 27.00	23.00		VANCE AND TRAVEL	EXPENSE COMPL	ITATION - PROVI	DER SLITE	54, 592	23.00
25.00 Assistants (line 4 times column 3, line 11) 0 25.00			WHITE THE THETE	EXI ENGE COM C	77777011 111011	DER OF TE		
26.00 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 27.00 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 28.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27) Optional Travel Allowance and Optional Travel Expense 29.00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 30.00 Assistants (column 3, line 10 times column 3, line 12) 31.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 32.00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 33.00 Standard travel allowance and standard travel expense (line 28) 34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE 36.00 Therapists (line 5 times column 1, line 11) 37.00 Assistants (line 5 times column 2, line 11) 38.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of lines 40 and 41) Optional Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, or 46, as appropriate.		1					0	
27. 00 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 28. 00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27) Optional Travel Allowance and Optional Travel Expense 29. 00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 30. 00 Assistants (column 3, line 10 times column 3, line 12) 31. 00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 32. 00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 33. 00 Standard travel allowance and standard travel expense (line 28) 34. 00 Optional travel allowance and standard travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 5 and 6) Optional travel allowance and optional travel expense Optional travel expense (line 7 times the sum of column 2, line 10) Assistants (column 3, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			6.11	4 105.6 1			-	
Others Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27) Optional Travel Allowance and Optional Travel Expense Optional Travel Allowance and Optional Travel Expense Optional Travel Allowance and Optional Travel Expense Optional Travel Allowance and Standard travel expense (line 12) Optional Travel Expense Opt						and 1 for all	-	
28.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 07) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 0.00 0.0	27.00	1	Tor respiratory	y therapy or st	illi Of Titles 3 a	and 4 roi arr	0	27.00
Optional Travel Allowance and Optional Travel Expense 29. 00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 Optional travel expense (line 8 times column 3 line 12) 32. 00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 33. 00 34. 00 Optional travel allowance and standard travel expense (line 28) 34. 00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 27 and 31) Optional travel allowance and Optional travel expense (sum of lines 31 and 32) Optional travel Expense 36. 00 Therapists (line 5 times column 2, line 11) 37. 00 Assistants (line 6 times column 3, line 11) 38. 00 Subtotal (sum of lines 36 and 37) Optional Travel Allowance and Optional Travel Expense 40. 00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.	28. 00		travel expense	at the provide	er site (sum of	lines 26 and	0	28. 00
29. 00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 0 30. 00 Assistants (column 3, line 10 times column 3, line 12) 0 30. 00 31. 00 31. 00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 0 31. 00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 0 32. 00 Optional travel allowance and standard travel expense (line 28) 0 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 0 Optional travel allowance and optional travel expense (sum of lines 31 and 32) 0 Optional travel allowance and optional travel expense (sum of lines 31 and 32) 0 Optional travel expense (sum of lines 31 and 32) 0 Optional travel expense (sum of lines 31 and 32) 0 Optional travel expense (sum of lines 31 and 32) 0 Optional travel expense (sum of lines 31 and 32) 0 Optional travel expense (sum of lines 31 and 32) 0 Optional travel expense (sum of lines 31 and 32) 0 Optional travel expense (sum of lines 31 and 32) 0 Optional travel expense (sum of lines 36 and 37) 0 Optional travel expense (line 6 times column 2, line 11) 0 Optional travel expense (line 7 times the sum of lines 5 and 6) 0 Optional travel expense (line 7 times the sum of lines 5 and 6) 0 Optional travel expense (line 8 times column 3, line 10) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 1			_					
30.00 Assistants (column 3, line 10 times column 3, line 12) 31.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 32.00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 32.00 Standard travel allowance and standard travel expense (line 28) 33.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) 35.00 Optional travel Expense 36.00 Therapists (line 5 times column 2, line 11) 38.00 Subtotal (sum of lines 36 and 37) 39.00 Subtotal (sum of lines 36 and 37) 39.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 40.00 Therapists (column 3, line 12.01 times column 3, line 10) 41.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 44.00 Standard travel expense (line 8 times the sum of columns 1-3, line 13.01) 54.00 Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 54.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 55.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 57.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 58.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 59.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 59.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 59.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 59.00 Standard travel allowance and standard travel expense (sum	20 00			1 2 line 12)			0	20 00
31.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 32.00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 33.00 Standard travel allowance and standard travel expense (line 28) 34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) Optional Travel Expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional Travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) O 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)				1 2, TITIE 12)				
columns 1-3, line 13 for all others) 33.00 34.00 34.00 35.00 Definal travel allowance and standard travel expense (line 28) 35.00 Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Quitonal travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 33.00 33.00 33.00 33.00 33.00 34.00 35.00 9 35.00 9 35.00 9 35.00 9 35.00 9 35.00 9 36.00 9 36.00 9 37.00 9 38.00 9 38.00 9 39.00 9 3		1		and 30 for al	I others)		0	•
33.00 Standard travel allowance and standard travel expense (line 28) 34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and standard travel expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 33.00 34.00 35.00 36.00 37.00 38.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 40	32. 00		s 1 and 2, line	13 for respira	atory therapy o	or sum of	0	32. 00
34.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 34.00 34.00 35.00 36.00 36.00 36.00 37.00 38.00 39.00 39.00 36.00 36.00 36.00 36.00 37.00 38.00 39.00 39.00 39.00 30.00	22.00	1	Lauranca (Lina	20)			_	22.00
35.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00 45.00 46.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					1 31)			•
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36.00 Therapists (line 5 times column 2, line 11) 0 36.00 37.00 Assistants (line 6 times column 3, line 11) 0 37.00 Subtotal (sum of lines 36 and 37) 0 38.00 Standard travel expense (line 7 times the sum of lines 5 and 6) 0 38.00 Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 0 40.00 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 0 41.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00							-	
36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 36.00 37.00 37.00 37.00 37.00 38.00 39.00 39.00 39.00 39.00 40.00 40.00 41.00 42.00 42.00 43.00 44.00 45.00 46. as appropriate.						CES OUTSIDE PRO	OVIDER SITE	
37. 00 Assistants (line 6 times column 3, line 11) 0 37. 00 38. 00 Subtotal (sum of lines 36 and 37) 0 38. 00 39. 00 Optional Travel Allowance and Optional Travel Expense 40. 00 Assistants (sum of columns 1 and 2, line 12.01 times column 2, line 10) 0 40. 00 41. 00 Assistants (column 3, line 12.01 times column 3, line 10) 0 41. 00 42. 00 Subtotal (sum of lines 40 and 41) 0 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 42. 00 43. 00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 1 0 43. 00 44. 00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44. 00	04.00							1 07 00
38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 38.00 0 39.00 0 40.00 0 40.00 0 41.00 0 42.00 0 42.00 0 43.00 0 44.00								
39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 39.00 40.00 40.00 41.00 42.00 43.00 44.00 44.00		,						
40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 40.00 00 00 00 00 00 00 00 00 00 00 00 00		1	m of lines 5 and	d 6)			0	ı
41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 41.00 42.00 43.00 44.00								
42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 42.00 And the following three lines 44, 45, or 46, as appropriate.								
43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 43.00								
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00		1	m of columns 1-3	3, line 13.01)				
44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00		Total Travel Allowance and Travel Expense - 0			of the follow	ving three line	es 44, 45,	
	44.00		ovnonce (=::=	of lines 20 -	1 20	ruoti ana)	^	14 00
10, 00 op. 10, a. 1, a								
		1-F-1. 2 Crave. a. Cenarios and Standard Cravel	Count		2 300 11130	201. 0.10)	·	

 Heal th Financial
 Systems
 DUKES MEMOR

 REASONABLE
 COST
 DETERMINATION FOR THERAPY SERVICES FURNISHED BY
 DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2018 11: 18 am Provider CCN: 15-1318 Peri od: From 01/01/2017 To 12/31/2017 OUTSIDE SUPPLIERS Speech Pathology Cost 1.00 46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)

Therapists Assistants Aides Trainee 0 46.00 Therapi sts Assi stants Trai nees Total 1.00 3.00 4. 00 2.00 5.00

PART V - OVERTIME COMPUTATION 47. 00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 48. 00 Overtime rate (see instructions) 0.00 0.00 0.00 49. 00 Total overtime (including base and overtime 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0. 00 0. 00 0. 00 0. 00	0.00	48. 00 49. 00
period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 48.00 Overtime rate (see instructions) 0.00 0.00 0.00 49.00 Total overtime (including base and overtime 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0.00		48. 00 49. 00
equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 48.00 Overtime rate (see instructions) Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0. 00	0.00	49. 00
complete lines 48-55 and enter zero in each column of line 56) 48.00 Overtime rate (see instructions) Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0. 00	0.00	49. 00
column of line 56) 48.00 Overtime rate (see instructions) Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0. 00	0.00	49. 00
48.00 Overtime rate (see instructions) 49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line) 0.00 0.00 0.00 0.00 0.00 0.00	0. 00	0.00	49. 00
49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	0. 00	0.00	49. 00
allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0	0.00	0.00	
CALCULATION OF LIMIT 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.		0.00	50. 00
50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.		0.00	50.00
(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0		0.00	00.00
by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0	0.00		
51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0	0. 00		
for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0	0.00		
percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0		0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0			
52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0			_
(see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0			4
53.00 Overtime cost limitation (line 51 times line 0 0 0	0. 00		52. 00
			F0 00
	0		53. 00
52) 54.00 Maximum overtime cost (enter the lesser of 0 0 0	0		54.00
line 49 or line 53)	٩		34.00
55.00 Portion of overtime already included in 0 0	0		55. 00
hourly computation at the AHSEA (multiply	Ĭ		33.00
line 47 times line 52)			
56.00 Overtime allowance (line 54 minus line 55 - 0 0 0	o	0	56.00
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	
Dort VI COMPUTATION OF THE DADY LIMITATION AND EVERY COST ADJUSTMENT		1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 57.00 Salary equivalency amount (from line 23)		F4 F02	57. 00
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35))		54, 592 0	
59.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	1
60.00 Overtime allowance (from column 5, line 56)		0	
61.00 Equipment cost (see instructions)		0	1
62.00 Supplies (see instructions)		0	
63.00 Total allowance (sum of lines 57-62)		54, 592	
64.00 Total cost of outside supplier services (from your records)		01, 0,2	
65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	
LINE 33 CALCULATION			1 00.00
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all other	rs		100. 01
100.02 Line 33 = line 28 = sum of lines 26 and 27		0	100. 02
LINE 34 CALCULATION			
101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all other	rs	0	101.00
101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101. 01
101.02 Line 34 = sum of lines 27 and 31		0	101. 02
LINE 35 CALCULATION			1
102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102. 00
1	1-3, line	0	102. 01
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns			
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 13 for all others	I I		
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns		0	102. 02

Health Financial Systems

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1318

Period:
From 01/01/2017
To 12/31/2017

Part I
Date/Time Prepared:
5/31/2018 11: 18 am

CAPITAL RELATED COSTS

Cost Center Description

Net Expenses

BLDG & FIXT | MVBLE EQUIP | EMPLOYEE | ADMITTING

					10) 12/31/201/	Date/IIME Pre 5/31/2018 11:	
				CAPI TAL REI	ATED COSTS		7 0 7 0 17 20 10 111	10 0
	(Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMITTING	
			for Cost			BENEFITS		
			Allocation			DEPARTMENT		
			(from Wkst A					
			col . 7)	1 00	2.00	4.00	F 01	
	CENEDA	L SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	5. 01	
1. 00		CAP REL COSTS-BLDG & FIXT	1, 050, 990	1, 050, 990				1. 00
2.00		CAP REL COSTS-BEDG & TTXT	2, 121, 662	1,030,770	2, 121, 662			2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	1, 362, 819	7, 417		1, 385, 270		4. 00
5. 01		ADMITTING	668, 907	11, 285		49, 163	752, 229	5. 01
5. 02		ADMINISTRATIVE AND GENERAL	5, 779, 115	53, 508		131, 132	0	5. 02
7. 00		OPERATION OF PLANT	1, 799, 360	311, 009		29, 644	0	7. 00
8.00		LAUNDRY & LINEN SERVICE	81, 778	12, 210		0	0	8. 00
9.00		HOUSEKEEPI NG	380, 646	10, 109		30, 129	0	9. 00
10.00		DIETARY	284, 572	25, 522		17, 515	0	10.00
11.00	01100	CAFETERI A	9, 894	16, 392		4, 095	0	11. 00
13.00	01300	NURSING ADMINISTRATION	247, 324	4, 767	9, 663	36, 896	0	13.00
14.00		CENTRAL SERVICES & SUPPLY	212, 777	25, 017	50, 709	8, 945	0	14.00
15.00		PHARMACY	692, 231	11, 678	23, 672	51, 167	0	15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY	321, 823	21, 106	42, 782	10, 548	0	16. 00
17. 00		SOCIAL SERVICE	74, 264	0	0	7, 278	0	17. 00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDI ATRI CS	2, 280, 613	175, 192		169, 776	34, 131	30. 00
31. 00		INTENSIVE CARE UNIT	484, 613			39, 941	6, 180	
43. 00		NURSERY	120, 783	4, 017	8, 142	10, 923	1, 636	43. 00
F0 00		ARY SERVICE COST CENTERS	000 000	00.400	4/0.440	40.040	00.040	F0 00
50.00		OPERATING ROOM	889, 932	80, 488		49, 262	88, 912	
51.00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	333, 723	5, 794		28, 423 0	15, 307	51.00
52. 00 53. 00		ANESTHESI OLOGY	0	0	-	0	0	52. 00 53. 00
54.00		RADI OLOGY-DI AGNOSTI C	1, 399, 962	56, 610	-	94, 061	162, 306	
54. 00		ULTRASOUND	1, 399, 902	0 36,610		94, 001	102, 300	54. 00
56. 00		RADI OI SOTOPE	0	0		0	0	56. 00
57. 00		CT SCAN	0	0		0	0	57. 00
58. 00	05800		0	0	-	0	0	58.00
60.00		LABORATORY	1, 559, 854	22, 633	-	81, 059	107, 034	
65. 00		RESPI RATORY THERAPY	507, 605	9, 715		45, 455	10, 062	65. 00
66. 00		PHYSI CAL THERAPY	461, 776	13, 333		244	12, 061	66. 00
67. 00		OCCUPATIONAL THERAPY	129, 366	4, 363		0	4, 960	
68.00	06800	SPEECH PATHOLOGY	21, 522	176		0	452	
69.00	06900 I	ELECTROCARDI OLOGY	143, 580	6, 592	13, 362	13, 302	25, 901	69. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68, 873	0	0	0	23, 537	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	592, 119	0	0	0	17, 087	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	857, 631	0	-	0	110, 615	
76. 00		SLEEP LAB	87, 363	9, 412	19, 078	7, 083	3, 078	76. 00
		IENT SERVICE COST CENTERS	000 074		10.400	00.050	0.077	
			320, 071	6, 119		29, 959	2, 977	
		EMERGENCY	4, 267, 816	38, 988	79, 029	411, 457	97, 090	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	376, 618	15, 701	31, 825	27, 795	28, 903	95. 00
93.00		L PURPOSE COST CENTERS	370,010	15, 701	31, 023	21, 175	20, 903	93.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29, 991, 982	979, 456	1, 985, 366	1, 385, 252	752, 229	118 00
110.00		MBURSABLE COST CENTERS	27, 771, 702	777, 100	1, 700, 000	1, 000, 202	702,227	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 294	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	180			18	0	192. 00
194.00	07950	OTHER NRCC	ol	0	0	o		194. 00
		MARKETI NG	ol	0	0	o		194. 01
		SENI OR CIRCLE	43	0	0	o		194. 02
		FREE MEALS	0	0	0	0	0	194. 03
200.00		Cross Foot Adjustments						200. 00
201.00		Negative Cost Centers		0	0	0		201. 00
202.00) -	TOTAL (sum lines 118 through 201)	29, 992, 205	1, 050, 990	2, 121, 662	1, 385, 270	752, 229	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/31/2018 | 11: 18 am

						5/31/2018 11:	18 am
	Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5A. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & 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 ADMINISTRATIVE AND GENERAL	6, 072, 216	6, 072, 216				5. 02
7.00	00700 OPERATION OF PLANT	2, 770, 437	703, 289	3, 473, 726			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	118, 739	30, 142	63, 518	212, 399		8. 00
9.00	00900 HOUSEKEEPI NG	441, 375	112, 045	52, 586	0	606, 006	9. 00
10.00	01000 DI ETARY	379, 343	96, 298	132, 766	0	23, 963	10. 00
11. 00	01100 CAFETERI A	63, 608	16, 147	85, 272	0	15, 391	11. 00
13.00	01300 NURSING ADMINISTRATION	298, 650	75, 814	24, 798	0	4, 476	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	297, 448	75, 509	130, 137	0	23, 488	14. 00
15.00	01500 PHARMACY	778, 748	197, 689	60, 751	0	10, 965	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	396, 259	100, 592	109, 794	0	19, 816	16. 00
17.00	01700 SOCIAL SERVICE	81, 542	20, 700	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 014, 827	765, 329	911, 349	161, 869	164, 485	30.00
31.00	03100 INTENSIVE CARE UNIT	592, 191	150, 331	105, 615	32, 309	19, 062	31.00
43.00	04300 NURSERY	145, 501	36, 936	20, 896	18, 221	3, 771	43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	1, 271, 743	322, 838	418, 696	0	75, 569	50.00
51.00	05100 RECOVERY ROOM	394, 991	100, 270	30, 140	0	5, 440	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	1, 827, 687	463, 967	294, 482	0	53, 150	54. 00
54. 01	05401 ULTRASOUND	0	0	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	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	1, 816, 458	461, 117	117, 737	0	21, 250	1
65. 00	06500 RESPI RATORY THERAPY	592, 530			0	9, 121	
66. 00	06600 PHYSI CAL THERAPY	514, 440				12, 518	
67. 00	06700 OCCUPATI ONAL THERAPY	147, 532				4, 096	1
68. 00	06800 SPEECH PATHOLOGY	22, 506				165	1
69. 00	06900 ELECTROCARDI OLOGY	202, 737				6, 189	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	92, 410			0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	609, 206			0	ő	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	968, 246			o o	Ö	73.00
76. 00	03610 SLEEP LAB	126, 014				8, 837	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	120,011	01, 707	10, 700	J	0,007	70.00
90. 00	09000 CLINIC	371, 528	94, 314	31, 828	0	5, 745	90. 00
91. 00	09100 EMERGENCY	4, 894, 380					1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		202,010	J	00,000	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0					72.00
95. 00	09500 AMBULANCE SERVICES	480, 842	122, 064	81, 674	0	14, 741	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	400, 042	122,004	01,074	<u> </u>	14, 741	75.00
118.00		29, 784, 134	6, 019, 396	3, 101, 611	212, 399	538, 844	112 00
110.00	NONREI MBURSABLE COST CENTERS	27, 704, 134	0,017,370	3, 101, 011	212, 377	330, 044	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 294	1, 090	22, 335	0	4 021	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	203, 734					192. 00
	07950 OTHER NRCC	203, 734		349, 780			194. 00
				1	_		
	07951 MARKETI NG 2 07952 SENI OR CI RCLE	0		1	_		194. 01 194. 02
		43		0	_		
	3 07953 FREE MEALS	0		0	ا	0	194. 03
200.00		0	_	_	_	_	200.00
201.00		20,002,205	(072 214	2 472 704	212 200		201. 00
202.00	TOTAL (sum lines 118 through 201)	29, 992, 205	6, 072, 216	3, 473, 726	212, 399	606, 006	1202.00

				10) 12/31/201/	5/31/2018 11:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	10 4
	· ·			ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
	OFNEDAL CEDIUSE COCT OFNEDO	10. 00	11. 00	13. 00	14. 00	15. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING						5. 01
5. 01	00570 ADMITTING 00590 ADMINISTRATIVE AND GENERAL						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY	632, 370					10.00
11. 00	01100 CAFETERI A	0	180, 418				11. 00
13. 00	01300 NURSING ADMINISTRATION	o	8, 016				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	O	3, 177	0	529, 759		14. 00
15. 00	01500 PHARMACY	O	6, 440	0	15, 624	1, 070, 217	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	О	3, 735	0	734	0	16. 00
17.00	01700 SOCIAL SERVICE	О	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	481, 930	34, 743	74, 145	28, 127	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	96, 191	6, 204	16, 503	3, 264	0	
43.00	04300 NURSERY	54, 249	0	5, 873	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS	ما	10.0/0	05.440	407.054		
50.00	05000 OPERATI NG ROOM	0	10, 063	· ·	107, 054	0	
51.00	05100 RECOVERY ROOM	0	4, 455	13, 826	5, 448	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	O O	10 543	47.0(2	24 722	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	0	19, 543 0	47, 063	26, 722 0	0	54. 00 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	0	21, 864	37, 711	97, 996	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	8, 127	37, 711	9, 166	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	Ö	87	0	2, 350	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	0	0	2, 555	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	2, 494	o	1, 461	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0	0	51, 088	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	О	0	0	140, 393	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1, 070, 217	73. 00
76.00	03610 SLEEP LAB	0	1, 290	0	1, 210	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	4, 790		6, 501	0	
91. 00	09100 EMERGENCY	0	38, 652	191, 464	17, 629	0	
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	٥	/ 712		14 007		05.00
95. 00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	6, 713	0	14, 886	0	95. 00
118. 00		632, 370	180, 393	411, 754	529, 653	1, 070, 217	118 00
110.00	NONREI MBURSABLE COST CENTERS	032, 370	100, 373	411,754	327, 033	1,070,217	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	25	0	106		192.00
	07950 OTHER NRCC	O	0		0		194. 00
	07951 MARKETI NG	О	0	0	0	0	194. 01
	07952 SENI OR CIRCLE	0	0	0	О		194. 02
194. 03	07953 FREE MEALS	0	0	0	o		194. 03
200.00	Cross Foot Adjustments						200. 00
201.00		o	0	0	o		201. 00
202.00	TOTAL (sum lines 118 through 201)	632, 370	180, 418	411, 754	529, 759	1, 070, 217	202. 00

Heal th Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B
Part |
Date/Time Prepared:
5/31/2018 11: 18 am COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1318 Period: From 01/01/2017 To 12/31/2017 Cost Center Description MEDI CAL SOCIAL SERVICE Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 24. 00 16. 00 17. 00 25.00 26.00

		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS				<u>.</u>		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					ļ	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING					l	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL					ļ	5. 02
7. 00	00700 OPERATION OF PLANT					ļ	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					ļ	8. 00
9. 00	00900 HOUSEKEEPI NG					ļ	9. 00
10.00	01000 DI ETARY					ļ	10.00
11. 00	l l					ļ	
	01100 CAFETERI A					ļ	11.00
13.00	01300 NURSING ADMINISTRATION					ļ	13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY					ļ	14. 00
15. 00	01500 PHARMACY					ļ	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	630, 930				ļ	16. 00
17. 00	01700 SOCI AL SERVI CE	0	102, 242				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	28, 629	77, 919	5, 743, 352	0	5, 743, 352	30.00
31.00	03100 INTENSIVE CARE UNIT	5, 184	15, 552	1, 042, 406	0	1, 042, 406	31. 00
43.00	04300 NURSERY	1, 372	8, 771	295, 590	O	295, 590	43.00
	ANCILLARY SERVICE COST CENTERS				<u> </u>		1
50.00	05000 OPERATING ROOM	74, 578	0	2, 305, 710	0	2, 305, 710	50.00
51. 00	05100 RECOVERY ROOM	12, 839	0	567, 409	0	567, 409	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	o	0	52. 00
53. 00	05300 ANESTHESI OLOGY		o	0	ő	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	136, 111	o	2, 868, 725	ő	2, 868, 725	54. 00
54. 01	05401 ULTRASOUND	130, 111	o	2, 000, 725		2, 000, 729	54. 01
56. 00	05600 RADI OI SOTOPE		0	0	0	0	56.00
57. 00	05700 CT SCAN		o	0	0	0	57.00
58. 00	05800 MRI		0	0	0	0	58.00
		00 770	-	2 ((2 011	٩	0 ((2 0 0 1 1	
60.00	06000 LABORATORY	89, 778	0	2, 663, 911	0	2, 663, 911	60.00
65.00	06500 RESPIRATORY THERAPY	8, 440	0	828, 339	0	828, 339	65. 00
66. 00	06600 PHYSI CAL THERAPY	10, 117	0	739, 463	0	739, 463	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	4, 160	0	215, 935	0	215, 935	
68. 00	06800 SPEECH PATHOLOGY	379	0	29, 676	0	29, 676	
69. 00	06900 ELECTROCARDI OLOGY	21, 726	0	320, 365	0	320, 365	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 742	0	186, 699	0	186, 699	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	14, 333	0	918, 582	0	918, 582	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	92, 782	0	2, 377, 039	0	2, 377, 039	73.00
76.00	03610 SLEEP LAB	2, 582	0	220, 882	0	220, 882	76. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	2, 497	0	517, 203	0	517, 203	90.00
91.00	09100 EMERGENCY	81, 438	o	6, 705, 457	o	6, 705, 457	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	1	2, . 22, . 2 .	o	-, ,	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
95. 00	09500 AMBULANCE SERVICES	24, 243	0	745, 163	0	745, 163	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	2.72.0	9	, 10, 100	<u> </u>	7 107 100	70.00
118.00		630, 930	102, 242	29, 291, 906	0	29, 291, 906	118 00
110.00	NONREI MBURSABLE COST CENTERS	000, 700	102, 212	27, 271, 700	<u> </u>	27,271,700	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	31, 750	0	31, 750	190 00
	19200 PHYSICIANS' PRIVATE OFFICES		o	668, 495	0	668, 495	
	07950 OTHER NRCC		O O	000, 493			194. 00
			o	0	o		
	07951 MARKETI NG		O	0	O O		194. 01
	07952 SENI OR CI RCLE	0	O	54	O		194. 02
	07953 FREE MEALS	0	이	0	이		194. 03
200.00	1 1			0	0		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	630, 930	102, 242	29, 992, 205	0	29, 992, 205	202.00

| Peri od: | Worksheet B | From 01/01/2017 | Part | I | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 1 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1318

					То	12/31/2017	Date/Time Pre 5/31/2018 11:	pared: 18 am
				CAPI TAL REI	ATED COSTS		070172010 11.	TO CITI
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs				DEI / III TIII EI II	
	I		0	1. 00	2.00	2A	4. 00	
1 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1 00
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT	0	7, 417	15, 034	22, 451	22, 451	4. 00
5.01		ADMITTI NG	0	11, 285	22, 874	34, 159	797	5. 01
5. 02		ADMINISTRATIVE AND GENERAL	0	53, 508		161, 969	2, 126	5. 02
7.00	1	OPERATION OF PLANT	0	311, 009		941, 433	480	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	12, 210 10, 109		36, 961 30, 600	0 488	8. 00 9. 00
10. 00		DI ETARY	o o	25, 522		77, 256	284	
11. 00	1	CAFETERI A	0	16, 392		49, 619	66	
13. 00		NURSI NG ADMI NI STRATI ON	0	4, 767	9, 663	14, 430	598	
14.00		CENTRAL SERVICES & SUPPLY	0	25, 017		75, 726	145	
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	11, 678 21, 106		35, 350 63, 888	829 171	15. 00 16. 00
17. 00		SOCIAL SERVICE	0	21, 100		03, 888	118	17. 00
		ENT ROUTINE SERVICE COST CENTERS		-	-1	-1		
30. 00		ADULTS & PEDI ATRI CS	0	175, 192		530, 307	2, 752	30. 00
31.00		INTENSIVE CARE UNIT	0	20, 303		61, 457	647	31.00
43. 00		NURSERY _ARY SERVICE COST CENTERS	0	4, 017	8, 142	12, 159	177	43. 00
50. 00		OPERATING ROOM	0	80, 488	163, 149	243, 637	798	50. 00
51. 00		RECOVERY ROOM	0	5, 794		17, 538	461	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1	o	0	52. 00
53.00		ANESTHESI OLOGY	0	0	l i	0	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	56, 610	1	171, 358	1, 525	
54. 01 56. 00	1	ULTRASOUND RADI OI SOTOPE	0	0		0	0	54. 01 56. 00
57. 00	1	CT SCAN	0	0		Ö	0	57. 00
58. 00	05800		0	Ō	Ō	ō	0	58. 00
60.00	1	LABORATORY	0	22, 633		68, 511	1, 314	60. 00
65. 00		RESPI RATORY THERAPY	0	9, 715		29, 408	737	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	13, 333		40, 359	4	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	4, 363 176		13, 206 532	0	68.00
69. 00	1	ELECTROCARDI OLOGY	Ö	6, 592		19, 954	216	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00		DRUGS CHARGED TO PATIENTS SLEEP LAB	0	0 413	1	0	0	73.00
76. 00		TIENT SERVICE COST CENTERS	U	9, 412	19, 078	28, 490	115	76. 00
90. 00		CLINIC	0	6, 119	12, 402	18, 521	486	90. 00
91. 00		EMERGENCY	0	38, 988	79, 029	118, 017	6, 666	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
05 00		REI MBURSABLE COST CENTERS		15 701	21 025	47 52/	451	05.00
95.00		AL PURPOSE COST CENTERS	0	15, 701	31, 825	47, 526	451	95. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	979, 456	1, 985, 366	2, 964, 822	22, 451	118. 00
		MBURSABLE COST CENTERS		,	,	,	,	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 294		4, 294		190. 00
		PHYSICIANS' PRIVATE OFFICES	0	67, 240	136, 296	203, 536		192. 00
		OTHER NRCC MARKETI NG	0	0		0		194. 00 194. 01
		SENIOR CIRCLE		0		0		194. 01
		FREE MEALS	Ö	o		ő		194. 03
200.00		Cross Foot Adjustments				o		200. 00
201.00	1	Negative Cost Centers		0	0	0	0	201. 00
202.00	y	TOTAL (sum lines 118 through 201)	0	1, 050, 990	2, 121, 662	3, 172, 652	22, 451	202. 00

In Lieu of Form CMS-2552-10
Worksheet B
01/2017 Part II
81/2017 Date/Time Prepared:
5/31/2018 11: 18 am Peri od: From 01/01/2017 To 12/31/2017

	Cost Center Description	ADMI TTI NG	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	TO alli
		5. 01	AND GENERAL 5. 02	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	3.01	3.02	7.00	0.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING	34, 956					5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	0 0					5. 02
7. 00	00700 OPERATION OF PLANT	0					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	815				8. 00
9. 00	00900 HOUSEKEEPI NG					48, 663	9. 00
10.00	01000 DI ETARY	0	2, 602			1, 924	10.00
11. 00	01100 CAFETERI A	0	436			1, 924	11.00
		0	2, 049		0		ł
13.00	01300 NURSING ADMINISTRATION	0			0	359	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	2, 040			1, 886	14.00
15. 00	01500 PHARMACY	0	5, 342			880	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0				1, 591	16.00
17. 00	01700 SOCIAL SERVICE	0	559	0	0	0	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 507	20 (02	252.000	40, 100	10.011	20.00
30.00	03000 ADULTS & PEDI ATRI CS	1, 587					30.00
31.00	03100 I NTENSI VE CARE UNI T	287					
43. 00	04300 NURSERY	76	998	5, 780	4, 748	303	43. 00
	ANCILLARY SERVICE COST CENTERS	T	T	T			
50. 00	05000 OPERATING ROOM	4, 134			0	6, 068	50. 00
51. 00	05100 RECOVERY ROOM	712			0	437	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	1	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 528	12, 538	81, 461	0	4, 268	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	4, 977	12, 461	32, 569	0	1, 706	60.00
65.00	06500 RESPI RATORY THERAPY	468	4, 065	13, 980	0	732	65. 00
66.00	06600 PHYSI CAL THERAPY	561	3, 529	19, 186	0	1, 005	66. 00
67.00	06700 OCCUPATIONAL THERAPY	231	1, 012	6, 278	0	329	67. 00
68.00	06800 SPEECH PATHOLOGY	21	154	253	0	13	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 204	1, 391	9, 486	0	497	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 094	634	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	794	4, 179	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 143	6, 642	0	0	0	73. 00
76. 00	03610 SLEEP LAB	143			0	710	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	138	2, 549	8, 805	0	461	90.00
91. 00	09100 EMERGENCY	4, 514		56, 104			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	.,	00,001	00, 101	J	1	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	1, 344	3, 299	22, 593	0	1, 184	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	1,011	0,277	22,070	J J	1, 101	70.00
118. 00		34, 956	162, 668	857, 982	55, 347	43, 270	118 00
110.00	NONREI MBURSABLE COST CENTERS	34, 730	102,000	037, 702	33, 347	43, 270	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29	6, 178	0	324	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0					192. 00
	07950 OTHER NRCC		1, 370	70, 730			194. 00
	07951 MARKETI NG			0			194. 00
	207952 SENI OR CI RCLE			~			194. 01
	307953 FREE MEALS						194. 02
					ا	l	200. 00
200.00		_	_	_		_	
201.00		0	_	040.010	EE 247		201.00
202.00	TOTAL (sum lines 118 through 201)	34, 956	164, 095	960, 918	55, 347	48, 663	J2U2. UU

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | T

			10) 12/31/201/	5/31/2018 11:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11 00	12.00	SUPPLY	15.00	
GENERAL SERVICE COST CENTERS	10. 00	11. 00	13. 00	14. 00	15. 00	
1. 00 O0100 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 ADMINISTRATIVE AND GENERAL						5. 02
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	118, 792					10.00
11. 00 01100 CAFETERI A	0	74, 945				11. 00
13.00 01300 NURSING ADMINISTRATION	O	3, 330	27, 626			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	1, 320	0	117, 116		14.00
15. 00 01500 PHARMACY	0	2, 675	0	3, 454	65, 335	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1, 551	0	162	0	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	90, 531	14, 432	4, 974	6, 218	0	30. 00
31. 00 03100 INTENSIVE CARE UNIT	18, 070	2, 577	1, 107	722	0	31. 00
43. 00 04300 NURSERY	10, 191	0	394	0	0	43. 00
ANCI LLARY SERVI CE COST CENTERS	ما	4 100	1 (00	22.77	0	FO 00
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM	0	4, 180		23, 667	0	50. 00 51. 00
	0	1, 850	928 0	1, 204	-	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	U O	0	0	U O	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0 110	2 157	5, 908	0	53. 00 54. 00
54. 00 05400 RADI 0E0G1-DI AGNOSTI C 54. 01 05401 ULTRASOUND	0	8, 118	3, 157	5, 906	0	54. 00
56. 00 05600 RADI OI SOTOPE	o	0	0	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 05800 MRI	Ö	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0	9, 082	2, 530	21, 664	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	3, 376	2, 330	2, 026	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	36	o o	519	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	o o	0.7	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	1, 036	0	323	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	11, 294	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	0	31, 039	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	0	0	65, 335	73.00
76. 00 03610 SLEEP LAB	O	536	0	268	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	1, 990		1, 437	0	90. 00
91. 00 09100 EMERGENCY	0	16, 057	12, 847	3, 897	0	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	ما	0.700		0.004	0	05.00
95. 00 09500 AMBULANCE SERVI CES SPECIAL PURPOSE COST CENTERS	0	2, 789	0	3, 291	0	95. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	118, 792	74, 935	27, 626	117, 093	65, 335	110 00
NONREI MBURSABLE COST CENTERS	110, 792	74, 933	27,020	117, 093	00, 330	116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	o	10	0	23		192. 00
194. 00 07950 OTHER NRCC	ő	0		0		194. 00
194. 01 07951 MARKETI NG	ő	0	· -	Ö		194. 01
194. 02 07952 SENI OR CI RCLE	ő	0	0	o		194. 02
194. 03 07953 FREE MEALS	o	0	0	o		194. 03
200.00 Cross Foot Adjustments	٩	3		٦		200. 00
201.00 Negative Cost Centers	ol	0	o	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	118, 792	74, 945	27, 626	117, 116	65, 335	
· · · · · · · · · · · · · · · · · · ·	·		· ·			

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1318 Peri od: Worksheet B From 01/01/2017 Part II 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am Cost Center Description MEDI CAL SOCIAL SERVICE Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5.01 5. 01 00590 ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 100, 453 16.00 01700 SOCIAL SERVICE 17.00 677 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 561 516 984.050 984.050 30.00 31.00 03100 INTENSIVE CARE UNIT 826 103 129, 024 0 129, 024 31.00 43.00 04300 NURSERY 58 35, 103 0 35, 103 43.00 219 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11,883 0 420, 602 0 420, 602 50.00 05100 RECOVERY ROOM 0 0 51.00 51.00 2,046 36, 224 36, 224 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 C 0 0 52.00 05300 ANESTHESI OLOGY 53 00 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 21,610 0 317, 471 317, 471 54.00 05401 ULTRASOUND 0 54.01 0 0 0 0 0 0 0 0 0 0 0 0 54.01 05600 RADI OI SOTOPE 0 56, 00 0 0 0 56, 00 05700 CT SCAN 0 0 0 57.00 0 57.00 58.00 05800 MRI 0 0 0 0 58.00 06000 LABORATORY 169, 119 60.00 14, 305 169, 119 60 00 65.00 06500 RESPIRATORY THERAPY 1, 345 0 56, 137 56, 137 65.00 06600 PHYSI CAL THERAPY 0 66.00 1,612 66, 811 66, 811 66 00 06700 OCCUPATIONAL THERAPY 21, 719 21, 719 67.00 67.00 663 06800 SPEECH PATHOLOGY 68.00 60 0 1,033 1,033 68.00 06900 ELECTROCARDI OLOGY 69.00 3, 462 0 37, 569 37, 569 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 3, 146 16, 168 16, 168 71.00 2, 284 38, 296 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 38, 296 72.00 07300 DRUGS CHARGED TO PATIENTS 14, 783 0 91, 903 91, 903 73.00 73.00 03610 SLEEP LAB 0 45, 081 45, 081 76.00 411 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 398 34, 785 0 34, 785 90.00 267, 598 09100 EMERGENCY 91.00 12, 976 C 267, 598 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 86, 340 95.00 09500 AMBULANCE SERVICES 3, 863 0 86, 340 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100, 453 677 2, 855, 033 0 2, 855, 033 118. 00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 10, 825 190, 00 10, 825 0 306, 794 192. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 306, 794 194. 00 07950 OTHER NRCC 0 0 0 0 0 194.00 194. 01 07951 MARKETI NG 0 0 194. 01 0 0 0 0 0 0 194. 02 07952 SENI OR CIRCLE 0 0 0 194, 02 194. 03 07953 FREE MEALS 0 C 0 0 194, 03

100, 453

0 200.00

0 201.00

3, 172, 652 202. 00

0

C

3, 172, 652

677

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1318 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** ADMI TTI NG Reconciliation Cost Center Description (SQUARE FEE T) (SQUARE FEE T) (GROSS CHAR BENEFITS DEPARTMENT GES) (GROSS SALARI ES) 1.00 2.00 5. 01 5A. 02 4.00 GENERAL SERVICE COST CENTERS 197 538 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 196, 731 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 394 1, 394 12, 941, 677 4.00 00570 ADMITTING 5 01 2, 121 459, 301 5 01 2 121 175, 765, 142 5.02 00590 ADMINISTRATIVE AND GENERAL 10,057 10,057 1, 225, 087 -6, 072, 216 5.02 7.00 00700 OPERATION OF PLANT 58, 456 58, 456 276, 944 0 7.00 00800 LAUNDRY & LINEN SERVICE 2, 295 2, 295 8.00 8.00 0 0 00900 HOUSEKEEPI NG 1, 900 9 00 1 900 281, 480 0 9 00 10.00 01000 DI ETARY 4, 797 4, 797 163, 631 0 10.00 01100 CAFETERI A 3,081 11.00 3,081 38, 254 0 11.00 01300 NURSING ADMINISTRATION 344, 699 13.00 13.00 896 896 0 01400 CENTRAL SERVICES & SUPPLY 4, 702 14.00 4.702 83.570 0 14.00 15.00 01500 PHARMACY 2, 195 2, 195 478, 025 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 3,967 3, 967 98, 541 0 16.00 01700 SOCIAL SERVICE <u>67</u>, 991 0 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 32, 928 32, 928 1, 586, 117 7, 974, 563 30.00 0 31.00 03100 INTENSIVE CARE UNIT 3,816 3, 816 373, 143 1, 443, 892 0 31.00 04300 NURSERY 755 102,048 382, 225 0 43.00 43.00 755 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 15, 128 460, 221 50.00 15, 128 20, 773, 885 0 50.00 05100 RECOVERY ROOM 3, 576, 286 0 51.00 51.00 1.089 1.089 265, 543 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 10,640 10, 640 878, 757 37, 932, 740 54.00 54.01 05401 ULTRASOUND 0 0 54.01 0 0 56.00 05600 RADI OI SOTOPE 0 C 0 0 0 56.00 05700 CT SCAN 57.00 57.00 0 0 0 0 58.00 05800 MRI 0 0 58.00 06000 LABORATORY 757, 289 25, 007, 892 60.00 4.254 4.254 Λ 60.00 65.00 06500 RESPIRATORY THERAPY 1,826 1,826 424, 660 2, 351, 036 0 65.00 06600 PHYSI CAL THERAPY 66.00 2,506 2,506 2, 275 2, 818, 046 0 66.00 06700 OCCUPATIONAL THERAPY 1, 158, 770 67.00 820 820 67.00 06800 SPEECH PATHOLOGY 68.00 33 33 105, 532 0 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 239 1, 239 124, 274 6,051,685 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 5, 499, 198 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 C 0 3 992 398 0 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 \cap 25, 844, 627 0 73.00 76.00 03610 SLEEP LAB 1,769 1, 769 66, 173 719, 259 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 279 888 90 00 1 150 1 150 695 456 0 91.00 09100 EMERGENCY 7,328 7, 328 3, 843, 923 22, 684, 607 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 2, 951 6, 753, 045 2, 951 09500 AMBULANCE SERVICES 259, 672 Ωl 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 12, 941, 506 175, 765, 142 184, 093 184, 093 -6, 072, 216 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN വ വ 807 192.00 19200 PHYSICIANS' PRIVATE OFFICES 12,638 12, 638 171 0 0 192.00 194.00 07950 OTHER NRCC 0 0 194. 00 0 0 194. 01 07951 MARKETI NG 0 0 0 194 01 0 C 194. 02 07952 SENI OR CIRCLE 0 0 0 0 194. 02 194. 03 07953 FREE MEALS 0 0 0 194. 03 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 1,050,990 2, 121, 662 1, 385, 270 752, 229 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 5. 320445 10. 784584 0.107039 0.004280 203.00 204.00 Cost to be allocated (per Wkst. B, 22, 451 34, 956 204 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001735 0.000199 205.00 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207 00 207 00 Parts III and IV)

				To	12/31/2017	Date/Time Pre 5/31/2018 11:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		AND GENERAL	PLANT		(SQUARE FEE T)		
		(ACCOM. COST)	(SQUARE FEE I)	(TOTAL PATIENT DAYS)		DAYS)	
		5. 02	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	ı	1	1			
1.00	00100 CAP REL COSTS ANVELS FOLL D						1.00
2. 00 4. 00	OO2OO CAP REL COSTS-MVBLE EQUIP OO4OO EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00570 ADMI TTI NG						5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	23, 919, 989					5. 02
7.00	00700 OPERATION OF PLANT	2, 770, 437	l .				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	118, 739	l .		404 045		8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	441, 375 379, 343		1	121, 315 4, 797	3, 905	9. 00 10. 00
11. 00	01100 CAFETERI A	63, 608		0	3, 081	3, 703	11.00
13. 00	01300 NURSING ADMINISTRATION	298, 650	l ·	ő	896	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	297, 448		0	4, 702	0	14. 00
	01500 PHARMACY	778, 748		i	2, 195	0	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	396, 259 81, 542		0	3, 967 0	0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	01, 342		U U	U	0	17.00
30.00	03000 ADULTS & PEDIATRICS	3, 014, 827	32, 928	2, 976	32, 928	2, 976	30.00
	03100 INTENSIVE CARE UNIT	592, 191	3, 816		3, 816	594	31.00
43. 00	04300 NURSERY	145, 501	755	335	755	335	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS	1 271 742	15 120	1 0	15 120	0	E0 00
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	1, 271, 743 394, 991	15, 128 1, 089	1	15, 128 1, 089	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1,007	1	1, 007	0	1
53. 00	05300 ANESTHESI OLOGY	0	Ö	Ö	Ö	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 827, 687	10, 640	0	10, 640	0	54.00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
56. 00 57. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
58. 00	05700 CT SCAN 05800 MRI	0	0	0	0	0	57. 00 58. 00
60. 00	06000 LABORATORY	1, 816, 458	4, 254	Ö	4, 254	0	60.00
65. 00	06500 RESPI RATORY THERAPY	592, 530		1	1, 826	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	514, 440	l .	1	2, 506	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	147, 532	l .	1	820	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	22, 506 202, 737	33 1, 239		33 1, 239	0	68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	92, 410	l ·	0	1, 237	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	609, 206	l .	ő	Ö	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	968, 246	0	0	0	0	73. 00
76. 00	03610 SLEEP LAB	126, 014	1, 769	0	1, 769	0	76. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	371, 528	1, 150	0	1, 150	0	90.00
91. 00	09100 EMERGENCY	4, 894, 380		1	7, 328	0	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,011,000	1,,,,,		.,	_	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	480, 842	2, 951	0	2, 951	0	95. 00
110 00	SPECIAL PURPOSE COST CENTERS	22 711 010	112 045	3, 905	107 970	2 005	118. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	23, 711, 918	112, 065	3, 900	107, 870	3, 903	1110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 294	807	0	807	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	203, 734	12, 638	0	12, 638	0	192. 00
	07950 OTHER NRCC	0	0	0	0		194. 00
	07951 MARKETI NG	0	0	0	0		194. 01
	07952 SENIOR CIRCLE 07953 FREE MEALS	43	0	0	0		194. 02 194. 03
200.00					O	0	200. 00
201.00							201. 00
202.00		6, 072, 216	3, 473, 726	212, 399	606, 006	632, 370	202. 00
202 22	Part I)	0.050055	07 /7/00:	E4 204E12	4 005043	1/1 0005:0	202 00
203. 00 204. 00	1	0. 253855		1	4. 995310 48, 663		1
∠∪4. 00	Part II)	164, 095	960, 918	55, 347	48, 663	118, 792	204.00
205.00	l '	0. 006860	7. 656107	14. 173367	0. 401129	30. 420487	205. 00
206. 00							206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,	-					207. 00
207.00	Parts III and IV)						
		•	•		'		•

		cial Systems	DUKES MEMORI.	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCA	TION - STATISTICAL BASIS		Provi der Co		eriod: rom 01/01/2017	Worksheet B-1	
					To		Date/Time Pre	pared:
			045575014	L NUIDOLNIA	OFNEDAL	BUABAAN I	5/31/2018 11:	18 am
		Cost Center Description	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	
			(1123)	ADMINI STRATION	SUPPLY	REQUIS.)	LI BRARY	
				(NURSING SA	(COSTED REQ U)	,	(GROSS CHAR	
			44.00	LARIES)	11.00	45.00	GES)	
	GENED	AL SERVICE COST CENTERS	11.00	13.00	14. 00	15. 00	16. 00	
1.00		CAP REL COSTS-BLDG & FLXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		ADMINISTRATIVE AND CENEDAL						5. 01
5. 02 7. 00		ADMINISTRATIVE AND GENERAL OPERATION OF PLANT						5. 02 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE						8. 00
9. 00	1	HOUSEKEEPI NG						9. 00
	1	DIETARY	44 540					10.00
	1	CAFETERIA NURSING ADMINISTRATION	14, 540 646	1				11. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	256	1 ' '				14. 00
15.00		PHARMACY	519	0	62, 640	848, 922		15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	301	l .	_,	0	175, 765, 142	16. 00
17. 00		SOCIAL SERVICE LENT ROUTINE SERVICE COST CENTERS	0) 0	0	0	0	17. 00
30. 00		ADULTS & PEDIATRICS	2, 800	1, 288, 311	112, 766	ol	7, 974, 563	30.00
	1	INTENSIVE CARE UNIT	500			Ō	1, 443, 892	31.00
43.00		NURSERY	0	102, 048	0	0	382, 225	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	811	437, 325	429, 195	ol	20, 773, 885	50.00
		RECOVERY ROOM	359	1		0	3, 576, 286	1
52. 00		DELIVERY ROOM & LABOR ROOM	0	0	1	Ō	0	52. 00
		ANESTHESI OLOGY	0	0	0	o	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	1, 575	817, 754	107, 134	0	37, 932, 740	
	1	ULTRASOUND RADI OI SOTOPE	0	0	0	0	0	54. 01 56. 00
57. 00		CT SCAN	0	Ö	ő	o	0	57. 00
58.00	05800		0	0	0	O	0	58. 00
60.00		LABORATORY	1, 762	1		0	25, 007, 892	60.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	655	0	36, 748 9, 420	0	2, 351, 036 2, 818, 046	
	1	OCCUPATI ONAL THERAPY	0	Ö	0, 420	o	1, 158, 770	
68. 00	1	SPEECH PATHOLOGY	0	0	0	0	105, 532	
		ELECTROCARDI OLOGY	201	0	5, 859	0	6, 051, 685	
71.00 72.00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	204, 820 562, 855	0	5, 499, 198 3, 992, 398	
		DRUGS CHARGED TO PATIENTS	0	Ö	0	848, 922	25, 844, 627	73. 00
76. 00	03610	SLEEP LAB	104	. 0	4, 852	0	719, 259	76. 00
		TIENT SERVICE COST CENTERS	00/	1	1 0, 0, 0	ام		
		CLI NI C EMERGENCY	386 3, 115					
		OBSERVATION BEDS (NON-DISTINCT PART	3, 113	3, 320, 023	70,070	ď	22, 004, 007	92.00
	OTHER	REIMBURSABLE COST CENTERS						
95. 00		AMBULANCE SERVICES	541	0	59, 681	0	6, 753, 045	95. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	14, 538	7, 154, 505	2, 123, 457	848, 922	175, 765, 142	110 00
116.00		IMBURSABLE COST CENTERS	14, 330	7, 154, 505	2, 123, 437	040, 922	175, 765, 142]116.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	2	. 0		0		192. 00
		OTHER NRCC	0	0	0	0		194. 00 194. 01
		MARKETING SENIOR CIRCLE	0	0	0	0		194. 01
		FREE MEALS	0	Ö	ő	o		194. 03
200.00		Cross Foot Adjustments						200. 00
201.00		Negative Cost Centers	100 410	411 754	F20 7F0	1 070 017	/20 020	201. 00
202. 00	'	Cost to be allocated (per Wkst. B, Part I)	180, 418	411, 754	529, 759	1, 070, 217	630, 930	202.00
203. 00		Unit cost multiplier (Wkst. B, Part I)	12. 408391	0. 057552	0. 249430	1. 260678	0. 003590	203. 00
204.00		Cost to be allocated (per Wkst. B,	74, 945	1		65, 335		
205 00		Part II)	E 154400	0.002074	0.055140	0.074040	0.000570	20E 00
205. 00	1	Unit cost multiplier (Wkst. B, Part II)	5. 154402	0. 003861	0. 055142	0. 076962	0. 000572	203.00
206. 00		NAHE adjustment amount to be allocated						206. 00
207.62		(per Wkst. B-2)						207 20
207. 00	"	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	1	. a. to fir and rv)	ı	1	1	I		ı

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1318 Period: Worksheet B-1

From 01/01/2017 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am Cost Center Description SOCIAL SERVICE (TOTAL PATIENT DAYS) 17.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00570 ADMITTING 5.01 00590 ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17. 00 01700 SOCIAL SERVICE 3,905 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 30.00 2 976 31.00 03100 INTENSIVE CARE UNIT 594 31.00 43.00 04300 NURSERY 335 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 50 00 0 05100 RECOVERY ROOM 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 000000000000000 52.00 53. 00 05300 ANESTHESI OLOGY 53 00 |05400| RADI OLOGY-DI AGNOSTI C 54.00 54.00 54.01 05401 ULTRASOUND 54.01 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57 00 57 00 58.00 05800 MRI 58.00 06000 LABORATORY 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 03610 SLEEP LAB 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 92.00 95.00 09500 AMBULANCE SERVICES 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 3, 905 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190. 00 0 192.00 194.00 07950 OTHER NRCC 194.00 194. 01 07951 MARKETI NG 0 194.01 194. 02 07952 SENI OR CIRCLE 0 194. 02 194.03 07953 FREE MEALS 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 102. 242 202.00 Cost to be allocated (per Wkst. B, 202. 00 Part I) 203 00 203 00 Unit cost multiplier (Wkst. B, Part I) 26. 182330 204.00 Cost to be allocated (per Wkst. B, 204.00 677 Part II) Unit cost multiplier (Wkst. B, Part 205.00 0. 173367 205.00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1318	Period: Worksheet C From 01/01/2017 Part I

				rom 01/01/2017 o 12/31/2017	Part Date/Time Pre	pared:
					5/31/2018 11:	18 am
		Title	XVIII	Hospi tal	Cost	
				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)					
LUBATI FUT DOUTLING OFFICE COOT OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	5 740 050		F 740 056			
30. 00 03000 ADULTS & PEDI ATRI CS	5, 743, 352		5, 743, 352		1	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 042, 406		1, 042, 406			31.00
43. 00 04300 NURSERY	295, 590		295, 590	0	0	43. 00
ANCILLARY SERVICE COST CENTERS	0.005.740		0.005.74			
50. 00 05000 OPERATING ROOM	2, 305, 710		2, 305, 710		-	
51. 00 05100 RECOVERY ROOM	567, 409		567, 409		1	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		(0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0		(0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 868, 725		2, 868, 725	0	0	54.00
54. 01 05401 ULTRASOUND	0		(0	0	54. 01
56. 00 05600 RADI 01 SOTOPE	0		(0	0	56. 00
57. 00 05700 CT SCAN	0		(0	0	57. 00
58. 00 05800 MRI	0		(0	0	58. 00
60. 00 06000 LABORATORY	2, 663, 911	_	2, 663, 911		0	60.00
65. 00 06500 RESPI RATORY THERAPY	828, 339	0	828, 339		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	739, 463	0	739, 463		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	215, 935	0	215, 935		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	29, 676	0	29, 676		1	68. 00
69. 00 06900 ELECTROCARDI OLOGY	320, 365		320, 365		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	186, 699		186, 699		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	918, 582		918, 582		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 377, 039		2, 377, 039			73. 00
76. 00 03610 SLEEP LAB	220, 882		220, 882	2 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	517, 203		517, 203			
91. 00 09100 EMERGENCY	6, 705, 457		6, 705, 457		1	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	991, 403		991, 403	3	0	92. 00
OTHER REIMBURSABLE COST CENTERS	, ,					
95. 00 09500 AMBULANCE SERVICES	745, 163		745, 163			95. 00
200.00 Subtotal (see instructions)	30, 283, 309	0	00,200,00.			200. 00
201.00 Less Observation Beds	991, 403		991, 403			201. 00
202.00 Total (see instructions)	29, 291, 906	0	29, 291, 906	0	0	202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1318	Peri od: Worksheet C
		From 01/01/2017 Part I
		T- 10/01/0017 D-+-/T: D

				To 12/31/2017	Date/Time Pre 5/31/2018 11:	
		Title	xVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 127, 173		6, 127, 17		i	30. 00
31.00 03100 INTENSIVE CARE UNIT	1, 443, 892		1, 443, 89		i	31. 00
43. 00 04300 NURSERY	382, 225		382, 22	5		43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 421, 752	15, 352, 133			0. 000000	
51.00 05100 RECOVERY ROOM	700, 174	2, 876, 112	3, 576, 28		0. 000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 494, 521	31, 438, 219	37, 932, 74		0. 000000	54.00
54. 01 05401 ULTRASOUND	0	0		0. 000000	0. 000000	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0		0. 000000	0. 000000	56. 00
57.00 05700 CT SCAN	0	0		0. 000000	0. 000000	57. 00
58. 00 05800 MRI	0	0		0. 000000	0. 000000	58. 00
60. 00 06000 LABORATORY	6, 343, 532	18, 664, 360			0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 785, 349	565, 687			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	540, 197	2, 277, 849			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	359, 443	799, 327			0. 000000	67. 00
68.00 06800 SPEECH PATHOLOGY	18, 252	87, 280			0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 842, 733	4, 208, 952			0. 000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 706, 907	2, 792, 291			0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 678, 363	1, 314, 035			0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	14, 461, 156	11, 383, 471			0. 000000	73. 00
76. 00 03610 SLEEP LAB	9, 842	709, 417	719, 25	9 0. 307097	0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	61, 802	633, 654			0. 000000	90. 00
91. 00 09100 EMERGENCY	2, 839, 342	19, 845, 265			0. 000000	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	378, 733	1, 468, 657	1, 847, 39	0. 536651	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	6, 753, 045			0. 000000	95. 00
200.00 Subtotal (see instructions)	54, 595, 388	121, 169, 754	175, 765, 14	2	i	200. 00
201.00 Less Observation Beds					ı	201. 00
202.00 Total (see instructions)	54, 595, 388	121, 169, 754	175, 765, 14	2	i	202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1	From 01/01/2017	Worksheet C Part I Date/Time Prepared: 5/31/2018 11:18 am

NPATIENT ROUTINE SERVICE COST CENTERS 11.00 11.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 14.00 13.00 14.0				10 12/31/2017	5/31/2018 11:18 am
INPATI ENT ROUTI NE SERVICE COST CENTERS 11.00			Title XVIII	Hospi tal	
NPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 31.00 03100 INTENSI VE CARE UNIT 31.00 31.00 03100 INTENSI VE CARE UNIT 43.00	Cost Center Description	PPS Inpatient			
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDI ATRICS 31.00 31.00 03300 ADULTS & PEDI ATRICS 31.00 43.00 04300 NURSERY 43.00 ANGULLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATI NG ROOM 0.000000 51.00 51.00 05100 RECOVERY ROOM 0.000000 52.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI DLOGY-DI AGNOSTI C 0.000000 54.00 54.01 05401 ULTRASOUND 0.5400 0.000000 54.01 55.00 05500 RADI OLOGY-DI AGNOSTI C 0.000000 54.01 56.00 05600 RADI DI SOTOPE 0.000000 54.01 57.00 05700 CT SCAN 0.000000 55.00 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MRI 0.000000 58.00 58.00 05800 MRI 0.000000 58.00 65.00 06600 LABORATORY 0.000000 65.00 66.00 06600 DASDIGATORY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 65.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 65.00 68.00 06800 SPECH PATHOLOGY 0.000000 67.00 68.00 06900 ELECTROCARDI OLOGY 0.000000 67.00 68.00 06900 ELECTROCARDI OLOGY 0.000000 77.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 77.00 72.00 07200 IMPLE THERE OLOGY 0.000000 77.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 77.00 74.00 03610 SLEEP LAB 0.000000 77.00 75.00 09900 CLINIC COST CENTERS 76.00 09900 CLINIC COST CENTERS 0.000000 97.00 76.00 09900 CLINIC COST CENTERS 97.00 77.00 07900 MBULANCE SERVICES 0.000000 97.00 78.00 09900 CLINIC REIMBURSABLE COST CENTERS 97.00 78.00 09900 AMBULANCE SERVICES 0.000000 97.00 78.00 09900 CLINIC REIMBURSABLE COST CENTERS 97.00 78.00 09900 CLINIC REIMBURSABLE COST C		Ratio			
30. 00 3000 ADULTS & PEDIATRICS 30. 00 31. 00		11. 00			
31.00	INPATIENT ROUTINE SERVICE COST CENTERS				
43.00 04300 NURSERY	30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT				31.00
50. 00 05000 0PERATI NG ROOM 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000					43. 00
51.00 05100 RECOVERY ROOM					
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.53.00 05300 AMESTHESI OLOGY 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.01 05401 ULTRASOUND 0.000000 0.000000 54.01 05401 ULTRASOUND 0.000000 55.00 05500 RADI OLOGY-DI AGNOSTI C 0.000000 55.00 05500 RADI OLOGY-DI AGNOSTI C 0.000000 57.00 05700 CT SCAN 0.000000 57.00 05700 CT SCAN 0.000000 57.00 05700 CT SCAN 0.000000 58.00 05800 MRI 0.000000 58.00 06000 LABORATORY 0.000000 06500 RSPI RATORY THERAPY 0.000000 06500 RSPI RATORY THERAPY 0.000000 06500 RSPI RATORY THERAPY 0.000000 06700 0CCUPATI ONAL THERAPY 0.000000 06700 0CCUPATI ONAL THERAPY 0.000000 06800 SPECH PATHOLOGY 0.000000 06900 ELECTROCARDI OLOGY 0.000000 06900 ELECTROCARDI OLOGY 0.000000 06900 ELECTROCARDI OLOGY 0.000000 071.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 07300 DRUGS CHARGED TO PATI ENTS 0.000000 07300 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0.000000 07300 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	50.00 05000 OPERATING ROOM	0. 000000			50.00
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 55. 00 55. 00 05600 RADI OLOGY-DI AGNOSTI C 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 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 RESPI RATORY THERAPY 0.000000 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 08600 SPECH PATHOLOGY 0.000000 68. 00 69. 00 08900 ELECTROCARDI OLOGY 0.000000 68. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71. 00 72. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 76. 00 03610 SLEEP LAB 0.000000 76. 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 OLOGY-DI AGNOSTI CE 0.000000 56. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MRI 0.000000 58. 00 60. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 65. 00 06500 PHYSI CAL THERAPY 0.000000 67. 00 67. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 67. 00 69. 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 PATI ENT 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 76. 00 08580 SERVATI ON BEDS (NON-DI STI NCT PART 0.000000 90.00 92. 00 O9100 EMERGENCY		0. 000000			
54. 01 05401 ULTRASOUND 0.000000 54. 01	53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
56. 00 05600 RADI OI SOTOPE 0.000000 56. 00 57. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MRI 0.000000 58. 00 06800 MRI 0.000000 58. 00 06. 00 06000 LABORATORY 0.000000 065. 00 06500 RESPI RATORY THERAPY 0.000000 065. 00 06500 RESPI RATORY THERAPY 0.000000 06. 00 06500 PHYSI CAL THERAPY 0.000000 067. 00 06700 0CCUPATI ONAL THERAPY 0.000000 067. 00 06700 0CCUPATI ONAL THERAPY 0.000000 069. 00 06900 ELECTROCARDI OLOGY 0.000000 06900 ELECTROCARDI OLOGY 0.000000 071. 00 07100 MBU CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 072. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0.00000 074. 00 075. 00	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
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 SUPPLI ES CHARGED TO PATI ENT 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 76. 00 03610 SLEEP LAB 0.000000 76. 00 00 - 00000 Ogood Drugs Charge Cost Centers 0.000000 90. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART Occupant) 0.000000 91. 00 070. 00 09500 AMBULANCE SERVI CES 0.000000 95. 00 070. 00 09000 AMBULANCE SERVI CES 0.000000	54. 01 05401 ULTRASOUND	0. 000000			54. 01
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. 00 001.00 UTPATIENT SERVICE COST CENTERS 0.000000 90. 00 90. 00 O9000 CLINIC 0.000000 91. 00 092. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART O.000000 92. 00 075. 00 ONDORD SUBSERVATION SEDVICES 0.000000 09500 AMBULANCE SERVICES 0.000000 09500 AMBULANCE SERVICES 0.000000 09500 AMBULANCE S	56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
60. 00 06000 LABORATORY 0.000000 65. 00 65. 00 665. 00 665. 00 665. 00 665. 00 665. 00 665. 00 666. 00 666. 00 666. 00 667. 00 667. 00 667. 00 667. 00 667. 00 668. 00 668. 00 668. 00 669. 00	57. 00 05700 CT SCAN	0. 000000			57. 00
65. 00	58. 00 05800 MRI	0. 000000			58. 00
66. 00 67. 00 67. 00 67. 00 67. 00 67. 00 68. 00 68. 00 68. 00 68. 00 69. 00 69. 00 69. 00 69. 00 71. 00 71. 00 72. 00 73. 00 73. 00 74. 00 75. 00 75. 00 76. 00 76. 00 77	60. 00 06000 LABORATORY	0. 000000			60.00
67. 00		0. 000000			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 03610 SLEEP LAB 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 03610 SLEEP LAB 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		0. 000000			69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 76. 00 03610 SLEEP LAB 0.000000 76. 00 000000 000000 000000 000000 000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
76. 00 03610 SLEEP LAB 0.000000 76. 00 000000 76. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 90. 00 000000 91. 00 000000 91. 00 000000 92. 00 000000 00000 92. 00 0000000 92. 00 0000000 000000 92. 00 0000000 92. 00 0000000 000000 92. 00 0000000 0000000 000000 92. 00 0000000 000000 000000 000000 000000		0. 000000			72. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 90. 00 091. 00 091. 00 092.	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
90. 00 09000 CLINIC 0.000000 91. 00 92. 00 92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART 0.000000 92. 00 070000 07000 07000 07000 07000 07000 07000 07000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 07000000 07000000 07000000 07000000 07000000 07000000 07000000 07000000 07000000 07000000 070000000 070000000 070000000 070000000 070000000 070000000 070000000 070000000 0700000000	76. 00 03610 SLEEP LAB	0. 000000			76. 00
91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0. 000000 92. 00 0THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0. 000000 000000 000000 000000 000000	OUTPATIENT SERVICE COST CENTERS				
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000 92. 00 0THER 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	90. 00 09000 CLI NI C	0. 000000			90. 00
0THER REIMBURSABLE COST CENTERS 95. 00 95. 00 200. 00 Subtotal (see instructions) Less Observation Beds 0. 000000 95. 00 200. 00 201. 00	91. 00 09100 EMERGENCY	0. 000000			91. 00
95. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
	200.00 Subtotal (see instructions)				
202.00 Total (see instructions)					•
	202.00 Total (see instructions)				202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-1	0
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C	
		From 01/01/2017 Part	

				o 12/31/2017	Date/Time Prep 5/31/2018 11:	pared: 18 am
		Ti tl	e XIX	Hospi tal	PPS	
				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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 743, 352		5, 743, 352		5, 743, 352	
31.00 03100 INTENSIVE CARE UNIT	1, 042, 406		1, 042, 406			1
43. 00 04300 NURSERY	295, 590		295, 590	0	295, 590	43. 00
ANCILLARY SERVICE COST CENTERS	_		•			
50.00 05000 OPERATING ROOM	2, 305, 710		2, 305, 710		2, 305, 710	1
51.00 05100 RECOVERY ROOM	567, 409		567, 409	0	567, 409	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0		C	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 868, 725		2, 868, 725	0	2, 868, 725	54.00
54. 01 05401 ULTRASOUND	0		C	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0		C	0	0	56. 00
57. 00 05700 CT SCAN	0		C	0	0	57. 00
58. 00 05800 MRI	0		C	0	0	58. 00
60. 00 06000 LABORATORY	2, 663, 911		2, 663, 911	0	2, 663, 911	60.00
65. 00 06500 RESPIRATORY THERAPY	828, 339	0	828, 339	0	828, 339	65. 00
66. 00 06600 PHYSI CAL THERAPY	739, 463	0	739, 463	0	739, 463	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	215, 935	0	215, 935	0	215, 935	67.00
68. 00 06800 SPEECH PATHOLOGY	29, 676	0	29, 676	0	29, 676	68. 00
69. 00 06900 ELECTROCARDI OLOGY	320, 365		320, 365	0	320, 365	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	186, 699		186, 699	0	186, 699	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	918, 582		918, 582	. 0	918, 582	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 377, 039		2, 377, 039	0	2, 377, 039	73. 00
76. 00 03610 SLEEP LAB	220, 882		220, 882	. 0	220, 882	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	517, 203		517, 203	0	517, 203	90.00
91. 00 09100 EMERGENCY	6, 705, 457		6, 705, 457	0	6, 705, 457	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	991, 403		991, 403		991, 403	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	745, 163		745, 163	0	745, 163	95. 00
200.00 Subtotal (see instructions)	30, 283, 309	0	30, 283, 309	0	30, 283, 309	200. 00
201.00 Less Observation Beds	991, 403		991, 403		991, 403	201. 00
202.00 Total (see instructions)	29, 291, 906	0	29, 291, 906	0	29, 291, 906	202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1318	Peri od: Worksheet C
		From 01/01/2017 Part I
		T- 10/01/0017 D-+-/T: D

				To 12/31/2017	Date/Time Pre 5/31/2018 11:	pared: 18 am
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 127, 173		6, 127, 17		i	30. 00
31.00 03100 INTENSIVE CARE UNIT	1, 443, 892		1, 443, 89		i	31. 00
43. 00 04300 NURSERY	382, 225		382, 22	5		43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 421, 752	15, 352, 133			0. 000000	50. 00
51.00 05100 RECOVERY ROOM	700, 174	2, 876, 112	3, 576, 28		0. 000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 494, 521	31, 438, 219	37, 932, 74		0. 000000	54.00
54. 01 05401 ULTRASOUND	0	0		0. 000000	0. 000000	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0		0. 000000	0. 000000	56. 00
57.00 05700 CT SCAN	0	0		0. 000000	0. 000000	57. 00
58. 00 05800 MRI	0	0		0. 000000	0. 000000	58. 00
60. 00 06000 LABORATORY	6, 343, 532	18, 664, 360			0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 785, 349	565, 687			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	540, 197	2, 277, 849			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	359, 443	799, 327			0. 000000	67. 00
68.00 06800 SPEECH PATHOLOGY	18, 252	87, 280			0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 842, 733	4, 208, 952			0. 000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 706, 907	2, 792, 291			0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 678, 363	1, 314, 035			0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	14, 461, 156	11, 383, 471			0. 000000	73. 00
76. 00 03610 SLEEP LAB	9, 842	709, 417	719, 25	9 0. 307097	0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	61, 802	633, 654			0. 000000	90.00
91. 00 09100 EMERGENCY	2, 839, 342	19, 845, 265	· · ·		0. 000000	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	378, 733	1, 468, 657	1, 847, 39	0. 536651	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	6, 753, 045	· · ·		0. 000000	95. 00
200.00 Subtotal (see instructions)	54, 595, 388	121, 169, 754	175, 765, 14	2	İ	200. 00
201.00 Less Observation Beds					ı	201. 00
202.00 Total (see instructions)	54, 595, 388	121, 169, 754	175, 765, 14	2	ı	202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of	Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1318	From 01/01/2017 Par To 12/31/2017 Dat	rksheet C rt I te/Time Prepared: 31/2018 11:18 am

COST Center Description				10 12/01/201/	5/31/2018 11: 18 am
INPATI ENT ROUTI NE SERVICE COST CENTERS 11.00			Title XIX	Hospi tal	PPS
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 33.00 3	Cost Center Description	PPS Inpatient			
INPATI ENT ROUTH NE_SERVICE COST CENTERS 30.00 30.00 30300 ADULTS & PEDI ATRICS 31.00 31.00 03300 INTENSIVE CARE UNIT 31.00 43.00 04300 NURSERY 43.00 ANGILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATI NC ROOM 0.110991 51.00 51.00 05100 RECOVERY ROOM 0.158659 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DI AGROSTI C 0.075627 54.00 54.01 05401 ULTRASOUND 0.000000 54.01 55.00 05500 RADIOLOGY-DI AGROSTI C 0.000000 54.01 56.00 05600 RADIOLOGY-DI AGROSTI C 0.000000 54.01 57.00 05700 CT SCAN 0.000000 54.01 58.00 05500 MRI 0.000000 57.00 58.00 05500 MRI 0.000000 57.00 58.00 05500 MRI 0.000000 58.00 58.00 06500 LABORATORY 0.106523 60.00 56.00 06600 LABORATORY 0.352329 65.00 56.00 06600 DABORATORY 0.352329 65.00 56.00 06600 DABORATORY 0.352329 65.00 57.00 06700 OCCUPATI ONAL THERAPY 0.352329 65.00 57.00 06700 OCCUPATI ONAL THERAPY 0.262403 66.00 57.00 06700 OCCUPATI ONAL THERAPY 0.186348 67.00 57.00 07700 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0.281204 68.00 57.00 0700 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0.281204 69.00 57.00 0700 0700 MURIC SCHARGED TO PATI ENTS 0.281204 69.00 57.00 0700 0700 MURIC SCHARGED TO PATI ENTS 0.281204 69.00 57.00 0700 0700 MURIC SCHARGED TO PATI ENTS 0.295595 90.00 57.00 0700 0700 MEDICAL SUPPLIES CENTERS 0.091974 73.00 57.00 0700 0700 MURIC SCHARGED TO PATI ENTS 0.295595 90.00 57.00 0700 0700 MURIC SCHARGED TO PATI ENTS 0.295595 90.00 57.00 0700 0700 MURIC SCHARGED TO PATI ENTS 0.295595 90.00 57.00 0700 0700 MURIC SCHARGED TO PATI ENTS 0.295595 90.00 57.00 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 0700 070					
30.00		11. 00			
31. 00 03100 INTENSIVE CARE UNIT					
43.00					
ANCILLARY SERVICE COST CENTERS 50.00	31.00 03100 I NTENSI VE CARE UNIT				31.00
50. 00 05000 OPERATI NC ROOM 0. 110991 50. 00					43. 00
51, 00 05100 RECOVERY ROOM 0.158659 0.5200 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0.52.00 0.53.00 0.05300 ANESTHESI OLOGY 0.000000 0.54.00 RADI OLOGY-DI AGNOSTI C 0.775627 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55.00 0.05000 RADI OLOGY-DI AGNOSTI C 0.000000 0.5500 0.05000 RADI OLOGY-DI AGNOSTI C 0.000000 0.5500 0.000000 0.5500 0.000000 0.5500 0.000000 0.5500 0.000000 0.5500 0.000000 0.5500 0.000000 0.5500 0.000000 0.5500 0.000000 0.5500 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0.53. 00 05300 AMESTHESI DLOCY 0.000000 0.53. 00 05400 RADI OLOGY-DI AGNOSTI C 0.075627 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1			
53.00 05300 ANESTHESI OLOGY 0.000000 53.00		1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.075627 54. 01 54. 01 05401 ULTRASOUND 0.000000 54. 01 56. 00 05600 RADI OLOGY-DI AGNOSTI C 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 0.106523 66. 00 65. 00 06500 RESPI RATORY THERAPY 0.262403 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.186348 66. 00 68. 00 06800 SPECH PATHOLOGY 0.186348 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0.252938 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.033950 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.230083 72. 00 76. 00 07300 BRUGS CHARGED TO PATI ENTS 0.307097 76. 00 76. 00 09000 CLINIC 0.743689 90. 00 90. 00 99000 EMERGENCY 0.295595 91. 00 92. 00 09200 BERSENATI ON BEDS (NON-DISTINCT PART OLES Subtotal (see instru		1			
54. 01 05401 ULTRASOUND 0.000000 54. 01 56. 00 RADI OI SOTOPE 0.000000 55. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MRI 0.000000 58. 00 60. 00 05800 MRI 0.000000 58. 00 60. 00 06000 LABORATORY 0.106523 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.352329 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.362403 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.186348 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.281204 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.052938 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.033950 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.230083 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.091974 73. 00 76. 00 03610 SLEEP LAB 0.307097 76. 00 90. 00 09000 CLI NI C 0.743689 90. 00 91. 00 09100 EMERGENCY 0.295595 91. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART 0.536651 92. 00 97. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
56. 00 05600 RADI OI SOTOPE 0.000000 55. 00 57. 00 05700 CT SCAN 0.000000 57. 00 0.000000 58. 00 05800 MRI 0.000000 58. 00 06800 MRI 0.000000 58. 00 06600 LABORATORY 0.106523 66. 00 06500 RESPI RATORY THERAPY 0.352329 65. 00 06700 0CCUPATI ONAL THERAPY 0.262403 66. 00 06700 0CCUPATI ONAL THERAPY 0.186348 67. 00 06700 0CCUPATI ONAL THERAPY 0.281204 68. 00 06900 ELECTROCARDI OLOGY 0.281204 68. 00 06900 ELECTROCARDI OLOGY 0.052938 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.033950 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.230083 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.091974 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.091974 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.091974 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.091974 73. 00 07900 CLI NI C 0.0000 CLI NI C 0.00000 CLI NI C 0.000000 CLI NI C 0.00000000 CLI NI C 0.00000000000 0.00000000000000000	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 075627			54.00
57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MRI 0.000000 58. 00 60. 00 06000 LABORATORY 0.106523 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.352329 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.262403 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.186348 67. 00 68. 00 06800 SPECH PATHOLOGY 0.281204 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.281204 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.033950 71. 00 72. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0.230083 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.091974 73. 00 76. 00 03610 SLEEP LAB 0.307097 76. 00 90. 00 0900 DESERVATI ON BEDS (NON-DI STINCT PART 0.536651) 91. 00 91. 00 09200 DESERVATI ON BEDS (NON-DI STINCT PART 0.536651) 92. 00 007500 Less Observation Beds 0.110345 95. 00	54. 01 05401 ULTRASOUND	0. 000000			54. 01
58. 00 05800 MRI 0.000000 58. 00 60. 00 06000 LABORATORY 0.106523 60. 00 65. 00 06500 RESPIRATORY THERAPY 0.356239 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.262403 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 186348 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 281204 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 052938 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 033950 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 230083 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 091974 73. 00 76. 00 03610 SLEEP LAB 0. 307097 76. 00 091. 00 09000 CLINIC 0. 743689 90. 00 91. 00 09100 EMERGENCY 0. 295595 91. 00 092. 00 09200 BSERVATI ON BEDS (NON-DI STI NCT PART O. 536651 92. 00 070. 00 09500 AMBULANCE SERVI CES 0. 110345 00. 00 200. 00 200. 00 200. 00 201. 00 <	56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
60. 00	57. 00 05700 CT SCAN	0. 000000			57. 00
65. 00	58. 00 05800 MRI	0. 000000			58. 00
66. 00 06600 06600 06600 06600 06600 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06800 06800 06800 06800 06800 06900	60. 00 06000 LABORATORY	0. 106523			60.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 186348 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 281204 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 052938 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 033950 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 230083 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 091974 73. 00 03610 SLEEP LAB 0. 307097 76. 00 0017PATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 743689 91. 00 91. 00 09100 EMERGENCY 0. 295595 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 536651) 07100 OPSOO AMBULANCE SERVI CES 0. 110345 95. 00 09500 AMBULANCE SERVI CES 0. 110345 95. 00 09000 CLI SERVI CE COST CENTERS 0. 110345 95. 00 09000 CLI SERVI CES 0. 110345 95. 00	65. 00 06500 RESPIRATORY THERAPY	0. 352329			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 262403			66. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 052938 69. 00 71. 00 77100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 033950 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0. 230083 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 091774 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 091774 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 091774 73. 00 07400	67. 00 06700 OCCUPATI ONAL THERAPY	0. 186348			67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 281204			68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 230083 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 091974 73. 00 03610 SLEEP LAB 0. 307097 76. 00 0000 CLI NI C 0. 743689 90. 00 09100 EMERGENCY 0. 295595 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 536651 0000 0000 OTHER REIMBURSABLE COST CENTERS 0. 110345 0.	69. 00 06900 ELECTROCARDI OLOGY	0. 052938			69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 091974 73. 00 03610 SLEEP LAB 0. 307097 76. 00 0000 CLI NI C 0. 743689 90. 00 09100 EMERGENCY 0. 295595 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 536651 00500 00500 AMBULANCE SERVI CES 0. 110345 95. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 0000 201. 00 Control of the control of th	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 033950			71. 00
76. 00 03610 SLEEP LAB 0. 307097 76. 00		0. 230083			72. 00
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0. 743689 90. 00 91. 00 09100 EMERGENCY 0. 295595 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 536651 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 110345 95. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201		0. 091974			73. 00
90. 00 09000 CLI NI C 0.743689 90. 00 91. 00 09100 EMERGENCY 0.295595 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.536651 92. 00 OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 0.110345 95. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 Control of the c	76. 00 03610 SLEEP LAB	0. 307097			76. 00
91. 00 09100 EMERGENCY 0. 295595 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 536651 92. 00 000	OUTPATIENT SERVICE COST CENTERS				
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0. 536651 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 200. 00 Subtotal (see instructions) Less Observation Beds 92. 00 201. 00 0. 110345 95. 00 200. 00 201. 00 0. 110345 0.					
OTHER REI MBURSABLE COST CENTERS 95.00 9500 AMBULANCE SERVI CES 0.110345 95.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91. 00 09100 EMERGENCY	0. 295595			91.00
95. 00 09500 AMBULANCE SERVICES 0. 110345 95. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 536651			92. 00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
201.00 Less Observation Beds 201.00		0. 110345			
202.00 Total (see instructions) 202.00					
	202.00 Total (see instructions)				202. 00

Heal th Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY DUKES MEMORIAL HOSPITAL Provider CCN: 15-1318

						5/31/2018 11:	18 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reducti on	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 305, 710	420, 602	1, 885, 108	0	0	00.00
51.00	05100 RECOVERY ROOM	567, 409	36, 224	531, 185	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	2, 868, 725	317, 471	2, 551, 254	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, 663, 911	169, 119	2, 494, 792	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	828, 339	56, 137	772, 202	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	739, 463	66, 811	672, 652	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	215, 935	21, 719	194, 216	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	29, 676	1, 033	28, 643	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	320, 365	37, 569	282, 796	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	186, 699	16, 168	170, 531	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	918, 582	38, 296	880, 286	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 377, 039	91, 903	2, 285, 136	0	0	73. 00
76.00	03610 SLEEP LAB	220, 882	45, 081	175, 801	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS					•	
90.00	09000 CLI NI C	517, 203	34, 785	482, 418	0	0	90.00
91. 00	09100 EMERGENCY	6, 705, 457	267, 598		0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	991, 403	169, 864		0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	,	,	52., 55.			
95.00	09500 AMBULANCE SERVI CES	745, 163	86, 340	658, 823	0	0	95. 00
200.00	I I	23, 201, 961	1, 876, 720		0		200. 00
201.00		991, 403	169, 864		0		201. 00
202.00	I I	22, 210, 558	1, 706, 856		0		202. 00
	1 1 (==== ===	,,	., , 000		ŭ	,	, .=

Health Financial Systems

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICALD ONLY

Provider CCN: 15-1318
Period: From 01/01/2017
To 12/31/2017
Date/Time Prepared:

					10 12/31/201/	5/31/2018 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and		Cost to Charge			
		Operating Cost)		
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 305, 710					50.00
	05100 RECOVERY ROOM	567, 409	3, 576, 286	1			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 000000			52. 00
	05300 ANESTHESI OLOGY	0	0	0. 000000			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	2, 868, 725	37, 932, 740				54.00
	05401 ULTRASOUND	0	0	0.00000	O		54. 01
56.00	05600 RADI 0I S0T0PE	0	0	0.00000	O		56. 00
57.00	05700 CT SCAN	0	0	0.00000	O		57. 00
58.00	05800 MRI	0	0	0.00000	O		58. 00
60.00	06000 LABORATORY	2, 663, 911	25, 007, 892	0. 106523	3		60.00
65.00	06500 RESPI RATORY THERAPY	828, 339	2, 351, 036	0. 352329	9		65. 00
66.00	06600 PHYSI CAL THERAPY	739, 463	2, 818, 046	0. 262403	3		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	215, 935	1, 158, 770	0. 186348	8		67. 00
68. 00	06800 SPEECH PATHOLOGY	29, 676	105, 532	0. 281204	4		68. 00
69. 00	06900 ELECTROCARDI OLOGY	320, 365	6, 051, 685	0. 052938	8		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	186, 699	5, 499, 198	0. 033950	O		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	918, 582	3, 992, 398	0. 230083	3		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 377, 039	25, 844, 627	0. 091974	4		73. 00
76.00	03610 SLEEP LAB	220, 882	719, 259	0. 30709	7		76. 00
	OUTPATIENT SERVICE COST CENTERS				<u>'</u>		
90.00	09000 CLI NI C	517, 203	695, 456	0. 743689	9		90. 00
91.00	09100 EMERGENCY	6, 705, 457	22, 684, 607	0. 29559!	5		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	991, 403	1, 847, 390	0. 53665 ⁻	1		92.00
	OTHER REIMBURSABLE COST CENTERS				<u> </u>		
95.00	09500 AMBULANCE SERVICES	745, 163	6, 753, 045	0. 11034!	5		95. 00
200.00	Subtotal (sum of lines 50 thru 199)	23, 201, 961	167, 811, 852				200. 00
201.00	Less Observation Beds	991, 403					201. 00
202.00	Total (line 200 minus line 201)	22, 210, 558	167, 811, 852				202. 00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF INDATIENT ANOLUL ADVI CEDVI OF CADITAL	COCTC	D ' I OON 45 4040	D . I	W I I D

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co	CN: 15-1318	Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narod:
				10 12/31/2017	5/31/2018 11:	18 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)			4 00		
ANOULL ADV. CEDVILOE, COCT. CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	120 (02	20 772 005	0.0000	1 1 170 100	20. 772	FO 00
50. 00 05000 0PERATI NG ROOM	420, 602					
51. 00 05100 RECOVERY ROOM 1 APOR ROOM	36, 224	3, 576, 286			1	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0			0	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	217 471	ľ				54. 00
54. 01 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05401 ULTRASOUND	317, 471	37, 932, 740	0.00836		17, 021 0	54. 00
56. 00 05600 RADI 01 SOTOPE		0	0.00000		0	56. 00
57. 00 05700 CT SCAN		0	0. 00000		0	57. 00
58. 00 05800 MRI	0	0	0. 00000		0	58.00
60. 00 06000 LABORATORY	169, 119	25, 007, 892				60.00
65. 00 06500 RESPI RATORY THERAPY	56, 137					65. 00
66. 00 06600 PHYSI CAL THERAPY	66, 811	2, 818, 046				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	21, 719					67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 033					68.00
69. 00 06900 ELECTROCARDI OLOGY	37, 569					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 168					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	38, 296					
73. 00 07300 DRUGS CHARGED TO PATIENTS	91, 903					
76. 00 03610 SLEEP LAB	45, 081	719, 259				76. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	·	<u>'</u>		<u> </u>	
90. 00 09000 CLI NI C	34, 785	695, 456	0.0500	18 4, 060	203	90. 00
91. 00 09100 EMERGENCY	267, 598	22, 684, 607	0. 01179	5, 655	67	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	169, 864	1, 847, 390	0. 09194	18 927	85	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	1, 790, 380	161, 058, 807	l	17, 967, 971	147, 211	200. 00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1318	Peri od:	Worksheet D
TUDOUGU COCTC			From 01/01/2017	Dart IV

THROUGH COSTS To 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Post-Stepdown Anesthetist Post-Stepdown Cost Adjustments Adjustments 3. 00 2.00 1.00 2A 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 0 05401 ULTRASOUND 0 54.01 54.01 0 05600 RADI OI SOTOPE 56.00 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 58.00 0 06000 LABORATORY 60.00 0 60.00 0 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY OI 67.00 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 72.00 0 0 72.00 73.00 0 0 73.00 76.00 03610 SLEEP LAB
OUTPATIENT SERVICE COST CENTERS 0 0 0 0 76.00 90.00 0 90.00 09000 CLI NI C 0 0 0 0 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 0 0 92.00 92.00 0 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	DUKES MEMORIAL I	HOSPI TAL	I	n Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1318	Peri od:	Worksheet D

From 01/01/2017 Part IV
To 12/31/2017 Date/Time Prepared: THROUGH COSTS 5/31/2018 11:18 am Title XVIII Hospi tal Cost All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges Medi cal (sum of col 1 Outpati ent (from Wkst. C, Education Cost through col. Cost (sum of Part I, col. $(col. 5 \div col$ col. 2, 3 and 8) 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 773, 885 0.000000 50.00 0 05100 RECOVERY ROOM 51.00 3, 576, 286 0.00000051.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 OI 05400 RADI OLOGY-DI AGNOSTI C 0 37, 932, 740 54.00 0.000000 54.00 54.01 05401 ULTRASOUND 0 0 0.000000 54.01 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0 57.00 05700 CT SCAN 0 0.000000 57.00 |05800| MRI 0 0 58.00 0.000000 58.00 60.00 06000 LABORATORY 25, 007, 892 0.000000 60.00 06500 RESPIRATORY THERAPY 0 2, 351, 036 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 2, 818, 046 0.000000 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 158, 770 0.000000 67.00 06800 SPEECH PATHOLOGY 105, 532 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 6, 051, 685 0.000000 69.00 69 00 Ω 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 5, 499, 198 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 3, 992, 398 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 25, 844, 627 0.000000 73.00 03610 SLEEP LAB 0 0.000000 76.00 719, 259 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 695, 456 0.000000 90.00 0 0 0.000000 91.00 09100 EMERGENCY 0 22, 684, 607 91.00 1, 847, 390 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 Total (lines 50 through 199) 0 0 0 161, 058, 807 200.00 200.00

	DUMES MEMORIAL	LICCOL TAI			6.5. 040.6	550.40
Health Financial Systems	DUKES MEMORIAL	HUSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provi der Co	CN: 15-1318	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017	Part IV	
1111100011 00010				To 12/31/2017	Date/Time Prep	oared:
					5/31/2018 11: ³	18 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(001 4 001	_	Coctc (col	0	Cocto (col 0	

		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS	,					
50. 00 05000 OPERATI NG ROOM	0. 000000	1, 470, 498		0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	206, 850	0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 033, 865	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. 000000	2, 363, 593	0	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 119, 007	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	257, 454	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	193, 520	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	13, 597	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	960, 070	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 197, 571	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 112, 375	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 024, 671	0	0	0	73. 00
76. 00 03610 SLEEP LAB	0. 000000	4, 258	0	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	4, 060	0	0	0	90. 00
91. 00 09100 EMERGENCY	0. 000000	5, 655	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	927	0	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	·					
95. 00 09500 AMBULANCE SERVICES				•		95. 00
200.00 Total (lines 50 through 199)		17, 967, 971	0	0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
To 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co			Worksheet D	
Cost Center Description					From 01/01/2017		
Title XVIII Hospital Cost Cos					To 12/31/2017	Date/Time Pre	pared:
Cost Center Description			T: +1 o	. VIII I	Hooni tal		18 am_
Cost Center Description			l litte		поѕрі таі		
Ratio From Worksheet C, Part I, col. 9 Services (see Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (Cost Contor Doscription	Cost to Chargo	DDS Doimburged		Cost		
Worksheet C, Part I, col. 9 Inst.) Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Subject To Ded. Subject Ded. Subject To Ded. Subject Ded. Subject Ded. Subject To Ded. Subject D	COST Center Description						
Part I, col. 9						(See Hist.)	
Ded. & Coi ns. See i nst. Ded. & Coi ns. See i nst. See i nst. Ded. & Coi ns. Ded. & Coi ns. See i nst. Ded. & Coi ns. Ded. & Ded. & Coi ns. Ded. & Ded. & Coi ns. Ded. & Coi ns. Ded. & Ded. & Coi ns. Ded. & Ded. & Ded. Ded. & Ded. & Ded. D							
NOTE Content Note		rait i, coi. 9					
1.00 2.00 3.00 4.00 5.00							
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.110991 0 3,636,528 0 0 50.00		1 00	2 00			5.00	
50. 00 05000 OPERATI NG ROOM 0. 110991 0 3, 636, 528 0 0 50. 00 51. 00 O5100 RECOVERY ROOM 0. 158659 0 718, 770 0 0 51. 00 52. 00 O5200 DELI VERY ROOM & LABOR ROOM 0. 000000 0 0 0 0 53. 00 O5300 ANESTHESI OLOGY 0. 000000 0 0 0 0 0 53. 00 54. 00 O5400 RADI OLOGY-DI AGNOSTI C 0. 075627 0 11, 853, 696 0 0 54. 00 54. 01 O5401 ULTRASOUND 0. 000000 0 0 0 0 0 54. 00 56. 00 O5600 RADI OI SOTOPE 0. 000000 0 0 0 0 0 57. 00 0 0 0 0 56. 00 57. 00 O5700 CT SCAN 0. 000000 0 0 0 0 0 0 57. 00 57. 00 0 0 0 0 57. 00 58. 00 60. 00 0 0 0 0 0 0 57. 00 60. 00	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
51.00 05100 RECOVERY ROOM 0. 158659 0 718,770 0 0 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0. 000000 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. 075627 0 11, 853, 696 0 0 0 54.00 54.01 05401 ULTRASOUND 0. 000000 0 0 0 0 54.01 56.00 05600 RADI OI SOTOPE 0. 000000 0 0 0 0 56.00 57.00 05700 CT SCAN 0. 000000 0 0 0 0 57.00 58.00 05800 MRI 0. 000000 0 0 0 0 58.00 60.00 06500 LABDRATORY 0. 106523 0 6, 961, 344 0 0 60.00 65.00 0650		0 110991		3 636 53	0.8	0	50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 54.01 05400 RADI OLOGY-DI AGNOSTI C 0.075627 0 11,853,696 0 0 54.01 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 0 56.00 58.00 05800 MRI 0.000000 0 0 0 0 57.00 65.00 06500 RESPI RATORY THERAPY 0.106523 0 6,961,344 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.352329 0 263,719 0 0 0 0 0 0			1			ŭ	
53. 00 05300 ANESTHESI OLOGY 0.000000 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.075627 0 11, 853, 696 0 0 54. 00 54. 01 05401 ULTRASOUND 0.000000 0 0 0 0 54. 01 56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 0 0 0 56. 00 58. 00 05800 MRI 0.000000 0				710,77			
54. 00							
54. 01 05401 ULTRASOUND 0.000000 0 0 0 54. 01 56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 57. 00 58. 00 05800 MRI 0.000000 0 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0.106523 0 6, 961, 344 0 <td></td> <td>1</td> <td></td> <td>11 853 60</td> <td>0</td> <td></td> <td></td>		1		11 853 60	0		
56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 57. 00 58. 00 05800 MRI 0.000000 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0.106523 0 6, 961, 344 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.352329 0 263, 719 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.262403 0 545, 801 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.186348 0 30, 015 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.281204 0 7, 784 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.052938 0 1, 933, 610 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.230083 0 440, 718 0 0 72. 00 73. 00		1		11, 055, 0	0	-	
57. 00 05700 CT SCAN 0.000000 0 0 0 57. 00 58. 00 05800 MRI 0.000000 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0.106523 0 6.961,344 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.352329 0 263,719 0 0 66. 00 66. 00 06600 PHYSI CAL THERAPY 0.262403 0 545,801 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.186348 0 30,015 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.281204 0 7,784 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.052938 0 1,933,610 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.033950 0 587,010 0 0 71							
58. 00 05800 MRI 0.000000 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0.106523 0 6, 961, 344 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.352329 0 263, 719 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.262403 0 545, 801 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.186348 0 30, 015 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.281204 0 7, 784 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.052938 0 1, 933, 610 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.033950 0 587, 010 0 0 71. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.230083 0 440, 718 0 0 73. 00 76. 00 03610 SLEEP							
60. 00		1				-	
65. 00 06500 RESPIRATORY THERAPY 0. 352329 0 263, 719 0 0 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 67. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 68. 00 69. 00 6				4 041 2/	0	-	
66. 00							
67. 00 06700 OCCUPATI ONAL THERAPY 0. 186348 0 30, 015 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 281204 0 7, 784 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 052938 0 1, 933, 610 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 033950 0 587, 010 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 230083 0 440, 718 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 091974 0 4, 832, 144 0 0 0 73. 00 03610 SLEEP LAB 0. 0. 307097 0 164, 079 0 0 76. 00 0UTPATI ENT SERVI CE COST CENTERS							
68. 00 06800 SPEECH PATHOLOGY 0. 281204 0 7, 784 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 052938 0 1, 933, 610 0 0 69. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 033950 0 587, 010 0 0 71. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0. 230083 0 440, 718 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 091974 0 4, 832, 144 0 0 73. 00 03610 SLEEP LAB 0. 307097 0 164, 079 0 0 0 76. 00 00TPATI ENT SERVI CE COST CENTERS		1				-	
69. 00 06900 ELECTROCARDI OLOGY 0.052938 0 1,933,610 0 0 69. 00 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.033950 0 587,010 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.230083 0 440,718 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.091974 0 4,832,144 0 0 73. 00 03610 SLEEP LAB 0.307097 0 164,079 0 0 0 0 0 0 0 0 0		1				-	
71. 00		1					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 230083 0 440, 718 0 0 72. 00 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 07300 0 07300 0 0 0 0 0 0 0 0 0							
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 091974 0 4, 832, 144 0 0 0 73. 00 0 0 0 0 0 0 0 0 0		1				ŭ	
76. 00 03610 SLEEP LAB 0. 307097 0 164, 079 0 0 76. 00 OUTPATI ENT SERVI CE COST CENTERS						-	
OUTPATIENT SERVICE COST CENTERS							
		0. 30/09/	0	164, 07	9 0	0	76.00
	90. 00 09000 CLINIC	0. 743689	0	40.43	31 0	0	90.00
90. 00 09000 CLI NI C 0. 743689 0 60, 431 0 0 90. 00 91. 00 09100 EMERGENCY 0. 295595 0 5, 975, 757 0 0 91. 00						-	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 536651 0 704, 325 0 0 92. 00			ł .				
OTHER REIMBURSABLE COST CENTERS		0. 530051		704, 32	.5 0	0	72.00
95. 00 09500 AMBULANCE SERVI CES 0. 110345 0 95. 00		0 110245		1			05.00
200. 00 Subtotal (see instructions) 0, 110345 0 38, 715, 731 0 0 200. 00		0. 110343	l e	20 715 73	-	0	
201. 00 Subtotal (see First detrois)				30, /13, /3		U	
Only Charges							201.00
202.00 Net Charges (line 200 - line 201) 0 38,715,731 0 0 202.00			1	38 715 73	0	n	202 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2017 | Part V | To 12/31/2017 | Date/Time Prepared: | 5/31/2018 | 11:18 am

						5/31/2018 TT: 18 alli
				XVIII	Hospi tal	Cost
			sts			
	Cost Center Description	Cost	Cost			
		Rei mbursed	Rei mbursed			
		Servi ces	Services Not			
		Subject To	Subject To			
		Ded. & Coins.	Ded. & Coins.			
		(see inst.)	(see inst.)			
		6.00	7. 00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	403, 622	0			50.00
51.00	05100 RECOVERY ROOM	114, 039	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	896, 459	0			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	1 0			58. 00
	06000 LABORATORY	741, 543	0			60.00
	06500 RESPIRATORY THERAPY	92, 916				65.00
	06600 PHYSI CAL THERAPY	143, 220				66.00
	06700 OCCUPATI ONAL THERAPY	5, 593				67. 00
	06800 SPEECH PATHOLOGY	2, 189				68. 00
	06900 ELECTROCARDI OLOGY	102, 361				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19, 929	0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	101, 402				72.00
	07300 DRUGS CHARGED TO PATIENTS	444, 432				73. 00
	03610 SLEEP LAB	50, 388				76. 00
	OUTPATIENT SERVICE COST CENTERS	30, 300				76.00
	09000 CLINIC	44, 942	Ο			90.00
	09100 EMERGENCY	1, 766, 404				90.00
						92.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	377, 977	0			92.00
	OTHER REIMBURSABLE COST CENTERS	1 0	T	I		05.00
	09500 AMBULANCE SERVICES	5 207 414				95. 00
200.00		5, 307, 416	0			200. 00
201.00						201. 00
000 00	Only Charges	F 007 44/				
202. 00	Net Charges (line 200 - line 201)	5, 307, 416	0	l		202. 00

			Component	CCN: 15-Z318	To 12/31/2017	Date/Time Pre 5/31/2018 11:	pared:
			Ti tl e	XVIII S	Swing Beds - SNF		TO dill
				Charges	g = = = = = = = = = = = = = = = = =	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	· · · · · · · · · · · · · · · · · · ·		Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	` ′	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 110991	0)	0	0	50. 00
51.00	05100 RECOVERY ROOM	0. 158659	0)	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	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 075627	0)	0 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. 106523	0)	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 352329	0)	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 262403	Ö)	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 186348	Ö)	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 281204	Ö)	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 052938	O)	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 033950	O)	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 230083	O)	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 091974	O)	0	0	73. 00
76.00	03610 SLEEP LAB	0. 307097	Ö)	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	'					1
90.00	09000 CLI NI C	0. 743689	C)	0 0	0	90.00
91.00	09100 EMERGENCY	0. 295595	Ö)	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 536651	Ö)	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	'		,	_		1
95.00	09500 AMBULANCE SERVI CES	0. 110345			O		95. 00
200.00	Subtotal (see instructions)		Ö)	0	0	200. 00
201.00					o		201.00
	Only Charges					l	
202.00			O)	0	0	202. 00

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICI		Provider C	CN: 15-1318	Period: From 01/01/2017	worksheet D	2552-10
		Component	Component CCN: 15-Z318		Date/Time Pre 5/31/2018 11:	pared: 18 am
		Ti tl e	XVIII	Swing Beds - SNF	Cost	
	C	osts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins	. Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				

	Cost Center Description	Cost	Cost	
		Rei mbursed Servi ces	Reimbursed Services Not	
		Subject To Ded. & Coins.	Subject To	
			Ded. & Coins.	
		(see inst.) 6.00	(see inst.) 7.00	-
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	
	05000 OPERATING ROOM	1 0	0	50.00
	05100 RECOVERY ROOM	0		51.00
	05200 DELIVERY ROOM & LABOR ROOM	0		52. 00
	05300 ANESTHESI OLOGY	0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	0		54. 00
	05401 ULTRASOUND	0		54. 01
	05600 RADI OI SOTOPE	0		56.00
	05700 CT SCAN	0		57. 00
	05800 MRI	0		58. 00
	06000 LABORATORY	0	0	60.00
	06500 RESPIRATORY THERAPY	0	o	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	o	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	ol	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	ol	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	o	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o	73. 00
76.00	03610 SLEEP LAB	0	o	76. 00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS			
	09500 AMBULANCE SERVICES	0		95. 00
200.00		0	0	200. 00
201.00	9	0		201. 00
	Only Charges			
202. 00	Net Charges (line 200 - line 201)	0	0	202. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017		narod:
				10 12/31/2017	5/31/2018 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	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 & PEDI ATRI CS	984, 050	28, 002	956, 04	8 3, 619	264. 17	30.00
31.00 INTENSIVE CARE UNIT	129, 024		129, 02	4 594	217. 21	31.00
43. 00 NURSERY	35, 103		35, 10	3 335	104. 79	43.00
200.00 Total (lines 30 through 199)	1, 148, 177		1, 120, 17	5 4, 548		200. 00
Cost Center Description	I npati 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 & PEDI ATRI CS	47	12, 416				30. 00
31.00 INTENSIVE CARE UNIT	17	3, 693				31.00
43. 00 NURSERY	18	1, 886				43.00
200.00 Total (lines 30 through 199)	82	17, 995				200. 00

Health Financial Systems	DUKES MEMORIAL I	HOSPI TAL	In L	ieu of Form CMS-2552-10
ADDODEL ON MENT OF LANDATI ENT. ANOLUL ADV. OF DAY OF CARLEY	00070	5 1 1 000 15 1010 5 1		T

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der Co	Provider CCN: 15-1318		Worksheet D	
				From 01/01/2017 To 12/31/2017		nanad.
				To 12/31/2017	5/31/2018 11:	pareu: 18 am
		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)					
ANOLILA DIVI OFRIVI OF COOT OFFITERS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	400 (00	00 770 005	0.0000	17 100 010	0.014	F0 00
50. 00 05000 OPERATING ROOM	420, 602					50.00
51. 00 05100 RECOVERY ROOM	36, 224	3, 576, 286				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		1	52.00
53. 00 05300 ANESTHESI OLOGY	217 471	0 27 022 740	0.00000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	317, 471	37, 932, 740				
54. 01 05401 ULTRASOUND 56. 00 05600 RADI OI SOTOPE	0	0	0. 00000 0. 00000		0	54. 01 56. 00
57. 00 05700 CT SCAN	0	0	0.00000		0	57.00
58. 00 05700 CT SCAN 58. 00 05800 MRI	0	0	0.00000		0	58.00
60. 00 06000 LABORATORY	169, 119	25, 007, 892	0.0000			60.00
65. 00 06500 RESPIRATORY THERAPY	56, 137					65.00
66. 00 06600 PHYSI CAL THERAPY	66, 811	2, 818, 046				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	21, 719					67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 033				0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	37, 569					69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 168					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	38, 296					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	91, 903					73. 00
76. 00 03610 SLEEP LAB	45, 081	719, 259				76. 00
OUTPATIENT SERVICE COST CENTERS	,	, = 0 .		- 1		
90. 00 09000 CLI NI C	34, 785	695, 456	0.05001	18 253	13	90.00
91. 00 09100 EMERGENCY	267, 598	22, 684, 607	0. 01179	46, 592	550	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	169, 864	1, 847, 390	0. 09194	10, 933	1, 005	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	1, 790, 380	161, 058, 807		882, 781	8, 681	200. 00

Health Financial Systems	DUKES MEMORIA			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	PASS THROUGH COST:		F	Period: From 01/01/2017 To 12/31/2017	5/31/2018 11:	pared: 18 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School N Post-Stepdown Adjustments	·	Post-Stepdown Adjustments	Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	
31. 00 03100 INTENSIVE CARE UNIT	0	0	(0	0	
43. 00 04300 NURSERY	0	0	(0	0	43. 00
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
		(sum of cols.	Days	5 ÷ col. 6)	Program Days	
		1 through 3,				
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	3, 619		47	30. 00
31.00 03100 INTENSIVE CARE UNIT		0	594		17	31. 00
43. 00 04300 NURSERY		0	335		18	
200.00 Total (lines 30 through 199)		0	4, 548	3	82	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30. 00
						31.00
31.00 03100 INTENSIVE CARE UNIT	0					
31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0					43. 00 200. 00

Health Financial Systems	DUKES MEMORIAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1318	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	Part IV

12/31/2017 Date/Time Prepared: To 5/31/2018 11:18 am Title XIX Hospi tal PPS Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Post-Stepdown Anesthetist Post-Stepdown Cost Adjustments Adjustments 2.00 3.00 1.00 2A 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 0 05401 ULTRASOUND 54.01 0 54.01 0 05600 RADI OI SOTOPE 56.00 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 58.00 0 60.00 06000 LABORATORY 0 60.00 0 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 03610 SLEEP LAB
OUTPATIENT SERVICE COST CENTERS 0 0 0 0 76.00 90.00 0 90.00 09000 CLI NI C 0 0 0 0 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 0 200.00 Total (lines 50 through 199) 0 0 0 200.00

Heal	th Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lieu of Form CMS-2552-10		
APP	ORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1318	Peri od:	Worksheet D	

From 01/01/2017 | Part IV To 12/31/2017 | Date/Time Prepared: THROUGH COSTS 5/31/2018 11:18 am Title XIX Hospi tal All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total Outpati ent to Charges Medi cal (sum of col 1 (from Wkst. C, Education Cost through col. Cost (sum of Part I, col. (col. 5 ÷ col col. 2, 3 and 8) 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 773, 885 0.000000 50.00 0 05100 RECOVERY ROOM 51.00 3, 576, 286 0.00000051.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 OI 05400 RADI OLOGY-DI AGNOSTI C 0 37, 932, 740 54.00 0.000000 54.00 54.01 05401 ULTRASOUND 0 0 0.000000 54.01 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0 57.00 05700 CT SCAN 0 0.000000 57.00 |05800| MRI 0 0 58.00 0.000000 58.00 60.00 06000 LABORATORY 25, 007, 892 0.000000 60.00 06500 RESPIRATORY THERAPY 0 2, 351, 036 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 2, 818, 046 0.000000 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 158, 770 0.000000 67.00 06800 SPEECH PATHOLOGY 105, 532 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 6, 051, 685 0.000000 69.00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 5, 499, 198 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 3, 992, 398 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 25, 844, 627 0.000000 73.00 03610 SLEEP LAB 0 0.000000 76.00 719, 259 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 695, 456 0.000000 90.00 0 0 0.000000 91.00 09100 EMERGENCY 0 22, 684, 607 91.00 1, 847, 390 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 Total (lines 50 through 199) 0 0 0 161, 058, 807 200.00 200.00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1318	Peri od:	Worksheet D

From 01/01/2017 Part IV
To 12/31/2017 Date/Time Prepared: THROUGH COSTS 5/31/2018 11:18 am Title XIX Hospi tal PPS Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. Costs (col. (col. 6 ÷ col x col. 10) 11.00 x col . 12) 13.00 7) 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0.000000 109, 343 0 50.00 0 05100 RECOVERY ROOM 0.000000 51.00 15, 465 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 54.00 138, 014 0 54.00 54.01 05401 ULTRASOUND 0.000000 0 54.01 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 0 57.00 05700 CT SCAN 0.000000 0 57.00 Ω 05800 MRI 0 0.000000 58.00 0 58.00 60.00 06000 LABORATORY 0.000000 123, 511 0 60.00 06500 RESPIRATORY THERAPY 0.000000 0 65.00 65.00 52, 861 0 0 06600 PHYSI CAL THERAPY 0.000000 2,069 66.00 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 68.00 0 06900 ELECTROCARDI OLOGY 0 0.000000 36, 292 69.00 69 00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.000000 32, 333 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0.000000 315, 115 0 03610 SLEEP LAB 0.000000 0 ol 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 253 0 0 0 90.00 09100 EMERGENCY 0.000000 0 0 91.00 91.00 46, 592 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 000000 10, 933 0 92.00 0 92.00 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

882, 781

0

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1318 Peri od: Worksheet D From 01/01/2017 Part V 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 110991 116, 685 0 50.00 51.00 05100 RECOVERY ROOM 0. 158659 24, 044 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52 00 0 05300 ANESTHESI OLOGY 53.00 0.000000 0 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.075627 309, 467 0 54.00 54. 01 05401 ULTRASOUND 0.000000 0 0 54.01 0 05600 RADI OI SOTOPE 0.000000 0 56.00 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 0.000000 58.00 0 0 58.00 06000 LABORATORY 0.106523 315, 377 60 00 60 00 0 65.00 06500 RESPIRATORY THERAPY 0.352329 4, 294 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 262403 16, 269 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.186348 67.00 22, 647 0 06800 SPEECH PATHOLOGY 68.00 875 0. 281204 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.052938 0 45, 141 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.033950 31, 403 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 230083 0 14, 087 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.091974 0 97, 334 73.00 73.00 0 76.00 03610 SLEEP LAB 0. 307097 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 743689 2, 278 0 90.00 0 09100 EMERGENCY 0 91.00 0. 295595 C 443, 846 Ω 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.536651 0 14,682 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES

0.110345

138, 620

0

0

0

1, 597, 049

1, 597, 049

Ω

0

95.00

201.00

0 200. 00

0 202.00

95.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

From 01/01/2017 Part V 12/31/2017 Date/Time Prepared: 5/31/2018 11:18 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Reimbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12, 951 0 50.00 51. 00 | 05100 RECOVERY ROOM 3, 815 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 53. 00 | 05300 | ANESTHESI OLOGY 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 23, 404 54.00 05401 ULTRASOUND 0 54. 01 54.01 0 05600 RADI OI SOTOPE 0 56.00 0 56.00 57. 00 05700 CT SCAN 0 0 57.00 05800 MRI 0 58.00 0 58.00 0 06000 LABORATORY 60 00 33, 595 60 00 65.00 06500 RESPIRATORY THERAPY 1,513 65.00 66. 00 06600 PHYSI CAL THERAPY 4, 269 0 66.00 06700 OCCUPATIONAL THERAPY 4, 220 67.00 67.00 06800 SPEECH PATHOLOGY 0 68.00 246 68.00 69.00 06900 ELECTROCARDI OLOGY 2, 390 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1,066 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 3, 241 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 8, 952 0 03610 SLEEP LAB 76.00 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 694 90.00 0 09100 EMERGENCY 91.00 131, 199 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 7,879 0 92.00 OTHER REIMBURSABLE COST CENTERS

15, 296

255, 730

255, 730

0

0

95.00

200.00

201.00

202.00

95.00

200.00

201.00

202.00

09500 AMBULANCE SERVICES

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1318	From 01/01/2017	Worksheet D-1 Date/Time Prepared: 5/31/2018 11:18 am
	Title XVIII	Hospi tal	Cost

Cost Center Description PART All PROVIDER COMPONERTS			Title XVIII	Hospi tal	5/31/2018 11: Cost	18 am
HAMITERI IMPS HAMITERI IMPS HAMITERI IMPS HAMITERI IMPS 1.00 Important days (Including private room days, excluding paling-bed days, excluding newborn) 3,275 1.00 1.0		Cost Center Description	THE AVIII	1103pi tui	0031	
Impartient days (including private room days and swing-bed days, excluding needorn) 3,725		DADT I ALL DROWNER COMPONENTS			1. 00	
Impatient days (including private room days and swing-bed days, excluding newborn) 3,725 1.00						
Impatient days (including private room days)	1.00		s, excluding newborn)		3, 725	1. 00
do not complete this line. 4. 00 Sell-private room days (excluding swing-bed and observation bed days) 1. 10 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed W type inpatient days (including private room days) brough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed W type inpatient days (including private room days) brough becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and nextern days) including private room days) after becember 31 of the cost reporting period (see instruction) through December 31 of the cost reporting period (see instruction) through December 31 of the cost reporting period (see instruction) through December 31 of the cost reporting period (see instruction) (including private room days) after becember 31 of the cost reporting period (see instruction) (including private room days) after becember 31 of the cost reporting period (see instruction) (including private room days) (including private room days) (including period reporting period (see instruction)) (including private room days) (including private room days) (including period reporting period (see instruction)) (including private room days) (including private room days) (including period reporting period (see instruction)) (including private room days) (including private roo					· ·	
Semi-private room days (excluding swing-bed and observation bed days) 1.00	3.00		ys). If you have only pri	vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	4.00	· ·	ed days)		2. 976	4.00
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)				31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost on the sum of the sum o				24 6 11		, 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	6.00		om days) after December .	31 of the cost	0	6.00
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)	7.00		m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through becember 31 of the cost reporting period (see instructions) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through becember 31 of the cost reporting period (see instructions) 13. 00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) after becember 31 of the cost reporting period (see instructions) 13. 00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 14. 00 15. 00 Total nursery days (title V or XIX only) 0 15. 00 16. 00 Nursery days (title V or XIX only) 0 15. 00 17. 00 Total BED ADUSEMBRY 18. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period (accer rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (accer rate for swing-bed SNF services applicable to services after December 31 of the cost (accer are to for swing-bed SNF services applicable to services after December 31 of the cost (accer are to for swing-bed SNF services after December 31 of the cost reporting period (line 5 2, 4, 5) 18. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 2, 5, 743, 352 2, 10, 10) 22. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 2, 5, 79, 917) 23. 00 Swing-bed cost appl						
Total Inpatient days Including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10.10	8.00		m days) after December 3	l of the cost	0	8.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 15.00 Including Private room days applicable to the Program (excluding swing-bed days) 15.00 Including North Swing Swing-bed Cost applicable to NF type services after December 31 of the cost reporting period (line 1 x ine 18) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 2 x ine 18) Swing-bed cost applicable to NF type services for December 31 of the cost reporting period (line 2 x ine 18) Swing-bed cost applicable to NF type services for December 31 of the cost reporting period (line 2 x ine 18) Swing-bed cost (see instructions) Swing-bed cost applicable to NF type servic	9. 00		the Program (excluding	swing-bed and	1, 556	9. 00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if callendar year, enter 0 on this line) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NT type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Total nursery days (title V or XIX only) 1.00 No Including Swing-bed Swin	40.00					40.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Wedically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Medical are rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (led cale rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (led cale rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (led cale rate for swing-bed NF services applicable to services after December 31 of the cost of the cost reporting period (led cale rate for swing-bed NF services applicable to services after December 31 of the cost of the cost reporting period (line of the cost led to services) 18.00 Nursery days (litle V or XIX only) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the cost led to services) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the cost ine 10) 18.10 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of the X line 18) 18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of X line 18) 18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of X line 18) 18.01 Swing-bed cost (10.00			oom days)	104	10.00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period of the December 31 of the cost reporting period (if callendary year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Modicarly necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 18.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost or reporting period on reporting period on period necessary private room to service services after December 31 of the cost or reporting period on reporting period on period necessary private room to shift years are services after December 31 of the cost reporting period (line 5 x iline 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x iline 18) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x iline 28) 25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x iline 29) 26.00 Total swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x iline 35) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpat	11. 00			oom days) after	0	11. 00
through December 31 of the cost reporting period 13.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 16.00 Total nursery days (title V or XIX only) 16.00 17.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 18.00 Novery days (title V or XIX only) 18.00 Novery days (title V or XIX only) 19.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Modica did rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Modical did rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 Seming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 28.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 29.00 Nover the swing-bed cost applicable to NF type service after December 31 of the cost reporting period (line 8 x line 20) 29.00 Nover the swing	40.00					40.00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including privater room days) 13.00 14.00 14.00 14.00 16.00	12.00		Conly (including private	e room days)	0	12.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 15.00 16.00 Nursery days (title V or XIX only) 0 16.00 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18.00 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19.00	13. 00		only (including private	e room days)	0	13. 00
15.00 Total nursery days (title V or XIX only) 17.00 SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see Instructions) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 26.00 Total swing-bed cost (see Instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed ost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 20.00 Total swing-bed cost (see linstructions) 30.00 Semi-private room charges (excluding swing-bed charges) 20.00 Ottal swing-bed cost (see line charge (line 30 + line 4) 30.00 Average period memory to the memory of the cost reporting period (line 8 cost applicable to SF, 579, 917 31.00 Average per diem private room cost differential (line 27 + line 28) 32.00 Average per diem private room cost differential (line	44.00					
16.00 Nursery days (title V or XIX only) Ned EDD ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost (19.00 Medicare rate for swing-bed cost (19.00 Medicare rate for sw			am (excluding swing-bed of	days)		
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost (19.00 NF services) (19.00 NF serv						
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Average perivate room per diem charge (line 29 + line 3) 31.00 General inpatient routine service cost charges (as line 3) 32.00 Average per diem private room charge differential (line 3 x line 31) 33.00 Average per diem private room charge differential (line 3 x line 31) 34.00 Average per diem private room cost differential (line 3 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Proyram general inpatient routine service cost per diem (see instructions) 37.00 Average semi-private room cost differential (line 3 x line 38) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Average s						
18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 19. 0	17. 00		es through December 31 o	f the cost		17. 00
19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (100 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 29. 00 Private room charges (excluding swing-bed charges) 29. 00 Private room charges (excluding swing-bed charges) 29. 00 Average perivate room per diem charge (line 30 + line 4) 30. 00 Average peridem private room per diem charge (line 30 + line 4) 30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30. 00 Average per diem private room charge differential (line 32 minus line 33) 30. 00 Average per diem private room charge differential (line 32 minus line 33) 30. 00 Average per diem private room charge differential (line 32 minus line 33) 30. 00 Average per diem private room charge differential (line 32 minus line 33) 30. 00 Average per diem private room charge differential (line 32 minus line 33) 30. 00 Average per diem private room cost differential (line 32 minus line 33) 30. 00 Average per diem private room cost diff	18. 00	'	es after December 31 of	the cost		18. 00
reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Program general inpatient routine service cost per diem (see instructions) 36.00 Program general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient ro	40.00					40.00
reporting period Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 25.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) Deprivate room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) O 0.00 30.00 Semi-private room charges (excluding swing-bed charges) O 0.00 30.00 Semi-private room charges (excluding swing-bed charges) O 0.00 30.00 Semi-private room charges (excluding swing-bed charges) O 0.00 30.00 Semi-private room charges (excluding swing-bed charges) O 0.00 30.00 Semi-private room charges (excluding swing-bed charges) O 0.00 30.00 Semi-private room charges (excluding swing-bed charges) O 0.00 30.00 Semi-private room charge (line 30 + line 3) O 0.00 30.00 Semi-private room cost differential (line 32 minus line 33)(see instructions) O 0.00 30.00 30.00 Average peridiem private room cost differential (line 32 minus line 33)(see instructions) S 0.00 Average peridiem private room cost differential (line 32 minus line 31) O 0.00 30.00 30.00 All used deperal inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine ser	19.00		s through December 31 of	the cost	0.00	19.00
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 26.00 Total general inpatient routine service cost through December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Private ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Private room cost differential (line 32 minus line 33)(see instructions) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20. 00		s after December 31 of th	ne cost	0.00	20. 00
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 32.00 Average private room per diem charge (line 29 * line 3) 33.00 Average semi-private room charge differential (line 30 * line 31) 34.00 Average per diem private room charge differential (line 30 * line 31) 36.00 Private room cost differential (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 27.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21. 00		5)		5, 743, 352	21. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charges (line 29 + line 3) 30.00 Semi-private room charge service cost differential (line 27 + line 28) 30.00 Average per diem private room charge (line 29 + line 3) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 31.00 General inpatient routine service cost differential (line 34 x line 31) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 35) 34.00 Average per diem private room cost differential (line 34 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 37.00 PRART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (per diem (see instructions)) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22. 00		er 31 of the cost reporti	ng period (line	0	22. 00
x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25. 00 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 32. 00 Average private room charges (excluding swing-bed charges) 33. 00 Average private room per diem charge (line 27 + line 28) 34. 00 Average private room per diem charge (line 29 + line 3) 35. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 36. 00 Average per diem private room charge differential (line 34 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 37. 00 Average per diem private room cost differential (line 3 x line 35) 38. 00 Average per diem private room cost differential (line 3 x line 35) 39. 00 Program general inpatient routine service cost per diem (see instructions) 30. 00 Average per diem private room cost differential (line 5, 579, 917) 37. 00 Program general inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	,	31 of the cost reporting	period (line 6	0	23. 00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8		x line 18)	•	, , ,		
x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average semi-private room per diem charge (line 30 + line 4) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 0 Program general inpatient routine service cost (line 9 x line 38) 0 Adjusted general inpatient routine service cost (line 9 x line 38) 0 Adjusted general inpatient routine service cost (line 9 x line 38) 0 Aucumption (see instructions) 1,541.84 2,399,103 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		⁻ 31 of the cost reporti	ng period (line	0	24. 00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 31) 30.00 Average per diem private room	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 5,579,917 27. 00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28. 00 Pri vate room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-pri vate room charges (excluding swing-bed charges) 0 29. 00 31. 00 Semi-pri vate room charges (excluding swing-bed charges) 0 29. 00 32. 00 Average pri vate room per diem charge (line 29 ÷ line 3) 0 0.000000 33. 00 Average per diem pri vate room per diem charge (line 30 ÷ line 4) 0 0.00 33. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 0 0.00 34. 00 Average per diem pri vate room cost differential (line 34 x line 31) 0 0.00 35. 00 Average per diem pri vate room cost differential (line 34 x line 31) 0 0.00 35. 00 Average per diem pri vate room cost differential (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 7. 579, 917 27 minus line 36) 7. 579, 917 7. 579, 917 28. 00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1. 541. 84 38. 00 38. 00 Program general inpatient routine service cost (line 9 x line 38) 2, 399, 103 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	26. 00				163, 435	26. 00
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 0. 29. 00 0. 30. 00 Semi-private room charges (excluding swing-bed charges) 0. 30. 00 Semi-private room charges (excluding swing-bed charges) 0. 30. 00 Semi-private room charges (excluding swing-bed charges) 0. 0000000 31. 00 Average private room per diem charge (line 29 ÷ line 3) 0. 00 0. 32. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 0. 00 0. 33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0. 00 0. 0	27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 29.00 29.00 30.00 0.00 30.00 0.00 31.00 0.00 32.00 0.00 0	20.00		dd			20.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			a and observation bed cha	arges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 000 000 000 000 000 000 000 0						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.00 34.00 37.00 36.00 37.00 36.00 37.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	31.00		+ line 28)		0.000000	
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 36.00 5, 579, 917 37.00 1, 541.84 38.00 2, 399, 103 39.00		Average private room per diem charge (line 29 ÷ line 3)	,			
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
36.00 37.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 579, 917 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 541.84 38.00 Program general inpatient routine service cost (line 9 x line 38) 2, 399, 103 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34.00
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 5, 579, 917) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 5, 579, 917 5, 579, 917 5, 579, 917 5, 579, 917 5, 579, 917 6, 579, 917 7, 541. 84 7, 541. 84 7, 39, 103 7, 39, 103 7, 39, 00 1, 541. 84 7, 39, 103 7, 39, 103 7, 39, 103 7, 39, 103	35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35. 00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,541.84 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,399,103 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,541.84 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,399,103 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	,	and private room cost di	fferential (line	5, 579, 917	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,541.84 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,399,103 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,541.84 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,541.84 38.00 2,399,103 39.00			JSTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,399,103 39.00 40.00	38.00				1, 541. 84	38. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	39. 00	, , , , , , , , , , , , , , , , , , , ,				
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 2,399,103 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)	l	2, 399, 103	41.00

Provider Cott. 19-1319 Port Cott. 19-1319 Por		Financial Systems	DUKES MEMORIA				eu of Form CMS-2	
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (CCN: 15-1318			
Cast Center Description			To 12/31/2017				Date/Time Pre	
Inpart ent Cost Impaction Look 20, 20 Cost 3							Cost	
1.00 1.00 1.00 2.00 3.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 5.00 4.00 6.00		Cost Center Description						
MRSERY (LILEY V & XIX only)					col . 2)		4)	
Internal via Cure Type Impattient Rospital Units 1,042,406 594 1,754,89 331 580,869 43,00 1000MeV CARE UNIT 4,400 44,00	42.00	NIIDSEDV (title V & VIV only)						42.00
44.00 CORONARY CARE UNIT 45.00 SIRNI RITRISUP CARE UNIT 45.00 SIRNI RITRISUP CARE UNIT 45.00 SIRNI RITRISUP CARE UNIT 45.00 Force SIRVI RITRISUP CARE UNIT 45.00 Force SI	42.00		Ŭ.		0, 0	0	0	42.00
			1, 042, 406	59	4 1, 754. 8	331	580, 869	
46.00 SIRRICAL INTERINET CARE UNIT 4.70. OTHER SPECIAL CARE (SPECIFY) 5.00 THER SPECIFY 5.00 THE SPECIFY 5.00 THER SPECIFY 5.00 THER SPECIFY 5.00 THE SPECIFY								
2.00 Program Inpatient ancillary service cost (Wist. D.3, col. 3, line 200) 2, 103,379 48,00 1012 Program Inpatient ancillary service cost (Wist. D.3, col. 3, line 200) 2, 103,379 48,00 1012 Program Inpatient costs (sun of lines 41 through 48) (see instructions) 5, 663,301 49,00 2012 2012 2013	46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
1.00	47. 00							47. 00
10.00 Program inpatient costs (sum of Flines 41 through 48) (see instructions) 5,083, 201 5,000 Pass through costs applicable to Program inpatient routine services (from Wkst. 0, sum of Parts I and 0 5,000 11.00 11		<u> </u>					1.00	
PASS THROUGH COST ADJUSTNENTS					ons)			•
111 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II 0 51.00 and IV) 10 10 10 10 10 10 10 1	49.00		41 through 48)(see mstructi	ons)		5, 083, 301	49.00
51.00 Pass through costs applicable to Program inpatient ancillary services (From Wikst. 0, sum of Parts II and IV) 0 51.00 and IV) 0 52.00 Total Program excludable cost (sum of lines 50 and 51) 0 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0 53.00	50. 00		atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50. 00
	51. 00		atient ancillar	v services (f	rom Wkst. D. s	um of Parts II	0	51. 00
53.00 Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 54.00 Program discharges 54.00 Program discharges 55.00 I Target amount per discharge 56.00 I Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Desparation of the state of t		and IV)			·		_	
medical education costs (line 49 minus line 52) 54.00 Frogram discharges 0.0 55.00 7 Program discharges 0.0 7 Program dispatient routine service costs (line 72 + line 73) 7 Program discharges 0.0 7 Program di				lated non-ph	vsician anesth	etist and	_	
Program discharges 0 64.00	00.00	medical education costs (line 49 minus line		Tated, Horr pri	ysi ci dii dilesti		Ŭ	00.00
55.00 Target amount (per discharge 0.00 55.00 55.00 57.00	54 00						1 0	54.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 59.00 Person payment (see instructions) 0 58.00 Person payment (see instructions) 0 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 If line 53/54 is less than the lower of lines 55.50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient of cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient of cost plus incentive payment (see instructions) 0 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (litle XVIII only) 1 66.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 1 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 1 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 66.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 66.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 67.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 77 + line 20) 71.00 Skilled unrising facility/often runsing facility/		, 3						
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 is 185 from the cost report, updated by the market basket 61.00 Lesser of lines 53/54 is 185 than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Relief payment (see instructions) 65.00 Relief are swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only) 65.00 Relief care swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 69.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Payment Titl - SKILLED NURSING FACILITY, Office RUISING FACILITY, Office Cost (line 37) 70.00 Algorization and the service cost (line 9 x line 71) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Program capital related costs (line 74 minus line 77) 74.00 Program capital related costs (line 74 minus line 77) 75.00 Aggregate charges to beneficiaries for excess costs (from			ing cost and to	mast smount (line E/ minue	Line E2)		
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/other nursing facility/lor/lip routine service cost (line 37) 71.00 Adjusted general inpatient routine service costs (line 70 + line 2) 72.00 Porgam routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 77 + line 20) 75.00 Capital-related cost (line 9 x line 70) 76.00 Per diem capital-related costs (line 9 x line 77) 77.00 Porgam capital-related costs (line 9 x line 77) 78.00 Capital-related cost (line 9 x line 78) 78.00 Inpatient routine service cost (line 74 minus line 77			ing cost and ta	rget amount (line 56 minus	11 ne 53)		
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by 61.00 Which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56). Ontherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Relief payment (see instructions) 64.00 Relief payment (see instructions) 65.00 Relief payment (see instructions) 65.00 Relief payment (see instructions) 66.00 Relief payment (see instructions)	59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	empounded by the	0.00	59. 00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relice payment (see instructions) 63.00 PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Wedicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) 68.00 Total Figure 12 x line 19) 68.00 Total Figure 13 x line 20) 69.00 Total Figure 14 x line 20) 69.00 Total Figure 15 x line 20 x line 31 x line 20) 69.00 Total Figure 20 x line 31 x line 20 x line 32 x line 33 x line 32 x line 34 x line 32 x line 3	60. 00		cost report, up	dated by the	market basket		0.00	60.00
amount (I line 56), otherwise enter zero (see instructions) 0 62.00		If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of			ı
62.00 Relief payment (see instructions) 63.00 All owable Inpatient cost plus incentive payment (see instructions) 63.00 All owable Inpatient cost plus incentive payment (see instructions) 64.00 Wedicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions) (Instructions) (Instructio				s (lines 54 x	60), or 1% of	the target		
PROGRAM INPATIENT ROUTINE SWING BED COST		Relief payment (see instructions)	,					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions) CAH (See instruction	63. 00		ent (see instru	ctions)			0	63.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 160,351 16	64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	160, 351	64. 00
instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) Total title V or XIX swing-bed NF inpatient routine service costs (line 70 + line 2) Total title V or XIX swing-bed NF inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Total Program general inpatient routine service costs (from provider records) Total Program capital related costs (line 75 + line 2) Total volume Service cost (line 74 minus line 77) Total title V or XIX swing-bed NF inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) Total Program routine service cost (see instructions) Total Program inpatient routine service costs (see instructions) Total Program inpatient ancillary services (see instructions) Total Program inpatient ancillary services (see instructions	65 00		ts after Necemb	er 31 of the	cost reporting	narind (See	0	65.00
CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/OFTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/OFTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital related costs (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost see instructions) 82.00 Program inpatient ancillary services (see instructions) 83.00 Resonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 75.01 Total Program inpatient operating costs (sum of lines 83 through 85) 76.02 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 76.03 Total Observation bed days (see instructions) 77.04 78.05 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.00 78.0	03.00	instructions)(title XVIII only)				,		03.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 68.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost period (line 14 x line 35) 72.00 Total Program general inpatient routine service costs (line 72 + line 73) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Per diem capital-related costs (line 75 + line 2) 75.00 Program capital-related costs (line 75 + line 2) 76.00 Program capital-related costs (line 74 minus line 77) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Program inpatient routine service costs (see instructions) 79.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 82.00 Inpatient routine service cost (see instructions) 83.00 Program inpatient ancillary services (see instructions) 83.00 Program inpatient operating costs (see instructions) 84.00 Utilization review - physician compensation (see instructions) 70.00 Vial Program inpatient operating costs (see instructions) 70.00 Vial Program inpatient pout operating costs (see instructions) 70.00 Vial Program i	66. 00		ne costs (line	64 plus line	65)(title XVII	I only). For	160, 351	66. 00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 68.00 (line 13 x line 20) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) 76.00 Program capital-related costs (line 75 + line 2) 76.00 Program capital-related costs (line 74 minus line 77) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Reasonable inpatient routine service cost (see instructions) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 70.01 Program inpatient ancillary services (see instructions) 79.00 70.01	67. 00		e costs through	December 31	of the cost re	porting period	0	67. 00
Cline 13 x line 20 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY. OTHER NURSING FACILITY, AND ICF/IID ONLY	68 00		a costs after D	lecember 31 of	the cost reno	urting period	0	68 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 76. 00 77. 00 78. 00 79. 00	00.00		e costs after b	ecember 31 01	the cost repo	itting period		00.00
70. 00 71. 00 71. 00 72. 00 73. 00 74. 00 74. 00 75. 00 76. 00 77. 00 77. 00 78. 00 79	69. 00						0	69. 00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84 88.00	70. 00			•				70. 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 173.00 74.00 75.00 76.00 77.00 76.00 77.00 77.00 78.00 79.		,		ine 70 ÷ line	2)			
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 78 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 174.00 75.00 76.00 76.00 76.00 76.00 76.00 77.00				ı(line 14 x l	ine 35)			ł
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76.00 77.0		Total Program general inpatient routine serv	ce costs (line	72 + line 73)			ı
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Regregate charges to beneficiaries for excess costs (from provider records) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 77.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient ancillary services (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 DART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 17.00 Total observation bed days (see instructions) 17.00 Total observation bed days (see instructions) 18.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 18.00 Total observation bed days (see instructions) 18.00 Total observation bed days (see instructions) 19.00 Total observation	75. 00		routine service	costs (from	Worksheet B, P	art II, column		75.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		Per diem capital-related costs (line 75 ÷ li						
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Robbit Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Robbit Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Robbit Agminus Inpatient 79 80.00 80.00 81.00 81.00 82.00 83.00 84.00 85.00 86.00 87.00 87.00		,	,					
81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 85.00 Reasonable inpatient ancillary services (see instructions) 85.00 Reasonable inpatient outine costs (see instructions) 85.00 Reasonable inpatient operating costs (see instructions) 86.00 Reasonable inpatient routine costs (see instructions) 86.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84 88.00		,	,	rovi der recor	ds)			ł
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 85.00 Reasonable inpatient operation (see instructions) 85.00 Reasonable inpatient operation (see instructions) 85.00 Reasonable inpatient operation (see instructions) 86.00 Reasonable inpatient operation (see instructions) 87.00 Reasonable inpatient operation (see instructions) Reasonable inpatient operation (see				ost limitatio	n (line 78 min	us line 79)		ı
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient routine service costs (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		·)				1
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	83. 00	Reasonable inpatient routine service costs (see instruction	* .				83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		, , , , , , , , , , , , , , , , , , , ,		ins)				
87.00 Total observation bed days (see instructions) 643 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84 88.00		Total Program inpatient operating costs (sum	of lines 83 th					ł
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84 88.00	07 00						442	07 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 991,403 89.00		,		line 2)				1
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)	-			991, 403	89. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/31/2018 11:	
		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	984, 050	5, 743, 352	0. 17133	7 991, 403	169, 864	90.00
91.00 Nursing School cost	0	5, 743, 352	0.00000	991, 403	0	91.00
92.00 Allied health cost	0	5, 743, 352	0.00000	991, 403	0	92.00
93.00 All other Medical Education	0	5, 743, 352	0.00000	991, 403	0	93.00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-13	18 Period: From 01/01/2017	Worksheet D-1
		To 12/31/2017	Date/Time Prepared: 5/31/2018 11:18 am
	Title XIX	Hosni tal	PPS

-		Title XIX	Hospi tal	5/31/2018 11: PPS	18 am_
	Cost Center Description	II tie xix	поѕрі таі	PPS	
				1. 00	
-	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS			0.705	
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			3, 725	
2. 00 3. 00	Private room days (excluding swing-bed and observation bed day		vato room days	3, 619 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only pri	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 976	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost		5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December (31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	m days) through December	21 of the cost	0	7. 00
7.00	reporting period	ii days) tili odgir becelliber	31 Of the Cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	47	9. 00
40.00	newborn days)				10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		Join days) arter		11.00
12.00	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				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	iii (excruaring swring-bea t	uays)	335	
16. 00	Nursery days (title V or XIX only)				16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost		17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of 1	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	3 through becomber 31 of	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			5, 743, 352	•
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)		9		
24.00	Swing-bed cost applicable to NF type services through December	and 31 of the cost reporting	ng period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			163, 435	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 579, 917	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	Line 20)		0 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	F 11 ne 28)		0. 000000 0. 00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin		,	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dit	fferential (line	5, 579, 917	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 541. 84	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			72, 466	
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		72, 466	41. 00

Intensive Care Type Inpatient Heightal Units 1,042,456 994 1,754,89 17 29,833 44.00 CRRWARY CARE UNIT 1,042,456 994 1,754,89 17 29,833 44.00 000 17,754,89 17 29,833 44.00 000 17,754,89 17 29,833 44.00 000 17,754,89 17 29,833 44.00 17,754,89 17 29,833 45.00 17,754,89 17 29,833 45.00 17,754,89 17 29,833 45.00 17,754,89 17 29,833 45.00 17,754,89 17 29,833 45.00 17,754,89 17 29,833 45.00 17,754,89 17 29,833 45.00 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17,754,89 17 29,833 17 29,833 17,754,89 17 29,833		Financial Systems	DUKES MEMORIA			In Lie	eu of Form CMS-2	
Total Tota	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1318			
Title XIX Respired PSS Program Cost Cold 3 x cold 1								
Total Total Severage Pert Program Days (Program Da				Ti	tle XIX	Hospi tal		18 am
		Cost Center Description	Total				Program Cost	
1.00 2.00 3.00 4.00 5.00 5.00 3.00 4.00 5.00			Inpatient Cost	Inpatient Da		1 ÷		
			1.00	2.00		4.00		
	42. 00							42. 00
44.00				_		00		
45.00 SIBRIC LINTENSIVE CARE UNIT 45.00			1, 042, 406	5	1, /54	. 89	29, 833	ł
46.00 SURCICLAL INTERSIVE CARE UNIT 46.07								45. 00
Cost Center Description		SURGICAL INTENSIVE CARE UNIT						46. 00
1.00	47. 00							47. 00
48.00 Program Inpati ent and Illery service cost (West D-3, col. 3, line 200) 109, 180 48.00 104, 19		Cost Center Description					1 00	
ASS TINDUCH COST ADJUSTNEMNS 50.00 Pass through costs applicable to Program inpatient routine services (from West. D, sum of Parts I and 17,995 50.01 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II 8,661 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II 8,661 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II 8,661 51.00 Pass through costs applicable to Program inpatient operating cost excluding capital related, non-physician anesthetist, and 200,665 53.00 Target Amount Application posts (fine 40 minus II no 53.00 Program discharges 0.00 55.00 Parget amount per discharge 0.00 55.00 Parget amount per discharge 0.00 55.00 Parget amount (I line 54 x I ine 55) 0.00 Farget amount (I line 54 x I ine 55) 0.00 Farget amount (I line 54 x I ine 55) 0.00 Parts of I lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 90 0.00 55.00 Discharge of I lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 90 0.00 56.00 0.00 56.	48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	B, line 200)				48. 00
5.0.00 Passs through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and I 17,995 50.00 Into Passs through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 8, 681 51.00 and IV) 5.0.00 Total Program excludable cost (sum of lines 50 and 51) 5.0.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 200, 685 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 200, 685 53.00 Total Program inpatient operating cost into 53.00 Total Program inpatient operating cost into 53.00 Total Program inpatient operating cost and target amount (line 5 minus line 53) 5.0.00 Target amount (line 54 x line 55) 5.0.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 5.0.00 Total payment (see instructions) 5.0.00 Easser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket basket basket basket in the lower of lines 55, 59 or 66 enter the lesser of 50% of the amount by 0.00 market basket in the lower of lines 55, 59 or 66 enter the lesser of 50% of the amount by 0.00 market basket in the lower of lines 55, 59 or 66 enter the lesser of 50% of the amount by 0.00 market basket in the lower of lines 55, 59 or 66 enter the lesser of 50% of the amount by 0.00 market basket in the lower of lines 55, 59 or 66 enter the lesser of 50% of the amount by 0.00 market basket in the lower of lines 55, 59 or 66 enter the lesser of 50% of the amount by 0.00 market basket in the lower of lines 55, 59 or 66 enter the lesser of 50% of the amount by 0.00 market basket in the lower of lines 55, 59 or 66 enter the lesser of 50% of the target amount (line 50, otherwise enter zero (see instructions) 6.0.00 Relice payment (see instructions) 0.00 market basket in the lines 50, otherwise enter 2 end (see instructions) 0.00 market basket in the lines 50, otherwise enter 2 end (see instructio	49. 00		41 through 48)((see instruct	i ons)		227, 361	49. 00
1110 1111	F0 00				WI+ D	£ Dt - 1d	17.005	
51.00 Pass through costs applicable to Program Inpatient ancillary services (from Wkst. 0, sum of Parts II 8,681 51.00 and IProgram excludable cost (sum of lines 50 and 51) 26.676 20,676 20,000	50.00		atrent routine	services (11	OIII WKSt. D, S	um or Parts r and	17, 995	50.00
20,676 \$2.00 Total Program excludable cost (sum of lines 50 and 51) 26,676 \$2.00 Total Program inpetient operating cost excluding capital related, non-physician anesthetist, and 200,685 \$2.00 \$2.0	51. 00		atient ancillar	y services (from Wkst. D,	sum of Parts II	8, 681	51.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and model education costs (line 49 minus line 52)	E2 00	1	EO and E1)				2/ /7/	E2 00
medical education costs (line 49 minus line 52)				alated non-r	hvsician anes	thetist and	l	1
54.00 Program discharges 0.00 55.00 55.00 Target amount per discharge 0.00 55.00 55.00 Target amount per discharge 0.00 55.00 55.00 Target amount (line 54 x line 55) 0.50 0.	33. 00			ratea, non p	niysi ci aii anes	thetrst, and	200,003	33.00
55.00 Target amount per discharge 6.00 Target amount per discharge 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Target amount per discharge instructions) 6.00 Target amount per discharge instructions) 6.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6.00 Rose payment (see instructions) 6.00 Nos payment (see instructions) 6.00 Target of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Target of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Target of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Target of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Target of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Target of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Target of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Target of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.00 Target of lines 53/54 or 55 from prior year cost gent prior year cost of the target amount (line 56), otherwise enter zero (see instructions) 6.00 Target of lines 53/54 or 55 from prior year cost gent lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 6.00 Target of lines 53/54 or 55 from prior year cost strough December 31 of the cost reporting period (See instructions) (line 30 x line 30) (line 30 x line 30 x line 30) (line 30 x line 30 x								
56.00 Target amount (line 54 x line 55) 0 56.00 57.00		, 3						•
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 S 7.00 S 80.00 Bonus payment (see instructions) 0 S 80.00 Bonus (line 53/54 or 55 from prior year cost report, updated by the market basket 0.00 Bonus (line 56) otherwise enter zero (see instructions) 0 Bonus (line 55) otherwise enter zero (see instructions) 0 Bonus (line 56) otherwise enter zero (see instructions) 0 Bonus (line 56) otherwise enter zero (see instructions) 0 Bonus (line 56) otherwise enter zero (see instructions) 0 Bonus (line 56) otherwise enter zero (see instructions) 0 Bonus (line 50) otherwise enter							1	1
1. 1. 1. 1. 1. 1. 1. 1.		, ,	ing cost and ta	arget amount	(line 56 minus	s line 53)	0	•
market basket 0.00 Loses of Flines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 61.00 If Tline 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine scosts (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine scost (line 67 + line 28) 70.00 Allowable (line 30 + line 31) 70.00 Allowable (line 30 + line 30 + line 31)								
6.0.0 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.0.0 line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser 50% of the amount by 0 of 1.00 which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 7.0.0 lesser of lines 53/54 or 55 from provider the lower of lines 53, 59 or 60 enter the lesser of 50% of the amount by 0 of 1.00 lesser amount (line 56), otherwise enter zero (see instructions) 8.0.1 lesser of lines 53/54 or 55 from provider the cost lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 8.0.1 lesser of lines 53/54 or 55 from provider the cost structions (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 8.0.1 lesser of lines 53/54 in patient cost lines from the cost reporting period (See Instructions) (title XVIII only) 8.0.1 lesser of lines 53/54 in patient routine costs (line 64 plus line 65) (title XVIII only). For 1.0 lesser of 1.0 les	59.00		porting period	ending 1996,	updated and	compounaea by the	0.00	59.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target anount (line 56), otherwise enter zero (see instructions) 62. 00 Relief payment (see instructions) 63. 00 Allowable Inpatient cost plus Incentive payment (see instructions) 64. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 66. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only) 67. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 20) 70. 00 SXIII en anusing facility/Other nursing facility/Tot/TID routine service cost (line 37) 70. 01 Adjusted general inpatient routine service costs (line 72 + line 73) 71. 02 Operame routine service cost (line 9 x line 71) 72. 03 Operame routine service cost (line 9 x line 70) 73. 04 (line 45) 74. 05 (line 45) 75. 06 Capital -related costs (line 9 x line 76) 77. 07. 07. 07. 07. 07. 07. 07. 07. 07.	60.00		cost report, up	dated by the	e market baske	t	0.00	60.00
amount (line 56), otherwise enter zero (see instructions) 62.00 80.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 ReoGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only) 67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 68.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Aljusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program routine service cost (line 9 x line 71) 75.00 76.00 77.00 77.00 78.00 79.00	61. 00						0	61. 00
62.00 Relief payment (see instructions) 0 62.00 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Reliable Inpatient Provides 0 64.00 65.00 Reliable Inpatient Provides 0 64.00 Reliable Instructions) (title XVIII only) 0 0 0 Reliable Instructions) 0 0 0 0 0 0 0 0 0				rs (lines 54	x 60), or 1%	of the target		
PROGRAM INPATIENT ROUTINE SWING BED COST 4. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 67. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Octal Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69. 00 Total title V or XIX swing-bed NF inpatient routine scosts (line 70 + line 68) 70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75. 00 Capital-related costs (line 75 + line 2) 76. 00 Per diem capital-related costs (line 74 minus line 77) 77. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 78. 00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Apparent noutine service costs (see instructions) 82. 00 Apparent noutine service costs (see instructions) 83. 00 Apparent noutine service co	62.00		instructions)				0	62.00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 69.00 Porgram routine service cost (line 9 x line 71) 69.00 Porgram routine service cost (line 9 x line 71) 69.00 Porgram ageneral inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 69.00 Total Program routine service cost (line 74 minus line 77) 69.00 Aggregate charges to benefic airies for excess costs (from provider records) 69.00 Total Program routine service cost (line 74 minus line 77) 69.00 Aggregate charges to benefic iaries for excess costs (from provider records) 69.00 Total Program routine service cost (see instructions) 69.00 Total Program inpatient routine service cost (see instructions) 69.00 Total Program inpatient poperating costs (sum of lines 83 through 85) 60.00	63. 00		ent (see instru	uctions)			0	63. 00
instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 70.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total itile V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20) 70.00 Skilled nursing facility/other nursing facility/othe	64 00		ts through Dece	amber 31 of t	he cost repor	ting pariod (See	0	64.00
Instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) CAH (see	04.00		ts thi ough beec		ine cost repor	tring period (see		04.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost period edid line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 78 minus line 79) 80.00 Total Program coutine service costs (from provider records) 81.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 82.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 87.00 Total Program inpatient operating costs (sum of lines 83 through 85) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	65. 00		ts after Decemb	oer 31 of the	e cost reporti	ng period (See	0	65. 00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/other nursing facility/ICT/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service costs (see instructions) 82.00 Inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 75.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total Program inpatient routine cost per diem (line 27 + line 2) 77.00 Program contine service costs for	66 00		ne costs (line	64 nlus line	45)(title XV	III only) For	0	66 00
(line 12 x line 19) (line 13 x line 20) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine service (sost (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	00.00		10 00313 (11110	or prus rrine	, 00) (ti ti e xv	111 0111 371 101		00.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Program routine service cost (line 9 x line 71) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to benefici aries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77.01 Total observation bed days (see instructions) 87.02 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	67. 00		e costs through	n December 31	of the cost	reporting period	0	67. 00
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 82.00 Reasonable inpatient encourine service (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77.01 Total observation bed days (see instructions) 87.02 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	68 00		e costs after [ecember 31 c	of the cost re	norting period	0	68 00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/lCF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 1, 541.84 88.00	00.00			occombor 51 c	inc cost re	por tring perrou		00.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total Observation bed days (see instructions) 88.00 Adjusted general inpatient routine service in cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Total Observation bed days (see instructions) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (line 2	69. 00						0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	70.00	·		•		7)		70 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 73.00 74.00 74.00 74.00 74.00 75.00 74.00 74.00 75.00			•		•	, ,		71.00
Total Program general inpatient routine service costs (line 72 + line 73) 74.00 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) Program capital -related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 1. patient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine services (see instructions) Program inpatient ancillary services (see instructions) 84.00 Willization review - physician compensation (see instructions) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 74.00 75.00 76.00 77.00 76.00 77.00 77.00 78.00 77.00 78.00 79.00 80.00		Program routine service cost (line 9 x line	71)		•			72. 00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84								73.00
26, line 45) Per diem capital-related costs (line 75 ÷ line 2) 76.00 Program capital-related costs (line 9 x line 76) Root Inpatient routine service cost (line 74 minus line 77) Root Aggregate charges to beneficiaries for excess costs (from provider records) Root Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Root Inpatient routine service cost per diem limitation Reasonable inpatient routine service costs (see instructions) Reasonable inpatient routine services (see instructions) Root Program inpatient ancillary services (see instructions) Root Utilization review - physician compensation (see instructions) Root PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Root Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76.00 77.00 77.00 78.00 77.00 78.00 77.00 78.00 78.00 79.00 80.00 Reasonable routine service costs (see instructions) Root Reasonable inpatient routine services (see instructions) Root Reasonable inpatient routine services (see instructions) Root Reasonable inpatient routine service costs (see instructions) Root Reasonable inpatient routine service cost (see instructions) Root Reasonable inpatient			•		•	Part II. column		75.00
77. 00 Program capital -related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2.00	'						
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 188.00 Total Program inpatient routine cost per diem (line 27 ÷ line 2) 188.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1	•					76. 00
Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation Reasonable inpatient routine service costs (see instructions) 82.00 Program inpatient ancillary services (see instructions) 83.00 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 84.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 79.00 80.00 81.00 81.00 82.00 83.00 84.00 85.00 86.00 87.00 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		, ,	,					
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1 .		provider reco	ords)			79. 00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				cost limitati	on (line 78 m	inus line 79)		80.00
Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 85.00 Reasonable inpatient routine service costs (see instructions) 86.00 Reasonable inpatient routine service costs (see instructions) 86.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructions) 87.00 Reasonable inpatient routine services (see instructions) 88.00 Reaso		1 .		1)				81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient ancillary services (see instructions) 85.00 85.00 86.00 86.00 87.00 88.		1		* .				82.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1		•				84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84 88.00								85. 00
87.00 Total observation bed days (see instructions) 643 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84 88.00	86.00			irough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,541.84 88.00	87. 00						643	87. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 991,403 89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	,			1, 541. 84	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				991, 403	89.00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/31/2018 11:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	984, 050	5, 743, 352	0. 17133	7 991, 403	169, 864	90.00
91.00 Nursing School cost	0	5, 743, 352	0.00000	991, 403	0	91.00
92.00 Allied health cost	0	5, 743, 352	0.00000	991, 403	0	92.00
93.00 All other Medical Education	0	5, 743, 352	0. 00000	991, 403	0	93. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1318	Peri od:	Worksheet D-3	
			From 01/01/2017	WOLKSHEET D-3)
			To 12/31/2017	Date/Time Pre 5/31/2018 11:	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			2, 945, 657		30.00
31. 00 03100 NTENSI VE CARE UNI T			930, 441		31.00
43. 00 04300 NURSERY			730, 441		43.00
ANCI LLARY SERVI CE COST CENTERS					10.00
50. 00 05000 OPERATING ROOM		0. 1109	91 1, 470, 498	163, 212	50.00
51.00 05100 RECOVERY ROOM		0. 1586	59 206, 850	32, 819	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	00 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000	00 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0756			
54. 01 05401 ULTRASOUND		0.0000		0	
56. 00 05600 RADI 0I SOTOPE		0.0000		0	
57. 00 05700 CT SCAN		0.0000		0	
58. 00 05800 MRI		0.0000		0	
60. 00 06000 LABORATORY		0. 1065			
55. 00 06500 RESPI RATORY THERAPY 56. 00 06600 PHYSI CAL THERAPY		0. 3523 0. 2624		394, 259 67, 557	
57. 00 06000 PHYSTCAL THERAPY		0. 2824			
68. 00 06800 SPEECH PATHOLOGY		0. 1803			
69. 00 06900 ELECTROCARDI OLOGY		0. 0529			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0339		40, 658	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2300		1	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 0919		646, 087	1
76. 00 03610 SLEEP LAB		0. 3070	97 4, 258	1, 308	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 7436			
91. 00 09100 EMERGENCY		0. 2955			
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 5366	51 927	497	92.00
OTHER REIMBURSABLE COST CENTERS					05.65
95. 00 09500 AMBULANCE SERVICES			17 0/7 074	2 102 222	95. 00
Total (sum of lines 50 through 94 and 96 through 100 Less PBP Clinic Laboratory Services-Program			17, 967, 971	2, 103, 329	200.00
Net charges (line 200 minus line 201)	only charges (Time 61)		17, 967, 971		201.00

Health Financial Systems DUKES MEMORIAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	_	CN: 15-1318	Peri od:	eu of Form CMS-2 Worksheet D-3	
INPATTENT ANGILLARY SERVICE COST APPORTIONMENT	Provider C		From 01/01/2017	WOLKSHEEL D-3	'
	Component		Го 12/31/2017	Date/Time Pre 5/31/2018 11:	
	Ti tl e	e XVIII S	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				ı	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 INTENSI VE CARE UNI T			0		31.00
43. 00 O4300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS 50.00 OFFRATING ROOM		0. 11099	1 0	0	50.00
50. 00 05000 0FERATING ROOM 51. 00 05100 RECOVERY ROOM		0.11099		•	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 000000		0	52.00
53. 00 05200 DELI VERT ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0.00000		1, 496	
54. 01 05401 ULTRASOUND		0.00000			
56. 00 05600 RADI OI SOTOPE		0. 000000		0	56.00
57. 00 05700 CT SCAN		0. 000000		0	57.00
58. 00 05800 MRI		0. 000000		Ö	58.00
60. 00 06000 LABORATORY		0. 10652			
65. 00 06500 RESPIRATORY THERAPY		0. 35232			
66. 00 06600 PHYSI CAL THERAPY		0. 26240			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 18634			1
68.00 06800 SPEECH PATHOLOGY		0. 28120	4 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 05293	1, 753	93	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 033950	17, 747	603	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 23008	3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 09197		17, 984	
76. 00 03610 SLEEP LAB		0. 30709	7 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 74368	9 0	0	90.00
91. 00 09100 EMERGENCY		0. 29559	5 0	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 53665	5, 390	2, 893	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1	440. 763	71 712	1200 00

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

440, 763 440, 763 71, 712 200. 00 201. 00 202. 00

200. 00 201. 00

202.00

Health Financial Systems	DUKES MEMORIAL HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO		Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/31/2018 11:	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			_		
30. 00 03000 ADULTS & PEDIATRICS			89, 622		30. 00
31.00 03100 INTENSIVE CARE UNIT			47, 787		31. 00
43. 00 04300 NURSERY			20, 456		43. 00
ANCILLARY SERVICE COST CENTERS			_		
50.00 05000 OPERATING ROOM		0. 11099			
51.00 05100 RECOVERY ROOM		0. 15865		2, 454	1
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 07562		10, 438	1
54. 01 05401 ULTRASOUND		0.00000		0	54. 01
56. 00 05600 RADI 0I SOTOPE		0.00000	0 0	0	56. 00
57. 00 05700 CT SCAN		0.00000	0 0	0	57. 00
58. 00 05800 MRI		0.00000		0	58. 00
60. 00 06000 LABORATORY		0. 10652	3 123, 511	13, 157	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 35232	9 52, 861	18, 624	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 26240	2, 069	543	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 18634	.8	0	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 28120	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 05293	8 36, 292	1, 921	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 03395	0 32, 333	1, 098	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 23008	3 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 09197	4 315, 115	28, 982	73. 00
76. 00 03610 SLEEP LAB		0. 30709		0	76. 00
OUTPATIENT SERVICE COST CENTERS			•		
90. 00 09000 CLI NI C		0. 74368	9 253	188	90. 00
91. 00 09100 EMERGENCY		0. 29559	5 46, 592	13, 772	91.00
02 00 00200 OBSERVATION PERS (NON DISTINCT DART		0 52//5	1 10 022	F 0/7	02 00

0. 536651

10, 933

882, 781

882, 781

5, 867

109, 180 200. 00 201. 00 202. 00

92. 00

95.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

92.00

200. 00 201. 00

202.00

			127 017 2017	5/31/2018 11:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5, 307, 416	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	ti ons)		0	2. 00
3.00	OPPS payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 307, 416	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)	,		0	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	3	•	l ol	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e		a ona govaoro	į	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	
19. 00	Excess of customary charges over reasonable cost (complete only	v if line 18 exceeds li	ne 11) (see	Ö	
17.00	instructions)	y II IIIIe IO exceeds II	110 11) (300	Ĭ	17.00
20. 00	Excess of reasonable cost over customary charges (complete onl	v if line 11 exceeds li	ne 18) (see	o	20. 00
20.00	instructions)	y II IIIIe II exceeds II	110 10) (300	į	20.00
21. 00	Lesser of cost or charges (see instructions)			5, 360, 490	21 00
22. 00	Interns and residents (see instructions)			0,000,170	•
23. 00	Cost of physicians' services in a teaching hospital (see instr	cuctions)		l o	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	4611 0113)			24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			66, 611	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAU soo instructions)		6, 348, 865	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]			-1, 054, 986	
27.00	instructions)	orus the sum of fittes 22	and 23] (See	-1,034,900	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	no 50)		o	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	Tie 50)			29. 00
30.00	Subtotal (sum of lines 27 through 29)			-1, 054, 986	
31. 00	Primary payer payments			1, 045	
32.00	Subtotal (line 30 minus line 31)				
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	rec)		-1, 056, 031	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33. 00
34. 00	Allowable bad debts (see instructions)			998, 208	
35.00	Adjusted reimbursable bad debts (see instructions)			648, 835	
36. 00	, , , , , , , , , , , , , , , , , , , ,	sustions)		879, 746	
37.00	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		-407, 196	
	1			-407, 196	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R				
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-)		١	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	TI ons)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			-407, 196	
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41. 00	Interim payments			1, 300, 483	1
42. 00	Tentative settlement (for contractors use only)			0	
43. 00	Balance due provider/program (see instructions)			-1, 707, 679	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
_	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems DUK ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1318

			'	0 12/31/2017	5/31/2018 11:	
		Title	xVIII	Hospi tal	Cost	
		Inpatien	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 710, 462		1, 300, 483	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	08/08/2017	111, 700		0	3. 01
3.02			. 0		ol	3. 02
3. 03			1 0)	0	3. 03
3.04			1 0)	ol	3. 04
3. 05			1 0)	ol	3. 05
	Provider to Program			•		
3.50	ADJUSTMENTS TO PROGRAM		0)	0	3.50
3. 51			0)	o	3. 51
3.52			0)	0	3. 52
3.53			0)	ol	3. 53
3.54			0)	ol	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		111, 700)	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		3, 822, 162		1, 300, 483	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1, 552, 155	
	TO BE COMPLETED BY CONTRACTOR		l	l		
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0.00
	Program to Provider			•		
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0)	0	5.02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0)	0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		774, 206		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		774, 200		1, 707, 679	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 596, 368		-407, 196	7. 00
			., ., ., ., .	Contractor Number	NPR Date (Mo/Day/Yr)	7. 50
			0	1. 00	2. 00	
8. 00	Name of Contractor		-		2.00	8. 00
2.00		1		T.	'	2.00

Health Financial Systems DUK ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	JCIN. 13-Z310 1	0 12/31/2017	5/31/2018 11:	
		Title	XVIII S	wing Beds - SNF		
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		164, 293	3	0	1. 00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)	<u> </u>				ļ
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3. 02			(0	3. 02
3.03			(0	3. 03
3.04			(0	3. 04
3.05			()	0	3.05
	Provi der to Program	1	_		1	
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			(0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
4. 00	3.50-3.98)		1/4 202	,	0	4.00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		164, 293		0	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	I				
5.00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	1			l	ĺ
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02			d		0	5. 02
5.03					0	5. 03
	Provider to Program	•	•			ĺ
5.50	TENTATI VE TO PROGRAM		()	0	5.50
5. 51					0	5. 51
5.52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		65, 403	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C	1	0	6. 02
7.00	Total Medicare program liability (see instructions)		229, 696		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Mana of Contractor	()	1. 00	2.00	0.00
8.00	Name of Contractor	1				8.00

Heal th	Financial Systems DUKES MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1318 Period: W From 01/01/2017 P To 12/31/2017 D				pared:
-				5/31/2018 11:	18 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	ON			
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4.00					
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00
7. 00					7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestratio	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31. 00
	Ralance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ie)		32 00

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

32.00

				5/31/2018 11:	18 am
		Title XVIII	Swing Beds - SNF	•	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		144.055		
1.00	Inpatient routine services - swing bed-SNF (see instructions)		161, 955	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)		70.400		2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		72, 429	0	3. 00
4.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins Per diem cost for interns and residents not in approved teachi			0.00	4. 00
4.00	instructions)	ng program (see		0.00	4.00
5. 00	Program days		104	0	5. 00
6. 00	Interns and residents not in approved teaching program (see in	nstructions)		0	
7. 00	Utilization review - physician compensation - SNF optional met		0	Ü	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		234, 384	0	
9. 00	Primary payer payments (see instructions)		0	0	
10. 00	Subtotal (line 8 minus line 9)		234, 384	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	
	professional services)	, , , , , ,			
12.00	Subtotal (line 10 minus line 11)		234, 384	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	234, 384	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	•			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
4, 00	adjustment (see instructions)				4, 00
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01 18. 00	Adjusted reimbursable bad debts (see instructions)	rueti enel	0	0	17. 01
19. 00	Allowable bad debts for dual eligible beneficiaries (see instr Total (see instructions)	uctions)	234, 384	0	
19. 00	Sequestration adjustment (see instructions)		4, 688	0	
19. 01	Demonstration adjustment (see Instructions) Demonstration payment adjustment amount after sequestration)		4, 000	0	
20. 00	Interim payments		164, 293	0	
21. 00	Tentative settlement (for contractor use only)		101, 270	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	65, 403	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordan		0	0	23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			1
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	/kst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, line			202. 00
202 00	200 (title XVIII swing-bed SNF))				202 00
	Total (sum of lines 201 and 202)				203. 00 204. 00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the currer	at 5 year demonst	ration	204.00
	period)	Thist year of the curren	it 5-year demonst	1 4 11 011	
205 00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
207.00	Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	•			208. 00
	and 3)				
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
	Reserved for future use	<u> </u>	<u> </u>		210. 00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see		· · · · · · · · · · · · · · · · · · ·	215. 00
	instructions)				

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1318		Worksheet E-3 Part V Date/Time Prepared: 5/31/2018 11:18 am

				5/31/2018 11:	18 am
	Title	XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERV	ICES - COST	REI MBURSEMENT		
1.00	Inpatient services			5, 083, 301	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2.00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			5, 083, 301	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 134, 134	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		,		
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for payment for s	ervices on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for	services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13. 00
14. 00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14	exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete only if line 6	exceeds lin	e 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	17. 00
10.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	40.00
	Direct graduate medical education payments (from Worksheet E-4, line 49)			0	
	Cost of covered services (sum of lines 6, 17 and 18) Deductibles (exclude professional component)			5, 134, 134 484, 288	
	Excess reasonable cost (from line 16)			484, 288	20.00
	Subtotal (line 19 minus line 20 and 21)			4, 649, 846	
	Coi nsurance			4, 049, 640	23.00
	Subtotal (line 22 minus line 23)			4, 649, 846	
	Allowable bad debts (exclude bad debts for professional services) (see ins	tructions)		62, 039	
	Adjusted reimbursable bad debts (see instructions)	ti ucti ons)		40, 325	
	Allowable bad debts for dual eligible beneficiaries (see instructions)			16, 642	
	Subtotal (sum of lines 24 and 25, or line 26)			4, 690, 171	
	MSP			4, 090, 171	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	29.50
	Demonstration payment adjustment amount before sequestration			0	29. 99
	Subtotal (see instructions)			4, 690, 171	
	Sequestration adjustment (see instructions)			93, 803	
	Demonstration payment adjustment amount after sequestration			93, 603	30.01
	Interim payments			3, 822, 162	
	Tentative settlement (for contractor use only)			3, 622, 162	32.00
	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		774, 206	
	Protested amounts (nonallowable cost report items) in accordance with CMS		chanter 1	528, 559	34.00
	The costed amounts (nonarrowable cost report richis) in accordance with ows	1 45. 15 2,	Chapter 1,	320, 337	J 37. 00

Health Financial Systems

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

Provider CCN: 15-1318

Peri od: Worksheet G
From 01/01/2017
To 12/31/2017 Date/Ti me Prepared: 5/31/2018 11: 18 am

Current Fund Pulmon Fund	OH y)					5/31/2018 11:	18 am_
			General Fund		Endowment Fund	Plant Fund	
Dissert ASSITS			1 00		2 00	4.00	
Cash on hand in Danies		CURRENT ASSETS	1.00	2.00	3.00	4.00	
Imaginary Investments	1.00		-111, 970	0	0	0	1.00
Notes receivable			1	1	0	o o	1
Online O	3.00		0	0	0	0	3. 00
All Oweneos For uncollectible notes and accounts receivable 5,2 28,867 0 0 0 0 0 0 0 0 0	4.00	Accounts recei vabl e	19, 245, 260	0	0	0	4. 00
1.008,430 0 0 0 0 0 0 0 0 0	5.00		0	0	0	0	5. 00
Pregaid dispenses 26,40d 0 0 0 0 0 0 0 0 0				0	0		
Other current assets				1	0		
10.00 Due from other funds			1	1	0		
1.00 Total current assets (sum of lines 1-10) 15, 408, 675 0 0 11, 00				1	0		
FixED_ASSETS			1	_	0		
12.00 Land Improvements	11.00		15, 408, 075	0	U	η υ	11.00
13.00 Land Improvements	12 00		500,000	0	0		12 00
14.00 Accumulated depreciation -110,052 0 0 14.00			1				
15.00 But I dings		· ·	1	1			1
17.00 Leasehold improvements	15.00		10, 491, 181	0	0) o	15. 00
18.00 Accumul ated depreciation -2, 004, 503 0 0 18.00 0 0 19.00 19.00 For operation -943, 043 0 0 0 19.00 1	16.00	Accumulated depreciation	-3, 154, 497	0	0	0	16. 00
19.00 Fixed equipment	17.00	Leasehold improvements	9, 572, 354	0	0	0	17. 00
20.00 Accumulated depreciation -943,043 0 0 0 20.00				1	0	1	1
21.00 Automobiles and trucks				1	0	0	
22.00 Accumulated depreciation -422,388 0 0 0 22.00					0	0	
23. 00 Maj or movable equipment			1	1	0	1	
24.00 Accumulated depreciation -5, 371, 257 0 0 24.00		•	1	1	0	1	
25.00 Minor equipment depreciable 2,841,093 0 0 0 25.00				1	0	1	1
26. 00 Accumulated depreciation -2, 355, 900 0 0 0 27, 00 28, 00 0 0 0 0 27, 00 28, 00 0 0 0 0 0 0 0 0 0				1	0		
27. 00				1	0	1	
28. 00 Accumulated depreciation 0 0 0 0 28. 00			2, 333, 700	0	0		1
29. 00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 0 0			0	0	0	1	
30.00 Total fixed assets (sum of lines 12-29) 18, 389, 441 0 0 0 30.00			0	Ó	0	0	
31.00	30.00		18, 389, 441	0	0	0	30.00
32.00 Deposits on Leases 0 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 0 33.00 34.00 Other assets 3 792,718 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 3,792,718 0 0 0 35.00 50.00 Total assets (sum of lines 11, 30, and 35) 37,590,234 0 0 0 0 50.00 CURRENT LIABILITIES		OTHER ASSETS					
33.00 Due from owners/officers 0 0 0 0 33.00 34.00 Other assets 3,792,718 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 3,792,718 0 0 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 37,590,234 0 0 0 0 35.00 OURRENT LIABILITIES			0		0		
34.00 Other assets 3,792,718 0 0 0 34.00		· ·	0		0		
35.00 Total other assets (sum of lines 31-34) 3,792,718 0 0 0 35.00			0	_	0		
36.00 Total assets (sum of lines 11, 30, and 35) 37,590,234 0 0 0 36.00				1	0		1
CURRENT LIABILITIES							
37.00 Accounts payable	30.00		37, 390, 234	1 0	U	,	30.00
38.00 Salaries, wages, and fees payable 994,089 0 0 0 38.00 39.00 Payroll taxes payable 99,371 0 0 0 39.00 04.00 Notes and loans payable (short term) 0 0 0 0 0 04.00 04.00 0 0 0 0 0 0 0 0 0	37 00		1 991 762	0	0		37 00
39.00 Payrol taxes payable 99,371 0 0 0 39.00				1			
40.00 Notes and Loans payable (short term)			1	0	0	1	1
41.00 Deferred income			0	Ō	0	o o	1
43.00 Due to other funds 44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 45.00 Total current liabilities (sum of lines 37 thru 44) 45.00 LONG TERM LIABILITIES 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 49.00 Other long term liabilities 48.00 Unsecured loans 49.00 Other long term liabilities 49.00 Other long term liabilities 49.00 Other long term liabilities 40.00 Total long term liabilities 40.00 Other long term l	41.00		0	0	0	٥ ار	41.00
44.00 Other current liabilities	42.00	Accel erated payments	0)			42.00
45.00 Total current liabilities (sum of lines 37 thru 44) -15,836,773 0 0 0 0 45.00	43.00	Due to other funds	-19, 310, 200	0	0	0	43.00
LONG TERM LIABILITIES			388, 205	0	0	0	44. 00
Mortgage payable 0 0 0 0 0 0 0 0 0	45. 00		-15, 836, 773	0	0) 0	45. 00
47. 00 Notes payable 0 0 0 0 0 47. 00 48. 00 Unsecured I oans 0 0 0 0 0 0 48. 00 49. 00 Other I ong term I i abi I i ti es (sum of I ines 46 thru 49) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			T	1			
48.00 Unsecured Loans 49.00 Other Long term Liabilities 50.00 Total long term Liabilities (sum of Lines 46 thru 49) 50.00 Total long term Liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50) 52.00 General fund balance 52.00 Specific purpose fund 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 55.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 37,590,234) 50.00 O O O O O O O O O O O O O O O O O O		1 0 0 1 3	0		_		
49.00 Other long term liabilities 0 0 0 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 1.00 Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS 52.00 General fund bal ance 52.00 Specific purpose fund 52.00 Donor created - endowment fund bal ance - restricted 53.00 Donor created - endowment fund bal ance - unrestricted 55.00 Donor created - endowment fund bal ance 56.00 Governing body created - endowment fund bal ance 57.00 Plant fund bal ance - invested in plant 58.00 Plant fund bal ance - reserve for plant improvement, replacement, and expansion 59.00 Total liabilities and fund bal ances (sum of lines 51 and 37,590,234) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	-	_	_		
Total long term liabilities (sum of lines 46 thru 49)							1
Total liabilities (sum of lines 45 and 50)		1		_	_		
CAPITAL ACCOUNTS 52.00 General fund balance 53,427,007 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 Governing body created - endowment fund balance 0 56.00 57.00 Flant fund balance - invested in plant 0 57.00 Flant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 53,427,007 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 37,590,234 0 0 0 60.00		,	-15 836 773				
52.00 General fund balance 53,427,007 52.00 53.00 53.00 54.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 56.00 56.00 56.00 56.00 57	31.00		13,030,773	· · · · · · · ·		1 0	31.00
53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 57.00 Plant fund balance - invested in plant 0 57.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 58.00 59.00 Total fund balances (sum of lines 52 thru 58) 53,427,007 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 37,590,234 0 0 0 60.00	52.00		53, 427, 007	1			52.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 53,427,007 60.00 Total liabilities and fund balances (sum of lines 51 and 37,590,234) 54.00 55.00 55.00 56.00 56.00				1			
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 37,590,234) 56.00 57.00 58.00 58.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00	1			0	ار	54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 37,590,234) 57.00 0 57.00 0 58.00 0 0 0 59.00 0 0 0 60.00	55.00				0)	55. 00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 37,590,234) 0 0 0 0 60.00	56.00	Governing body created - endowment fund balance			0)	56. 00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 37,590,234) 0 0 0 59.00		•					
59.00 Total fund balances (sum of lines 52 thru 58) 53,427,007 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 0.00 37,590,234 0 0 0 0 60.00	58. 00					0	58. 00
60.00 Total liabilities and fund balances (sum of lines 51 and 37,590,234 0 0 0 60.00							
				1	_		
	ou. 00		37, 590, 234		0	ή ο	00.00
		<i>∨′/</i>	I	I		1	1

DUKES MEMORIAL HOSPITAL

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1318

					To 12/31/2017	Date/Time Prep 5/31/2018 11:	pared: 18 am
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00 2.00 3.00 4.00	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)		46, 151, 753 7, 221, 614 53, 373, 367		0		1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00	(a, a, a	0 0 0			0 0 0 0 0 0 0	0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0	0 53, 373, 367		0 0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
16. 00 17. 00 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	0 53, 373, 367		0 0 0		16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 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		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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0		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 deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0		17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1318

			10 12/31/201/	5/31/2018 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	
	<u> </u>	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	6, 509, 39	3	6, 509, 398	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				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, 509, 39	3	6, 509, 398	
10.00	Intensive Care Type Inpatient Hospital Services	5, 55, 75,	<u>-</u>	0,00,,0,0	10.00
11. 00	INTENSIVE CARE UNIT	1, 443, 89		1, 443, 892	11. 00
12. 00	CORONARY CARE UNIT	1, 1.0, 07		17 1107 072	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes 1, 443, 89		1, 443, 892	16. 00
10.00	111-15)	1, 443, 07		1, 443, 072	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	7, 953, 29		7, 953, 290	17. 00
18. 00	Ancillary services	46, 642, 09	1	139, 111, 230	
19. 00	Outpatient services	i ' '	28, 700, 621	28, 700, 621	19. 00
20. 00	RURAL HEALTH CLINIC		0 28, 700, 621	20, 700, 621	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21. 00
21.00			٦	U	
	HOME HEALTH AGENCY			0	22. 00
23. 00	AMBULANCE SERVICES			0	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst. 54, 595, 38	121, 169, 753	175, 765, 141	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		21 727 727		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		31, 726, 633		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00		•			32.00
33. 00					33. 00
34. 00		•)		34. 00
35. 00)		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY))		37. 00
38. 00)		38. 00
39. 00			0		39. 00
40. 00)		40. 00
41.00			0		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	31, 726, 633		43. 00
	to Wkst. G-3, line 4)	1			

Heal th	Financial Systems DUKES	MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1318 Period:			Worksheet G-3	
			From 01/01/2017	Date/Time Pre	
				5/31/2018 11:	10 alli
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, colum	nn 3 line 28)		175, 765, 141	1. 00
2.00	Less contractual allowances and discounts on patients			136, 933, 396	2.00
3.00	Net patient revenues (line 1 minus line 2)	3 400041110		38, 831, 745	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part I	I line 43)		31, 726, 633	4. 00
5. 00	Net income from service to patients (line 3 minus lines)			7, 105, 112	5. 00
0.00	OTHER I NCOME	.5 .,		77 1007 112	0.00
6.00	Contributions, donations, bequests, etc			0	6. 00
7. 00					7. 00
8.00					8. 00
9.00	· ·				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
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to	o other than patients		0	16. 00
	Revenue from sale of drugs to other than patients	•		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and cantee	en		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			116, 502	24. 00
25. 00	Total other income (sum of lines 6-24)			116, 502	25. 00
26.00	Total (line 5 plus line 25)			7, 221, 614	26. 00
27 00	OTHER EXPENSES (SPECIEV)				27 00

0 27. 00 28. 00

7, 221, 614 29. 00

27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)