AND SETTLEMENT	SUMMARY	Provider CCN: 15-1318	From 01/01/2018	Parts I-III Date/Time Prepared: 5/31/2019 12:18 pm
PART I - COST	REPORT STATUS			·
Provi der	1. [X] Electronically filed cost report		Date: 5/31/20	19 Ti me: 12:18 pr
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 " $$		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 (3) Settled with Audit 9. [N]Final Report for (4) Reopened (5) Amended	or this Provider CCN 12		

PART II - CERTIFICATION

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 01/01/2018 and ending 12/31/2018 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)
Ti tl e
Nate

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	555, 189	-108, 896	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	-6, 230	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	548, 959	-108, 896	0	0	200. 00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boul evard, 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.

In Lieu of Form CMS-2552-10

Period: Worksheet S-2
From 01/01/2018 Part I
 Heal th Financial
 Systems
 DUKES MEMORIAL
 HOSPITAL

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

	THE THE HEALTH STATE COME COME	. 52				From 01/01 To 12/31		Part I Date/Ti	ime Pre	
	1.00	2.00		3. 00			4. 00	5/31/20	019 12:	18 pm
	Hospital and Hospital Health Care Co	mplex Address:								
1. 00 2. 00	Street: 275 WEST 12TH STREET City: PERU	PO Box: State: IN	Zip Cod	le: 469	970 Cou	nty: MLAMI				1.00
		Component Name	CCN	CBS	SA Provi de	er Date	1 2	nt Syst		
			Number	Numb	ber Type	Certi fi ed	1 1,	0, or		-
		1.00	2.00	3. (00 4.00	5. 00	6. 00			
3. 00	Hospital and Hospital-Based Componen Hospital	t Identification: DUKES MEMORIAL HOSPI	TAL 151318	999	915 1	07/01/196	6 N	0	P	3.00
4. 00	Subprovi der - IPF	DOKES WEWOKIAL HOSITI	131310	777	,13	077017170			'	4.00
5.00	Subprovi der - IRF									5.00
6. 00 7. 00	Subprovi der - (Other) Swing Beds - SNF	DUKES MEMORIAL HOSPIT	TAL 15Z318	999	915	12/01/200	3 N	0	N	6.00
		SB								
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF									9.00
10.00	Hospi tal -Based NF									10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA									11. 0
13. 00										13.00
14.00	· ·									14.00
15. 00 16. 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									15. 00
17. 00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis Other									18.00
17.00	other					From	1:	To):	17.00
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/		12/31		20. 00
	Type of Control (see instructions)					4	2010	12/31	7 20 10	21. 00
					1. 00	2. 0	0	3.	00	-
	Inpatient PPS Information					2.0		0.		
22. 00	Does this facility qualify and is it disproportionate share hospital adju				N					22.00
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		amendment							
22. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un		ents for th	is	l N	N				22. 0
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft	er October 1. (see in	structions)							
22. 02	Is this a newly merged hospital that payments to be determined at cost re	•			N	N				22. 02
	Enter in column 1, "Y" for yes or "N	" for no, for the por	tion of the	,						
	cost reporting period prior to Octob or "N" for no, for the portion of th									
	October 1.	c cost reporting peri	ou on or ar	toi						
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar				N	N		N	I	22. 03
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for			er						
	reporting period occurring on or aft									
	Does this hospital contain at least		•							
	counted in accordance with 42 CFR 41 yes or "N" for no.	2. 105)? Enter in coru	IIII 3, Y I	OI						
23. 00	Which method is used to determine Me	3				3 N				23.00
	below? In column 1, enter 1 if date if date of discharge. Is the method									
	reporting period different from the									
	reporting period? In column 2, ente			State	Out-of	Out-of	Medi cai	id 0	ther	
				cai d	State	State	HMO day	'	di cai d	
		parc		ji bl e pai d	Medicaid paid days	Medicaid eligible			days	
			da	iys	. ,	unpai d				
24 00	If this provider is an IPPS hospital		. 00 2.	00	3.00	4. 00	5. 00	0	5. 00 0	24. 00
24. UU	in-state Medicaid paid days in colum	n 1, in-state	۷	U] "			٦	U	24.00
	Medicaid eligible unpaid days in col									
	out-of-state Medicaid paid days in cout-of-state Medicaid eligible unpai									
	4, Medicaid HMO paid and eligible bu	t unpaid days in								
	column 5, and other Medicaid days in	column 6.			1 1			I		I

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	MEMORIAL HO	DSPLIAL Provider CC	:N: 15-1318	Peri od:	In Lie		Form CMS- sheet S-2	
	AL AND HOST THE HEALTH SAIL SOME EEX TREATH TOATH ON D				From 01/0 To 12/3	1/2018	Part Date 5/31	 /Time Pre /2019 12:	epared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO d	ays	Other Medicaid days	
. 00	If this provider is an IRF, enter the in-state	1.00	2. 00	3. 00	4. 00 0	5. 0	0 0	6. 00	25. (
J. 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.		0	o d		ural S		of Geogr	
					1.		Date	2. 00	+
7. 00	Enter your standard geographic classification (not we cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban center the effective date of the geographic reclassification in this is a sole community hospital (SCH), enter the	or rural. vage) status or "2" for r ication in	at the end ural. If ap column 2.	l of the cos oplicable,	t	:	2		26. (27. (35. (
J. 00	effect in the cost reporting period.	ie ridiliber or	perrous so	n status in		`			33.
					Begi n			ndi ng: 2. 00	
5. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb		30		2.00	36.
7 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), enter		r of portor	le MDU etatu	_	,			37.
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t	he MDH tran	sitional pa	nyment in		,			37.
. 00	accordance with FY 2016 OPPS final rule? Enter "Y" finstructions) If line 37 is 1, enter the beginning and ending date	3		•					38.
	greater than 1, subscript this line for the number of enter subsequent dates.	f periods i	n excess of	one and	Y/	'N		Y/N	
					1.			2. 00	
0.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum nts in	n	I		N	39.
). 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octono in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y					N	40.
						1. 0	0 2.		-
	Prospective Payment System (PPS)-Capital					1.0	0 2.	00 3.00	
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc	•	·			N N	N		45. 46.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	st. L, Pt. I	II and Wkst	:. L-1, Pt.	l through			ı N	
. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymer Teaching Hospitals	it? Enter "	Y" for yes	or "N" for	10.	N N			47. 48.
. 00	Is this a hospital involved in training residents in or "N" for no.	approved G	ML programs	s? Enter "Y	' for yes	N			56.
	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "N oth of this Y", complet I, if appli	" for no in cost report e Worksheet cable.	n column 1. ing period? :E-4. If co	f column Enter "Y' umn 2 is	'			57.
	If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		s as	N			58.
. 00	Are costs claimed on line 100 of Worksheet A? If ye	es, complete	Wkst. D-2,	Pt. I. NAHE 413.8 Y/N	5 Worksh Lin		Qual	-Through ification erion Code	
				1. 00	2.	00		3. 00	

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 Systems
 DUKES MEM

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
 In Lieu of Form CMS-2552-10 DUKES MEMORIAL HOSPITAL

		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5. 00	
61. 00	Did your hospital receive FTE slots under ACA	N			0.00		61. 00
	section 5503? Enter "Y" for yes or "N" for no in						
61 01	column 1. (see instructions) Enter the average number of unweighted primary care						61. 01
01.01	FTEs from the hospital's 3 most recent cost reports						01.01
	ending and submitted before March 23, 2010. (see						
(4.00	instructions)						(4.00
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61. 02
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
61. 03	Enter the base line FTE count for primary care						61. 03
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see						
	instructions)						
61. 04	Enter the number of unweighted primary care/or						61. 04
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						
61. 05	Enter the difference between the baseline primary						61. 05
	and/or general surgery FTEs and the current year's						
	primary care and/or general surgery FTE counts (line						
61 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being						61. 06
01.00	used for cap relief and/or FTEs that are nonprimary						01.00
	care or general surgery. (see instructions)						
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE	
					I IL COUIT	Count	
			1. 00	2. 00	3.00	4. 00	
61. 10					0. 00	0. 00	61. 10
	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in						
	column 1, the program name. Enter in column 2, the						
	program code. Enter in column 3, the IME FTE						
	unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
61. 20	Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61. 20
	program specialty, if any, and the number of FTE						
	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column						
	3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
						1.00	
	ACA Provisions Affecting the Health Resources and Ser	vi ces	Administration	(HRSA)		1.00	
62. 00	Enter the number of FTE residents that your hospital		d in this cost	reporting peri	od for which	0.00	62. 00
62 01	your hospital received HRSA PCRE funding (see instructions the number of FTE residents that rotated from a		na Hoalth Cont	tor (TUC) into	your bosnital	0.00	62. 01
02.01	during in this cost reporting period of HRSA THC prog		9	` '	your nospital	0.00	02.01
	Teaching Hospitals that Claim Residents in Nonprovide	er Sett	i ngs				
63. 00	Has your facility trained residents in nonprovider se					N	63. 00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete iine	es 64 through 6	Unweighted		Ratio (col. 1/	
				FTĔs	FTEs in	(col . 1 + col .	
				Nonprovi der	Hospi tal	2))	
				Si te	2.00	3 00	
	Section 5504 of the ACA Base Year FTE Residents in No	nprovi	der Settinas	1.00 This base year	2.00	3.00 reporting	
	period that begins on or after July 1, 2009 and befor	<u>e June</u>	30, 2010.	o zaso year			
64. 00	Enter in column 1, if line 63 is yes, or your facilit	y trair	ned residents	0.00	0. 00	0. 000000	64. 00
	in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in						
	settings. Enter in column 2 the number of unweighted		•				
	resident FTEs that trained in your hospital. Enter in	col umr	n 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see	instrud	ctions)	l			

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

OSPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	ATA Provider (riod: om 01/01/2018 12/31/2018	Date/Time Pre	pared:
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	5/31/2019 12: Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column			0.00	0.00	0. 000000	03. (
4)). (see instructions)						
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Vear FTE Residents i	n Nonnrovider Settin	1.00	2.00 r.cost reporti	3.00	
beginning on or after July 1, 20	10			·		
6.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpo unweighted non-prima al. Enter in column :	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66. (
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	3.00	4.00	5.00	67. (
				1. 00	0 2.00 3.00	
Inpatient Psychiatric Facility P		IDE) or does it cont	tain an IDE aubna			70.0
.00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	the facility have an efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program yo	n approved GME teachi 004? Enter "Y" for y llity train residents)(D)? Enter "Y" for y	ng program in the yes or "N" for no s in a new teachi yes or "N" for no	ne most D. (see ng	0	70. (
Inpatient Rehabilitation Facilit 5.00 Is this facility an Inpatient Re	habilitation Facility	y (IRF), or does it o	contain an IRF	N		75. (
subprovider? Enter "Y" for yes 10.00 If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente	the facility have and ing on or before Nove train residents in a	ember 15, 2004? Enter new teaching program	r "Y" for yes or m in accordance w	"N" for	0	76. C

	Financial Systems DUKES MEMORIA AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 15-1318	Peri od: From 01/01/2018 To 12/31/2018	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/31/2019 12:	epared:	
					1. 00	+	
	Long Term Care Hospital PPS				N	80.00	
	00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.						
	TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 6.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						
37. 00	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified ι	under section	1	N	87. 00	
	1000(d)(1)(b)(v1): Litter 1 101 yes of N 101 no.			V	XI X		
	Title V and XIX Services			1. 00	2. 00		
90. 00	nitie v and xix services Does this facility have title V and/or XIX inpatient hospita	I services? Er	nter "Y" for	N	Υ	90.00	
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			N	N	91.00	
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (du	al certificati			N	92.00	
93. 00	instructions) Enter "Y" for yes or "N" for no in the applica Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00	
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	in the	N	N	94. 0	
5. 00	appircable column. If line 94 is "Y", enter the reduction percentage in the app	licable column	۱.	0. 00	0. 00	95. 0	
6. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes	or "N" for no	in the	N	N	96. 0	
7. 00	applicable column. If line 96 is "Y", enter the reduction percentage in the app	licable column	٦.	0. 00	0. 00	97. 0	
98. 00	Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.			Y	Y	98. 0	
98. 01	Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.	porting of chatle V, and in	arges on Wkst column 2 for	Y Y	Υ	98. 0	
8. 02	Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Y	98. 0	
8. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye				N	98. 0	
8. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 0	
8. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Υ	98. 0	
8. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	reimbursed for 1 for title \	Wkst. D, /, and in	Y	Υ	98. 0	
	Rural Providers						
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive meth	nod of paymer	Y N		105. 00 106. 00	
07. OC	If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	1. (see instr	ructions) If			107. 0	
08. 00	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					108. 0	
		Physi cal 1.00	Occupationa 2.00	Speech 3.00	Respi ratory 4.00		
09. 00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for percent therapy.	Y	Y Y	Y Y	N N	109. 0	

Pts. I through IV? Enter "Y" for yes or "N" for no in column	n 1 for title \	/, and in					
column 2 for title XIX.							
Rural Providers							
105.00 Does this hospital qualify as a CAH?			Υ		105. 00		
106.00 If this facility qualifies as a CAH, has it elected the all	6.00 \mid lf this facility qualifies as a CAH, has it elected the all-inclusive method of payment \mid N						
for outpatient services? (see instructions)							
107.00 If this facility qualifies as a CAH, is it eligible for cos	N		107. 00				
training programs? Enter "Y" for yes or "N" for no in column	n 1. (see instr	ructions) If					
yes, the GME elimination is not made on Wkst. B, Pt. I, col.	. 25 and the pr	rogram is cost					
reimbursed. If yes complete Wkst. D-2, Pt. II.		_					
108.00 Is this a rural hospital qualifying for an exception to the		108. 00					
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							
	Physi cal	Occupati onal	Speech	Respi ratory			
	1.00	2.00	3. 00	4.00			
109.00 If this hospital qualifies as a CAH or a cost provider, are	Υ	Y	Y	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 Hospital	al Demonstratio	on project (§41	OA	N	110. 00		
Demonstration) for the current cost reporting period? Enter	"Y" for yes or	"N" for no. If	yes,				
complete Worksheet E, Part A, lines 200 through 218, and Wo	rksheet E-2, li	nes 200 throug	h 215, as				
appl i cabl e.							

	ORI AL HOSPI TAL	L 1E 1010		II LIE	u of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN	l: 15-1318	Period: From 01/01 To 12/31		Workshe Part I Date/Ti 5/31/20	me Pre	epared:
			1. 00	<u> </u>	2. ()O	+
111.00 If this facility qualifies as a CAH, did it participate Health Integration Project (FCHIP) demonstration for thi "Y" for yes or "N" for no in column 1. If the response t integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" fo for tele-health services.	s cost reporting pe to column 1 is Y, er s participating in c	eriod? Enter nter the column 2.	N	,	2.0		111.0
				1. 00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for ye is yes, enter the method used (A, B, or E only) in colum 3 either "93" percent for short term hospital or "98" pe psychiatric, rehabilitation and long term hospitals prov Pub. 15-1, chapter 22, §2208.1.	nn 2. If column 2 is ercent for long term viders) based on the	s "E", enter n care (incl e definition	in column udes	N		0	115. 0
l16.00 is this facility classified as a referral center? Enter 117.00 is this facility legally-required to carry malpractice i no.			"N" for	N N			116. C
118.00 Is the malpractice insurance a claims-made or occurrence claim-made. Enter 2 if the policy is occurrence.	e policy? Enter 1 if	the policy	is	1			118. 0
jordani mador Erresi E vi vite pervey re decervates.		Premi ums	Losse	es	Insur	ance	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 15, 1	2.00) 3, 350	3. 0		0118.0
10.01 List allouits of marpractice premiums and pard rosses.		15, 1	71	3, 330		<u>'</u>	0116.0
18.02 Are malpractice premiums and paid losses reported in a c		on the	1. 00 N)	2. (00	118. (
Administrative and General? If yes, submit supporting s and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient §3121 and applicable amendments? (see instructions) Ente "N" for no. Is this a rural hospital with < 100 beds tha Hold Harmless provision in ACA §3121 and applicable amen	Hold Harmless provi er in column 1, "Y" it qualifies for the	sion in ACA for yes or Outpatient			N		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 i patients? Enter "Y" for yes or "N" for no.	mplantable devices	charged to	Y				121. (
22.00 Does the cost report contain healthcare related taxes as Act?Enter "Y" for yes or "N" for no in column 1. If colu the Worksheet A line number where these taxes are included.	mn 1 is "Y", enter						122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y	" for yes and "N" f	or no. If	N				125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 ff this is a Medicare certified kidney transplant center in column 1 and termination date, if applicable, in colu		cation date	•				126.
27.00 f this is a Medicare certified heart transplant center, in column 1 and termination date, if applicable, in colu	enter the certific	cation date					127.
28.00 If this is a Medicare certified liver transplant center, in column 1 and termination date, if applicable, in colu	enter the certific	cation date					128.
29.00 of this is a Medicare certified lung transplant center, column 1 and termination date, if applicable, in column	2.		n				129.
30.00 olf this is a Medicare certified pancreas transplant cent date in column 1 and termination date, if applicable, in 31.00 of this is a Medicare certified intestinal transplant ce	column 2.						130.
date in column 1 and termination date, if applicable, in 32.00 of this is a Medicare certified islet transplant center,	column 2.						132.
in column 1 and termination date, if applicable, in colu 33.00 of this is a Medicare certified other transplant center,	enter the certific	cation date					133. (
in column 1 and termination date, if applicable, in colu	ımn 2.	n column 1					134. (
34.00 If this is an organ procurement organization (OPO), ente and termination date, if applicable, in column 2.	er the OPO number in	r corumir r					

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 01/01/2018 Part I То 12/31/2018 Date/Time Prepared: 5/31/2019 12:18 pm 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 Contractor's Number: 52280 141 00 Name: CHS/COMMUNITY HEALTH SYSTEMS, Contractor's Name: WPS 141 00 LNC 142.00 Street: 4000 MERIDIAN BLVD PO Box: 142.00 143.00 Ci ty: FRANKLIN State: Zip Code: 37067 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 1.00 2.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 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? Ν 146, 00 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 V Title XIX 1.00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155. 00 156.00 Subprovi der - IPF Ν 156. 00 Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 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? Enter "Y" for yes or "N" for no. Ν 165.00 FTE/Campus Zip Code Name County State **CBSA** 3.00 0 1.00 2.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act		
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the	1	1168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	hardshi p		168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions)	l"), enter the	0.00	0169. 00
	Begi nni ng	Endi ng	
	1. 00	2.00	1
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2018	03/31/2018	170. 00
	1. 00	2.00	1
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	C	0171.00

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 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/31/2019 12: 18 pm 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 $\overline{\text{the PS\&R Report onl y?}}$ 04/17/2019 04/17/2019 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 Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 N Ν Report data for corrections of other PS&R Report

information? If yes, see instructions.

Heal th	Financial Systems DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CM	IS-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-1318	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S Part II Date/Time F 5/31/2019 1	Prepared:
	·	Descr	i pti on	Y/N	Y/N	
			0	1. 00	3.00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	· · · · · · · · · · · · · · · · · · ·	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	HOSPLTALS)		1.00	
	Capital Related Cost	LI I OIII EDIKENS I	1031117423)			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost	N	23. 00
	reporting period? If yes, see instructions.			9		
24. 00	Were new leases and/or amendments to existing leases enterollifyes, see instructions	ed into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	'If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit	N	27. 00
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	reporting	N	28. 00		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	N	29. 00			
30. 00	Has existing debt been replaced prior to its scheduled mati	s, see	N	30. 00		
31. 00	Has debt been recalled before scheduled maturity without is instructions.	s, see	N	31. 00		
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru		ed through co	ontractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applies, see instructions.		ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an a	rrangement with	n provi der-ba	sed physicians?	Y	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based	Y	35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	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
39. 00	the provider? If yes, enter in column 2 the fiscal year en	d of the home o	offi ce.			39. 00
	If line 36 is yes, did the provider render services to othe see instructions.	•	,			
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1	. 00	2	00	
	Cost Report Preparer Contact Information			Σ.		
41. 00	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
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEAL	_TH SYSTEMS,			42. 00
	preparer.	I NC	•	VIIZIWA TOLOAGO	UC NET	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416		KUZI WA_TSI GA@CI	ns. Ne i	43. 00

Heal th	Financial Systems DUKES MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-13	F	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
					5/31/2019 12:	18 pm
		3.00		-		
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MANAGER				41. 00
	respectively.					
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 cost report preparer in columns 1 and 2, respectively.					43. 00

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:
 Heal th Financial
 Systems
 DUKES

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

					1	o 12/31/2018	Date/Time Pre 5/31/2019 12:	
							I/P Days / O/P	ГО р
							Visits / Trips	
	Component	Worksheet A Line Number	No	. of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		21	7, 665	66, 415. 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 I PF Subprovi der							3.00
4.00	HMO I RF Subprovi der							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF			0.4	7 //		0	6.00
7. 00	Total Adults and Peds. (exclude observation			21	7, 665	66, 415. 00	0	7. 00
0 00	beds) (see instructions)	21 00		4	1 4/6	0.00	0	0.00
8. 00 9. 00	INTENSIVE CARE UNIT	31. 00		4	1, 460	0.00	0	8. 00
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							9. 00 10. 00
11. 00	1							11.00
12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13.00
14. 00	Total (see instructions)	43.00		25	9, 125	66, 415. 00		14. 00
15. 00	CAH visits			25	7, 123	00,415.00	0	15. 00
16. 00	SUBPROVI DER - I PF						Ŭ	16.00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			25				27. 00
28.00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	()		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1318

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

33.01

5/31/2019 12:18 pm I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 6.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1, 443 20 2, 747 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 253 2 00 HMO and other (see instructions) 2 00 3.00 HMO IPF Subprovider 0 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 83 0 5.00 83 Hospital Adults & Peds. Swing Bed NF 6.00 C 6.00 7.00 Total Adults and Peds. (exclude observation 1,526 20 2,830 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 224 306 8.00 CORONARY CARE UNIT 9.00 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 252 13.00 197. 70 14.00 Total (see instructions) 1,750 28 3, 388 0.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 0 24. 10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26.25 Ω 0 26.25 27.00 Total (sum of lines 14-26) 0.00 197.70 27.00 28.00 Observation Bed Days 747 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 0 32.00 32.00 0 0 0 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

33.01 LTCH site neutral days and discharges

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1318

				To	12/31/2018	Date/Time Pre 5/31/2019 12:	pared: 18 pm
		Full Time	<u>'</u>	Di sch	arges	0,01,201,	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	11.00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	472	9	884	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)			81	0		2. 00
3.00	HMO IPF Subprovider			01	0		3.00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ŭ		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	0	472	9	884	
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00							20.00
21. 00 22. 00	OTHER LONG TERM CARE						21.00
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0	l		33. 01

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-1318	Peri od:	Worksheet S-3
		From 01/01/2018	Part IV

	To 12/31/2018	Date/Time Pre 5/31/2019 12:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	215, 020	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	Heal th Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	724, 147	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	9, 738	10. 00
11. 00	Life Insurance (If employee is owner or beneficiary)	10, 103	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	212	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	7, 237	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	124, 030	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	663, 484	17. 00
18.00	Medicare Taxes - Employers Portion Only	155, 170	18. 00
19.00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	32, 584	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1, 941, 725	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	12, 539	25. 00

	Financial Systems DUKES MEMORIAL HOSPI	I TAL	In Lie	u of Form CMS-2	2552-10		
HUSPI I		vider CCN: 15-1318	Peri od:	Worksheet S-10			
			From 01/01/2018 To 12/31/2018	Date/Time Prep 5/31/2019 12:			
				373172017 12.	ТО ріп		
				1.00			
	Uncompensated and indigent care cost computation						
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line 202 colum	n 8)	0. 178262	1. 00		
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			3, 197, 951	2. 00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?		3, 197, 931	3. 00			
4. 00							
5.00	If line 4 is no, then enter DSH and/or supplemental payments from	1 3		0	4. 00 5. 00		
6.00	Medi cai d charges			30, 462, 438	6. 00		
7.00	Medicaid cost (line 1 times line 6)			5, 430, 295	7. 00		
8. 00	Difference between net revenue and costs for Medicaid program (lin	ne 7 minus sum of li	nes 2 and 5; if	2, 232, 344	8. 00		
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for ex- Children's Health Insurance Program (CHIP) (see instructions for ex- CHIP)</pre>	ach line)					
9. 00	Net revenue from stand-alone CHIP	acii i i ile)		0	9. 00		
10. 00	Stand-allone CHIP charges			Ö	10. 00		
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	11. 00		
12.00	Difference between net revenue and costs for stand-alone CHIP (lin	ne 11 minus line 9;	if < zero then	0	12.00		
	enter zero)		-				
12.00	Other state or local government indigent care program (see instruc			122 222	12 00		
13. 00 14. 00	Net revenue from state or local indigent care program (Not include Charges for patients covered under state or local indigent care pr		•	123, 233 719, 742			
14.00	10)	ogram (Not Theraueu	III IIIles 0 01	717, 742	14.00		
15. 00	State or local indigent care program cost (line 1 times line 14)			128, 303	15. 00		
16.00	Difference between net revenue and costs for state or local indige	ent care program (li	ne 15 minus line	5, 070	16. 00		
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	and State/Local Indi	gent care program	is (see			
	Private grants, donations, or endowment income restricted to fundi				17. 00		
	Government grants, appropriations or transfers for support of hosp		(6.1.	0			
19. 00		00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 2,237,414 1					
	IR 12 and 16)			2, 237, 414	18. 00 19. 00		
	8, 12 and 16)	Uni nsured	Insured				
	8, 12 and 16)	Uni nsured pati ents	Insured patients	2, 237, 414 Total (col. 1 + col. 2)			
				Total (col. 1			
20, 00	Uncompensated Care (see instructions for each line)	patients 1.00	pati ents 2.00	Total (col. 1 + col. 2) 3.00	19. 00		
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	patients 1.00	pati ents 2.00	Total (col. 1 + col. 2) 3.00	19. 00		
	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions)	pati ents 1.00 ty 4,135,4	pati ents 2.00 85 17,767	Total (col. 1 + col. 2) 3.00 4,153,252	19. 00		
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	pati ents 1.00 ty 4,135,4	pati ents 2.00 85 17,767	Total (col. 1 + col. 2) 3.00	19. 00		
	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	ty 4, 135, 4 s (see 737, 2	pati ents 2.00 85 17,767	Total (col. 1 + col. 2) 3.00 4,153,252 754,967	19. 00 20. 00 21. 00		
21. 00 22. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ty 4,135,4 s (see 737,2	pati ents 2.00 85 17,767 00 17,767 35 0	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335	20. 00 21. 00 22. 00		
21. 00 22. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ty 4, 135, 4 s (see 737, 2	pati ents 2.00 85 17,767 00 17,767 35 0	Total (col. 1 + col. 2) 3.00 4,153,252 754,967	20. 00 21. 00 22. 00		
21. 00 22. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ty 4,135,4 s (see 737,2	pati ents 2.00 85 17,767 00 17,767 35 0	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335 754,632	20. 00 21. 00 22. 00		
21. 00 22. 00 23. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	pati ents 1.00 ty 4,135,4 s (see 737,2 as 3 736,8	pati ents 2.00 85 17,767 00 17,767 35 0 65 17,767	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335	20. 00 21. 00 22. 00 23. 00		
21. 00 22. 00 23. 00 24. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	patients 1.00 ty 4,135,4 s (see 737,2 as 3 736,8 days beyond a Length ogram?	pati ents 2.00 85 17,767 00 17,767 35 0 65 17,767 of stay limit	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335 754,632	20. 00 21. 00 22. 00 23. 00		
21. 00 22. 00 23. 00 24. 00 25. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit	ty 4,135,4 s (see 737,2 as 3 736,8 days beyond a length orgam? ndigent care progra	pati ents 2.00 85 17,767 00 17,767 35 0 65 17,767 of stay limit	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335 754,632 1.00 N	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient d imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i stay limit Total bad debt expense for the entire hospital complex (see instru	ty 4,135,4 s (see 737,2 as 736,8 days beyond a length orgram? ndigent care programations)	pati ents 2.00 85 17,767 00 17,767 35 0 65 17,767 of stay limit	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335 754,632 1.00 N 0 4,817,679	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	ty 4,135,4 s (see 737,2 as 736,8 days beyond a length ogram? ndigent care prograuctions) see instructions)	pati ents 2.00 85 17,767 00 17,767 35 0 65 17,767 of stay limit	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335 754,632 1.00 N 0 4,817,679 792,846	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	ty 4,135,4 s (see 737,2 as 736,8 days beyond a length ogram? ndigent care prograuctions) see instructions)	pati ents 2.00 85 17,767 00 17,767 35 0 65 17,767 of stay limit	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335 754,632 1.00 N 0 4,817,679 792,846 1,219,763	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	ty 4,135,4 s (see 737,2 s as 736,8 days beyond a length ogram? ndigent care prograuctions) see instructions) instructions)	pati ents 2.00 85 17,767 00 17,767 35 0 65 17,767 of stay limit m's length of	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335 754,632 1.00 N 0 4,817,679 792,846 1,219,763 3,597,916	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00		
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the istay limit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	ty 4,135,4 s (see 737,2 s as 736,8 days beyond a length ogram? ndigent care prograuctions) see instructions) instructions)	pati ents 2.00 85 17,767 00 17,767 35 0 65 17,767 of stay limit m's length of	Total (col. 1 + col. 2) 3.00 4,153,252 754,967 335 754,632 1.00 N 0 4,817,679 792,846 1,219,763	20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 27. 01 28. 00 29. 00		

Heal th	Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider Co		eri od:	Worksheet A	
					rom 01/01/2018		
				T	o 12/31/2018	Date/Time Pre	pared:
						5/31/2019 12:	18 pm
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		928, 199	928, 199	422, 433	1, 350, 632	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 313, 601	1, 313, 601	446, 521	1, 760, 122	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	118, 184	70, 230			1, 285, 349	•
5. 01	00570 ADMITTING	1.0, .0.	0	1		1, 243, 787	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	1, 857, 969	7, 488, 845			6, 254, 968	1
7. 00	00700 OPERATION OF PLANT	285, 811	1, 542, 183	1		2, 450, 995	7. 00
	1 1	200, 011					•
8.00	00800 LAUNDRY & LINEN SERVICE	004 075	71, 891	1		71, 891	8. 00
9.00	00900 HOUSEKEEPI NG	324, 875	107, 336			430, 309	9. 00
10. 00	01000 DI ETARY	198, 861	153, 403	1		277, 142	1
11. 00	01100 CAFETERI A	0	0			72, 944	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	515, 160	64, 582	579, 742	53, 346	633, 088	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	79, 708	189, 208	268, 916	-30, 292	238, 624	14.00
15.00	01500 PHARMACY	444, 825	1, 038, 013	1, 482, 838	-860, 213	622, 625	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	87, 167	241, 708			487, 175	
17. 00	01700 SOCIAL SERVICE	0	0	1		0	17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	٩		·			17.00
30. 00	03000 ADULTS & PEDIATRICS	1, 739, 334	1, 286, 869	3, 026, 203	-848, 277	2, 177, 926	30.00
31. 00	03100 NTENSI VE CARE UNI T	404, 409	82, 676			483, 489	
43. 00	04300 NURSERY	404, 407	108				
43.00	ANCI LLARY SERVI CE COST CENTERS	U	100	100	023, 304	023, 072	43.00
50. 00	05000 OPERATING ROOM	4F/ 11/	1 (70 545	2, 134, 661	-779, 646	1 255 015	50. 00
		456, 116	1, 678, 545	1			•
51.00	05100 RECOVERY ROOM	305, 430	48, 894			345, 931	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	U	0	1	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	120, 438			120, 438	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	493, 241	258, 240			1, 062, 198	1
54. 01	05401 ULTRASOUND	105, 390	13, 502			0	
56. 00	05600 RADI 0I SOTOPE	103, 957	104, 601			0	
57. 00	05700 CT SCAN	91, 462	139, 851			0	57. 00
58. 00	05800 MRI	89, 666	210, 057	299, 723	-299, 723	0	58. 00
60.00	06000 LABORATORY	849, 522	797, 082	1, 646, 604	-112, 551	1, 534, 053	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	424, 704	90, 695	515, 399	-25, 120	490, 279	65. 00
66.00	06600 PHYSI CAL THERAPY	2, 414	422, 475	424, 889	-2, 041	422, 848	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	175, 666			175, 666	1
68. 00	06800 SPEECH PATHOLOGY	0	44, 783			44, 783	1
69. 00	06900 ELECTROCARDI OLOGY	126, 188	23, 645			145, 116	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	120, 100	0			101, 360	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			610, 882	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1			
	03610 SLEEP LAB	(0.212	-	1	· ·		
76. 00	OUTPATIENT SERVICE COST CENTERS	69, 312	16, 443	85, 755	-1, 492	84, 263	76. 00
00 00		242 075	40 547	201 522	4 414	207 100	00 00
	09000 CLINIC	242, 975	48, 547				1
	09100 EMERGENCY	3, 925, 102	645, 254	4, 570, 356	-6, 277	4, 564, 079	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	271, 499	151, 651	423, 150	-23, 302	399, 848	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		13, 613, 281	19, 569, 221	33, 182, 502	15, 001	33, 197, 503	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	826	14, 328				192. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	13, 614, 107	19, 583, 549	33, 197, 656	0	33, 197, 656	200. 00

Provider CCN: 15-1318

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/31/2019 12: 18 pm

				5/31/2014 12.	TO PIII
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	,			
1.00	00100 CAP REL COSTS-BLDG & FLXT	119, 272	1, 469, 904		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-16, 489	1, 743, 633		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 285, 349		4. 00
5. 01	00570 ADMITTING	0	1, 243, 787		5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL	-365, 711	5, 889, 257		5. 02
7.00	00700 OPERATION OF PLANT	-22, 439	2, 428, 556		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	71, 891		8. 00
9.00	00900 HOUSEKEEPI NG	0	430, 309		9. 00
10.00	01000 DI ETARY	0	277, 142		10.00
11. 00	01100 CAFETERI A	-59, 834	13, 110	•	11. 00
13. 00	01300 NURSING ADMINISTRATION	-7, 418	625, 670	•	13. 00
	01400 CENTRAL SERVICES & SUPPLY	-7,418	238, 624		14. 00
		0			
	01500 PHARMACY	١	622, 625		15. 00
	01600 MEDI CAL RECORDS & LI BRARY	-5, 281	481, 894		16. 00
17. 00	01700 SOCI AL SERVI CE	0	0		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				4
30. 00	03000 ADULTS & PEDIATRICS	-935, 417	1, 242, 509		30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	483, 489		31. 00
43.00	04300 NURSERY	0	823, 672		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-515, 670	839, 345		50. 00
51.00	05100 RECOVERY ROOM	o	345, 931		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
	05300 ANESTHESI OLOGY	-120, 438	0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 062, 198	l .	54.00
54. 01	05401 ULTRASOUND	0	1,002,170	•	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	l .	56.00
		1	0	l .	
57. 00	05700 CT SCAN	0	U		57. 00
58. 00	05800 MRI	0	0		58. 00
60.00	06000 LABORATORY	0	1, 534, 053		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	l .	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	490, 279	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	422, 848		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	175, 666		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	44, 783		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-3, 602	141, 514		69. 00
71 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	101, 360		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	o	610, 882	•	72. 00
	07300 DRUGS CHARGED TO PATIENTS	o	788, 898		73. 00
	03610 SLEEP LAB	0	84, 263	•	76.00
76.00		l U	04, 203		1 78.00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	207 100		90.00
			287, 108	•	
	09100 EMERGENCY	0	4, 564, 079		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
	OTHER REIMBURSABLE COST CENTERS	,			4
95.00	09500 AMBULANCE SERVICES	0	399, 848		95. 00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-1, 933, 027	31, 264, 476		118. 00
	NONREI MBURSABLE COST CENTERS				1
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	153	i e	192. 00
200.00		-1, 933, 027		•	200. 00
_55.50	1 1.577.2 (55 5. 2.1425 116 thi bagii 177)	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5., 201, 027	1	1=00.00

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: Provider CCN: 15-1318

					/2019 12:18 pm
	Cook Cooks	Increases	C-1	0+1	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	A - EMPLOYEE BENEFITS	3.00	4.00	3.00	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 100, 304	1. 00
2.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	2,040	2. 00
	B - RENT AND LEASES		0	1, 102, 344	
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	417, 035	1.00
2.00		0.00	O	0	2. 00
3.00		0.00	0	0	3. 00
4. 00 5. 00		0. 00 0. 00	0	0	4. 00 5. 00
6. 00		0.00	0	0	6.00
7. 00		0.00	O	0	7. 00
8.00	1	0.00	0	0	8. 00
9. 00 10. 00		0. 00 0. 00	0	0	9. 00
11. 00		0.00	o	ő	11. 00
12.00		0.00	0	0	12. 00
13.00		0.00	0	0	13.00
14. 00 15. 00	1	0. 00 0. 00	0	0	14. 00 15. 00
16. 00		0.00	o	Ö	16. 00
17. 00		0. 00	0	0	17. 00
18.00		0.00	0	0	18.00
19. 00 20. 00		0. 00 0. 00	0	0	19. 00 20. 00
21. 00		0.00	o	Ö	21. 00
22. 00		0. 00	0	0	22. 00
23. 00			0	0 417, 035	23. 00
	C - OTHER CAPITAL COSTS		U	417, 035	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	73, 983	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	348, 450	2. 00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2 <u>9, 4</u> 86 451, 919	3. 00
	D - CNO COSTS		<u> </u>	451, 717	
1.00	NURSING ADMINISTRATION	1300	<u>516, 6</u> 09	11, 842	1. 00
	0 E MEDICAL CURRILEC		516, 609	11, 842	
1. 00	E - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71. 00	ol	101, 360	1. 00
1.00	PATI ENT	71.00		101, 000	1.00
2.00	IMPL. DEV. CHARGED TO	72. 00	0	610, 882	2. 00
	PATI ENTS	+			
	F - COST OF DRUGS/IV SOLUTIONS	5	<u> </u>	712, 242	
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	788, 898	1. 00
	O LABOR AND DELLYEDY		0	788, 898	
1.00	G - LABOR AND DELIVERY NURSERY	43.00	722, 779	100, 893	1. 00
	0		722, 779	100, 893	
	H - NURSING ADMIN COSTS				
1.00	ADMINISTRATIVE AND GENERAL	5. 02	271, 871	33, 409	1.00
2. 00	MEDI CAL RECORDS & LI BRARY	16.00	15 <u>3, 0</u> 76 424, 947	1 <u>2, 4</u> 12 45, 821	2. 00
	I - MISC DEPARTMENTS		12 17 7 17	107 02 1	
1.00	ADMI TTI NG		561, 035	682, 752	1. 00
	U		561, 035	682, 752	
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	390, 474	120, 935	1. 00
2.00		0.00	0	0	2. 00
3.00	1	0.00	0	0	3. 00
4. 00		0.00	00390, 474	0 120, 935	4. 00
	K - DIETARY COSTS TO CAFETERIA		370, 474	120, 435	
1.00	CAFETERI A	11.00	38, 608	34, 336	1. 00
	0		38, 608	34, 336	
1. 00	L - PHYSICIAN PRACTICES COSTS OPERATION OF PLANT	7. 00	826	14, 079	1.00
1.00	0			14,079	1.00
	M - REPAIRS AND MAINTENANCE		020	, ., ,	
1.00	OPERATION OF PLANT	7.00	0	621, 974	1. 00
2. 00 3. 00		0. 00 0. 00	0	0	2. 00 3. 00
4.00		0.00	0	0	4. 00
5. 00		0. 00	ő	Ö	5. 00
	<u>'</u>	· ·	· ·		<u>-</u>

Health Financial Systems RECLASSIFICATIONS DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1318

| Period: | Worksheet A-6 | From 01/01/2018 | Date/Time Prepared: 5/31/2019 12: 18 pm

				5/31/2019 12:18 pm
	Increases			
Cost Center	Li ne #	Sal ary	Other	
2. 00	3.00	4. 00	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
19. 00	0.00	0	0	19. 00
20. 00	0.00	0	0	20.00
21. 00	0.00	0	0	21. 00
22. 00	0.00	0	0	22. 00
23. 00	0.00	0	0	23. 00
24. 00	0.00	0	0	24. 00
25. 00	0.00	0	0	25. 00
26. 00	0.00	0	0	26. 00
27. 00	0.00	0	0	27. 00
0 — — — —		<u> </u>	621, 974	
500.00 Grand Total: Increases		2, 655, 278		500.00

RECLASSI FI CATI ONS

Provider CCN: 15-1318

Period: Worksheet A-6 From 01/01/2018

12/31/2018 Date/Time Prepared: 5/31/2019 12:18 pm 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 0 1, 102, 344 0 1.00 0 2.00 0.00 0 2.00 ō 1, 102, 344 B - RENT AND LEASES 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 10 1.00 1,623 2.00 ADMINISTRATIVE AND GENERAL 5.02 0 0 2.00 16, 132 0 0 3.00 OPERATION OF PLANT 7.00 13, 878 3.00 4.00 DI ETARY 10.00 0 1,623 0 4.00 NURSING ADMINISTRATION 0 5.00 13.00 2, 462 0 5.00 6 00 CENTRAL SERVICES & SUPPLY 14 00 0 0 6 00 18.373 0 7.00 PHARMACY 15.00 0 51, 116 7.00 8.00 MEDICAL RECORDS & LIBRARY 16.00 o 5, 255 0 8.00 9.00 ADULTS & PEDIATRICS 30.00 0 4, 621 0 9.00 INTENSIVE CARE UNIT 0 0 10 00 31 00 10 00 839 0 11.00 OPERATING ROOM 50.00 0 44, 136 11.00 12.00 RECOVERY ROOM 51.00 o 1,623 0 12.00 13.00 RADI OLOGY-DI AGNOSTI C 54.00 0 88, 153 0 13.00 0 01 105, 449 58 00 14.00 IMR I 14 00 15.00 LABORATORY 60.00 0 31, 182 0 15.00 RESPIRATORY THERAPY o 0 16.00 65.00 16,613 16.00 0 0 PHYSICAL THERAPY 66, 00 17.00 839 17.00 18.00 ELECTROCARDI OLOGY 69.00 0 1,623 0 18.00 SLEEP LAB 76.00 0 0 19.00 19.00 1, 394 90.00 0 3, 300 0 20.00 ICLI NI C 20.00 91.00 21.00 EMERGENCY 0 2.346 0 21 00 22.00 AMBULANCE SERVICES 95.00 0 4, 339 0 22.00 PHYSICIANS' PRIVATE OFFICES 23.00 192.00 0 116 0 23.00 ō 417, 035 - OTHER CAPITAL COSTS 1.00 ADMINISTRATIVE AND GENERAL 5.02 0 451, 919 12 1.00 2.00 0.00 0 13 2.00 3.00 0.00 3.00 0 12 0 451, 919 - CNO COSTS ADMINISTRATIVE AND GENERAL 5. 02 1.00 516, 609 11, 842 0 1.00 516, 609 11,842 - MEDICAL SUPPLIES 1.00 CENTRAL SERVICES & SUPPLY 14. 00 5, 657 0 1.00 OPERATING ROOM 2.00 706, 585 50.00 0 2.00 ō 712, 242 COST OF DRUGS/IV SOLUTIONS 15. 00 1.00 PHARMACY 0 788, 898 0 1.00 788, 898 G - LABOR AND DELIVERY 1.00 ADULTS & PEDIATRICS 30. 00 722, 779 100, 893 0 1.00 722, 779 100, 893 H - NURSING ADMIN COSTS 1.00 NURSING ADMINISTRATION 13.00 424, 947 45, 821 0 1.00 2.00 0.00 0 2.00 424, 947 45, 821 I - MISC DEPARTMENTS 1.00 ADMINISTRATIVE AND GENERAL 5. 02 561, 035 682, 752 0 1.00 682, 752 561, 035 J - OTHER RADIOLOGY 1.00 ULTRASOUND 54.01 105, 389 7,868 0 1.00 2.00 RADI OI SOTOPE 56.00 103, 957 68, 794 0 2.00 3.00 CT SCAN 57.00 91, 462 26, 234 0 3.00 MRI 4.00 <u>58.</u>00 89,666 18.039 0 4.00 390, 474 120, 935 DIETARY COSTS TO CAFETERIA 34, 336 1.00 DI ETARY 10.00 38, 608 0 1.00 38,608 34, 336 PHYSICIAN PRACTICES COST 1.00 PHYSICIANS' PRIVATE OFFICES 192.00 826 14, 079 0 1.00 826 14, 079 REPAIRS AND MAINTENANCE 1, 746 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 1.00 2.00 ADMINISTRATIVE AND GENERAL 5.02 0 54, 493 0 2.00 HOUSEKEEPI NG 1, 902 3.00 9.00 0 0 3.00 4.00 DI FTARY 10.00 0 555 0 4.00 5.00 NURSING ADMINISTRATION 13.00 0 1,875 0 5.00

0

6, 262

20, 199

0

0

6.00

7.00

PHARMACY

6.00

7.00

CENTRAL SERVICES & SUPPLY

14.00

15.00

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

Provider CCN: 15-1318

						5/31/2019 12:18 pm
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
8.00	MEDICAL RECORDS & LIBRARY	16. 00	0	1, 933	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	19, 984	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	2, 757	0	10.00
11.00	NURSERY	43.00	0	108	0	11.00
12.00	OPERATING ROOM	50.00	0	28, 925	0	12. 00
13.00	RECOVERY ROOM	51.00	0	6, 770	0	13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	112, 539	0	14. 00
15.00	ULTRASOUND	54. 01	0	5, 635	0	15. 00
16.00	RADI OI SOTOPE	56.00	0	35, 807	0	16. 00
17.00	CT SCAN	57.00	0	113, 617	0	17. 00
18.00	MRI	58.00	0	86, 569	0	18. 00
19.00	LABORATORY	60.00	0	81, 369	0	19. 00
20.00	RESPIRATORY THERAPY	65.00	0	8, 507	0	20.00
21.00	PHYSI CAL THERAPY	66.00	0	1, 202	0	21. 00
22.00	ELECTROCARDI OLOGY	69.00	0	3, 094	0	22. 00
23.00	SLEEP LAB	76.00	0	98	0	23. 00
24.00	CLINIC	90.00	0	1, 114	0	24. 00
25.00	EMERGENCY	91.00	0	3, 931	0	25. 00
26.00	AMBULANCE SERVICES	95.00	0	18, 963	0	26. 00
27.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	2, 020	0	27. 00
	0		0	621, 974		
500.00	Grand Total: Decreases		2, 655, 278	5, 105, 070		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 15-1318

Peri od: Worksheet A-7 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018

5/31/2019 12:18 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 193, 225 1.00 0 1.00 1, 000 1,014,684 0 2.00 Land Improvements 1,000 0 2.00 1, 071, 644 1, 071, 644 0 88, 952 3. 00 3.00 Buildings and Fixtures 27, 316, 962 0 4.00 Building Improvements 33, 379, 225 449, 469 449, 469 448, 681 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 0 6.00 0 7.00 297, 911 HIT designated Assets 4, 748, 489 152, 090 152, 090 7.00 0 8.00 Subtotal (sum of lines 1-7) 66, 652, 585 1, 674, 203 1, 674, 203 835, 544 8.00 9.00 Reconciling Items 0 9.00 66, 652, 585 835, 544 Total (line 8 minus line 9) 10.00 1, 674, 203 0 1, 674, 203 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 193, 225 0 1.00 2.00 Land Improvements 1, 015, 684 0 2.00 28, 299, 654 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 33, 380, 013 4.00 5.00 Fi xed Equipment 0 0 5.00 Movable Equipment 0 6.00 6.00 7.00 HIT designated Assets 4, 602, 668 0 7.00 Subtotal (sum of lines 1-7) 8.00 67, 491, 244 0 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 67, 491, 244 0 10.00

Heal th	r Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der CC		Period: From 01/01/2018 To 12/31/2018		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	928, 199	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 313, 601	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	2, 241, 800	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	928, 199				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 313, 601				2. 00
	T + 1 (C1' 4 O)			I			

0 0

928, 199 1, 313, 601 2, 241, 800

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Pre 5/31/2019 12:	pared:
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi talized	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	38, 658, 346	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	28, 832, 897					2. 00
3.00	Total (sum of lines 1-2)	67, 491, 243		67, 491, 24			3. 00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	0ther	Total (sum of	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART III DECONOLIIATION OF CARLTAL COCTE OF	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS		J	0 935, 788	97, 942	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	0			0 1, 296, 083		2.00
3.00	Total (sum of lines 1-2)				0 2, 231, 871		3.00
0.00	Total (Sam of Tries 12)		SI	JMMARY OF CAPI		011,777	0.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	13, 741	73, 983	348, 45	0 0	1, 469, 904	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 029			0 0		2.00
3.00	Total (sum of lines 1-2)	14, 770			-		
		, ,,,,,			· ·	, ., .,	

| Period: | Worksheet A-8 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1318

				To	12/31/2018	Date/Time Prep 5/31/2019 12:	pared:
				Expense Classification on		3/31/2019 12.	16 pili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		O				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	0	5. 00
6.00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	A	-19 991	ADMINISTRATIVE AND GENERAL	5. 02	0	7. 00
7.00	stations excluded) (chapter		.,,,,,	A SENERAL PROPERTY OF THE SENE	0.02		7.00
8.00	21) Television and radio service	А	-1, 870	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	Provi der-based physician	A-8-2	-1, 585, 345		0.00	o	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	О	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-170, 735			0	12. 00
	transactions (chapter 10)	701	170, 733				
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В В	-59, 834	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	О	15. 00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	О	17. 00
18. 00	Sale of medical records and	В	-5, 281	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines	В	-680	ADMINISTRATIVE AND GENERAL	5. 02	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to		0		0.00		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT	A	7, 589	CAP REL COSTS-BLDG & FLXT	1. 00	9	26. 00
27. 00	Depreciation - CAP REL	Α	-10, 205	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	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
55.00	therapy costs in excess of		0	SSSSITTI OWNE THEIRNIT	07.00		55. 50
30. 99	limitation (chapter 14) Hospice (non-distinct) (see	A	0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
51.00	pathology costs in excess of	A-0-3	U	DI ELON I ANNOLOGI	00.00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
	Depreciation and Interest TRAINING REVENUE	В	_7 /110	NURSING ADMINISTRATION	13. 00		33. 00
	ITALINI NO ILVENUL	ا ت	-7,418	MOLITATION DINIMINATION	13.00	ા	

From 01/01/2018 | Date/Time Prepared:

					0 12/31/2018	5/31/2019 12:	
	·			Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 01	FITNESS REVENUE	В	-45	ADMINISTRATIVE AND GENERAL	5. 02	0	33. 01
33. 02	OTHER MISC REVENUE - HOSPITAL	В	-36, 004	ADMINISTRATIVE AND GENERAL	5. 02	0	33. 02
33. 03	PATIENT PHONES BENEFITS COST	A	-5, 443	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 03
33. 04	PATIENT TV SERVICE COST	A	-22, 439	OPERATION OF PLANT	7. 00	0	33. 04
35.00	MARKETING EXPENSE	A	10, 229	ADMINISTRATIVE AND GENERAL	5. 02	0	35. 00
36.00	PENALTI ES	A	-195	ADMINISTRATIVE AND GENERAL	5. 02	0	36. 00
37.00	LOBBYING EXPENSE IN	A	-5, 140	ADMINISTRATIVE AND GENERAL	5. 02	0	37. 00
	ASSOCIATION DUES						
38. 00	COUNTRY CLUB / SOCIAL DUES	A	-520	ADMINISTRATIVE AND GENERAL	5. 02	0	38. 00
40.00	PHYSICIAN RECRUITING	A	-19, 700	ADMINISTRATIVE AND GENERAL	5. 02	0	40. 00
50.00	TOTAL (sum of lines 1 thru 49)		-1, 933, 027				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

 B. Amount Received if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-1318

Worksheet A-8-1 From 01/01/2018

				Го 12/31/2018	Date/Time Pre 5/31/2019 12:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00		l .	PASI CAPITAL COSTS - BLDG &	13, 741	0	1.00
2.00		l .	PASI CAPITAL COSTS - MOVEABL	1, 029	0	2.00
3.00			PASI OPERATING COSTS	127, 761	193, 961	3.00
3.02			SHARED SERVICE CENTER ALLOCA	780, 901	516, 900	
3.04	•	l .	NEW CAPITAL - BUILDING AND F	15, 131	0	3. 04
4.00	•	l .	NEW CAPITAL - MOVEABLE EQUIP	82, 811	0	4.00
4. 01	5. 02	l .	NON-CAPITAL HOME OFFICE COST	987, 955	0	4. 01
4.02	5. 02	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS	13, 350	491, 915	4. 02
4.03	5. 02	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	333, 368	4. 03
4.04	5. 02	ADMINISTRATIVE AND GENERAL	401K FEES	0	5, 164	4.04
4.05	5. 02	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	22, 169	4. 05
4.06	5. 02	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	432, 025	4.06
4.07	5. 02	ADMINISTRATIVE AND GENERAL	SSC ALLOCATION	0	152, 270	4. 07
4.08	5. 02	ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	23, 556	4. 08
4.09	5. 02	ADMINISTRATIVE AND GENERAL	PPSI FEES	0	22, 086	4. 09
5.00	TOTALS (sum of lines 1-4).			2, 022, 679	2, 193, 414	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nus n	ot been posted to norksheet A,	cor anno r ana/or z, the amoun	it allowable 311	oura de marcatea m coranin 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2.00	3.00	4. 00	5. 00	
	B. INTERRELATIONSHIP TO RELATE	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 COMMUNI TY 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.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

					10 12/31/2010	5/31/2019 12:	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED OF	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO						
1. 00	13, 741	11					1. 00
2.00	1, 029	11					2. 00
3.00	-66, 200	0					3.00
3.02	264, 001	0					3. 02
3.04	15, 131	10					3.04
4.00	82, 811	10					4.00
4.01	987, 955	0					4. 01
4.02	-478, 565	0					4. 02
4.03	-333, 368	0					4.03
4.04	-5, 164	0					4.04
4.05	-22, 169	0					4.05
4.06	-432, 025	0					4.06
4. 07	-152, 270	0					4. 07
4. 08	-23, 556	0					4. 08
4.09	-22, 086	0					4. 09
5.00	-170, 735						5.00
* The	amaunta an lin	oo 1 4 (and out	ocarinta as annronriata) ara trar	oformed in detail to Work	chast A saluma	/ Lines as	

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		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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
10. 00 100. 00		100.00

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

Provider CCN: 15-1318

Period: Worksheet A-8-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/31/2019 12: 18 pm

							5/31/2019 12:	18 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	,
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00		ADMINISTRATIVE AND GENERAL	31, 818					1. 00
2.00		ADULTS & PEDIATRICS	935, 417					1
3.00		OPERATING ROOM	515, 670					
		W Committee of the comm				_	1	1
4.00		ANESTHESI OLOGY	120, 438			(0	
5.00		ELECTROCARDI OLOGY	3, 602			[C	0	
6.00	91. 00	EMERGENCY	525, 967	0	525, 967	[C	0	6. 00
7.00	0.00		0	0	0		0	7. 00
8. 00	0.00		l 0	0	0	l	ol o	8. 00
9.00	0.00		1 0	0	0	1	ol o	9.00
10.00	0.00		1		0			
200.00	0.00		2, 132, 912	1, 585, 345	525, 967		1	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WKSt. A LITTE #	I denti fi er	Li mi t		Memberships &	Component	of Mal practice	
		i deliti i i ei	LIIIII	Li mi t	Continuing	Share of col.	Insurance	
				LIIIII	9		i risurance	
	4.00	0.00	0.00	0.00	Educati on	12	44.00	
	1. 00	2.00	8.00	9.00	12. 00	13.00	14.00	
1.00		ADMINISTRATIVE AND GENERAL	0	1	_	C		1
2.00	•	ADULTS & PEDIATRICS	0	1 ~	_	(0	
3.00	50.00	OPERATING ROOM	0	0	0	[C	0	3. 00
4.00		ANESTHESI OLOGY	0	0	0	C	0	4.00
5.00	69.00	ELECTROCARDI OLOGY	l o	0	0	l	ol o	5. 00
6. 00		EMERGENCY	1 0	0	0	1	ol o	6.00
7. 00	0.00		1		0			1
8. 00	0. 00							1
9. 00	0.00							
10. 00	0.00	1						
	0.00		0				1	
200.00	14/1 1 0 1 1 //	0 1 0 1 (B)	0	0	_	A 11 1 1	0	200. 00
	Wkst. A Line #	,	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14				_	
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE AND GENERAL	0	1	_	10, 218	•	1. 00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	935, 417	7	2. 00
3.00	50.00	OPERATING ROOM	0	0	0	515, 670		3. 00
4.00	53.00	ANESTHESI OLOGY	l o	0	0	120, 438	3	4.00
5. 00		ELECTROCARDI OLOGY	1	0	0	3, 602		5. 00
6. 00		EMERGENCY	1		_	0,002	-	6. 00
7. 00	0.00	MI CONTRACTOR OF THE CONTRACTO			1		3	7. 00
				-	_]		1
8.00	0.00			0	_			8. 00
9. 00	0.00		0	-		[C	2	9. 00
10.00	0.00		0	0	_	[C)	10.00
200.00			0	0	0	1, 585, 345	5	200.00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICE OUTSIDE SUPPLIERS	S FURNI SHED BY	Provi der CCN: 15-1318		Date/Time Prep 5/31/2019 12:	pared:
			Physical Therapy	Cost	
				1. 00	
PART I - GENERAL INFORMATION					
1.00 Total number of weeks worked (excluding ai	des) (see instructi	ions)		52	1.00
2 00 line 1 multiplied by 15 hours per week				780	2 00

				Ph	ysical Therapy	Cost	
						1.00	
	PART I - GENERAL INFORMATION					1. 00	
1.00	Total number of weeks worked (excluding aide:	s) (see instruc	tions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week	., (,			780	
3.00	Number of unduplicated days in which supervis					0	3. 00
4.00	Number of unduplicated days in which therapy		on provider si	te but neither	supervi sor	0	4. 00
5. 00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super		anists (soo in	etructions)		0	5. 00
6. 00	Number of unduplicated offsite visits - super				therapy	0	6.00
0.00	assistant and on which supervisor and/or the						0.00
	instructions)		9				
7.00	Standard travel expense rate					0.00	
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	5. 19 Trai nees	8. 00
		1. 00	2.00	3. 00	4. 00	5. 00	
9. 00	Total hours worked	0.00	4, 696. 84		3, 588. 45	0.00	9. 00
10.00	AHSEA (see instructions)	0. 00	70.00		17. 50	0. 00	10.00
11. 00	Standard travel allowance (columns 1 and 2,	35. 00	35.00	25. 25			11. 00
	one-half of column 2, line 10; column 3,						
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0	0			12. 00
12. 00	Number of travel hours (offsite)	o	0	o			12. 00
13. 00	, , ,	o	0	O			13. 00
13. 01	Number of miles driven (offsite)	0	0	0			13. 01
						1 22	
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
14. 00		line 10)				0	14. 00
15. 00	Therapists (column 2, line 9 times column 2,					328, 779	•
16.00	Assistants (column 3, line 9 times column 3,					206, 823	
17. 00	Subtotal allowance amount (sum of lines 14 au	nd 15 for respi	ratory therapy	or lines 14-16	for all	535, 602	17. 00
10.00	others)	10)				(2, 700	10.00
18. 00 19. 00						62, 798 0	1
20. 00	1		therapy or lin	es 17 and 18 fo	or all others)	598, 400	
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than		no entries on	lines 21 and 22	and enter on	line 23	
04.00	the amount from line 20. Otherwise complete	lines 21-23.		6 1 4		0.00	04.00
21. 00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,			m or columns I	and 2, line 9	0.00	21. 00
22. 00	Weighted allowance excluding aides and trained					0	22. 00
23. 00			,			598, 400	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVEL	_ EXPENSE COMP	UTATION - PROVI	DER SITE		ĺ
	Standard Travel Allowance						
	Therapists (line 3 times column 2, line 11)					0	
25. 00 26. 00		sum of lines 2	1 and 25 for a	II others)		0	
27. 00	Standard travel expense (line 7 times line 3			,	and 4 for all	0	ı
27.00	others)	10. 1006114101	, the apy of o	u 01 111100 0 0			27.00
28. 00		travel expense	at the provid	er site (sum of	lines 26 and	0	28. 00
	27)	-					
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		d 2 lino 12)		1	0	29. 00
30.00	Assistants (column 3, line 10 times column 3,		u 2, 1111e 12)			0	
31. 00	Subtotal (line 29 for respiratory therapy or	,	9 and 30 for a	II others)		Ö	
32.00					or sum of	0	32.00
	columns 1-3, line 13 for all others)					,	
33. 00	Standard travel allowance and standard travel			1 04)		0	
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel	•		,		0	
33.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				CES OUTSLDE PRO		33.00
	Standard Travel Expense		2711 21102 001111 0	THE OLIVE	20 0010132 1110	TI DEIX OTTE	
36.00	Therapists (line 5 times column 2, line 11)					0	36. 00
37. 00	Assistants (line 6 times column 3, line 11)					0	
38. 00	,	6.1.				0	
39.00	Standard travel expense (line 7 times the sur		a 6)			0	39. 00
40. 00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0		2. line 10)			0	40. 00
41. 00	Assistants (column 3, line 12.01 times column		=,			0	1
42. 00	Subtotal (sum of lines 40 and 41)					0	
43.00						0	43.00
	Total Travel Allowance and Travel Expense - (Offsite Services	s; Complete on	e of the follow	ving three line	s 44, 45,	
	or 46, as appropriate.						1

39. 00 Standard travel expense (line 7 times the sum of lines 5 and 6) 0 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. 41. 00 Assistants (column 3, line 12. 01 times column 3, line 10) 0 41. 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 43. 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.	37.00	Assistants (line 6 times column 3, line 11)	0	37.00
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) 0 44.	38. 00	Subtotal (sum of lines 36 and 37)	0	38. 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) 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.	39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39. 00
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. 42. 43. 44. 45. 46. 46. 47. 47. 48. 48. 49. 49. 40. 40. 40. 41. 41. 41. 41. 42. 43. 44. 45. 46. 46. 47. 47. 48. 48. 49. 49. 40. 40. 40. 41. 41. 41. 41. 42. 43. 44. 45. 46. 46. 47. 47. 48. 48. 48.		Optional Travel Allowance and Optional Travel Expense		1
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) 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.	40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
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.	41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
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.	42.00	Subtotal (sum of lines 40 and 41)	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.	43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.		Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line	es 44, 45,	1
		or 46, as appropriate.		i
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions) 0 45.	44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44. 00
	45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45. 00
MCRI F32 - 15. 5. 166. 1	MCRI F3:	2 - 15. 5. 166. 1		

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 15-1318 Peri od: Worksheet A-8-3 From 01/01/2018 Parts I-VI OUTSIDE SUPPLIERS Date/Time Prepared: 5/31/2019 12:18 pm 12/31/2018 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 Ai des Therapi sts Assi stants Total 3.00 5.00 2.00 PART V - OVERTIME COMPUTATION Overtime hours worked during reporting 47.00 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 50 00 Percentage of overtime hours by category 0 00 0 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 0.00 0.00 0.00 0.00 0.00 51.00 for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE 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 0 \mathcal{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 0 0 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 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT Salary equivalency amount (from line 23) 57.00 598, 400 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 58.00 58.00 0 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 59 00 59 00 0 60.00 Overtime allowance (from column 5, line 56) 60.00 0 61.00 Equipment cost (see instructions) 0 61.00 62.00 Supplies (see instructions) 62.00 0 598, 400 63.00 Total allowance (sum of lines 57-62) 63 00 Total cost of outside supplier services (from your records) 64.00 64.00 0 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 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

0 101, 00

0 101. 01

0 101. 02

0 102. 00

0 102. 01

0 102.02

101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others

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

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

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

101.02 Line 34 = sum of lines 27 and 31

102.02 Line 35 = sum of lines 31 and 32

LINE 35 CALCULATION

13 for all others

		DUKES MEMORIAL		15 1010		u of Form CMS-2	
	IABLE COST DETERMINATION FOR THERAPY SERVICES FUI DE SUPPLIERS	KINI SHED BA	Provider CCN:	15-1318	Peri od: From 01/01/2018 To 12/31/2018		pared:
					Occupati onal Therapy	Cost	
				l	тнег ару	1. 00	
	PART I - GENERAL INFORMATION						
1. 00 2. 00	Total number of weeks worked (excluding aides) Line 1 multiplied by 15 hours per week	(see instructi	ons)			52 780	
3.00	Number of unduplicated days in which supervisor					0	3.0
4. 00	Number of unduplicated days in which therapy as nor therapist was on provider site (see instruc		n provider site	but neithe	er supervisor	0	4.0
5.00	Number of unduplicated offsite visits - supervi	sors or therap				0	
6. 00	Number of unduplicated offsite visits - therapy assistant and on which supervisor and/or therap					0	6.0
7. 00	instructions) Standard travel expense rate					0. 00	7. (
8. 00	Optional travel expense rate per mile					0. 00	
		Supervi sors 1.00	Therapists 2.00	Assi stants 3.00	Ai des 4. 00	Trai nees 5. 00	
9. 00	Total hours worked	0. 00	1, 278. 00	854. C	0.00	0.00	1
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 35. 00	70. 00 35. 00	50. 5 25. 2		0.00	10. 0 11. 0
11.00	one-half of column 2, line 10; column 3,	33. 00	33.00	25.2			11.0
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o		0		12.0
12. 01	Number of travel hours (offsite)	O	0		0		12.0
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13. C
		·				1 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
	Supervisors (column 1, line 9 times column 1, l Therapists (column 2, line 9 times column 2, li					0 89, 460	
16. 00	Assistants (column 3, line 9 times column 3, li					43, 127	
17. 00	Subtotal allowance amount (sum of lines 14 and others)	15 for respira	atory therapy o	r lines 14-	16 for all	132, 587	17. 0
18. 00	Aides (column 4, line 9 times column 4, line 10	•				0	
19. 00 20. 00							
20.00	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 average rate excluding aides and train for respiratory therapy or columns 1 thru 3, li			of columns	1 and 2, line 9	0.00	21. 0
22. 00	Weighted allowance excluding aides and trainees					0	22. 0
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWAN	ICF AND TRAVEL	EXPENSE COMPUTA	ATION - PRO	VIDER SLTE	132, 587	23. (
	Standard Travel Allowance					_	ļ <u>.</u>
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	
	O Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						
						0	26.0
27. 00	Standard travel expense (line 7 times line 3 foothers)	or respiratory			and 4 for all	0	26. 0
26. 00 27. 00 28. 00	others) Total standard travel allowance and standard tr		therapy or sum	of lines 3			
27. 00 28. 00	others) Total standard travel allowance and standard tr 27) Optional Travel Allowance and Optional Travel E	ravel expense a	therapy or sum	of lines 3		0	26. 0 27. 0 28. 0
27. 00 28. 00 29. 00	others) Total standard travel allowance and standard tr 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of	ravel expense a expense columns 1 and	therapy or sum	of lines 3		0	26. (27. (28. (29. (
27. 00 28. 00 29. 00 30. 00 31. 00	others) Total standard travel allowance and standard tr 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su	expense a expense a expense columns 1 and ine 12) um of lines 29	therapy or sum at the provider 2, line 12) and 30 for all	of lines 3 site (sum others)	of lines 26 and	0 0 0 0 0 0	26. 0 27. 0 28. 0 29. 0 30. 0 31. 0
27. 00 28. 00 29. 00 30. 00 31. 00	others) Total standard travel allowance and standard tr 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1	expense a expense a expense columns 1 and ine 12) um of lines 29	therapy or sum at the provider 2, line 12) and 30 for all	of lines 3 site (sum others)	of lines 26 and	0 0 0 0	26. (27. (28. (29. (30. (31. (
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	others) Total standard travel allowance and standard tr 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 columns 1-3, line 13 for all others) Standard travel allowance and standard travel en	expense a fixpense columns 1 and ine 12) um of lines 29 and 2, line 1 expense (line 2	therapy or sum at the provider 2, line 12) and 30 for all 3 for respirate 28)	of lines 3 site (sum others) ory therapy	of lines 26 and	0 0 0 0 0 0	26. (27. (28. (30. (31. (32. (33. (
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	others) Total standard travel allowance and standard tr 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 columns 1-3, line 13 for all others)	expense (line 2) and 2, line 12 expense (sum of	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirate 28) Filines 27 and	of lines 3 site (sum others) ory therapy	of lines 26 and	0 0 0 0 0	26. (27. (28. (30. (31. (32. (33. (34. (
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	others) Total standard travel allowance and standard tracel 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 columns 1-3, line 13 for all others) Standard travel allowance and standard travel el Optional travel allowance and standard travel el Optional travel allowance and optional travel el Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE	ravel expense a expense columns 1 and ine 12) um of lines 29 and 2, line 1 expense (line 2 expense (sum of exp	therapy or sum at the provider 2, line 12) and 30 for all 3 for respirate 28) Flines 27 and Flines 31 and	of lines 3 site (sum others) ory therapy 31) 32)	of lines 26 and	0 0 0 0 0 0 0	26. C 27. C 28. C 30. C 31. C 32. C 33. C 34. C
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	others) Total standard travel allowance and standard tr 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 columns 1-3, line 13 for all others) Standard travel allowance and standard travel e Optional travel allowance and standard travel e Optional travel allowance and optional travel e Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANC Standard Travel Expense Therapists (line 5 times column 2, line 11)	ravel expense a expense columns 1 and ine 12) um of lines 29 and 2, line 1 expense (line 2 expense (sum of exp	therapy or sum at the provider 2, line 12) and 30 for all 3 for respirate 28) Flines 27 and Flines 31 and	of lines 3 site (sum others) ory therapy 31) 32)	of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 34. 0 35. 0
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	others) Total standard travel allowance and standard trazel Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 columns 1-3, line 13 for all others) Standard travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and optional travel optional travel allowance and optional travel Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	ravel expense a expense columns 1 and ine 12) um of lines 29 and 2, line 1 expense (line 2 expense (sum of exp	therapy or sum at the provider 2, line 12) and 30 for all 3 for respirate 28) Flines 27 and Flines 31 and	of lines 3 site (sum others) ory therapy 31) 32)	of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 34. 0 35. 0 36. 0 37. 0
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	others) Total standard travel allowance and standard trazel Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 columns 1-3, line 13 for all others) Standard travel allowance and standard travel optional travel allowance and standard travel optional travel allowance and optional travel optional travel allowance and optional travel Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	expense according to the sexpense (sum of sexpense sexpen	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirate 28) Filines 27 and Filines 31 and EXPENSE COMPUTA	of lines 3 site (sum others) ory therapy 31) 32)	of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 33. 0 35. 0 36. 0 37. 0 38. 0
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	others) Total standard travel allowance and standard trazel 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 Standard travel allowance and standard travel e Optional travel allowance and standard travel e Optional travel allowance and optional travel e Optional travel allowance and optional travel e Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANC Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of Optional Travel Allowance and Optional Travel E	ravel expense a expense columns 1 and ine 12) am of lines 29 and 2, line 1 expense (sum of expense sum of expense su	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirate 28) Flines 27 and Flines 31 and EXPENSE COMPUTA 6)	of lines 3 site (sum others) ory therapy 31) 32)	of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. C 27. C 28. C 30. C 31. C 32. C 34. C 35. C 37. C 38. C 39. C
27. 00	others) Total standard travel allowance and standard trazel 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 Standard travel allowance and standard travel expense (line 8 times columns 1 Optional travel allowance and standard travel expense (line 8 times columns 1 Optional travel allowance and standard travel expense (line 8 times column 1 Optional travel allowance and standard travel expense (line 5 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of	ravel expense a expense columns 1 and ine 12) am of lines 29 and 2, line 1 expense (sum of expense) and expense (sum of expense (sum of expense) and expense times column 2	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirate 28) Flines 27 and Flines 31 and EXPENSE COMPUTA 6)	of lines 3 site (sum others) ory therapy 31) 32)	of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. C 27. C 28. C 30. C 31. C 32. C 33. C 34. C 37. C 38. C 37. C 38. C 37. C 41. C 41. C 41. C
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	others) Total standard travel allowance and standard tracel standard travel allowance and optional Travel Elevatory Optional Travel Allowance and Optional Travel Elevatory Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, loubtotal (line 29 for respiratory therapy or supplication of the standard travel expense (line 8 times columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (line 8 times columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense and optional travel expense (line 7 times the sum of Coptional travel Expense (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of Coptional Travel Allowance and Optional Travel Expense (line 7 times the sum of Coptional Travel Allowance and Optional Travel Expense (line 7 times the sum of Coptional Travel Allowance and Optional Travel Expense (line 7 times the sum of Coptional Travel Allowance and Optional Travel Expense (line 7 times the sum of Coptional Travel Allowance and Optional Travel Expense (line 7 times the sum of Coptional Travel Allowance and Optional Travel Expense (line 7 times the sum of Coptional Travel Allowance and Optional Travel Expense (line 7 times column 3, line 12.01 times column 3,	ravel expense a fixpense columns 1 and ine 12) um of lines 29 and 2, line 1 expense (sum of expense (sum of expense (sum of E AND TRAVEL E	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirat 28) Flines 27 and Flines 31 and EXPENSE COMPUTA 6)	of lines 3 site (sum others) ory therapy 31) 32)	of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. C 29. C 30. C 31. C 33. C 35. C 37. C 38. C 37. C 41. C 42. C 42. C 42. C
27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	others) Total standard travel allowance and standard travel 27) Optional Travel Allowance and Optional Travel E Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, l Subtotal (line 29 for respiratory therapy or su Optional travel expense (line 8 times columns 1 Columns 1-3, line 13 for all others) Standard travel allowance and standard travel e Optional travel allowance and standard travel e Optional travel allowance and optional travel e Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWAND Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of Optional Travel Allowance and Optional Travel E Therapists (sum of columns 1 and 2, line 12.01 Assistants (column 3, line 12.01 times column 3	cavel expense a columns 1 and ine 12) um of lines 29 and 2, line 1 expense (sum of expense (su	therapy or sum at the provider 2, line 12) and 30 for all 13 for respirate 28) Filines 27 and Filines 31 and EXPENSE COMPUTA 6) Line 10)	of lines 3 site (sum others) ory therapy 31) 32) TION - SERV	of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. (30. (31. (33. (35. (37. (38. (39. (41. (42. (

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider C		Peri od: From 01/01/2018 To 12/31/2018	Worksheet A-8 Parts I-VI Date/Time Pre 5/31/2019 12:	pared:
					Occupati onal Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard travel					0	
46. 00	Optional travel allowance and optional travel		of lines 42 an				46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION						
17. 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	O. C	0.00	0.00	47.00
18. 00	Overtime rate (see instructions)	0. 00	0.00	•			48. 00
19. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0.00	0.0	0.00		49. 00
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)	0. 00	0.00	0.0	0.00	0.00	50.00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0. 00	O. C	0.00	0.00	51.00
2. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	70.00	50. 50	0.0	0.00		52. OC
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53. 00
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
						1 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FXCESS COST	AD.JUSTMENT			1. 00	
7. 00	Salary equivalency amount (from line 23)					132, 587	57.00
8. 00	Travel allowance and expense - provider site			`		0	58.00
9. 00 0. 00							59. 00 60. 00
	00 Equipment cost (see instructions)						61.00
	00 Supplies (see instructions)						62.00
3.00	.00 Total allowance (sum of lines 57-62) .00 Total cost of outside supplier services (from your records)						63.00
	100 lotal cost of outside supplier services (from your records) 100 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 11 LINE 33 CALCULATION						64. 00 65. 00
00 00	00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						100. OC
00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27						0	100. 01 100. 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 101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 101.02 Line 34 = sum of lines 27 and 31						0	101. 00 101. 01 101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 2	9 and 30 for a	II others			102. 00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others	13 for respira	tory therapy o	r sum of colu	mns 1-3, line		102. 01 102. 02
JZ. UZ	Line 35 = sum of lines 31 and 32					0	1102.

Health Financial Systems	DUKES MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
REASONABLE COST DETERMINATION FOR THE OUTSIDE SUPPLIERS	ERAPY SERVICES FURNISHED BY	Provider CCN: 15-1318	From 01/01/2018 To 12/31/2018	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/31/2019 12:18 pm
			Speech Pathology	Cost

						5/31/2019 12:	
				S _I	peech Pathology	Cost	
						1. 00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			52	
2. 00 3. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	sor or theranis	t was on provi	der site (see	instructions)	780 0	2. 00 3. 00
4. 00	Number of unduplicated days in which therapy			•		Ö	4. 00
	nor therapist was on provider site (see insti					_	
5. 00 6. 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				thorany	0	5. 00 6. 00
0.00	assistant and on which supervisor and/or the						0.00
	instructions)	·		() /	•		
7.00	Standard travel expense rate					0. 00 0. 00	7.00
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	8. 00
		1.00	2.00	3. 00	4. 00	5. 00	
9. 00 10. 00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	222. 00 69. 99			0. 00 0. 00	
11. 00	Standard travel allowance (columns 1 and 2,	35. 00	35. 00			0.00	11. 00
	one-half of column 2, line 10; column 3,						
10.00	one-half of column 3, line 10)		0				10.00
12. 00 12. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0	0			12. 00 12. 01
13. 00	Number of miles driven (provider site)	o	0				13. 00
13. 01	Number of miles driven (offsite)	o	0	0			13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14. 00	Supervisors (column 1, line 9 times column 1,						14. 00
15. 00 16. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					15, 538 0	15. 00 16. 00
17. 00	Subtotal allowance amount (sum of lines 14 ar		ratory therapy	or lines 14-1	6 for all	15, 538	
	others)	•				, , , , , ,	
18.00	Aides (column 4, line 9 times column 4, line					0	18.00
19. 00 20. 00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17–19 fo		therapy or lin	es 17 and 18 f	or all others)	0 15, 538	19. 00 20. 00
20.00	If the sum of columns 1 and 2 for respiratory					· · · · · · · · · · · · · · · · · · ·	20.00
	occupational therapy, line 9, is greater than		no entries on	lines 21 and 2	2 and enter on	line 23	
21. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by su	m of columns 1	and 2. line 9	69. 99	21. 00
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line for respiratory therapy or columns 1 thru 3, line 9 for all others)						200
22. 00	Weighted allowance excluding aides and traine		54, 592				
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	IANCE AND TRAVE	I FYDENSE COMD	IITATI ON _ DDOV	INED SITE	54, 592	23. 00
	Standard Travel Allowance	IDEN SITE					
24. 00	Therapists (line 3 times column 2, line 11)					0	
25. 00	Assistants (line 4 times column 3, line 11)	cum of lines 2	1 and 2E for a	II othors)		0	25. 00
26. 00 27. 00	, , , , , , , , , , , , , , , , , , , ,						26. 00 27. 00
	others)						
28. 00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 ar						28. 00
	27) Optional Travel Allowance and Optional Travel Expense						
29. 00							29. 00
30.00							30.00
31. 00 32. 00						0	31. 00 32. 00
32.00	columns 1-3, line 13 for all others)						32.00
33. 00	Standard travel allowance and standard travel expense (line 28)						33. 00
34. 00 35. 00							34. 00 35. 00
33.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER S						35.00
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	
37. 00 38. 00							37. 00 38. 00
39. 00							39. 00
40.00	Optional Travel Allowance and Optional Travel Expense						40.00
40. 00 41. 00							40. 00 41. 00
42.00	Subtotal (sum of lines 40 and 41)	. 5, TING 10 <i>)</i>				0	•
43. 00	Optional travel expense (line 8 times the sur					0	
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45,						
44. 00	or 46, as appropriate. 14.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 4						
	Optional travel allowance and standard travel						45. 00

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 15-1318 Peri od: Worksheet A-8-3 From 01/01/2018 Parts I-VI Date/Time Prepared: 5/31/2019 12:18 pm OUTSIDE SUPPLIERS 12/31/2018 Speech Pathology 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) 48.00 0.00 0.00 0.00 0.00 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 69.99 0.00 0.00 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 0 54.00 C 0 line 49 or line 53) 55.00 Portion of overtime already included in 0 C 0 0 55.00 hourly computation at the AHSEA (multiply line 47 times line 52) 56.00 Overtime allowance (line 54 minus line 55 -0 0 0 0 0 56.00

	if negative enter zero) (Enter in column 5		
	the sum of columns 1, 3, and 4 for		ł
	respiratory therapy and columns 1 through 3		1
	for all others.)		
		1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57. 00	Salary equivalency amount (from line 23)	54, 592	l .
58. 00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	
59. 00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59. 00
60.00	Overtime allowance (from column 5, line 56)	0	
61. 00	Equipment cost (see instructions)	0	61. 00
62.00	Supplies (see instructions)	0	
63.00	Total allowance (sum of lines 57-62)	54, 592	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
	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		100. 01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100. 02
	LINE 34 CALCULATION		
	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		101. 00
	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		101. 01
101. 02	Line 34 = sum of lines 27 and 31	0	101. 02
	LINE 35 CALCULATION		
	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

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part I
To 1/21/2019 Part II
To 1/21/2019 Part II Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1318

				To	12/31/2018	Date/Time Pre	pared:
			CAPI TAL REI	ATED COSTS		5/31/2019 12:	18 pm
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	ADMI TTI NG	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	Ü	1.00	2.00	1. 00	0.01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 469, 904	1, 469, 904				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	1, 743, 633		1, 743, 633	1 200 070		2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING	1, 285, 349 1, 243, 787	10, 366 15, 772		1, 308, 070 54, 377	1, 332, 734	4. 00 5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	5, 889, 257	74, 787		101, 982	1, 332, 734	5. 02
7.00	00700 OPERATION OF PLANT	2, 428, 556	434, 697		27, 782	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	71, 891	17, 066		0	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	430, 309	14, 129 35, 672		31, 488	0	9. 00 10. 00
11. 00	01100 CAFETERI A	277, 142 13, 110			15, 532 3, 742	0	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	625, 670			58, 815	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	238, 624	34, 965		7, 726	0	14. 00
15. 00	01500 PHARMACY	622, 625	16, 323		43, 114	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	481, 894			23, 285	0	16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17. 00
30. 00	03000 ADULTS & PEDI ATRI CS	1, 242, 509	244, 863	291, 842	98, 528	61, 847	30. 00
31.00	03100 INTENSIVE CARE UNIT	483, 489	28, 377	33, 821	39, 197	7, 731	31. 00
43.00	04300 NURSERY	823, 672	5, 614	6, 692	70, 054	1, 339	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	839, 345	112, 496	134, 080	44, 208	167, 531	50. 00
51. 00	05100 RECOVERY ROOM	345, 931	8, 098		29, 603	29, 050	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	-	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 062, 198	79, 122	94, 303	85, 652	278, 311	54.00
54. 01 56. 00	05401 ULTRASOUND 05600 RADI OI SOTOPE	0	0	0	O O	0	54. 01 56. 00
57. 00	05700 CT SCAN	0	0	I -	0	0	57. 00
58. 00	05800 MRI	0	Ö	I -	Ö	0	58. 00
60.00	06000 LABORATORY	1, 534, 053	32, 586	37, 703	82, 338	176, 692	60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	-	0	0	62. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	490, 279 422, 848	13, 579 18, 635		41, 164 234	19, 262 21, 133	•
67. 00	06700 OCCUPATI ONAL THERAPY	175, 666			234	11, 618	
68. 00	06800 SPEECH PATHOLOGY	44, 783	245		Ö	895	
69. 00	06900 ELECTROCARDI OLOGY	141, 514	9, 214	26, 660	12, 231	41, 638	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	101, 360	0		0	42, 701	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	610, 882 788, 898	0 0		O O	38, 182 194, 389	72. 00 73. 00
76. 00	03610 SLEEP LAB	84, 263			6, 718	194, 369	
, 0. 00	OUTPATIENT SERVICE COST CENTERS	01,7200	107.00	<u> </u>	3, 7, 13	107 107	, 0. 00
90.00	09000 CLI NI C	287, 108			23, 550	3, 467	
91.00	09100 EMERGENCY	4, 564, 079	54, 493	64, 948	380, 436	168, 710	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	399, 848	21, 945	26, 155	26, 314	57, 799	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		31, 264, 476	1, 369, 923	1, 631, 622	1, 308, 070	1, 332, 734	118. 00
190 00	NONREIMBURSABLE COST CENTERS 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 001		ol	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	153			0		190.00
200.00		.55	, 5, 700	, 511	J	Ü	200. 00
201.00	Negative Cost Centers		0	_	О		201. 00
202.00	TOTAL (sum lines 118 through 201)	31, 264, 629	1, 469, 904	1, 743, 633	1, 308, 070	1, 332, 734	202. 00

Provider CCN: 15-1318

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: | 5/31/2019 | 12: 18 pm | Prepared |

						5/31/2019 12:	18 pm
	Cost Center Description	Subtotal	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	
			AND GENERAL	PLANT	LINEN SERVICE		
		5A. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT					I	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					I	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4.00
5. 01	00570 ADMITTING					I	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	6, 155, 162	6, 155, 162			I	5. 02
7.00	00700 OPERATION OF PLANT	3, 409, 132		4, 244, 823		I	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	109, 298				I	8.00
9. 00						(77 752	9.00
	00900 HOUSEKEEPI NG	492, 766				677, 753	
10.00	01000 DI ETARY	370, 862		162, 072		26, 771	10.00
11. 00	01100 CAFETERI A	67, 070	1			17, 195	•
13.00	01300 NURSING ADMINISTRATION	699, 089			0	5, 000	
14. 00	01400 CENTRAL SERVICES & SUPPLY	322, 989			0	26, 241	14. 00
15. 00	01500 PHARMACY	701, 516	171, 965	74, 161	0	12, 250	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	569, 839	139, 686	134, 030	0	22, 139	16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 939, 589	475, 457	1, 112, 509	177, 562	183, 765	30.00
31. 00	03100 INTENSIVE CARE UNIT	592, 615				21, 296	ł
43. 00	04300 NURSERY	907, 371	222, 427			4, 214	•
10.00	ANCI LLARY SERVI CE COST CENTERS	707,071	222, 127	20,007	10, 207	1,211	10.00
50. 00	05000 OPERATI NG ROOM	1, 297, 660	318, 099	511, 117	0	84, 427	50.00
51. 00	05100 RECOVERY ROOM	422, 334	103, 528			6, 078	
52. 00	1 1	422, 334	103, 328			0,078	52.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		-	_	1
53. 00	05300 ANESTHESI OLOGY	4 500 504	1	1	-	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 599, 586	i .	359, 485		59, 380	1
54. 01	05401 ULTRASOUND	0	0	0		0	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	·		0	
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, 863, 372	456, 774	148, 051	0	24, 455	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	580, 468	142, 292	61, 693	0	10, 191	65. 00
66.00	06600 PHYSI CAL THERAPY	485, 061	118, 904	84, 668	0	13, 986	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	200, 650				4, 576	67. 00
68. 00	06800 SPEECH PATHOLOGY	46, 215				184	68. 00
69. 00	06900 ELECTROCARDI OLOGY	231, 257	56, 689		0	6, 915	•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	144, 061	35, 314		٦	0, 713	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	649, 064			, , , , , , , , , , , , , , , , , , ,	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS				0	0	73.00
		983, 287	241, 036			Ĭ	1
76. 00	03610 SLEEP LAB	114, 575	28, 086	59, 768	0	9, 872	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	332, 869			0	6, 418	ł
91.00	09100 EMERGENCY	5, 232, 666	1, 282, 702	247, 585	0	40, 896	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	532, 061	130, 426	99, 703	0	16, 469	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	31, 052, 484	6, 103, 158	3, 790, 569	213, 630	602, 718	118. 00
	NONREI MBURSABLE COST CENTERS						İ
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 001	1, 471	27, 265	0	4.504	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	206, 144				70, 531	
200.00		200, 144	00, 000	120, 707	l ~	, 0, 001	200.00
201.00			0	_	0	Λ.	201.00
201.00		31, 264, 629			213, 630		
202.00	TOTAL (Sum TITIES TTO LINGUIGHT 201)	31, 204, 029	J 0, 133, 102	1 4, 244, 023	213,030	011, 133	1202.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | To 12/31/2019 | To 12/ Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1318

				10	12/31/2018	Date/lime Pre 5/31/2019 12:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	lo piii
				ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
	NERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
1	0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	D570 ADMI TTI NG						5. 01
1	D590 ADMINISTRATIVE AND GENERAL						5. 02
1	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
	0900 HOUSEKEEPING						9. 00
	1000 DI ETARY	650, 616					10.00
	1100 CAFETERI A	030, 010	204, 801				11.00
	1300 NURSING ADMINISTRATION	0	8, 856				13. 00
	1400 CENTRAL SERVICES & SUPPLY	o	3, 317		590, 584		14. 00
	1500 PHARMACY	o	7, 111		16, 700	983, 703	15. 00
	1600 MEDICAL RECORDS & LIBRARY	O	3, 476		518	0	16. 00
1	1700 SOCIAL SERVICE	O	0		O	0	17. 00
	IPATIENT ROUTINE SERVICE COST CENTERS	'		·			
30.00 03	BOOO ADULTS & PEDIATRICS	540, 769	39, 953	194, 607	31, 500	0	30. 00
31.00 03	3100 INTENSIVE CARE UNIT	60, 239	7, 745	45, 256	2, 534	0	31. 00
	1300 NURSERY	49, 608	0	0	0	0	43. 00
	ICILLARY SERVICE COST CENTERS						
	5000 OPERATI NG ROOM	0	10, 573		103, 200	0	50. 00
	5100 RECOVERY ROOM	0	5, 394		5, 516	0	51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	5300 ANESTHESI OLOGY	0	01 700	0	20 505	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	0	21, 780		28, 585	0	54.00
	5401 ULTRASOUND	0	0	0	0	0	54. 01 56. 00
	5600 RADI OI SOTOPE 5700 CT SCAN	0	0	0	0	0	57.00
1	5800 MRI	0	0		0	0	58.00
	5000 LABORATORY	0	25, 212	95, 067	123, 374	0	60.00
	5200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	23, 212	73,007	123, 374	0	62.00
	5500 RESPIRATORY THERAPY	0	8, 885		10, 662	0	65.00
	6600 PHYSI CAL THERAPY	0	101	0	2, 275	0	66. 00
	5700 OCCUPATIONAL THERAPY	o		0	62	0	67. 00
	5800 SPEECH PATHOLOGY	o	0	o	ol	0	68. 00
	5900 ELECTROCARDI OLOGY	O	2, 784	0	1, 086	0	69. 00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	220, 059	0	72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	983, 703	73. 00
76.00 03	3610 SLEEP LAB	0	1, 529	0	1, 131	0	76. 00
	JTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	0	5, 135		7, 281	0	90. 00
	P100 EMERGENCY	0	42, 046	439, 239	18, 807	0	91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	THER REIMBURSABLE COST CENTERS	ما	10.0/1		47.007	0	05.00
	9500 AMBULANCE SERVI CES	0	10, 861	0	17, 207	0	95. 00
118. 00	PECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	650, 616	204, 758	914, 587	590, 497	983, 703	110 00
	ONREIMBURSABLE COST CENTERS	030, 010	204, 730	714, 507	370, 477	703, 703	1110.00
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	0	O	O	n	190. 00
	2200 PHYSI CLANS' PRI VATE OFFI CES	Ö	43		87		192.00
200.00	Cross Foot Adjustments	٩	10		0,		200. 00
201.00	Negative Cost Centers	o	0	0	О		201. 00
202.00	TOTAL (sum lines 118 through 201)	650, 616	204, 801	914, 587	590, 584		
'					· '		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/31/2019 | 12:18 pm | Total Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS DUKES MEMORIAL HOSPITAL Provider CCN: 15-1318

	Cost Center Description	MEDI CAL	SOCIAL SERVICE	Subtotal	Intern &	Total	lo piii
	F	RECORDS &			Residents Cost		
		LI BRARY			& Post		
					Stepdown		
					Adjustments		
	CENEDAL CEDALCE COST CENTEDS	16. 00	17. 00	24. 00	25. 00	26. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-BUBBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00570 ADMITTING						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						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	869, 688					16. 00
17. 00	01700 SOCI AL SERVI CE	0	0				17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	40, 358		4, 736, 069		4, 736, 069	1
31. 00	03100 NTENSI VE CARE UNI T	5, 045		1, 028, 706		1, 028, 706	
43. 00	04300 NURSERY	874	0	1, 226, 292	0	1, 226, 292	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	100 224	1 0	2 405 442		2 405 442	F0 00
50.00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	109, 324	1	2, 485, 442		2, 485, 442	1
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	18, 957 0	l	632, 779 0		632, 779 0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		0	0	l l	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	181, 616		2, 697, 740	- I	2, 697, 740	54.00
54. 01	05401 ULTRASOUND	101,010		2,077,740		2, 077, 740	54. 01
56. 00	05600 RADI OI SOTOPE		Ö	0	Ö	0	56. 00
57. 00	05700 CT SCAN		Ö	0	Ö	0	57. 00
58. 00	05800 MRI	0	ol	0	o	0	58. 00
60.00	06000 LABORATORY	115, 302	o	2, 851, 607	0	2, 851, 607	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o	0	l l	0	62.00
65.00	06500 RESPIRATORY THERAPY	12, 569	o	826, 760	o	826, 760	65. 00
66.00	06600 PHYSI CAL THERAPY	13, 791	o	718, 786		718, 786	
67.00	06700 OCCUPATI ONAL THERAPY	7, 581	o	289, 760	0	289, 760	67. 00
68.00	06800 SPEECH PATHOLOGY	584	0	59, 427	0	59, 427	68. 00
69. 00	06900 ELECTROCARDI OLOGY	27, 171	0	367, 763	0	367, 763	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27, 865		207, 240	0	207, 240	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	24, 916		1, 053, 146		1, 053, 146	
73. 00	07300 DRUGS CHARGED TO PATIENTS	126, 850		2, 334, 876		2, 334, 876	1
76. 00	03610 SLEEP LAB	6, 812	0	221, 773	0	221, 773	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	2, 262		474, 416		474, 416	
91. 00	09100 EMERGENCY	110, 093	0	7, 414, 034		7, 414, 034	1
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART				0		92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	27 710	ا	044 445	٥	044 445	05.00
95.00	09500 AMBULANCE SERVI CES	37, 718	0	844, 445	0	844, 445	J 95.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	869, 688	o	30, 471, 061	O	30, 471, 061	110 00
118.00	NONREIMBURSABLE COST CENTERS	009, 088	ı O	30, 471, 061	ų ų	30, 4/1, 061	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	39, 241	O	20 2/11	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES			754, 327		754, 327	
200.00			1	754, 327			200.00
201.00		0	o	0	- 1		201. 00
202.00		869, 688		31, 264, 629	- I	31, 264, 629	
50	1	, 22., 300	,	, 52 /		. ,, /	

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1318

				То	12/31/2018	Date/Time Prep 5/31/2019 12:	
			CAPI TAL REL	ATED COSTS		3/31/2017 12.	ГО РІІІ
			BLBO & FLVT	10/01 5 50// 0		5451 0\/55	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	CENEDAL CEDIULCE COCT CENTEDO	0	1. 00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	10, 366	12, 355	22, 721	22, 721	4. 00
5. 01	00570 ADMITTING	0	15, 772	18, 798	34, 570	945	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	0	74, 787		163, 923	1, 772	5. 02
7.00	00700 OPERATION OF PLANT	0	434, 697		952, 794	483	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	17, 066 14, 129		37, 407 30, 969	0 547	8. 00 9. 00
10.00	01000 DI ETARY	0	35, 672		78, 188	270	10.00
11. 00	01100 CAFETERI A	0	22, 911		50, 218	65	11. 00
13.00	01300 NURSING ADMINISTRATION	0	6, 663		14, 604	1, 022	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	34, 965		76, 639	134	14. 00
15. 00	01500 PHARMACY	0	16, 323		35, 777	749	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	29, 500		64, 660	405	16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	U	0	0	0	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	0	244, 863	291, 842	536, 705	1, 712	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	28, 377		62, 198	681	31. 00
43.00	04300 NURSERY	0	5, 614	6, 692	12, 306	1, 217	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	112, 496		246, 576	768	50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELI VERY ROOM & LABOR ROOM	0	8, 098 0		17, 750 0	514 0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	79, 122	94, 303	173, 425	1, 488	
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	1	0	0	56. 00
57. 00	05700 CT SCAN	0	0	1	0	0	57. 00
58. 00 60. 00	05800 MRI 06000 LABORATORY	0	0 32, 586		70, 289	0 1, 431	58. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	32, 300	37, 703	70, 207	0	62. 00
65. 00	06500 RESPIRATORY THERAPY	0	13, 579	16, 184	29, 763	715	
66. 00	06600 PHYSI CAL THERAPY	0	18, 635	22, 211	40, 846	4	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	6, 098		13, 366	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	245	1	537	0	68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY	0	9, 214 0		35, 874 0	213	69. 00 71. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	o	0	73. 00
76. 00	03610 SLEEP LAB	0	13, 155	1	13, 155	117	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	8, 552		18, 744		90.00
91.00	09100 EMERGENCY	0	54, 493	64, 948	119, 441 0	6, 603	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				<u> </u>		92. 00
95. 00	09500 AMBULANCE SERVICES	0	21, 945	26, 155	48, 100	457	95. 00
	SPECIAL PURPOSE COST CENTERS		= 17 1 19	==7 .55	.5, .55		
118.00		0	1, 369, 923	1, 631, 622	3, 001, 545	22, 721	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 001		6, 001		190. 00
192. 00 200. 00	19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments		93, 980	112, 011	205, 991 0		192. 00 200. 00
200.00	, ,		0	0	0		200.00
202.00		0			3, 213, 537	22, 721	
		•					•

Provider CCN: 15-1318

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/31/2019 12: 18 pm

						5/31/2019 12:	18 pm_
	Cost Center Description	ADMITTING	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	
		5. 01	AND GENERAL 5. 02	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	5.01	3.02	7.00	8.00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00							2.00
	00200 CAP REL COSTS-MVBLE EQUIP						
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	05 545					4.00
5. 01	00570 ADMITTING	35, 515					5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	0	1				5. 02
7. 00	00700 OPERATION OF PLANT	0					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0		17, 824	•		8. 00
9.00	00900 HOUSEKEEPI NG	0		14, 756		49, 524	9. 00
10.00	01000 DI ETARY	0				1, 956	10.00
11. 00	01100 CAFETERI A	0	443			1, 256	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	.,		0	365	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 131	36, 518	0	1, 917	14. 00
15. 00	01500 PHARMACY	0	4, 629	17, 048	0	895	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	3, 760	30, 810	0	1, 618	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 650	12, 799	255, 736	46, 506	13, 431	30. 00
31. 00	03100 INTENSIVE CARE UNIT	206		29, 637	5, 180	1, 556	31.00
43.00	04300 NURSERY	36	5, 988	5, 864	4, 266	308	43.00
	ANCILLARY SERVICE COST CENTERS				1		
50.00	05000 OPERATING ROOM	4, 469	1			6, 169	50.00
51. 00	05100 RECOVERY ROOM	775	2, 787	8, 458	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 385	10, 556	82, 636	0	4, 339	54.00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	-	0	0	0	56. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58.00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	4, 714	12, 296	34, 033	0	1, 787	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	514	3, 831	14, 182	0	745	65. 00
66.00	06600 PHYSI CAL THERAPY	564	3, 201	19, 463	0	1, 022	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	310	1, 324	6, 369	0	334	67.00
68.00	06800 SPEECH PATHOLOGY	24	305	256	0	13	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 111	1, 526	9, 623	0	505	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 139	951	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 019	4, 283	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 186		0	0	0	73.00
76.00	03610 SLEEP LAB	278			0	721	76. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>	<u>'</u>		<u>'</u>		ĺ
90.00	09000 CLI NI C	92	2, 197	8, 932	0	469	90.00
91.00	09100 EMERGENCY	4, 501	34, 528	56, 913	0	2, 988	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 542	3, 511	22, 919	0	1, 203	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	, , , , , , , , , , , , , , , , , , , ,	35, 515	164, 295	871, 352	55, 952	44, 041	118. 00
	NONREI MBURSABLE COST CENTERS				T		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 360	98, 154	0	5, 154	192. 00
200.00							200. 00
201.00	9	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	35, 515	165, 695	975, 774	55, 952	49, 524	202. 00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1318

				To	12/31/2018	Date/Time Pre	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	5/31/2019 12: PHARMACY	16 pili
	5550 5511651 55551 1 per 511	5.2.7	57.11 E 1 E 1 (1 7 1	ADMI NI STRATI ON	SERVI CES &		
					SUPPLY		
		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 & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 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	120, 117					10. 00
11. 00	01100 CAFETERI A	0	75, 911	1			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	3, 283	1	440 540		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	1, 230	1	118, 569	4E 007	14.00
15. 00 16. 00	01600 MEDI CAL RECORDS & LI BRARY		2, 636 1, 288	1	3, 353 104	65, 087 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		1, 200	1	0	0	17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u>ا</u>		1 0	<u> </u>		17.00
30.00	03000 ADULTS & PEDIATRICS	99, 837	14, 809	6, 563	6, 324	0	30.00
31.00	03100 INTENSIVE CARE UNIT	11, 121	2, 871	1, 526	509	0	31. 00
43.00	04300 NURSERY	9, 159	0	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATI NG ROOM	0	3, 919		20, 719	0	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	1, 999 0	·	1, 107 0	0	51. 00 52. 00
52.00	05300 ANESTHESI OLOGY		0		0	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		8, 073		5, 739	0	54. 00
54. 01	05401 ULTRASOUND	l ol	0, 0, 0		0	0	54. 01
56.00	05600 RADI OI SOTOPE	O	0	0	o	0	56. 00
57.00	05700 CT SCAN	0	0	0	o	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	0	9, 345	3, 206	24, 769	0	60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	0	3, 293	1	2, 140	0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY	0	37 0		457	0	66. 00 67. 00
68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		0		13	0	68.00
69. 00	06900 ELECTROCARDI OLOGY		1, 032	- 1	218	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	1	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	O	44, 180	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	0	0	o	65, 087	73. 00
76. 00	03610 SLEEP LAB	0	567	0	227	0	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS		4 000		4 440		00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0	1, 903	1	1, 462	0	90.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	٩	15, 584	14, 816	3, 776	U	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>					72.00
95. 00	09500 AMBULANCE SERVICES	0	4, 026	0	3, 455	0	95. 00
	SPECIAL PURPOSE COST CENTERS				·		
118.00		120, 117	75, 895	30, 846	118, 552	65, 087	118. 00
100.00	NONREI MBURSABLE COST CENTERS	-			51		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 16		0 17		190.00
200.00	19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments		16	0	17		192. 00 200. 00
200.00			0	o	o		200.00
202.00		120, 117	75, 911		118, 569		
							•

| Period: | Worksheet B | From 01/01/2018 | Part II | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS DUKES MEMORIAL HOSPITAL Provider CCN: 15-1318

				-	Го 12/31/2018	Date/Time Pre 5/31/2019 12:	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post	Total	16 piii
		Erbivati			Stepdown		
		47.00	47.00	0.4.00	Adjustments	0/ 00	
	GENERAL SERVICE COST CENTERS	16. 00	17. 00	24. 00	25. 00	26. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING						5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL						5. 02
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	102, 645					16. 00
17. 00	01700 SOCI AL SERVI CE	0	0				17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	4, 759	0	1, 000, 83	1 0	1, 000, 831	30.00
31. 00	03100 INTENSIVE CARE UNIT	4, 759 595				119, 991	1
43. 00	04300 NURSERY	103	0		1	39, 247	
	ANCILLARY SERVICE COST CENTERS				-,		1
50.00	05000 OPERATING ROOM	12, 892	0	423, 288	3 0	423, 288	50. 00
51. 00	05100 RECOVERY ROOM	2, 235	0	37, 222	2 0	37, 222	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ULTRASOUND	21, 505	0	317, 00		317, 007	1
56. 00	05600 RADI OI SOTOPE	0	0		0 0	0	1
57. 00	05700 CT SCAN	0	0			0	
58. 00	05800 MRI	0	0		o o	0	
60.00	06000 LABORATORY	13, 597	0	175, 46	7 0	175, 467	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	1, 482	0	56, 66!		56, 665	1
66.00	06600 PHYSI CAL THERAPY	1, 626	0		1	67, 220	1
67. 00 68. 00	O6700 OCCUPATIONAL THERAPY O6800 SPEECH PATHOLOGY	894 69	0	22, 610		22, 610	1
69. 00	06900 ELECTROCARDI OLOGY	3, 204	0	.,		1, 204 53, 306	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 286	0		1	5, 376	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 938	0	52, 420	1	52, 420	1
73.00	07300 DRUGS CHARGED TO PATIENTS	14, 959	0		1	91, 721	1
76. 00	03610 SLEEP LAB	803	0	30, 363	3 0	30, 363	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	267	0	'	1	34, 475	1
	09100 EMERGENCY	12, 983	0	272, 13		272, 133	l
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92.00
95 00	09500 AMBULANCE SERVICES	4, 448	0	89, 66	1 0	89 661	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	1, 110		07,00	٠١	077001	70.00
118.00		102, 645	0	2, 890, 20	7 0	2, 890, 207	118. 00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	'	1		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0			310, 692	
200. 00 201. 00	3	^	_		0 0		200. 00 201. 00
201.00		102, 645	0				
202.00	1.5 (53 1.1.55 116 till 64gil 251)	102,040	•	3,210,00	· 1	5,215,557	,_02. 00

		TON - STATISTICAL BASIS	DOKES WEWOKI7		CN: 15-1318 P	eri od:	Worksheet B-1	
					F T	rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
			CAPITAL REL	 _ATED_COSTS			5/31/2019 12:	18 pm
		Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	ADMI TTI NG (GROSS CHARGES)	Reconciliation	
			1.00	2.00	SALARI ES) 4. 00	5. 01	5A. 02	
		AL SERVICE COST CENTERS	11.00	2.00		0.01	57.I. 02	
1. 00 2. 00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	197, 666	l				1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	1, 394	196, 731 1, 394	1			4.00
5. 01	00570	ADMITTI NG	2, 121	2, 121	1			5. 01
5. 02		ADMINISTRATIVE AND GENERAL	10, 057	1	1		-6, 155, 162	
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	58, 456 2, 295			0	0	
9. 00	00900	HOUSEKEEPI NG	1, 900			0	0	1
10.00		DIETARY	4, 797	1	1		0	
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	3, 081 896	1	1		0	11. 00 13. 00
		CENTRAL SERVICES & SUPPLY	4, 702				0	14. 00
		PHARMACY	2, 195	2, 195	1		0	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	3, 967	3, 967	240, 243		0	
17.00		ENT ROUTINE SERVICE COST CENTERS	0		η <u></u>	0	0	17.00
30.00		ADULTS & PEDIATRICS	32, 928	1	1		0	
31. 00 43. 00		INTENSIVE CARE UNIT NURSERY	3, 816 755		1		0	
43.00		LARY SERVICE COST CENTERS	/55	/55) 122,117	171,725	0	43.00
50. 00	05000	OPERATING ROOM	15, 128		1		0	
		RECOVERY ROOM	1, 089	1, 089			0	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0			0	0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	10, 640	10, 640	883, 715	35, 699, 422	0	1
54. 01	1	ULTRASOUND	0	0	1	0	0	54. 01
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	0	0	0	0	56. 00 57. 00
58. 00	05800		0			0	0	1
60.00		LABORATORY	4, 382	4, 254	849, 522	22, 661, 521	0	60.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1 02/	0	0	0	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	1, 826 2, 506				0	65. 00 66. 00
67. 00		OCCUPATI ONAL THERAPY	820	820	1		0	1
68. 00	1	SPEECH PATHOLOGY	33	ł			0	00.00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	1, 239	3, 008	126, 188		0	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö			0	
		DRUGS CHARGED TO PATIENTS	0		0		0	
76. 00		SLEEP LAB	1, 769	0	69, 312	1, 338, 883	0	76. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	1, 150	1, 150	242, 975	444, 631	0	90.00
91. 00	1	EMERGENCY	7, 328	7, 328	3, 925, 102	21, 637, 859	0	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92.00
95. 00		AMBULANCE SERVICES	2, 951	2, 951	271, 499	7, 413, 036	0	95. 00
		AL PURPOSE COST CENTERS						
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	184, 221	184, 093	13, 495, 923	170, 933, 901	-6, 155, 162	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	807	О	0	0	0	190. 00
192. 00	19200	PHYSICIANS' PRIVATE OFFICES	12, 638	l .	1			192. 00
200.00		Cross Foot Adjustments						200.00
201. 00 202. 00	1	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 469, 904	1, 743, 633	1, 308, 070	1, 332, 734		201. 00 202. 00
203. 00	,	Part I) Unit cost multiplier (Wkst. B, Part I)	7. 436302	8. 863031	0. 096923	0. 007797		203. 00
204.00	1	Cost to be allocated (per Wkst. B,			22, 721			204. 00
205.00		Part II)			0.001/04	0.000000		205 00
205. 00 206. 00		Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated			0. 001684	0.000208		205. 00
		(per Wkst. B-2)						
207. 00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1318

					T	o 12/31/2018	Date/Time Prep 5/31/2019 12:	
		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	18 piii
		·	AND GENERAL	PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL PATIENT	
			(ACCUMULATED	(SQUARE FEET)	(TOTAL PATIENT		DAYS)	
			COST) 5. 02	7. 00	DAYS) 8.00	9. 00	10.00	
	GENER	AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
4. 00 5. 01		ADMITTING						4. 00 5. 01
5. 02		ADMINISTRATIVE AND GENERAL	25, 109, 467					5. 02
7.00	1	OPERATION OF PLANT	3, 409, 132	125, 638				7. 00
8.00		LAUNDRY & LINEN SERVICE	109, 298					8. 00
9.00		HOUSEKEEPI NG	492, 766			121, 443		9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	370, 862 67, 070	4, 797 3, 081	0	4, 797 3, 081	3, 305 0	10. 00 11. 00
13. 00	1	NURSING ADMINISTRATION	699, 089		0	896	0	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	322, 989			4, 702	0	14. 00
15. 00		PHARMACY	701, 516	2, 195	0	2, 195	0	15.00
16. 00		MEDICAL RECORDS & LIBRARY	569, 839			3, 967	0	16. 00
17. 00		SOCIAL SERVICE	0	0	0	0	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	1, 939, 589	32, 928	2, 747	32, 928	2, 747	30. 00
31. 00		INTENSIVE CARE UNIT	592, 615			3, 816	306	31. 00
43.00		NURSERY	907, 371	755		755	252	43.00
		LARY SERVICE COST CENTERS			_		_	
50.00		OPERATING ROOM	1, 297, 660			15, 128	0	50.00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	422, 334 0	1, 089 0		1, 089 0	0	51. 00 52. 00
53. 00		ANESTHESI OLOGY	0	0		0	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	1, 599, 586	10, 640	0	10, 640	0	54.00
54. 01	1	ULTRASOUND	0	0		0	0	54. 01
56. 00	1	RADI OI SOTOPE	0	0		0	0	56. 00
57. 00 58. 00	05/00	CT SCAN	0	0		0	0	57. 00 58. 00
60.00	1	LABORATORY	1, 863, 372	4, 382	1	4, 382	0	60.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	Ö	0	0	62. 00
65.00	06500	RESPI RATORY THERAPY	580, 468	1, 826	0	1, 826	0	65.00
66. 00		PHYSI CAL THERAPY	485, 061	2, 506		2, 506	0	66. 00
67.00		OCCUPATIONAL THERAPY	200, 650			820	0	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	46, 215 231, 257	33 1, 239		33 1, 239		68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	144, 061	0		0	0	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	649, 064	0	0	0	0	72.00
73. 00		DRUGS CHARGED TO PATIENTS	983, 287	0		0	0	73.00
76. 00		SLEEP LAB TIENT SERVICE COST CENTERS	114, 575	1, 769	0	1, 769	0	76. 00
90. 00		CLINIC	332, 869	1, 150	0	1, 150	0	90. 00
91.00	1	EMERGENCY	5, 232, 666				0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	532, 061	2, 951	0	2, 951	0	95. 00
73.00		AL PURPOSE COST CENTERS	332,001	2, 731		2, 731	0	73.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24, 897, 322	112, 193	3, 305	107, 998	3, 305	118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 001	807		807		190.00
200.00	1	PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments	206, 144	12, 638	0	12, 638		192. 00 200. 00
201.00	1	Negative Cost Centers						200.00
202.00	1	Cost to be allocated (per Wkst. B,	6, 155, 162	4, 244, 823	213, 630	677, 753		
		Part I)	0.045400	00 70/4/0			10/ 05000/	
203. 00 204. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 245133 165, 695			5. 580832 49, 524	196. 858094 120, 117	
204.00	1	Part II)	103, 073	775,774	33, 732	47, 324	120, 117	204.00
205.00		Unit cost multiplier (Wkst. B, Part	0. 006599	7. 766552	16. 929501	0. 407796	36. 344024	205. 00
204 00		NAME adjustment amount to be allegated						204 00
206.00	'	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00		NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)			1			

	ILLOCATION - STATISTICAL BASIS	DONES MEMORY	Provider Co	CN: 15-1318	Peri od:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/31/2019 12:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	ГО ріп
		(FTES)	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQ)	RECORDS & LI BRARY	
			(NURSI NG	(COSTED REQ)		(GROSS	
		11 00	SALARI ES)	14.00	15.00	CHARGES)	
	GENERAL SERVICE COST CENTERS	11.00	13. 00	14. 00	15. 00	16. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
4. 00 5. 01	00570 ADMITTING						5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL						5. 02
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	14, 199 614	1				11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	230		1, 968, 339			14. 00
15. 00	01500 PHARMACY	493		55, 658			15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	241	1	1, 726		170, 933, 901 0	ı
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		,,		<u> </u>	0	17.00
30.00	03000 ADULTS & PEDIATRICS	2, 770				7, 932, 090	1
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	537 0	1	1		991, 593 171, 725	
43.00	ANCI LLARY SERVI CE COST CENTERS		,,		<u>Л</u>	171, 723	43.00
	05000 OPERATING ROOM	733				21, 486, 551	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	374	1	18, 383	I I	3, 725, 795 0	1
53.00	05300 ANESTHESI OLOGY	0	_			0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 510	493, 241	95, 269	9 0	35, 699, 422	
54. 01 56. 00	05401 ULTRASOUND 05600 RADI OI SOTOPE	0	0	(0	
57. 00	05700 CT SCAN	0	Ö			0	1
58. 00	05800 MRI	0	0	(o	0	58. 00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 748	849, 522	411, 189		22, 661, 521 0	1
65. 00	06500 RESPIRATORY THERAPY	616	Ö	35, 534		2, 470, 385	
66. 00	06600 PHYSI CAL THERAPY	7	0	7, 582	I I	2, 710, 426	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	208		1, 490, 067 114, 735	1
69. 00	06900 ELECTROCARDI OLOGY	193	Ö	3, 619	ol ol	5, 340, 285	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	-	700 100	-1	5, 476, 574	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	1	733, 438	3 0 796, 575	4, 897, 050 24, 931, 273	
76. 00	03610 SLEEP LAB	106		3, 770		1, 338, 883	
00.00	OUTPATIENT SERVICE COST CENTERS	05/		04.045		111 (01	00.00
	09000 CLI NI C 09100 EMERGENCY	356 2, 915		24, 203		444, 631 21, 637, 859	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	_,]	,			92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	753		F7 246		7 412 024	05.00
95.00	SPECIAL PURPOSE COST CENTERS	/53	0	57, 348	3 0	7, 413, 036	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	14, 196	8, 172, 839	1, 968, 050	796, 575	170, 933, 901	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			1 (0	190. 00
	19000 PHYSI CLANS' PRI VATE OFFI CES	3	0	289	1		190.00
200.00	Cross Foot Adjustments	_					200. 00
201.00		204 901	014 507	E00 E0	1 002 702	869, 688	201. 00
202.00	Part I)	204, 801	914, 587	590, 584	983, 703	009, 000	202.00
203.00		14. 423621				0. 005088	
204.00	Cost to be allocated (per Wkst. B, Part II)	75, 911	30, 846	118, 569	65, 087	102, 645	204. 00
205.00	1 1	5. 346222	0. 003774	0. 060238	0. 081709	0.000600	205. 00
20/ 22	NAUE adjustment amount to be allegated						204 22
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	I	I	I	1 I		I

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 01/01/2018 12/31/2018 Date/Time Prepared: 5/31/2019 12:18 pm 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 10.00 01000 DI ETARY 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, 305 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 30.00 2 747 31.00 03100 INTENSIVE CARE UNIT 306 31.00 43.00 04300 NURSERY 252 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 00000000000000000 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 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 03610 SLEEP LAB 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 91.00 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 3, 305 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 0 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) Unit cost multiplier (Wkst. B, Part 205. 00 205.00 0.000000 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	Provider CCN: 15-1318	Peri od: Worksheet C From 01/01/2018 Part I

				rom 01/01/2018 Fo 12/31/2018	Part I Date/Time Pre 5/31/2019 12:	
		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)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		l		.1 _1		
30. 00 03000 ADULTS & PEDI ATRI CS	4, 736, 069	l e	4, 736, 069		0	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 028, 706		1, 028, 706		0	31.00
43. 00 04300 NURSERY	1, 226, 292		1, 226, 292	<u> 2 </u>	0	43. 00
ANCILLARY SERVICE COST CENTERS		I				
50. 00 05000 OPERATI NG ROOM	2, 485, 442		2, 485, 442		0	50. 00
51. 00 05100 RECOVERY ROOM	632, 779		632, 779	이	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		(이	0	52.00
53. 00 05300 ANESTHESI OLOGY	0		(이	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 697, 740		2, 697, 740	이	0	54. 00
54. 01 05401 ULTRASOUND	0		(이	0	54. 01
56. 00 05600 RADI OI SOTOPE	0		(이	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, 851, 607		2, 851, 607	7 0	0	60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		(이	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	826, 760		826, 760		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	718, 786		718, 786	6 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	289, 760	0	289, 760	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	59, 427	0	59, 427	7 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	367, 763		367, 763	3 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	207, 240		207, 240		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 053, 146		1, 053, 146	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 334, 876		2, 334, 876	5 0	0	73.00
76. 00 03610 SLEEP LAB	221, 773		221, 773	3 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	474, 416		474, 416	5 0	0	90.00
91. 00 09100 EMERGENCY	7, 414, 034		7, 414, 034	4 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	989, 050		989, 050		0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	844, 445		844, 445	5 0	0	95. 00
200.00 Subtotal (see instructions)	31, 460, 111	0	31, 460, 11 ²	ı o	0	200. 00
201.00 Less Observation Beds	989, 050		989, 050		0	201. 00
202.00 Total (see instructions)	30, 471, 061	0	30, 471, 06°	ı o	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 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

				Т	o 12/31/2018	Date/Time Prep 5/31/2019 12:	
			Title	XVIII	Hospi tal	Cost	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	5, 699, 159		5, 699, 159			30. 00
31. 00	03100 INTENSIVE CARE UNIT	991, 593		991, 593			31. 00
43.00	04300 NURSERY	171, 725		171, 725			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 442, 520	16, 044, 031			0.000000	
51.00	05100 RECOVERY ROOM	693, 712	3, 032, 083	3, 725, 795		0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0. 000000	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0	C	0.000000	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 296, 739	30, 402, 683	35, 699, 422		0.000000	
54. 01	05401 ULTRASOUND	0	0	C	0. 000000	0.000000	54. 01
56.00	05600 RADI OI SOTOPE	0	0	C	0. 000000	0.000000	56. 00
57.00	05700 CT SCAN	0	0	C	0.000000	0.000000	57.00
58. 00	05800 MRI	0	0	C	0.000000	0.000000	
60.00	06000 LABORATORY	5, 476, 938	17, 184, 583	22, 661, 521	0. 125835	0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0.000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	1, 790, 441	679, 944			0.000000	
66. 00	06600 PHYSI CAL THERAPY	623, 536	2, 086, 890	2, 710, 426		0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	484, 873	1, 005, 194	1, 490, 067		0.000000	
68. 00	06800 SPEECH PATHOLOGY	19, 611	95, 124	114, 735	0. 517950	0.000000	
69. 00	06900 ELECTROCARDI OLOGY	1, 367, 420	3, 972, 865	5, 340, 285	0. 068866	0.000000	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 341, 375	3, 135, 199	5, 476, 574	0. 037841	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 376, 447	1, 520, 603	4, 897, 050	0. 215057	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 554, 216	13, 377, 057	24, 931, 273	0. 093652	0.000000	73. 00
76. 00	03610 SLEEP LAB	16, 126	1, 322, 757	1, 338, 883	0. 165640	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	102, 680	341, 951	444, 631	1. 066988	0.000000	90. 00
91.00	09100 EMERGENCY	2, 382, 548	19, 255, 311	21, 637, 859	0. 342642	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	363, 637	1, 869, 294	2, 232, 931	0. 442938	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	5, 908	7, 407, 128	7, 413, 036	0. 113914	0.000000	
200.00	Subtotal (see instructions)	48, 201, 204	122, 732, 697	170, 933, 901			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	48, 201, 204	122, 732, 697	170, 933, 901			202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1318	From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/31/2019 12:18 pm

				5/31/2019 12:18 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50. 00
51.00 05100 RECOVERY ROOM	0. 000000			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01 05401 ULTRASOUND	0. 000000			54. 01
56. 00 05600 RADI 01 SOTOPE	0. 000000			56. 00
57.00 05700 CT SCAN	0. 000000			57. 00
58. 00 05800 MRI	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
65. 00 06500 RESPIRATORY 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 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03610 SLEEP LAB	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 000000			90. 00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	·			·

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C
		From 01/01/2018 Part

				Ť	o 12/31/2018	Date/Time Prep 5/31/2019 12:	pared: 18 pm
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Ādj .		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 & PEDIATRICS	4, 736, 069		4, 736, 069	0	4, 736, 069	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 028, 706		1, 028, 706	0	1, 028, 706	31. 00
	04300 NURSERY	1, 226, 292		1, 226, 292	0	1, 226, 292	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 485, 442		2, 485, 442		2, 485, 442	
	05100 RECOVERY ROOM	632, 779		632, 779	0	632, 779	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 697, 740		2, 697, 740	0	2, 697, 740	54. 00
54. 01	05401 ULTRASOUND	0		C	0	0	54. 01
	05600 RADI 0I SOTOPE	0		C	0	0	56. 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, 851, 607		2, 851, 607	0	2, 851, 607	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		C	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	826, 760	0	826, 760	0	826, 760	65. 00
66.00	06600 PHYSI CAL THERAPY	718, 786	0	718, 786	0	718, 786	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	289, 760	0	289, 760	0	289, 760	67.00
68.00	06800 SPEECH PATHOLOGY	59, 427	0	59, 427	0	59, 427	68. 00
69. 00	06900 ELECTROCARDI OLOGY	367, 763		367, 763	0	367, 763	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	207, 240		207, 240	0	207, 240	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 053, 146		1, 053, 146	0	1, 053, 146	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 334, 876		2, 334, 876	0	2, 334, 876	73. 00
76.00	03610 SLEEP LAB	221, 773		221, 773	0	221, 773	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	474, 416		474, 416	0	474, 416	90.00
91.00	09100 EMERGENCY	7, 414, 034		7, 414, 034	. 0	7, 414, 034	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	989, 050		989, 050)	989, 050	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	844, 445		844, 445	0	844, 445	95. 00
200.00	Subtotal (see instructions)	31, 460, 111	0	31, 460, 111	0	31, 460, 111	200. 00
201.00	Less Observation Beds	989, 050		989, 050)	989, 050	201. 00
202.00	Total (see instructions)	30, 471, 061	0	30, 471, 061	0	30, 471, 061	202. 00
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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 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

Title XIX
Cost Center Description
Inpati ent Outpati ent Total (col. 6
NPATIENT ROUTINE SERVICE COST CENTERS 5,699,159 5,699,159 30.00 3100 INTENSIVE CARE UNIT 991,593 991,593 31.00 43.00 NURSERY 171,725 171,725 43.00 ANCILLARY SERVICE COST CENTERS 5,442,520 16,044,031 21,486,551 0.115674 0.000000 50.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 693,712 3,032,083 3,725,795 0.169837 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0.000000 53.00 54.00 54.00 05400 RADI OLOGY-DI AGNOSTIC 5,296,739 30,402,683 35,699,422 0.075568 0.000000 54.00
INPATIENT ROUTINE SERVICE COST CENTERS
INPATIENT ROUTI NE SERVI CE COST CENTERS 5, 699, 159 5, 699, 159 30. 00 310 0 310 0 1 NTENSI VE CARE UNI T 991, 593 991, 593 31. 00 31. 00 0 0 0 0 0 0 0 0 0
30. 00 03000 ADULTS & PEDI ATRI CS 5, 699, 159 5, 699, 159 31. 00
31. 00
43. 00 04300 NURSERY 171, 725 171, 725 43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00
50. 00 05000 OPERATI NG ROOM 5, 442, 520 16, 044, 031 21, 486, 551 0. 115674 0. 000000 50. 00 51. 00 05100 RECOVERY ROOM 693, 712 3, 032, 083 3, 725, 795 0. 169837 0. 000000 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0. 000000 0. 000000 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0. 000000 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 296, 739 30, 402, 683 35, 699, 422 0. 075568 0. 000000 54. 00
51. 00 05100 RECOVERY ROOM 693, 712 3, 032, 083 3, 725, 795 0. 169837 0. 000000 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0. 000000 0. 000000 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0. 000000 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 296, 739 30, 402, 683 35, 699, 422 0. 075568 0. 000000 54. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0.000000 0.000000 52. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0.000000 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 296, 739 30, 402, 683 35, 699, 422 0.075568 0.000000 54. 00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 296, 739 30, 402, 683 35, 699, 422 0. 075568 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 0. 000000 0. 000000 57. 00
58. 00 05800 MRI 0 0 0 0. 000000 0. 000000 58. 00
60. 00 06000 LABORATORY 5, 476, 938 17, 184, 583 22, 661, 521 0. 125835 0. 000000 60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0.000000 0.000000 62.00
65. 00 06500 RESPI RATORY THERAPY 1, 790, 441 679, 944 2, 470, 385 0. 334668 0. 000000 65. 00
66. 00 06600 PHYSI CAL THERAPY 623, 536 2, 086, 890 2, 710, 426 0. 265193 0. 000000 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 484, 873 1, 005, 194 1, 490, 067 0. 194461 0. 000000 67. 00
68. 00 06800 SPEECH PATHOLOGY 19, 611 95, 124 114, 735 0. 517950 0. 000000 68. 00
69. 00 06900 ELECTROCARDI OLOGY 1, 367, 420 3, 972, 865 5, 340, 285 0. 068866 0. 000000 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 341, 375 3, 135, 199 5, 476, 574 0. 037841 0. 000000 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3,376,447 1,520,603 4,897,050 0.215057 0.000000 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 11, 554, 216 13, 377, 057 24, 931, 273 0. 093652 0. 000000 73. 00
76. 00 03610 SLEEP LAB 16, 126 1, 322, 757 1, 338, 883 0. 165640 0. 000000 76. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 102, 680 341, 951 444, 631 1. 066988 0. 000000 90. 00
91. 00 09100 EMERGENCY 2,382,548 19,255,311 21,637,859 0.342642 0.000000 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 363, 637 1, 869, 294 2, 232, 931 0. 442938 0. 000000 92. 00
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES 5, 908 7, 407, 128 7, 413, 036 0. 113914 0. 000000 95. 00
200.00 Subtotal (see instructions) 48, 201, 204 122, 732, 697 170, 933, 901 200.00
201.00 Less Observation Beds 201.00
202.00 Total (see instructions) 48, 201, 204 122, 732, 697 170, 933, 901

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 01/01/2018 Part I Date/Time Prepared: 5/31/2019 12:18 pm

INPATI ENT ROUTINE SERVICE COST CENTERS 11.00 11.00 13.00 33						5/31/2019 12	:18 pm
RATIO 11.00				Title XIX	Hospi tal	PPS	
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 31.00 310.01 31.00	Cost Center Descr	iption					
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 30.00 30300 ADULTS & PEDI ATRI CS 31.00 43.00 04300 RUISES VECARE UNI T 31.00 43.00 04300 RUISESEY 43.00 43.00 05300 RUISES VECARE UNI T 43.00 43.00 05300 RUISES VECARE UNI T 50.00 50.00 05000 OPERATI ING ROOM 0.169837 51.00 50.00 05000 OPERATI ING ROOM 0.169837 51.00 50.00 05300 RESULT ROOM 0.169837 51.00 50.00 05300 RUISES VECARE							
30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 03100 INTENSIVE CARE UNIT 31. 00 43. 00 04300 INTENSIVE CARE UNIT 31. 00 ANCILLARY SERVICE COST CENTERS 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 50.00			11. 00				
31.00 03100 INTENSIVE CARE UNIT							
43.00							•
ANCILLARY SERVICE COST CENTERS		ΙΤ					31. 00
50. 00 05000 0FERATI NG ROOM 0. 115674 50. 00 51. 00 05100 RECOVERY ROOM 0. 169837 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 000000 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 000000 53. 00 05300 ANESTHESI OLOGY 0. 0000000 53. 00 05300 ANESTHESI OLOGY 0. 000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 075568 54. 00 05401 ULTRASOUND 0. 000000 54. 00 05401 ULTRASOUND 0. 000000 54. 00 05401 ULTRASOUND 0. 000000 55. 00 05700 CT SCAN 0. 000000 57. 00 05700 CT SCAN 0. 000000 57. 00 05800 MRI 0. 000000 58. 00 05800 MRI 0. 000000 58. 00 06800 RESPI RATORY THERAPY 0. 125835 60. 00							43. 00
51.00		CENTERS					
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0.53. 00 05300 AMESTHESI OLOGY 0.000000 0.53. 00 05400 RADI OLOGY-DI AGNOSTI C 0.075568 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.54. 01 0.5401 ULTRASOUND 0.000000 0.54. 01 0.5401 ULTRASOUND 0.000000 0.54. 01 0.000000 0.55. 00 0.0000000 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 0.00000000			0. 115674				
53. 00 05300 ANESTHESI OLOGY 0.000000 54. 00 53. 00 54. 01 05401 ULTRASOUND 0.500000 54. 01 54. 01 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 55. 00 56. 00 57. 00 05600 RADI OLOGY-DI AGNOSTI C 0.000000 55. 00 56. 00 57. 00 05700 CT SCAN 0.000000 58. 00 0.000000 57. 00 60. 00 06800 MRI 0.000000 06800 MRI 0.000000 0.125835 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 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 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	51.00 05100 RECOVERY ROOM		0. 169837				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.075568 54. 00 54. 01 05401 ULTRASOUND 0.000000 56. 00 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 0.000000 62. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62. 00 65. 00 06500 RESPIRATORY THERAPY 0.334668 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 265193 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 194461 67. 00 68. 00 06800 SPECEH PATHOLOGY 0. 517950 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 517950 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 37841 71. 00 72. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0. 215057 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 215057 73. 00 90. 00 09000 CLI NI C 0. 342642 <t< td=""><td>52.00 05200 DELIVERY ROOM & L</td><td>ABOR ROOM</td><td>0. 000000</td><td></td><td></td><td></td><td>52. 00</td></t<>	52.00 05200 DELIVERY ROOM & L	ABOR ROOM	0. 000000				52. 00
54. 01 05401 ULTRASOUND 0.000000 54. 01 56. 00 05600 RADI OI SOTOPE 0.000000 55. 00 57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MR 0.000000 58. 00 60. 00 06600 LABORATORY 0.125835 60. 00 62. 00 06500 RESPIRATORY THERAPY 0.334668 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.265193 66. 00 66. 00 06600 PHYSI CAL THERAPY 0.194461 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.194461 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.157950 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.06886 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.037841 71. 00 72. 00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.215057 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.215057 72. 00 70. 00 07300 SLEEP LAB 0.165640 0.165640 00 07400 SEREPRATION BEDS (NON-DI STI NCT PART 0.442938 0.165640 0.113914 90. 00 09100 EMERGENCY 0.342642 91. 00 90. 00 09200 OSBERVATI ON BEDS (NON-DI STI NCT PART 0.442938 0.113914 0.0000 90. 00 09500 AMBULANCE SERVI CES 0.113914 0.00000 90. 00 Subtotal (see instructions) 200. 00 90. 00 200. 00 Subtotal (see instructions) 200. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00	53. 00 05300 ANESTHESI OLOGY		0. 000000				53. 00
56. 00 05600 RADI OI SOTOPE 0.000000 57. 00 57. 00 570. 00 570. 00 570. 00 570. 00 580. 00 580. 00 580. 00 580. 00 6	54. 00 05400 RADI OLOGY-DI AGNOS	TIC	0. 075568				54. 00
57. 00	54. 01 05401 ULTRASOUND		0. 000000				54. 01
57. 00 05700 CT SCAN 0.000000 57. 00 58. 00 05800 MRI 0.000000 0.000000 60. 00 06000 LABORATORY 0.125835 66. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0.334668 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.265193 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.194461 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.517950 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.068866 69. 00 671. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.037841 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.215057 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.215057 72. 00 76. 00 03610 SLEEP LAB 0.16540 0UTPATIENT SERVI CE COST CENTERS 0.093652 73. 00 70. 00 09900 CLI NI C 1.066988 90. 00 91. 00 09900 EMERGENCY 0.342642 91. 00 92. 00 09500 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.442938 92. 00 0THER REIMBURSABLE COST CENTERS 0.113914 95. 00 200. 00 Less Observation Beds 200. 00 201. 00 Less Observation Beds 201. 00	56. 00 05600 RADI 0I SOTOPE		0. 000000				56. 00
60. 00	57.00 05700 CT SCAN						57. 00
62. 00	58. 00 05800 MRI		0. 000000				58. 00
65. 00	60. 00 06000 LABORATORY		0. 125835				60.00
66. 00 06600 PHYSI CAL THERAPY 0. 265193 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 194461 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 517950 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 068866 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 037841 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 215057 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 093652 73. 00 76. 00 03610 SLEEP LAB 0. 165640 76. 00 0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0. 342642 91. 00 91. 00 09100 EMERGENCY 0. 342642 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 442938 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09000 Subtotal (see instructions) Less Observation Beds 200. 00 201. 00 Less Observation Beds	62.00 06200 WHOLE BLOOD & PAC	KED RED BLOOD CELLS	0. 000000				62. 00
67. 00	65. 00 06500 RESPIRATORY THERA	PY	0. 334668				65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY		0. 265193				66. 00
69. 00	67. 00 06700 OCCUPATIONAL THER	APY	0. 194461				67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY		0. 517950				68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 215057 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 093652 73. 00 03610 SLEEP LAB 0. 165640 0.	69. 00 06900 ELECTROCARDI OLOGY		0. 068866				69. 00
73. 00 76. 00 07300 DRUGS CHARGED TO PATIENTS 0. 093652 0. 165640 0UTPATIENT SERVICE COST CENTERS 90. 00 91. 00 91. 00 91. 00 9200 DBSERVATION BEDS (NON-DISTINCT PART 0. 442938) 95. 00 07HER REIMBURSABLE COST CENTERS 95. 00 09200 AMBULANCE SERVICES 0. 113914 95. 00 200. 00 201. 00 Less Observation Beds 73. 00 76. 00 78. 00 7	71.00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENT	0. 037841				71. 00
76. 00 03610 SLEEP LAB 0. 165640 76. 00 0UTPATIENT SERVICE COST CENTERS 90. 00 90. 00 09900 CLINIC 1. 066988 91. 00 91. 00 09100 EMERGENCY 0. 342642 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0. 442938 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 95. 00 09500 AMBULANCE SERVICES 0. 113914 95. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	72. 00 07200 I MPL. DEV. CHARGE	D TO PATIENTS	0. 215057				72. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 1. 066988 90. 00 91. 00 09100 EMERGENCY 0. 342642 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 442938 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES 0. 113914 95. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	73.00 07300 DRUGS CHARGED TO	PATI ENTS	0. 093652				73. 00
90. 00 09000 CLINIC 1.066988 90. 00 91. 00 09100 EMERGENCY 0.342642 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.442938 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.113914 95. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	76.00 03610 SLEEP LAB		0. 165640				76. 00
91. 00 09100 EMERGENCY 0. 342642 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 442938 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 113914 95. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00	OUTPATIENT SERVICE COST	CENTERS					
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.442938 92.00	90. 00 09000 CLI NI C		1. 066988				90. 00
OTHER REIMBURSABLE COST CENTERS 95.00	91. 00 09100 EMERGENCY		0. 342642				91. 00
95. 00	92.00 09200 OBSERVATION BEDS	(NON-DISTINCT PART	0. 442938				92. 00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	OTHER REIMBURSABLE COST	CENTERS					
201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVICE	S	0. 113914				95.00
	200.00 Subtotal (see ins	tructions)					200. 00
202. 00 Total (see instructions) 202. 00	201.00 Less Observation	Beds					201. 00
	202.00 Total (see instru	ctions)					202. 00

Heal th Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY In Lieu of Form CMS-2552-10 DUKES MEMORIAL HOSPITAL Provider CCN: 15-1318

Peri od: Worksheet C From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

						5/31/2019 12:	18 pm
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos	t Capi tal	Operating Cost	
		(Wkst. B, Part				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						
	05000 OPERATING ROOM	2, 485, 442	423, 288	2, 062, 15	4 0	0	50. 00
51.00	05100 RECOVERY ROOM	632, 779	37, 222	595, 55	7 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, 697, 740	317, 007	2, 380, 73	3 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, 851, 607	175, 467	2, 676, 14	0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	826, 760	56, 665	770, 09	5 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	718, 786	67, 220	651, 56	6 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	289, 760	22, 610	267, 15	0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	59, 427	1, 204	58, 22	3 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	367, 763	53, 306	314, 45	7 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	207, 240	5, 376	201, 86	4 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 053, 146	52, 420	1, 000, 72	6 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 334, 876	91, 721	2, 243, 15	5 0	0	73. 00
76.00	03610 SLEEP LAB	221, 773	30, 363	191, 41	0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	474, 416	34, 475	439, 94	1 0	0	90. 00
91.00	09100 EMERGENCY	7, 414, 034	272, 133	7, 141, 90	1 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	989, 050	209, 007	780, 04	3 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	844, 445	89, 661	754, 78	4 0	0	95. 00
200.00	Subtotal (sum of lines 50 thru 199)	24, 469, 044	1, 939, 145	22, 529, 89	9 0	0	200. 00
201.00	Less Observation Beds	989, 050	209, 007	780, 04	3 0	0	201. 00
202.00	Total (line 200 minus line 201)	23, 479, 994	1, 730, 138	21, 749, 85	6 0	0	202. 00

Heal th 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 01/01/2018
To 12/31/2018

Part II
Date/Time Prepared:
5/31/2019 12: 18 pm

Cost Center Description							5/31/2019 12:18 pm
Capital and Operating Cost Part I. column Ratio (col. 6 Reduction Ratio (col. 6 Reduction Ratio (col. 6 Reduction Ratio (col. 6 Zol. 7) Reduction Ratio (col. 6 Zol. 7) Reduction Reduct						Hospi tal	PPS
ANCILLARY SERVICE COST CENTERS Reduction Row According to Row R		Cost Center Description					
Reduction B)							
ANCI LLARY SERVICE COST CENTERS						6	
ANCILLARY SERVICE COST CENTERS 50.00							
50. 00			6. 00	7. 00	8. 00		
51.00 05100 RECOVERY ROOM 632,779 3,725,795 0.169837 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 53.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 54.01 05400 RADI OLOGY-DI AGNOSTI C 2,697,740 35,699,422 0.75568 54.00 54.01 05401 ILTRASOUND 0 0 0.000000 54.01 56.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0.000000 54.01 56.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0.000000 54.01 55.00 05500 CRAN 0 0 0.000000 55.00 57.00 05700 CT SCAN 0 0 0.000000 57.00 58.00 05800 MRI 0 0 0.000000 58.00 60.00 06000 LABORATORY 2,851,607 22,661,521 0.125835 60.00 62.00 06500 RESPI RATORY THERAPY 826,760 2,470,385 0.334668 65.00 65.00 06500 RESPI RATORY THERAPY 718,786 2,710,426 0.265193 66.00 66.00 06600 PHYSI CAL THERAPY 289,760 1,490,067 0.194461 67.00 68.00 06800 SPEECH PATHOLOGY 59,427 114,735 0.517950 68.00 69.00 06900 ELECTROCARDI OLOGY 367,763 5,340,285 0.068866 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 207,240 5,476,574 0.037841 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENT 2,034,876 24,931,273 0.093652 73.00 74.00 0700 0000 CLIN IL C 444,631 1,06698 0.093652 73.00 75.00 09000 CLIN IL SERVI CE COST CENTERS 99.050 2,232,931 0.442938 92.00 000 09100 EMERGENCY 7,414,034 21,637,859 0.342642 91.00 000 09100 EMERGENCY 7,414,034 21,637,859 0.342642 91.00 00100 09500 AMBULANCE SERVI CES 844,445 7,413,036 0.113914 59.00 00100 00100 Less Observati on Beds 99.050 2,232,931 0.442938 92.00 00100 00100 Less Observation Beds 99.050 0.00 0.000000000000000000000000							
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0					l .		
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0			632, 779	3, 725, 795			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 697, 740 35, 699, 422 0. 075568 54. 00 54. 01 05401 ULTRASOUND 0 0 0. 000000 54. 01 56. 00 05600 RADI OI SOTOPE 0 0 0. 000000 56. 00 0. 000000 57. 00 57. 00 05700 CT SCAN 0 0 0. 000000 57. 00 58. 00 05800 MRI 0 0 0. 000000 58. 00 60. 00 0. 000000 58. 00 60. 00 0. 000000 58. 00 60. 00 0. 000000 58. 00 60. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 62. 00 0. 000000 63. 00 0. 000000 64. 00 0. 000000 64. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 0000000 65. 00 0. 000000 65. 00 0. 000000 65. 00 0. 00000000 65. 00 0. 00000000 65. 00 0. 00000000000 65. 00 0. 00000000000000000000000000000			0	0			
54. 01 05401 ULTRASOUND 0 0 0 0 0 0 0 0 0			0	0			
56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0			2, 697, 740	35, 699, 422			
57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0			0	0			
58. 00 05800 MRI 0 0 0.000000 58. 00 0.000000 58. 00 0.000000 60.00 0.000000 0.000000 0.000000 0.000000			0	0	l .		
60. 00 06000 LABORATORY			0	0	0.00000	00	
62. 00	58. 00	05800 MRI	0	0	0.00000	00	58. 00
65. 00	60.00	06000 LABORATORY	2, 851, 607	22, 661, 521	0. 12583	35	
66. 00			0	0	0.00000	00	
67. 00			826, 760	2, 470, 385	0. 33466	58	
68. 00	66. 00	06600 PHYSI CAL THERAPY	718, 786	2, 710, 426	0. 26519	93	66. 00
69. 00	67. 00	06700 OCCUPATI ONAL THERAPY	289, 760	1, 490, 067	0. 19446	51	67. 00
71. 00	68. 00	06800 SPEECH PATHOLOGY	59, 427	114, 735	0. 5179	50	68. 00
72. 00	69. 00	06900 ELECTROCARDI OLOGY	367, 763	5, 340, 285	0. 06886	66	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 334, 876 24, 931, 273 0. 093652 73. 00 221, 773 1, 338, 883 0. 165640 76. 00 000	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	207, 240	5, 476, 574	0. 03784	11	71. 00
76. 00 03610 SLEEP LAB 221, 773	72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 053, 146	4, 897, 050	0. 2150	57	72. 00
OUTPATIENT SERVICE COST CENTERS 90.00 O9000 CLINIC 474,416 444,631 1.066988 90.00 O9100 EMERGENCY 7,414,034 21,637,859 0.342642 91.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 989,050 2,232,931 0.442938 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES 844,445 7,413,036 0.113914 95.00 200.00 Subtotal (sum of lines 50 thru 199) 24,469,044 164,071,424 200.00 201.00 Less Observation Beds 989,050 0 0 0 0 0 0 0 0 0	73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 334, 876	24, 931, 273	0. 0936	52	73.00
90. 00 09000 CLINIC 474, 416 444, 631 1.066988 90. 00 91. 00 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 989, 050 2, 232, 931 0.442938 92. 00 07HER REIMBURSABLE COST CENTERS 844, 445 7, 413, 036 0.113914 95. 00 200. 00 Subtotal (sum of lines 50 thru 199) 24, 469, 044 164, 071, 424 200. 00 201. 00 Less Observation Beds 989, 050 0 201. 00 201	76. 00	03610 SLEEP LAB	221, 773	1, 338, 883	0. 16564	10	76. 00
91. 00 09100 EMERGENCY 7, 414, 034 21, 637, 859 0. 342642 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 989, 050 2, 232, 931 0. 442938 92. 00 OTHER REI MBURSABLE COST CENTERS 844, 445 7, 413, 036 0. 113914 95. 00 200. 00 Subtotal (sum of lines 50 thru 199) 24, 469, 044 164, 071, 424 200. 00 201.		OUTPATIENT SERVICE COST CENTERS					
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 989,050 2,232,931 0.442938 92.00 95. 00 09500 AMBULANCE SERVICES 844,445 7,413,036 0.113914 95. 00 200. 00 Subtotal (sum of lines 50 thru 199) 24,469,044 164,071,424 200.00 201. 00 Less Observation Beds 989,050 0 201.00	90. 00	09000 CLI NI C	474, 416	444, 631	1. 06698	38	90.00
OTHER REIMBURSABLE COST CENTERS 95. 00	91. 00	09100 EMERGENCY	7, 414, 034	21, 637, 859	0. 34264	12	91. 00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	989, 050	2, 232, 931	0. 44293	38	92.00
200.00 Subtotal (sum of lines 50 thru 199) 24,469,044 164,071,424 200.00 201.00 Less Observation Beds 989,050 0			·				
201.00 Less Observation Beds 989,050 0 201.00	95. 00	09500 AMBULANCE SERVICES	844, 445	7, 413, 036	0. 1139°	14	95. 00
201.00 Less Observation Beds 989,050 0 201.00	200.00	Subtotal (sum of lines 50 thru 199)	24, 469, 044	164, 071, 424			200. 00
202. 00 Total (line 200 minus line 201) 23, 479, 994 164, 071, 424 202. 00	201.00		989, 050	0			201. 00
	202.00	Total (line 200 minus line 201)	23, 479, 994	164, 071, 424			202. 00

Health Financial Systems	DUKES MEMORI.	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-1318	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/31/2019 12:	
	_	Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26) 1.00	Total Charges (from Wkst. C, Part I, col. 8)		Program	Capital Costs (column 3 x column 4)	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	423, 288	21, 486, 551	0. 01970	1, 638, 608	32, 281	50.00

Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	·	(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T		,			
50.00 05000 OPERATING ROOM	423, 288		0. 019700	1, 638, 608	32, 281	50.00
51.00 05100 RECOVERY ROOM	37, 222	3, 725, 795	1	219, 690	2, 195	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	317, 007	35, 699, 422	1	1, 709, 618	15, 181	54.00
54. 01 05401 ULTRASOUND	0	0	0. 000000	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0. 000000	0	0	56. 00
57.00 05700 CT SCAN	0	0	0.000000	0	0	57.00
58. 00 05800 MRI	0	0	0.000000	0	0	58. 00
60. 00 06000 LABORATORY	175, 467	22, 661, 521	0. 007743	2, 254, 549	17, 457	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	56, 665	2, 470, 385	0. 022938	1, 025, 824	23, 530	65.00
66. 00 06600 PHYSI CAL THERAPY	67, 220	2, 710, 426	0. 024801	310, 287	7, 695	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	22, 610	1, 490, 067	0. 015174	274, 150	4, 160	67.00
68.00 06800 SPEECH PATHOLOGY	1, 204	114, 735	0. 010494	11, 579	122	68.00
69. 00 06900 ELECTROCARDI OLOGY	53, 306	5, 340, 285	0. 009982	676, 357	6, 751	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 376	5, 476, 574	0. 000982	1, 011, 406	993	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	52, 420	4, 897, 050	0. 010704	1, 370, 335	14, 668	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	91, 721	24, 931, 273	0. 003679	5, 604, 661	20, 620	73.00
76. 00 03610 SLEEP LAB	30, 363	1, 338, 883	0. 022678	5, 864	133	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	34, 475	444, 631	0. 077536	1, 104	86	90.00
91. 00 09100 EMERGENCY	272, 133	21, 637, 859	0. 012577	285, 373	3, 589	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	209, 007	2, 232, 931	0. 093602	23, 590	2, 208	92.00
OTHER REIMBURSABLE COST CENTERS			,			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	1, 849, 484	156, 658, 388		16, 422, 995	151, 669	200. 00

 Heal th Financial
 Systems
 DUKES MEMORIAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 DUKES MEMORIAL HOSPITAL Provider CCN: 15-1318

THROUGH COSTS

					12, 01, 2010	5/31/2019 12:	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician N	lursing School	Nursing School	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	(0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
54. 01	05401 ULTRASOUND	0	0	(0	0	54. 01
56. 00	05600 RADI 0I SOTOPE	0	0	(0	0	56. 00
57.00	05700 CT SCAN	0	0	(0	0	57. 00
58. 00	05800 MRI	0	0	(0	0	58. 00
60.00	06000 LABORATORY	0	0	(0	0	60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 00	03610 SLEEP LAB	0	0	(0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS				_		
	09000 CLI NI C	0	0	(0	0	90. 00
91. 00	09100 EMERGENCY	0	0	(0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	DUKES MEMORIAL I	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
THROUGH COSTS			From 01/01/2018	Part IV

111100011 00310	,			1	o 12/31/2018	Date/Time Pre 5/31/2019 12:	
			Title	XVIII	Hospi tal	Cost	
(Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	•	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ARY SERVICE COST CENTERS						
50.00 05000 0	OPERATING ROOM	0	0	(21, 486, 551	0.000000	50.00
	RECOVERY ROOM	0	0	(3, 725, 795	0.000000	51.00
52. 00 05200	DELIVERY ROOM & LABOR ROOM	0	0	(0	0.000000	52. 00
53.00 05300 A	ANESTHESI OLOGY	0	0	(0	0.000000	53.00
54. 00 05400 F	RADI OLOGY-DI AGNOSTI C	0	0	(35, 699, 422	0.000000	54.00
54. 01 05401 L	JLTRASOUND	0	0	(0	0.000000	54. 01
56.00 05600 F	RADI OI SOTOPE	0	0	(0	0.000000	56. 00
57. 00 05700 0	CT SCAN	0	0	(0	0.000000	57. 00
58. 00 05800 N	MRI	0	0	(0	0.000000	58. 00
60. 00 06000 L	_ABORATORY	0	0	(22, 661, 521	0.000000	60.00
62. 00 06200 V	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0	0.000000	62. 00
65. 00 06500 F	RESPI RATORY THERAPY	0	0		2, 470, 385	0.000000	65. 00
66. 00 06600 F	PHYSI CAL THERAPY	0	0		2, 710, 426	0.000000	66. 00
67. 00 06700 0	OCCUPATIONAL THERAPY	0	0		1, 490, 067	0.000000	67. 00
68. 00 06800 5	SPEECH PATHOLOGY	0	0		114, 735	0.000000	68. 00
69. 00 06900 E	ELECTROCARDI OLOGY	0	0		5, 340, 285	0.000000	69. 00
71.00 07100 1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(5, 476, 574	0.000000	71. 00
	MPL. DEV. CHARGED TO PATIENTS	0	0		4, 897, 050		
	DRUGS CHARGED TO PATIENTS	0	0		24, 931, 273	0. 000000	
	SLEEP LAB	0	0		1, 338, 883	0. 000000	
	ENT SERVICE COST CENTERS				,		
90. 00 09000 0	CLINIC	0	0		444, 631	0.000000	90.00
91. 00 09100 E	EMERGENCY	0	0		21, 637, 859		
	DBSERVATION BEDS (NON-DISTINCT PART	0	0		2, 232, 931	0. 000000	
	REIMBURSABLE COST CENTERS						1
	AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(156, 658, 388		200. 00

Heal th	Financial Systems	DUKES MEMORIAL	_ HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS		Provi der CO		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV	pared:
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8		Outpatient Program Pass-Through 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, 638, 608	•	0	0	
51. 00	05100 RECOVERY ROOM	0. 000000	219, 690		0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 709, 618		0	0	54.00
54. 01	05401 ULTRASOUND	0. 000000	0		0	0	54. 01
56. 00	05600 RADI 0I 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. 000000	2, 254, 549		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	1, 025, 824		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	310, 287		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	274, 150		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	11, 579		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	676, 357		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 011, 406		0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 370, 335		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	5, 604, 661		0	0	73. 00
76.00	03610 SLEEP LAB	0. 000000	5, 864		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90 00	DOUDO CLINIC	0 000000	1 104	1		1	90 00

0. 000000 0. 000000 0. 000000 1, 104 285, 373

23, 590

16, 422, 995

0 0 0

0

0

0

0 90.00

0 92.00

0 91.00

95. 00 0 200. 00

90. 00 | 09000 | CLI NI C | 91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | 0BSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS

95. 00 | 09500 | AMBULANCE SERVICES 200. 00 | Total (Lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	ES AND VACCINE COST	Provider Co	1	Period: From 01/01/2018 Fo 12/31/2018	Worksheet D Part V Date/Time Pre 5/31/2019 12:	
		Title	xVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	1	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. 115674		., ===, =.		0	
51. 00 05100 RECOVERY ROOM	0. 169837		849, 450	0	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
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 075568	0	11, 226, 379	9 0	0	54.00
54. 01 05401 ULTRASOUND	0. 000000		(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. 125835	0	6, 026, 83	7 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CEI	_LS 0. 000000	0	(0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 334668	0	198, 156	6 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 265193	0	493, 299	9 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 194461	0	97, 433	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 517950	0	4, 79	7 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 068866	0	1, 731, 07	3 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NT 0. 037841	0	875, 116	6 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 215057	0	635, 459	9 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 093652	. 0	4, 746, 68!	3, 507	0	73. 00
76. 00 03610 SLEEP LAB	0. 165640	0	169, 10	5 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1. 066988	0	64, 63	1, 716	0	90.00
91. 00 09100 EMERGENCY	0. 342642	0	5, 378, 80	5 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAI	RT 0. 442938	0			0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 113914					95. 00
200.00 Subtotal (see instructions)		0	37, 480, 232	5, 223	0	200.00
201.00 Less PBP Clinic Lab. Services-Prod	gram			o o		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	37, 480, 232	5, 223	0	202. 00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1318		Worksheet D
			From 01/01/2018	Part V

Cost Cost Center Description Cost Co	APPORTI UNIMEN	NI OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CN: 15-1318	From 01/01/2018 To 12/31/2018	Part V Date/Time Pr 5/31/2019 12	
Cost Center Description				Title	XVIII	Hospi tal	Cost	
Rel imbursed Servi ces Subject To Ded. & Coins. Servi ces Subject To Des. Servi								
Services Subject To Ded. & Coins. (See Inst.)		Cost Center Description						
Subject To Ded & Coins (see inst.)								
Ded_ & Colins, (see inst.) Ded_ & Colins, (see inst.)								
See inst. (see inst. 6.00			,					
ANCI LLARY SERVICE COST CENTERS 50.00 50000 DPERATIN NO ROM 491, 709 0 50.00 51.00 050000 DPERATIN NO ROM 144, 268 0 51.00 52.00 050200 DELIVERY ROOM & LABOR ROOM 0 0 0 53.00 050200 DELIVERY ROOM & LABOR ROOM 0 0 0 54.00 050200 DELIVERY ROOM & LABOR ROOM 0 0 0 54.00 050200 DELIVERY ROOM & LABOR ROOM 0 0 0 54.00 050200 DELIVERY ROOM & LABOR ROOM 0 0 0 54.01 05400 RADI OLOGY-DI AGNOSTI C 848, 355 0 0 0 54.01 05401 ULTRASOUND 0 0 0 55.00 055700 CT SCAN 0 0 0 56.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 57.00 05700 CT SCAN 0 0 0 58.00 05800 MRI 0 0 0 58.00 05800 MRI 0 0 0 66.00 06600 DELES 0 0 0 66.00 06600 PHYSI CAL THERAPY 130, 819 0 66.00 06600 PHYSI CAL THERAPY 130, 819 0 67.00 06600 DELECTROCARDI OLOGY 19, 212 0 68.00 06600 DELECTROCARDI OLOGY 19, 212 0 69.00 06900 ELECTROCARDI OLOGY 19, 212 0 69.00 06900 ELECTROCARDI OLOGY 19, 212 0 69.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 33, 115 0 69.00 07200 DRUGS CHARGED TO PATI ENT 33, 115 0 69.00 07300 DRUGS CHARGED TO PATI ENT 33, 115 0 69.00 07300 DRUGS CHARGED TO PATI ENT 344, 537 328 69.00 07300 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 CLINI C 0 69.00 09000 DELETROCARDI OLOGY 1, 843, 005 0 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.00 09000 DRUGS CHARGED TO PATI ENTS 444, 537 328 69.0								
ANCI LLARY SERVICE COST CENTERS 50.00					-			
50.00		LARV OFFICE COOT OFFITTERS	6.00	7.00				
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0			104 700					
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0								
53. 00 05300 ANESTHESI OLOGY 0 0 0 54. 00 54. 01 05401 ULTRASOUND 0 0 0 0 54. 01 05401 ULTRASOUND 0 0 0 55. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 57. 00 05700 07 SCAN 0 0 0 58. 00 05800 MRI 0 0 0 58. 00 05800 MRI 0 0 0 60. 00 06000 LABORATORY 758, 387 0 0 60. 00 06000 LABORATORY 758, 387 0 0 60. 00 06500 RESPI RATORY THERAPY 66, 316 0 60. 00 06500 RESPI RATORY THERAPY 130, 819 0 60. 00 06600 PHYSI CAL THERAPY 130, 819 0 60. 00 06600 PHYSI CAL THERAPY 18, 947 0 60. 00 06600 SPEECH PATHOLOGY 2, 485 0 60. 00 06600 ELECTROCARDI OLOGY 119, 212 60 06600 06600 LECTROCARDI OLOGY 119, 212 60 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 33, 115 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 136, 660 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1444, 537 328 73. 00 75. 00 07300 DRUGS CHARGED TO PATI ENTS 444, 537 328 73. 00 76. 00 03610 SLEEP LAB 29, 011 0 00TPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLINI C 68, 961 1, 831 9 91. 00 09100 EMERGENCY 1, 843, 005 0 91. 00 00100 EMERGENCY 1, 843, 005 0 91. 00 00700 CLINI C 68, 961 1, 831 0 91. 00 00700 DRINGS CHARGED TO PATI ENTS 324, 313 0 91. 00 00700 DRINGS CHARGED COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 90. 00 OSONO CLINI C SE			144, 268	0				
54. 00			0	0	1			
54. 01 05401 ULTRASOUND 0 0 5500 RADI OI SOTOPE 0 0 0 0 5500 RADI OI SOTOPE 0 0 0 0 5500 CT SCAN 0 0 0 0 5700 CT SCAN 0 0 0 0 5700 CT SCAN 0 0 0 0 57. 00 05700 CT SCAN 0 0 0 0 58. 00 5800 MRI 0 0 0 0 0 5800 MRI 0 0 0 0 0 5800 MRI 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	1			
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 57.00 05700 CT SCAN		•	848, 355	0	1			
57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0 0 0			0	0	1			
58. 00			0	0	1			
60. 00 06000 LABORATORY 758, 387 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 66, 316 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 130, 819 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 18, 947 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 2, 485 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 119, 212 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 33, 115 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 136, 660 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 136, 660 0 72. 00 76. 00 03610 SLEEP LAB 28, 011 0 76. 00 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 68, 961 1, 831 0 90. 00 91. 00 09000 EMERGENCY 1, 843, 005 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 324, 313 0 0 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 0 920. 00 00 00 CLI Subtotal (see instructions) 5, 459, 100 2, 159 00 00 00 CLI Subtotal (see instructions) 5, 459, 100 2, 159 00 00 00 CLI Subtotal (see instructions) 5, 459, 100 2, 159 00 00 00 CLI Subtotal (see instructions) 5, 459, 100 2, 159 00 00 00 CLI Subtotal (see instructions) 5, 459, 100 2, 159 00 00 00 CLI Subtotal (see instructions) 5, 459, 100 2, 159 00 00 00 CLI Subtotal (see instructions) 5, 459, 100 2, 159 00 00 00 00 00 00 00 00 00 00 00 00 00			0	0	1			
62. 00	4	•	0	0	1			
65. 00			758, 387	0	1			
66. 00			0	0	1			
67. 00					1			
68. 00 06800 SPEECH PATHOLOGY 2, 485 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 119, 212 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 33, 115 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 136, 660 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 444, 537 328 73. 00 76. 00 03610 SLEEP LAB 28, 011 0 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 68, 961 1, 831 90. 00 91. 00 09100 EMERGENCY 1, 843, 005 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 324, 313 0 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 200. 00 Subtotal (see instructions) 5, 459, 100 2, 159 001 ON ONLY Charges			•	0	1			
69. 00 06900 ELECTROCARDI OLOGY 119, 212 0 69. 00 71. 00 71. 00 77.	1	•		0	1			
71. 00				0	1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 136, 660 0 0 0 0 0 0 0 0 0				0	1			
73. 00 07300 DRUGS CHARGED TO PATIENTS 444, 537 328 73. 00 76. 00 03610 SLEEP LAB 28, 011 0 76. 00 000 0000 CLI NI C 68, 961 1, 831 90. 00 91. 00 091. 00 09200 OBERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 324, 313 0 000 0000 ODES (NON-DI STINCT PART 324, 313 0 00000 ODES (NON-DI STINCT PART 324, 313 0 0000 ODES (NON-DI STINCT PART 324, 313 0		•	1	0	1			
76. 00 03610 SLEEP LAB 28, 011 0 76. 00 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 68, 961 1, 831 90. 00 91. 00 09100 EMERGENCY 1, 843, 005 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 324, 313 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 95. 00 200. 00 Subtotal (see instructions) 5, 459, 100 2, 159 200. 00 201. 00 Cless PBP Clinic Lab. Services-Program 0 001 y Charges 0 001 y Charges			•	_	1			
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 68,961 1,831 90.00 91.00 09100 EMERGENCY 1,843,005 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 324,313 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95.00 Subtotal (see instructions) 5,459,100 2,159 200.00 201.00 Cless PBP Clinic Lab. Services-Program 0 001 y Charges 0 0 001 y Charges 0 0 0 0 0 0 0 0 0								
90. 00 09000 CLINIC 68, 961 1, 831 90. 00 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 324, 313 0 92. 00 07HER REIMBURSABLE COST CENTERS 95. 00 Subtotal (see instructions) 5, 459, 100 201. 00 Clinic Lab. Services-Program 0 001 y Charges 0 0 001 y Charges 0 0 0 0 0 0 0 0 0			28, 011	0				76. 00
91. 00 09100 EMERGENCY 1,843,005 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 324,313 0 92. 00 000 00000 00000 0000 00000 00000 00000 0000 00000 0000 0000 0000 0000				T	1			
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 324,313 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 200. 00 Subtotal (see instructions) 5, 459, 100 201. 00 Class PBP Clinic Lab. Services-Program 0 0nl y Charges 0 001 0			•		1			
OTHER REI MBURSABLE COST CENTERS 95.00 95.00 AMBULANCE SERVI CES 0 95.00 200.00 Subtotal (see instructions) 5,459,100 2,159 200.00 201.00 Cess PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0				l e	1			
95. 00			324, 313	0				92. 00
200.00 Subtotal (see instructions) 5,459,100 2,159 200.00 201.00 0 0 0 0 0 0 0 0 0								
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges		•	0					
Only Charges			5, 459, 100	2, 159	1			
	201. 00		0					201. 00
202.00 Net Charges (line 200 - line 201) 5,459,100 2,159 202.00								
	202. 00	Net Charges (line 200 - line 201)	5, 459, 100	2, 159	1			J202. 00

Health Financial Systems	DUKES MEMORIAL I	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, (OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1318 Component CCN: 15-Z318	From 01/01/2018 To 12/31/2018	Date/Time Prepared:
		Title XVIII	Swing Reds - SNE	5/31/2019 12:18 pm

			Component	CCN: 15-Z318 T	o 12/31/2018	Date/Time Pre 5/31/2019 12:	
			Ti tl e	XVIII S	wing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.	Ded. & Coins.		
		1.00	0.00	(see inst.)	(see inst.)	F 00	
	ANOLI LADV CEDVI CE COCE CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0. 115674) 0	0	50.00
50.00			0	·		_	
51.00	05100 RECOVERY ROOM	0. 169837		C		0	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				0	
	05300 ANESTHESI OLOGY	0.000000				0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 075568	0		0	· ·	54. 00
54. 01	05401 ULTRASOUND	0. 000000			0	0	54. 01
56.00	05600 RADI OI SOTOPE	0.000000				0	56. 00
57. 00	05700 CT SCAN	0. 000000	0		0	0	
58. 00	05800 MRI	0. 000000	0		0	0	58.00
60.00	06000 LABORATORY	0. 125835	0		0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0. 334668	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 265193	0		0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 194461	0		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 517950	0		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 068866				0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 037841				0	
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 215057				0	
	07300 DRUGS CHARGED TO PATIENTS 03610 SLEEP LAB	0. 093652 0. 165640		C	_	0	73.00
76. 00	OUTPATIENT SERVICE COST CENTERS	0. 105040		C) U	U	76. 00
90. 00	09000 CLINIC	1. 066988	0) 0	0	90.00
91. 00	09100 EMERGENCY	0. 342642		1		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 442938		1		0	1
72.00	OTHER REIMBURSABLE COST CENTERS	0.442730) O	U	72.00
95. 00	09500 AMBULANCE SERVICES	0. 113914)		95. 00
200.00		0.113714	0		Ó	n	200.00
201.00							201.00
201.00	Only Charges						
202.00			О	c	0	0	202. 00

ealth Financial Systems	DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERV	ICES AND VACCINE COST	Provider CO		Peri od: From 01/01/2018		
		Component	CCN: 15-Z318	To 12/31/2018	Date/Time Prep 5/31/2019 12:1	oared: 18 pm
		Title	XVIII	Swing Beds - SNF	Cost	
	Co	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				

	oost center beserretten	0051	0031	
		Rei mbursed	Reimbursed	
		Servi ces	Services Not	
		Subject To	Subject To	
		Ded. & Coins.	Ded. & Coins.	
		(see inst.)	(see inst.)	
		6. 00	7. 00	
	ANCILLARY SERVICE COST CENTERS			
	05000 OPERATING ROOM	0	0	50. 00
	05100 RECOVERY ROOM	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	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	0	58. 00
	06000 LABORATORY	0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62. 00
	06500 RESPI RATORY THERAPY	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	73. 00
76. 00	03610 SLEEP LAB	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLI NI C	0	0	90. 00
	09100 EMERGENCY	0	0	91. 00
92.00	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		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 CAPI	TAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2018		
				Го 12/31/2018	Date/Time Prep 5/31/2019 12:	
		Ti tI	e XIX	Hospi tal	PPS	то рііі
Cost Center Description	Capi tal	Swi ng Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 000, 831	23, 223	977, 60	3, 494	279. 80	30. 00
31.00 INTENSIVE CARE UNIT	119, 991		119, 99	306	392. 13	31. 00
43. 00 NURSERY	39, 247		39, 24	7 252	155. 74	43.00
200.00 Total (lines 30 through 199)	1, 160, 069		1, 136, 84	4, 052		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 & PEDIATRICS	20	5, 596				30. 00
31.00 INTENSIVE CARE UNIT	6	2, 353	;			31. 00
43. 00 NURSERY	2	311			ļ	43. 00
200.00 Total (lines 30 through 199)	28	8, 260)			200. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 15-1318	Peri od:	Worksheet D	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	
					5/31/2019 12:	18 pm
		Ti	tle XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charge	es Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	C, to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col	. (col . 1 ÷ co	I. Charges	column 4)	
	Part II col	8)	2)			

						5/31/2019 12:	18 pm
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	423, 288	21, 486, 551	0. 019700	42, 348	834	50.00
51.00	05100 RECOVERY ROOM	37, 222	3, 725, 795	0. 009990	5, 434	54	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	317, 007	35, 699, 422	0.008880	55, 611	494	54.00
54. 01	05401 ULTRASOUND	0	0	0.000000	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57. 00
58.00	05800 MRI	0	0	0.000000	0	0	58. 00
60.00	06000 LABORATORY	175, 467	22, 661, 521	0.007743	50, 899	394	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	56, 665	2, 470, 385	0. 022938	13, 682	314	65. 00
66.00	06600 PHYSI CAL THERAPY	67, 220	2, 710, 426	0. 024801	1, 104	27	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	22, 610	1, 490, 067	0. 015174	1, 741	26	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 204	114, 735	0. 010494	445	5	68. 00
69. 00	06900 ELECTROCARDI OLOGY	53, 306	5, 340, 285	0. 009982	16, 396	164	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 376	5, 476, 574	0. 000982	14, 152	14	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	52, 420	4, 897, 050	0. 010704	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	91, 721	24, 931, 273	0.003679	137, 666	506	73. 00
76.00	03610 SLEEP LAB	30, 363	1, 338, 883	0. 022678	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>					
90.00	09000 CLI NI C	34, 475	444, 631	0. 077536	542	42	90.00
91. 00	09100 EMERGENCY	272, 133	21, 637, 859	0. 012577	20, 680	260	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	209, 007	2, 232, 931	0. 093602	1, 917	179	92.00
	OTHER REIMBURSABLE COST CENTERS	,		,	,		
95.00	09500 AMBULANCE SERVICES						95.00
200.00		1, 849, 484	156, 658, 388		362, 617	3, 313	200. 00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	PASS THROUGH COSTS			Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/31/2019 12:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments 1A	ursing School	Allied Health Post-Stepdown Adjustments 2A	Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	0 0	0 0 0		0 0 0 0 0 0	0 0 0	31. 00
Cost Center Description	Adjustment (Amount (see instructions) m	Total Costs sum of cols. 1 through 3, inus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0 0 0	3, 49 30 25 4, 05	6 0. 00 2 0. 00	6 2	30. 00 31. 00 43. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	, and the second	1, 00		20	200.00
30. 00	0 0 0					30. 00 31. 00 43. 00 200. 00

Health Financial Systems

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Period:
From 01/01/2018
Part IV

12/31/2018 Date/Time Prepared: 5/31/2019 12:18 pm Title XIX Hospi tal PPS Non Physician Nursing School Nursing School Allied Health Allied Health Cost Center Description Anesthetist Post-Stepdown Post-Stepdown Cost Adjustments Adjustments 1.00 2.00 3. 00 2A 3A ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 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 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 05401 ULTRASOUND 0 54.01 54.01 0 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 58.00 58.00 0 0 0 06000 LABORATORY 0 60.00 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 0 0 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 03610 SLEEP LAB 0 76.00 76.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09100 EMERGENCY 0 0 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 0 0 92.00 ol 92.00 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1318	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

				Τ	o 12/31/2018	Date/Time Pre 5/31/2019 12:	epared: 18 pm
			Ti tl	e XIX	Hospi tal	PPS	. с р
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(21, 486, 551	0.000000	50. 00
51.00	05100 RECOVERY ROOM	0	0	(3, 725, 795	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	(0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		35, 699, 422	0.000000	54.00
54. 01	05401 ULTRASOUND	0	0		0	0.000000	54. 01
56.00	05600 RADI 0I SOTOPE	0	0	(0	0.000000	56.00
57.00	05700 CT SCAN	0	0	(0	0.000000	57. 00
58.00	05800 MRI	0	0	(0	0.000000	58. 00
60.00	06000 LABORATORY	0	0	(22, 661, 521	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	Ö	·	0	0.000000	62.00
65.00	06500 RESPIRATORY THERAPY	0	O	·	2, 470, 385	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	Ö	·	2, 710, 426	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	O) (1, 490, 067	0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		114, 735	0. 000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		5, 340, 285	0. 000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	O	1 0	5, 476, 574	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	1 0	4, 897, 050	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	Ó		24, 931, 273	0. 000000	73. 00
	03610 SLEEP LAB	0	Ó		1, 338, 883	0. 000000	1
	OUTPATIENT SERVICE COST CENTERS				,		
90.00	09000 CLI NI C	0	O		444, 631	0. 000000	90.00
91.00	09100 EMERGENCY	0	Ó		21, 637, 859	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	Ó		2, 232, 931	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS			'			
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	o) c	156, 658, 388		200. 00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN THROUGH COSTS		Provider CO		Peri od: From 01/01/2018	Worksheet D Part IV Date/Time Pre	pared:
		Ti tl	e XIX	Hospi tal	5/31/2019 12: PPS	18 pm
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpatient Program Pass-Through	

		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-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 OPERATING ROOM	0. 000000	42, 348		0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	5, 434	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	55, 611	0	0	0	54. 00
54. 01 05401 ULTRASOUND	0. 000000	0	0	0	0	54. 01
56. 00 05600 RADI 01 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	50, 899	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	0	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	13, 682	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 104	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 741	O	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	445		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	16, 396		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	14, 152		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	137, 666	0	0	0	73. 00
76. 00 03610 SLEEP LAB	0. 000000	0		0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
90. 00 09000 CLI NI C	0. 000000	542	0	0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	20, 680	o	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 917	o	0	0	92.00
OTHER REIMBURSABLE COST CENTERS	,	•	1			
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		362, 617	o	0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1318 Peri od: Worksheet D From 01/01/2018 Part V 12/31/2018 Date/Time Prepared: 5/31/2019 12:18 pm Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 115674 88, 710 0 50.00 51.00 05100 RECOVERY ROOM 0. 169837 0 18,774 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52 00 0 0 05300 ANESTHESI OLOGY 0 53.00 0.000000 0 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.075568 274, 752 0 54.00 54. 01 05401 ULTRASOUND 0.000000 0 0 54.01 0 0 05600 RADI OI SOTOPE 0 0 56.00 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 0.000000 0 58.00 0 0 58.00 06000 LABORATORY 0 0 125835 208, 176 60 00 60 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 62.00 65.00 06500 RESPIRATORY THERAPY 0. 334668 6, 682 0 65.00 06600 PHYSI CAL THERAPY 66.00 0. 265193 11,032 66.00 0 06700 OCCUPATIONAL THERAPY 0 67.00 44, 778 0.194461 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.517950 0 0 1, 847 0 68.00 06900 ELECTROCARDI OLOGY 0.068866 24, 224 69.00 69.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.037841 0 0 37, 231 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72 00 0.215057 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.093652 0 0 75, 194 0 73.00 03610 SLEEP LAB 0 0 76.00 76.00 0.165640 0 7,542 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 1.066988 0 0 838 0 91.00 09100 EMERGENCY 0.342642 0 0 247, 880 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0.442938 0 0 6,059 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.113914 0 0 95.00 200.00 Subtotal (see instructions) 0 0 1, 053, 719 0 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00 Only Charges

0

1, 053, 719

0 202. 00

202.00

Net Charges (line 200 - line 201)

APPORTIONMENT OF MEDICAL. OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1318 Period: Worksheet D	Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
From 01/01/2018 Part V	APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1318		

					From 01/01/2018 To 12/31/2018		
			T' 11	VI V		5/31/2019 12:	:18 pm_
		0		e XIX	Hospi tal	PPS	
	Cost Center Description	Cost	Cost	-			
	cost center bescription	Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00	1			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	10, 261				50.00
	05100 RECOVERY ROOM	0	3, 189	p			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0)			52. 00
	05300 ANESTHESI OLOGY	0	0				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	20, 762	2			54.00
	05401 ULTRASOUND	0	0)			54. 01
	05600 RADI 0I S0T0PE	0	0)			56. 00
	05700 CT SCAN	0	0)			57. 00
	05800 MRI	0	0	1			58. 00
	06000 LABORATORY	0	26, 196	1			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1			62. 00
	06500 RESPI RATORY THERAPY	0	2, 236	•			65. 00
	06600 PHYSI CAL THERAPY	0	2, 926				66. 00
	06700 OCCUPATI ONAL THERAPY	0	8, 708				67. 00
	06800 SPEECH PATHOLOGY	0	957				68. 00
	06900 ELECTROCARDI OLOGY	0	1, 668	•			69. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	1, 409				71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0					73. 00
76. 00	03610 SLEEP LAB	0	1, 249	′			76. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		894	1			90.00
	09100 EMERGENCY	0		1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART			•			92.00
92.00	OTHER REIMBURSABLE COST CENTERS		2,004	+			92.00
95. 00	09500 AMBULANCE SERVICES	0					95.00
200.00			175, 115				200. 00
201.00			1,3,113				201. 00
201.00	Only Charges						[
202. 00		0	175, 115				202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1318	Peri od: From 01/01/2018	Worksheet D-1
		To 12/31/2018	Date/Time Prepared: 5/31/2019 12:18 pm
•	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	5/31/2019 12: Cost	18 pm
	Cost Center Description		noop. ta.	'	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 577	1. 00
2.00	Inpatient days (including private room days, excluding swing-k			3, 494	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(S). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 747	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	83	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember .	or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	i days) arter beceiliber 3	i or the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 443	9. 00
10.00	newborn days)	-1 (:1!		0.2	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	83	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period	conly (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost		18. 00
10.00	reporting period		1110 0031		10.00
19. 00					19. 00
20. 00					20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	3)		4, 736, 069	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	4, 730, 007	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
25. 00	7 x line 19) Swing had cost applicable to NE type services after December 2	21 of the cost reporting	ported (line 9	0	25. 00
23.00	Swing-bed cost applicable to NF type services after December (x,y)	of the cost reporting	perrou (Trie 6	U	25.00
26. 00	Total swing-bed cost (see instructions)			109, 894	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 626, 175	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		a. goo)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 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 27 minus line 36)	and private room cost di	rrerentiai (iine	4, 626, 175	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 324. 03	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			1, 910, 575	39. 00
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 1, 910, 575	40.00
41. 00	Trotal Trogram general impatrent routine service cost (ITNE 39	T ITHE 40)	ı	1, 910, 5/5	41.00

	Financial Systems	DUKES MEMORIA			In Lie	eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1318	Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre	pared:
			Ti t	le XVIII	Hospi tal	5/31/2019 12: Cost	18 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Day	ysDiem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0		0 0.0	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 028, 706	2)	06 3, 361.	78 224	753. 039	43. 00
44. 00	CORONARY CARE UNIT	1,026,700	31	3, 361.	70 224	755,059	44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					2, 139, 470	1
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instruct	i ons)		4, 803, 084	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine	services (fr	om Wkst D sur	n of Parts I and	0	50.00
00.00	[111)						00.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (from Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclusion		lated, non-p	hysician anesth	netist, and	0	
	medical education costs (line 49 minus line	52)	<u> </u>	-			
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	56. 00
57. 00	1	ing cost and ta	rget amount	(line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	endina 1996	undated and co	omnounded by the	0.00	
37.00	market basket	por tring perrou	ending 1770,	upuateu anu co	inpounded by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		5 (TITIES 54	x 60), 01 1% 01	the target		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of t	he cost reporti	na period (See	109, 894	64. 00
	instructions)(title XVIII only)	· ·		•			
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVII	I only). For	109, 894	66. 00
	CAH (see instructions)	`	·	, ,	3,		
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 o	f the cost repo	ortina period	0	68. 00
	(line 13 x line 20)				3 1		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facility		•)		70. 00
71. 00	Adjusted general inpatient routine service co	-					71. 00
72.00	Program routine service cost (line 9 x line		(1)	05)			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	,		*	Part II, column		75. 00
	26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
	Inpatient routine service cost (line 74 minus	,					78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p					79. 00
	Total Program routine service costs for compa		ost limitati	on (line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (•				83. 00
84. 00	Program inpatient ancillary services (see in		`				84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 65)				, 55.00
87. 00	Total observation bed days (see instructions))				747	•
88. 00	Adjusted general inpatient routine cost per (•	line 2)			1, 324. 03	
07. UU	Observation bed cost (line 87 x line 88) (see	= INSTIUCTIONS)				989, 050	J 09. UU

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 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 000, 831	4, 736, 069	0. 21132	1 989, 050	209, 007	90.00
91.00 Nursing School cost	0	4, 736, 069	0.00000	0 989, 050	0	91.00
92.00 Allied health cost	0	4, 736, 069	0.00000	0 989, 050	0	92.00
93.00 All other Medical Education	0	4, 736, 069	0. 00000	989, 050	0	93. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1318	Peri od: From 01/01/2018	Worksheet D-1
			Date/Time Prepared: 5/31/2019 12:18 pm
	Title XIX	Hospi tal	PPS

		Title XIX	Hospi tal	5/31/2019 12: PPS	18 pm
	Cost Center Description	TI LIE XIX	nospi tai	113	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		3, 577	1. 00
2. 00	Inpatient days (including private room days, excluding swing-b			3, 494	2.00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	2, 747	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	31 of the cost	83	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 2	l of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	i days) arter beceiiber 3	i oi the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	20	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	83	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		Join days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			252	
16. 00	Nursery days (title V or XIX only)			2	16. 00
47.00	SWING BED ADJUSTMENT		^ .I.		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of i	the cost		18. 00
	reporting period				
19. 00					19. 00
20. 00	reporting period 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost				20. 00
20.00	reporting period	s arter becember 31 or tr	ie cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		4, 736, 069	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
22.00	5 x line 17)	21 of the east reporting	nominal (line (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine o	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
	7 x line 19)	·	3 1		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			109, 894	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		4, 626, 175	
	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	29. 00
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	lino 20)		0. 000000	30. 00 31. 00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	F ITTIE 28)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33.00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	tions)	0.00	34. 00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private reem east did	Fforontial (1:	4 424 175	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	recentral (Tine	4, 626, 175	37. 00
	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, 324. 03	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			26, 481	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 26, 481	40.00
- 1. 00	Trocal Trogram general impatrent routine service cost (Time 37	11110 40)		20, 401	1 - 1. 00

Heal th	Financial Systems DUKES MEMORIAL HOSPITAL In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1318 Period: From 01/01/2018	Worksheet D-1	
	To 12/31/2018	Date/Time Prep 5/31/2019 12:	
	Title XIX Hospital	PPS	10 piii
	Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷	Program Cost (col. 3 x col.	
		4)	
42 00	1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 1,226,292 252 4,866.24 2	5. 00 9. 732	42. 00
	Intensive Care Type Inpatient Hospital Units		
43. 00 44. 00	INTENSIVE CARE UNIT	20, 171	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT		45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
47.00	Cost Center Description		47.00
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00 44, 941	48. 00
	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	101, 325	
EO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	9 240	50. 00
50. 00	Fass through costs approcable to Program ripatient routine services (from wast. b, sum of Parts Fand	8, 260	
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3, 313	51. 00
52. 00	Total Program excludable cost (sum of lines 50 and 51)	11, 573	52. 00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	89, 752	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54. 00 55. 00	Program discharges Target amount per discharge	0 00	54. 00 55. 00
56. 00	Target amount per discharge Target amount (line 54 x line 55)	0.00	56. 00
57. 00		0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0 00	58. 00 59. 00
	market basket		
60. 00 61. 00		0. 00 0	60. 00 61. 00
011 00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		011 00
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)	0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	109, 894	64. 00
	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)	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	109, 894	66. 00
67. 00		0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
	(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	0	69. 00
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
73.00	26, line 45)		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)		83. 00 84. 00
85. 00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00		747	87. 00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 324. 03 989, 050	
57.00	1 Section and cost (Time of A Time ob) (See Histiactions)	707, 030	07.00

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 01/01/2018 To 12/31/2018		pared: 18 pm_
		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	1, 000, 831	4, 736, 069	0. 21132	1 989, 050	209, 007	90.00
91.00 Nursing School cost	0	4, 736, 069	0.00000	0 989, 050	0	91.00
92.00 Allied health cost	0	4, 736, 069	0.00000	0 989, 050	0	92.00
93.00 All other Medical Education	0	4, 736, 069	0. 00000	989, 050	0	93. 00

NPATI ENT .	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1318	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Pre 5/31/2019 12:	pare
		Title	e XVIII	Hospi tal	Cost	1ο μι
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
LNDA	ATLENT POLITIME CERVI OF COCT OFFITERS		1.00	2. 00	3. 00	
	ATIENT ROUTINE SERVICE COST CENTERS DO ADULTS & PEDIATRICS		T	2, 681, 636		30.
1.00 0310	DO INTENSIVE CARE UNIT DO NURSERY			629, 664		31.
	LLARY SERVICE COST CENTERS			"		
1.00 0510	OO OPERATING ROOM OO RECOVERY ROOM OO DELIVERY ROOM & LABOR ROOM		0. 1156 0. 1698 0. 0000	37 219, 690	189, 544 37, 311 0	51.
3. 00 0530	DO DEEL VERY ROOM & LABOR ROOM DO ANESTHESI OLOGY DO RADI OLOGY-DI AGNOSTI C		0. 0000 0. 0000 0. 0755	00 0	0	53.
6. 00 0560	DO RADI OI SOTOPE		0. 0000 0. 0000	00 0	0	54. 56.
8. 00 0580	DO CT SCAN DO MRI DO LABORATORY		0. 0000 0. 0000 0. 1258	00 0	0 0 283, 701	1
2.00 0620	00 WHOLE BLOOD & PACKED RED BLOOD CELLS 00 RESPIRATORY THERAPY		0. 0000 0. 3346	00 0	0 343, 310	62.
7. 00 0670	DO PHYSI CAL THERAPY DO OCCUPATI ONAL THERAPY DO SPEECH PATHOLOGY		0. 2651 0. 1944 0. 5179	61 274, 150		67.
9. 00 0690 1. 00 0710	DO ELECTROCARDIOLOGY DO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0688 0. 0378	66 676, 357	46, 578	69.
3. 00 0730	DO IMPL. DEV. CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS TO SLEEP LAB		0. 2150 0. 0936 0. 1656	5, 604, 661	294, 700 524, 888 971	
	PATIENT SERVICE COST CENTERS		J U. 1000	40 ₁ 3,804	9/1	┤ ′°.
0.00	DO CLINIC DO EMERGENCY		1. 0669 0. 3426		1, 178 97, 781	
. 00 0920	DO OBSERVATION BEDS (NON-DISTINCT PART ER REIMBURSABLE COST CENTERS		0. 3426	· ·		1
	TOTAL (Sum of lines 50 through 94 and 96 through 94 Less PBP Clinic Laboratory Services-Program only 6			16, 422, 995	2, 139, 470	95. 200. 201.
02.00	Net charges (line 200 minus line 201)	Litar yes (Tine 61)		16, 422, 995		201

NPATI ENT .	ANCILLARY SERVICE COST APPORTIONMENT F	Provi der Co	CN: 15-1318	Peri od:	Worksheet D-3	3
	C	Component	CCN: 15-Z318	From 01/01/2018 To 12/31/2018		
		Title	XVIII	Swing Beds - SNF	Cost	•
	Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		1, 00	2.00	0.00	
	00 ADULTS & PEDIATRICS			0		30.
	DO INTENSIVE CARE UNIT			0		31.
	00 NURSERY					43.
ANCI	LLARY SERVICE COST CENTERS		<u> </u>		<u> </u>	
0.00 0500	OO OPERATING ROOM		0. 1156	74 0	0	50.
1.00 0510	OO RECOVERY ROOM		0. 1698:	37 0	0	51.
2.00 0520	DO DELIVERY ROOM & LABOR ROOM		0. 00000	00	0	52.
	OO ANESTHESI OLOGY		0.0000		0	53.
	DO RADI OLOGY-DI AGNOSTI C		0. 0755		701	54.
	01 ULTRASOUND		0. 00000		0	
	DO RADI OI SOTOPE		0. 00000		0	
	OO CT SCAN		0. 00000		0	1
	DO MRI		0. 00000		0	1
	DO LABORATORY		0. 1258:	· ·		
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000		0	
	00 RESPI RATORY THERAPY		0. 3346			1
	00 PHYSI CAL THERAPY		0. 2651			
- 1	OO OCCUPATIONAL THERAPY		0. 1944			
	OO SPEECH PATHOLOGY		0. 5179		1, 102	
	00 ELECTROCARDI OLOGY		0. 0688		1	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0378			
	00 IMPL. DEV. CHARGED TO PATIENTS		0. 2150		0	
3.00 0730	DO DRUGS CHARGED TO PATIENTS		0. 0936!	· ·		
	O SLEEP LAB		0. 1656	40 0	0	76.
	ATIENT SERVICE COST CENTERS		1 0//0	20		
	OO CLI NI C		1. 06698		1	1
	OO EMERGENCY		0. 3426		1	
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 44293	38 0	0	92.
	R REIMBURSABLE COST CENTERS					٠.
1	OO AMBULANCE SERVICES			274 240	45 474	95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)	(1:50 (1)		374, 248	65, 474	
01.00	Less PBP Clinic Laboratory Services-Program only charges ((iine 61)		074 040		201.
02.00	Net charges (line 200 minus line 201)		1	374, 248	I	202.

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	DUKES MEMORIAL HOSPITAL Provider C	CN: 15_1318	Peri od:	u of Form CMS-2 Worksheet D-3	
TWEATTENT ANGIELANT SERVICE COST ALTORITONIMENT	Trovider c		From 01/01/2018	Worksheet D-3	1
			To 12/31/2018	Date/Time Pre 5/31/2019 12:	
	Ti +I	e XIX	Hospi tal	973172019 12. PPS	ro pili
Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
oost conten bescriptron		To Charges	Program	Program Costs	
				(col. 1 x col.	
			3	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		•			
30. 00 03000 ADULTS & PEDI ATRI CS			47, 257		30.00
31.00 03100 INTENSIVE CARE UNIT			16, 866		31.00
43. 00 04300 NURSERY			1, 200		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 11567			
51. 00 05100 RECOVERY ROOM		0. 16983		923	
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0.00000		0	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 07556		4, 202	
54. 01 05401 ULTRASOUND		0. 00000		0	
56. 00 05600 RADI OI SOTOPE		0.00000		0	00.00
57. 00 05700 CT SCAN		0. 00000		0	57. 00
58. 00 05800 MRI		0.00000		0	00.00
60. 00 06000 LABORATORY		0. 12583		6, 405	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	02.00
65. 00 06500 RESPI RATORY THERAPY		0. 33466	•	4, 579	
66. 00 06600 PHYSI CAL THERAPY		0. 26519	•	293	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 19446		339	
68. 00 06800 SPEECH PATHOLOGY		0. 51795		230	
69. 00 06900 ELECTROCARDI OLOGY		0. 06886	•	1, 129	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 03784		536	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 21505		0	,
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 09365		12, 893	
76. 00 03610 SLEEP LAB		0. 16564	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS		1.0//00	DO 540	F70	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY		1. 06698 0. 34264		578	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 34264		7, 086 849	
OTHER REIMBURSABLE COST CENTERS		0. 44293	00 1,917	849	J 92. 00
95 OO OOSOO AMBIII ANCE SERVICES					95 00

362, 617

362, 617

44, 941 200. 00

95.00

201. 00 202. 00

95. 00 09500 AMBULANCE SERVICES

200.00

201.00

202.00

Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1318	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/31/2019 12:18 pm

			12,01,2010	5/31/2019 12:	18 pm
		Title XVIII	Hospi tal	Cost	
		1. 00			
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5, 461, 259	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		0	2.00
3.00	OPPS payments			7, 496, 721	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	IV, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 461, 259	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e 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	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	·		0	14.00
	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			ol	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e		3		
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)			ol	18. 00
19.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	ol	19.00
	instructions)		, ,		
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)		, ,		
21.00	Lesser of cost or charges (see instructions)			5, 515, 872	21.00
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			7, 496, 721	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		61, 866	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instr	uctions)	6, 318, 816	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			-864, 810	27. 00
	instructions)		- '		
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			-864, 810	30.00
31.00	Primary payer payments			1, 346	31.00
32.00	Subtotal (line 30 minus line 31)			-866, 156	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			1, 166, 072	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			757, 947	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		972, 939	36.00
37.00	Subtotal (see instructions)			-108, 209	37.00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		·	0	39. 99
40.00	Subtotal (see instructions)			-108, 209	40.00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40.02	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00	Interim payments			687	41.00
42.00					42.00
43.00					43.00
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2		'	- 1	
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
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)			اه	94. 00
			'		

Health Financial Systems DUK ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1318

					5/31/2019 12: 1	18 pm
		Titl∈	XVIII	Hospi tal	Cost	
		Inpatier	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		3, 782, 46	6	687	1. 00
2.00	Interim payments payable on individual bills, either			0	o	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)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER				0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER			0		3. 01 3. 02
3. 02				0		3. 02
3. 03				0		3. 03
3. 04				0		3. 04
3.03	Provider to Program			<u>U</u>	U	3. 03
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ABSOSTMENTS TO TROOK IIII			0	Ö	3. 51
3. 52				0	l ol	3. 52
3. 53				0	0	3. 53
3. 54				o	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	l ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 782, 46	6	687	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 01	Program to Provider TENTATIVE TO PROVIDER		I	0	0	5. 01
5. 01 5. 02	TENTATIVE TO PROVIDER			0		5. 01
5. 02				0		5. 02
5.05	Provider to Program			<u> </u>	U	5.05
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51	TENTITIVE TO TROOK IIII			0	o o	5. 51
5. 52				0	o o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
0. ,,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		555, 18	19	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	108, 896	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 337, 65	55	-108, 209	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00)	1. 00	2. 00	0.00
8. 00	Name of Contractor					8. 00

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

		Component	CCN. 13-Z316	10 12/31/2010	5/31/2019 12:	
		Title	XVIII S	Swing Beds - SNF		•
		Inpatien	it 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		178, 00	4	0	1. 00
2.00	Interim payments payable on individual bills, either			0	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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02	THE STATE OF THE TROUBER		l .	0		3. 02
3. 03				0	0	3. 03
3. 04				Ö		3. 04
3. 05				Ö	Ö	3. 05
	Provider to Program	'	'			
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3. 52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)		470.00			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		178, 00	4	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	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	TENTATI VE 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			0	0	5. 99
4 00	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		6, 23	-		6. 02
7. 00	Total Medicare program liability (see instructions)		171, 77			7. 00
	The second of th		,,,,	Contractor	NPR Date	7.50
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems DUKES MEMORIA	L HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1318 Period: From 01/01/2018 Poriod: From 01/01/2018				
		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	Total hospital discharges as defined in AARA §4102 from Wks	t. S-3, Pt. I col. 15 line	2 14		1. 00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168 $$	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				Ī
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	Other Adjustment (specify)				31.00
22 00	2.00 Palance due provider (line 0 (ar line 10) minus line 20 and line 21) (acc instructions)				

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

30. 00 31. 00 32. 00

				5/31/2019 12:	18 pm_
		Title XVIII S	wing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1	_	
1.00	Inpatient routine services - swing bed-SNF (see instructions)		110, 993	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, a		66, 129	0	3. 00
4 00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruct			0.00	4 00
4. 00	Per diem cost for interns and residents not in approved teaching pr	rogram (see		0. 00	4. 00
5. 00	instructions) Program days		83	0	5. 00
6. 00	Interns and residents not in approved teaching program (see instruc	stions)	0.5	0	6. 00
7. 00	Utilization review - physician compensation - SNF optional method of		0	U	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	on y	177, 122	0	8. 00
9. 00	Primary payer payments (see instructions)		177, 122	0	9. 00
10. 00	Subtotal (line 8 minus line 9)		177, 122	0	10. 00
11. 00	Deductibles billed to program patients (exclude amounts applicable	to physician	1,7,122	0	11. 00
11.00	professional services)	to physician		o o	11.00
12.00	Subtotal (line 10 minus line 11)		177, 122	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records) (exc	cl ude coi nsurance	1, 842	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 14)		175, 280	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 Demonstration	n) payment	0		16. 55
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		0	0	17. 00
	Adjusted reimbursable bad debts (see instructions)	_	0	0	17. 01
	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)	0	0	18. 00
	Total (see instructions)		175, 280	0	19. 00
	Sequestration adjustment (see instructions)		3, 506	0	19. 01
	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
	Interim payments		178, 004	0	20. 00
	Tentative settlement (for contractor use only)		4 220	0	21. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21	-	-6, 230	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	U U	0	23. 00
	<pre>chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration</pre>) Adiustment			
200 00	Is this the first year of the current 5-year demonstration period u				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
	Cost Reimbursement		<u>'</u>		
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst.	D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst	t. D-3, col. 3, line			202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in first	: year of the current	5-year demonst	rati on	
005.00	peri od)				005 00
	Medicare swing-bed SNF target amount	: 204)			205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times I				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instruction)				207.00
	,	,			207. 00
206.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col	. I, Suii of Titles I			208. 00
200 00	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instructions	:)			209. 00
	Reserved for future use	9)			209. 00
210.00	Comparision of PPS versus Cost Reimbursement				210.00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 pl	us line 210) (see	T		215. 00
2.0.00	instructions)	210) (300			
			1 1	!	1

Не	alth Financial Systems	DUKES MEMORIAL H	10SPI TAL			In Lie	u of Form CMS-2552-10
C	ALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN:	15-1318	From 01/01/2018	Worksheet E-3 Part V Date/Time Prepared: 5/31/2019 12:18 pm
			T: +1	I o VI	/	Hecni tal	Coct

				5/31/2019 12:	18 pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			4, 803, 084	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
3.00	Organ acqui si ti on	,		o	3.00
4.00	Subtotal (sum of lines 1 through 3)			4, 803, 084	4.00
5.00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 851, 115	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			1, 551, 115	
	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
10.00	Customary charges			0	10.00
11. 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge hasis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for		9	Ö	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)		ir a charge basis	O	12.00
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)			0.000000	14. 00
15. 00	Excess of customary charges over reasonable cost (complete on	Ly if line 14 exceeds li	na 6) (saa	0	15. 00
13.00	instructions)	Ty IT TITLE 14 EXCEEDS IT	116 0) (366	O	13.00
16. 00	Excess of reasonable cost over customary charges (complete on	lvifline 6 exceeds lin	e 14) (see	0	16. 00
10.00	instructions)	Ty IT TIME O EXCEEDS ITH	C 11) (300	J	10.00
17. 00				0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	. 401. 5.1.5)		J	
18. 00	Direct graduate medical education payments (from Worksheet E-	4 line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	.,		4, 851, 115	
20. 00	Deductibles (exclude professional component)			458, 160	20. 00
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			4, 392, 955	
23. 00	Coi nsurance			1, 675	
24. 00	Subtotal (line 22 minus line 23)			4, 391, 280	
25. 00	Allowable bad debts (exclude bad debts for professional service	res) (see instructions)		53, 691	
26. 00	Adjusted reimbursable bad debts (see instructions)	003) (300 111311 4011 0113)		34, 899	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		18, 059	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	ructions)		4, 426, 179	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			4, 420, 179	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	-)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration	5)		0	29. 99
				-	30.00
30.00	Subtotal (see instructions)			4, 426, 179	
30. 01	Sequestration adjustment (see instructions)			88, 524 0	
30. 02	Demonstration payment adjustment amount after sequestration			-	30. 02
31. 00	Interim payments			3, 782, 466	31.00
32.00	Tentative settlement (for contractor use only)	21 and 22)		0	32.00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0)		abanton 1	555, 189	33.00
34. 00	Protested amounts (nonallowable cost report items) in accordance in acco	nce with CMS Pub. 15-2,	chapter I,	0	34. 00
	§115. 2			l l	

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

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 Perion

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/31/2019 12: 18 pm

oni y)					5/31/2019 12:	18 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-47, 579	1	_	0	
2.00	Temporary investments	0	0	0	0	2. 00 3. 00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	24, 534, 120	0	0	0	
5. 00	Other recei vabl e	0	Ö	0	Ö	
6. 00	Allowances for uncollectible notes and accounts receivable	-5, 732, 952	Ö	0	0	
7.00	Inventory	960, 775	0	0	0	7. 00
8.00	Prepai d expenses	396, 871	1	-	0	1
9.00	Other current assets	-622, 152	1	-	0	
10.00	Due from other funds Total current assets (sum of lines 1-10)	10, 400, 003	_	-	0	
11. 00	FIXED ASSETS	19, 489, 083	0	U	0	11. 00
12. 00	Land	500, 000	0	0	0	12. 00
13.00	Land improvements	223, 845	1		0	
14.00	Accumulated depreciation	-124, 206	0	0	0	14. 00
15. 00	Bui I di ngs	10, 506, 686	1		0	
16. 00	Accumulated depreciation	-3, 475, 602	1	_	0	
17. 00 18. 00	Leasehold improvements	9, 793, 335	1	0	0	17. 00
19. 00	Accumulated depreciation Fixed equipment	-3, 197, 443 3, 089, 182	1	0	0	
20. 00	Accumulated depreciation	-1, 184, 969	i		0	1
21. 00	Automobiles and trucks	583, 590	1	_	0	
22. 00	Accumulated depreciation	-494, 445	1	0	0	22. 00
23. 00	Maj or movable equipment	7, 581, 469	0	0	0	23. 00
24. 00	Accumulated depreciation	-5, 927, 172		_	0	
25. 00	Mi nor equi pment depreci abl e	4, 732, 319	1	_	0	25. 00
26. 00	Accumulated depreciation HIT designated Assets	-2, 470, 960	0	0	0	26. 00
27. 00 28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e		Ö	-	0	1
30. 00	Total fixed assets (sum of lines 12-29)	20, 135, 629		-	0	
	OTHER ASSETS					
31. 00	Investments	0			0	1
32. 00	Deposits on Leases	0	0	0	0	32.00
33. 00	Due from owners/officers	0 7/0 700	0	0	0	1
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	8, 760, 738 8, 760, 738	1	_	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	48, 385, 450	1		0	1
00.00	CURRENT LIABILITIES	10,000,100				00.00
37. 00	Accounts payable	1, 038, 542	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 017, 180	1	0	0	
39. 00	Payroll taxes payable	-8, 954	0	0	0	1
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments	0	U	0	0	41. 00 42. 00
43. 00	Due to other funds	-10, 578, 962	0	0	0	1
44. 00	Other current liabilities	333, 509	1		Ö	
45.00	Total current liabilities (sum of lines 37 thru 44)	-8, 198, 685		0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	_		0	
47. 00	Notes payable	0			0	1
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	0	0	0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)		Ö	_	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	-8, 198, 685	1		Ö	
	CAPI TAL ACCOUNTS					
52.00	General fund balance	56, 584, 135				52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted			0		55. 00 56. 00
56.00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	1
_ 5. 00	replacement, and expansion					-3. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	56, 584, 135	1	0	0	1
60.00	Total liabilities and fund balances (sum of lines 51 and	48, 385, 450	0	0	0	60. 00
	[59]	I	I		I	I

Provider CCN: 15-1318

					То	12/31/2018	Date/Time Prep 5/31/2019 12:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	о рііі
				·				
4 00		1.00	2.00	3. 00		4. 00	5. 00	4 00
1.00	Fund balances at beginning of period		53, 427, 009			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		3, 157, 126			0		2.00
3. 00 4. 00	Additions (credit adjustments) (specify)		56, 584, 135		0	U	0	3. 00 4. 00
5.00	Additions (credit adjustillents) (specify)				0		0	5. 00
6. 00					0		0	6. 00
7. 00					0		0	7. 00
8.00		0			0		0	8. 00
9. 00		0			0		ol	9. 00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		56, 584, 135			0		11.00
12.00	Deductions (debit adjustments) (specify)	o			0		0	12.00
13.00		o			0		0	13.00
14.00		0			0		0	14.00
15. 00		0			0		0	15.00
16. 00		0			0		0	16.00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		56, 584, 135			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		ZIIGOIIIIOITE I GIIG						
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6.00			0					6. 00
7. 00 8. 00			0					7. 00 8. 00
9. 00			0					9. 00
10.00	Total additions (sum of line 4-9)		U		0			10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0		J			12. 00
13. 00	Security (Specify)		0					13. 00
14. 00			0					14. 00
15.00			o					15.00
16.00			0					16.00
17. 00			o					17.00
18. 00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)			I			l	

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

			0 12/31/2010	5/31/2019 12:	
	Cost Center Description	Inpatient	Outpati ent	Total	
	•	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•	<u>'</u>		
	General Inpatient Routine Services				
1.00	Hospi tal	5, 888, 559		5, 888, 559	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	· ·	1	Ü	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)	5, 888, 559		5, 888, 559	10.00
10.00	Intensive Care Type Inpatient Hospital Services	3,000,33	1	3, 000, 337	10.00
11. 00	INTENSIVE CARE UNIT	991, 593	2	991, 593	11. 00
12. 00	CORONARY CARE UNIT	,,,,,,,,	1	771,070	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	991, 593		991, 593	16. 00
16.00		991, 59.		991, 593	16.00
17 00	11-15)	4 000 15		/ 000 1F2	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	6, 880, 152		6, 880, 152	17. 00
18.00	Ancillary services	38, 130, 008		131, 729, 491	18.00
19.00	Outpatient services	2, 848, 86		31, 722, 549	19.00
20.00	RURAL HEALTH CLINIC		ή	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY		_	_	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 to Wkst.	47, 859, 02!	122, 473, 167	170, 332, 192	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		33, 197, 656		29. 00
30.00	ADD (SPECIFY)				30. 00
31. 00					31. 00
32. 00					32. 00
33. 00)		33. 00
34.00					34.00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00)		39. 00
40.00)		40. 00
41.00)		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	33, 197, 656		43. 00
	to Wkst. G-3, line 4)				

	Financial Systems	DUKES MEMORI AL HOSPI TAL		u of Form CMS-2	
STATEM				Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared:
			10 12/31/2010	5/31/2019 12:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I	, column 3, line 28)		170, 332, 192	1. 00
2.00	Less contractual allowances and discounts on p	patients' accounts		134, 101, 869	2. 00
3.00	Net patient revenues (line 1 minus line 2)			36, 230, 323	3. 00
4.00	Less total operating expenses (from Wkst. G-2,	Part II, line 43)		33, 197, 656	
5.00	Net income from service to patients (line 3 mi	nus line 4)		3, 032, 667	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneou	ıs communication services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guest	'S		0	14.00
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supp	olies to other than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patie	ents		0	17. 00
18.00	Revenue from sale of medical records and abstr	racts		0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, et	rc.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and	I canteen		0	20. 00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER (SPECIFY)			124, 459	24. 00
25.00	Total other income (sum of lines 6-24)			124, 459	25. 00
	Total (line 5 plus line 25)			3, 157, 126	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	
28 00	Total other expenses (sum of line 27 and subsc	rints)		0	28 00

28. 00

3, 157, 126 29. 00

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)