PART II - CERTIFICATION

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUPONT HOSPITAL (15-0150) for the cost reporting period beginning 04/01/2017 and ending 03/31/2018 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)
	`,
Title	
D-+-	
Date	

			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	161, 215	-10, 328	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
200.00	Total	0	161, 215	-10, 328	0	0	200. 00

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

Health Financial Systems DUPONT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0150 Peri od: Worksheet S-2 From 04/01/2017 Part I 03/31/2018 Date/Time Prepared: 8/31/2018 12:02 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 2520 E. DUPONT ROAD PO Box: 1.00 State: IN 2.00 City: FORT WAYNE Zi p Code: 46825-County: ALLEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fied Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal DUPONT HOSPITAL 150150 23060 05/24/2001 N 3.00 Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital-Based (CMHC) I 17.00 18. 00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2.00 1.00 04/01/2017 03/31/2018 20.00 Cost Reporting Period (mm/dd/yyyy) 20 00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23 00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medicaid Other

	Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	State Medicaid eligible unpaid	HMO days	Medi cai d days	
	1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24.00 If this provider is an IPPS hospital, enter the	568	368	24	80	6, 575	303	24. 00
in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in col 4, Medicaid HMO paid and eligible but unpaid days column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state	umn	0	0	0	0		25. 00
Medicaid paid days in column 1, the in-state 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-st Medicaid eligible unpaid days in column 4, Medica HMO paid and eligible but unpaid days in column 5	ai d			0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		Provi der C	CN: 15-0150	Period: From 04/01/2017 To 03/31/2018	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 8/31/2018 12:0	pared:
	Y/N	IME	Direct GME	IME	Direct GME	02 piii
	1. 00	2. 00	3. 00	4. 00	5. 00	
Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61. 04
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2. 00	3. 00	4.00	
51.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
0f the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				eriod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instru 62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	a Teachi gram. (s	see instructio		o your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovides Sa. 00 Has your facility trained residents in nonprovider s	ettings	during this c			N	63. 00
"Y" for yes or "N" for no in column 1. If yes, compl	ete line	es 64 through	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te	r Hospi tal	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in N period that begins on or after July 1, 2009 and befo			This base yea	ar is your cost r	reporting	
64.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty train n-primar all non d non-pr n column	ned residents ry care nprovider rimary care n 3 the ratio	0.	0. 00	0. 000000	64.00
Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2. 00	3. 00	4. 00	5.00	

	5, the ratio of (column 3								
	divided by (column 3 + column								
	4)). (see instructions)								
						1.00	2. 00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	IPF), or does it conta	ain an IPF subp	rovi der?	N			70. 00
	Enter "Y" for yes or "N" for no) <u>.</u>							
71.00	.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0								71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see								
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching								
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.								
	Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.								
	(see instructions)								
	Inpatient Rehabilitation Facilit	y PPS							
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or does it co	ontain an IRF		N			75. 00
	subprovider? Enter "Y" for yes	and "N" for no.							
76.00	If line 75 is yes: Column 1: Did	I the facility have ar	n approved GME teachir	ng program in t	he most			0	76.00
	recent cost reporting period end	ling on or before Nove	ember 15, 2004? Enter	"Y" for yes or	"N" for				
	no. Column 2: Did this facility	train residents in a	new teaching program	in accordance	with 42				
	CFR 412.424 (d)(1)(iii)(D)? Ente	er "Y" for yes or "N"	for no. Column 3: If	column 2 is Y,					
	indicate which program year bega	n during this cost re	eporting period. (see	instructions)					

resident FTEs that trained in your hospital. Enter in column

Long Term Care Hospital PPS OD Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. OI Is this a LTCH co-located within another hospital for part or all of the cost reporting peri "Y" for yes and "N" for no. TEFRA Providers OI Is this a new hospital under 42 CFR Section \$413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N OD Is this a new hospital under 42 CFR Section \$413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N OD Is this facility establish a new Other subprovider (excluded unit) under 42 CFR Section \$413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N OD Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Title V and XIX Services OD Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. OI is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. OO Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. OD boes this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. OD boes title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. OI filme 94 is "Y", enter the reduction percentage in the applicable column. OD loes title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wast. B, Pt. I. col. 252 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the enternal and residents post stepdown adjustments on Wast. B, Pt. I. col. 252 Enter "Y"		1.00 N N N N XIX 2.00 Y Y N N N O.00 N O.00	80. 00 81. 00 85. 00 86. 00 87. 00 91. 00 92. 00 93. 00 94. 00 95. 00 96. 00			
00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1s this a LTCH co-located within another hospital for part or all of the cost reporting peri "Y" for yes and "N" for no. TEFRA Providers 1s this a new hospital under 42 CFR Section \$413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N 00 Id this facility establish a new Other subprovider (excluded unit) under 42 CFR Section \$413.40(f)(1)(i) TEFRA? Enter "Y" for yes and "N" for no. 01 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(8)(v1)? Enter "Y" for yes or "N" for no. 11 Itle V and XIX Services 11 Itle V and XIX Services 12 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 13 Itle V and XIX Services 14 Itle XIX NF patients occupying title XVIII SNF beds (dual certification)? (see Instructions) Enter "Y" for yes or "N" for no in the applicable column. 15 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see Instructions) Enter "Y" for yes or "N" for no in the applicable column. 16 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 17 It line 94 is "Y", enter the reduction percentage in the applicable column. 18 It lie V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B. Pt. I., col. 25° Enter "Y" for yes or "N" for no in the applicable column. 18 It lie V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 18 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 19 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for	V 1.00 N N N O.00 N	N N N N X1 X 2.00 Y Y N N N N O.00 N	81. 00 85. 00 86. 00 87. 00 91. 00 92. 00 93. 00 94. 00 95. 00			
DISTRIS a new hospital under 42 CFR Section \$413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N DI 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. 10 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 11 Itle V and XIX Services 12 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 13 It is hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 20 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 21 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 22 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 23 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 24 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 25 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 26 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 27 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 28 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pt	V 1.00 N N N N O.00 N	N XI X 2. 00 Y Y N N N N N N O. 00 N N O. 00 O0	90. 00 91. 00 92. 00 93. 00 94. 00 95. 00			
Title V and XIX Services	N N N N O. 00 N O. 000	XI X 2.00 Y Y N N N 0.00 N	90. 00 91. 00 92. 00 93. 00 94. 00			
Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in parts Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an Icf/III facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes, and "N" for no in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25º Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst	N N N N O. 00 N O. 000	2.00 Y Y N N N 0.00 N	91. 00 92. 00 93. 00 94. 00 95. 00			
Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes, and "N" for no in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. II, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow	N N N N O. 00 N	Y Y N N N O. 00 N	91. 00 92. 00 93. 00 94. 00 95. 00			
Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes, and "N" for no in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. II, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow	N N N O. 00 N	Y N N N O. 00 N 0. 00	91. 0 92. 0 93. 0 94. 0 95. 0			
00 is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 00 Does title V or XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 00 If line 94 is "Y", enter the reduction percentage in the applicable column. 00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or	N N O. 00 N	N N N O. 00 N	92. 00 93. 00 94. 00 95. 00			
full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, P	N N O. 00 N	N N N O. 00 N	92. 00 93. 00 94. 00 95. 00			
instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers DOINT THE TIME TO THE AID TH	N O. 00 N O. 00	N N O. 00 N O. 00	93. 00 94. 00 95. 00			
Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (titl	N O. 00 N O. 00	N 0. 00 N 0. 00	94.00			
Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIV. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers DOD loes title XIX qualifies as a CAH?	0. 00 N	0. 00 N	95. 00			
100 lf line 94 is "Y", enter the reduction percentage in the applicable column. 101 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 102 line 96 is "Y", enter the reduction percentage in the applicable column. 103 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 11 Does title XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 2	N O. 00	N 0. 00				
Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers DOBOES this hospital qualify as a CAH? DOBOES this hospital qualify as a CAH?	N O. 00	N 0. 00				
16 line 96 is "Y", enter the reduction percentage in the applicable column. 10 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 11 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 12 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		ł	70.0			
column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 11 Rural Providers 12 Does title V qualifies as a CAH? 13 Does title view of title XIX. 14 Rural Providers 15 Does title view of XIX follow as a CAH? 15 Does title view of XIX follow as a CAH? 16 Does title view of XIX follow as a CAH? 17 Does title xiew of XIX follow as a CAH? 18 Does title view of XIX follow as a CAH? 18 Does title view of XIX follow as a CAH? 19 Does title view of XIX follow as a CAH? 10 Does title view of XIX follow as a CAH? 10 Does title view of XIX follow as a CAH? 10 Does title view of XIX follow as a CAH? 11 Does title view of XIX follow as a CAH? 12 Does title view of XIX follow as a CAH? 13 Does title view of XIX follow as a CAH? 14 Does title xitle xit		Y	97. 0 98. 0			
Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 30 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 40 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 50 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 50 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 60 Revenue Re	column 1 for title V, and in column 2 for title XIX. On Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for					
Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 5.00 Does this hospital qualify as a CAH? 5.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	Y	Y	98. 0			
04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 5.00 Does this hospital qualify as a CAH? 6.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N	N	98.0			
Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 5.00 Does this hospital qualify as a CAH? 5.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N	N	98.0			
Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 5.00 Does this hospital qualify as a CAH? 5.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	Υ	Y	98. 0			
5.00 Does this hospital qualify as a CAH? 5.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	Y	Y	98. 0			
0.00 f this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N		105. 0			
pror outpatrent Services? (See Instructions)	N		106. 0			
7.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost	N		107. 0			
reimbursed. If yes complete Wkst. D-2, Pt. II. 3.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			108. 0			
Physical Occupational	N	(
2.00 1.00 2.00 2.00 1.00 1.00 2.00 N	Speech	Respi ratory				
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Speech 3.00	4. 00	109 0			
	Speech		109. 0			

	1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	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 Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0150	Period: From 04/0° To 03/3°	1/2017 1/2018		S-2 Prepared: 12:02 pm
		1. 0	0	2. 00	
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for addition tele-health services.	st reporting period? Ente umn 1 is Y, enter the icipating in column 2.	N N			111.0
			1. 00	2.00 3	. 00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2.	If column 2 is "E", enter for long term care (inc b) based on the definition	er in column cludes			0 115. 0
17.00 ls this facility legally-required to carry malpractice insurano.	nnce? Enter "Y" for yes o		Y		117. 0
18.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the police	y is	1		118. 0
	Premi ums	Loss	es	Insuran	ce
	1.00	2.0		3. 00	
18.01 List amounts of malpractice premiums and paid losses:	53,	551	95, 918		0 118. 0
		1. 0	0	2.00	
18. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19. 00 DO NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies.	le listing cost centers Harmless provision in AC column 1, "Y" for yes or			N	118. 0 119. 0 120. 0
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implar	rs? (see instructions)				121. 0
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1	ned in §1903(w)(3) of th	ne Y		5. 03	122. 0
the Worksheet A line number where these taxes are included. Transplant Center Information					
25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	yes and "N" for no. If	N			125. C
26.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2.		e			126. 0
27.00 f this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 28.00 f this is a Medicare certified liver transplant center, enter					127. 0
in column 1 and termination date, if applicable, in column 2. 29.00 f this is a Medicare certified lung transplant center, enter					129. 0
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, and date in column 1 and termination date, if applicable, in column 1.					130. 0
B1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2 and termination date, if applicable, in column 3 a	enter the certification	ı			131. C
32.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.					132. 0
33.00 f this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. 34.00 f this is an organ procurement organization (OPO), enter the					133. C
and termination date, if applicable, in column 2. All Providers					
40.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y		Y		449008	140. 0

 Heal th Financial
 Systems
 DUPON

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
 In Lieu of Form CMS-2552-10 DUPONT HOSPITAL Peri od: Worksheet S-2
From 04/01/2017 Part I
To 03/31/2018 Date/Ti me Prepared: 8/31/2018 12: 02 pm Provider CCN: 15-0150 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141 ON Name: CHS/COMMINITY HEALTH SYSTEMS Contractor's Name: WPS LNC Contractor's Number: 10301

PO Box: State: T	N	Zip C	Code:	370	067	142. 00 143. 00
	14	ZIPC	ouc.	370	1	143.00
included in Worksheet						
included in Worksheet					1.00	
	A?				Y	144. 00
			-	1. 00	2.00	_
ned on Wkst. A, line 74	4, are the costs	for		Y	2.00	145. 00
de Medicare utilization						
olumn 1. (See CMS Pub.) If	N		146. 00
					1.00	_
basis? Enter "Y" for	yes or "N" for	no.			N	147. 00
					N	148. 00
cost finding method? I						149. 00
	n exemption from	the appl	licatio	on of the low	ver of costs	
for no for each compo			B. (Se			155. 00
					1	156. 00
					1	157. 00
						158. 00
	N	N		N	N	159. 00
	N	N		N	N	160. 00
		N		N	N	161. 00
					1.00	-
ıs hospital that has oı	ne or more campu	ıses in di	fferer	nt CBSAs?	N	165. 00
Name	County	State			FTE/Campus	
0	1. 00	2. 00	3.0	00 4.00	_	00 166. 00
					0.0	50 166. 00
					1.00	
ncentive in the Ameri	can Recovery and	Rei nves	tment /	Act		
s "Y") and is a meaning	ngful user (line			enter the	N	167. 00 0168. 00
nter "Y" for yes or "N'	for no. (see i	nstructio	ons)	·	0.0	168. 01 00 169. 00
						1.27.30
			-	Begi nni ng		_
nning date and ending	date for the re	porting		1.00	2.00	170. 00
				1.00	2.00	
er have any days for it	ndi vi dual si encol	led in			2.00	0 171. 00
orted on Wkst. S-3, Pt. 1. If column 1 is yes,	I, line 2, col	. 6? Ente		IV		5171.00
	or yes or "N" for no in de Medicare utilization no in column 2. In column 2. In column 1. (See CMS Pub. 1779) in column 2. basis? Enter "Y" for location? Enter "Y" for cost finding method? In cost	pr yes or "N" for no in column 1. If cole Medicare utilization for this cost no in column 2. Changed from the previously filed cost olumn 1. (See CMS Pub. 15-2, chapter 4 (27)) in column 2. basis? Enter "Y" for yes or "N" for location? Enter "Y" for yes or "N" for cost finding method? Enter "Y" for yes cost finding method? Enter "Y" for yes or "N" for no for each component for Part A	pr yes or "N" for no in column 1. If column 1 ide Medicare utilization for this cost reporting no in column 2. Changed from the previously filed cost report? Changed from 1. (See CMS Pub. 15-2, chapter 40, §4020) (Application) for location? Enter "Y" for yes or "N" for no. Cost finding method? Enter "Y" for yes or "N" for no. Cost finding method? Enter "Y" for yes or "N"	pr yes or "N" for no in column 1. If column 1 is de Medicare utilization for this cost reporting no in column 2. The column 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See CMS Pub. 15-2, chapter 40, §4020) If plumn 1. (See instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a meaningful user, does this provider qualify for a neter "Y" for yes or "N" for no. (see instructions) a neter "Y" for yes or "N" for no. (see instructions) a neter "Y" for yes or "N" for no. (see instructions) a neter "Y" for yes or "N" for no. (see	pryes or "N" for no in column 1. If column 1 is de Medicare utilization for this cost reporting no in column 2. The Medicare utilization for this cost reporting no in column 2. The Medicare utilization for this cost report? The Medicare utilization for this cost report? The Medicare utilization for this cost report? The Medicare utilization of the previously filed cost report? The Medicare utilization of the Medicare utilization? Enter "Y" for yes or "N" for no. Incation? Enter "Y" for yes or "N" for no. Dasis? Enter "Y" for yes or "N" for no.	pryes or "N" for no in column 1. If column 1 is de Medicare utilization for this cost reporting no in column 2. The previously filed cost report? slumn 1. (See CMS Pub. 15-2, chapter 40, \$4020) If plumn 1. (See

SPLI	Financial Systems DUPONT H		CN: 15-0150	Peri od:	worksheet S-2	
JI I I	AL AND HOST THE HEALTH SAKE RETWINDONSEMENT QUESTIONIVALKE	Trovider o	1	From 04/01/2017 Fo 03/31/2018	Part II	
					8/31/2018 12:	
				Y/N	Date	
				1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Enter	all dates in t	rne	
_	Provider Organization and Operation			T	I	٠.
0	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	the cost	N		1.
	reporting period? IT yes, enter the date of the change in c	corumn 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
0	Has the provider terminated participation in the Medicare F	Program? If	N N	2.00	3.00	2
	yes, enter in column 2 the date of termination and in colum					
`	voluntary or "I" for involuntary.		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			١,
)	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		Y			3
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)	5. 5 · G.				
			Y/N	Type	Date	
			1. 00	2. 00	3. 00	
	Financial Data and Reports					
)	Column 1: Were the financial statements prepared by a Cert		N			4
	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1					
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
`	column 3. (see instructions) If no, see instructions.	arant from	NI NI			
)	Are the cost report total expenses and total revenues differentiations on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differentiations.		N			5
	Those of the fired irriancial statements? If yes, submit rec	CONCITTATION.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
)	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		7 6
	the legal operator of the program?					
C	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7
)	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8
	cost reporting period? If yes, see instructions.					_
)	Are costs claimed for Interns and Residents in an approved		cal education	N		9
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		ho current	N		10
JU	cost reporting period? If yes, see instructions.	or renewed in t	ne current	IN		10
00	Are GME cost directly assigned to cost centers other than I	& Rin an Apr	proved	N		11
	Teaching Program on Worksheet A? If yes, see instructions.	a a				' '
	,			.	Y/N	
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Υ	12
00	If line 12 is yes, did the provider's bad debt collection p	oolicy change o	during this cos	st reporting	N	13
	period? If yes, submit copy.					
00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	tructi ons.	N N	_ 14
20	Bed Complement		!		l N	٦,
00	Did total beds available change from the prior cost reporti	, , ,	-		N N	15
		Y/N	Tt A Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data	1.00	2.00	0.00	1. 00	
	Was the cost report prepared using the PS&R Report only?	Υ	06/18/2018	Υ	06/18/2018	16
00	I was the cost report prepared using the Pook Report only?					
00	If either column 1 or 3 is yes, enter the paid-through					
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				i	
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)					
	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) Was the cost report prepared using the PS&R Report for	N		N		17
	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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17
	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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17
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) Was the cost report prepared using the PS&R Report for 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)					
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) Was the cost report prepared using the PS&R Report for 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) If line 16 or 17 is yes, were adjustments made to PS&R	N N		N N		
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) Was the cost report prepared using the PS&R Report for 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed					
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) Was the cost report prepared using the PS&R Report for 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	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) Was the cost report prepared using the PS&R Report for 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18
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) Was the cost report prepared using the PS&R Report for 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					

	Financial Systems DUPONT HO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0150	Peri od: From 04/01/2017 To 03/31/2018	wof Form CMS- Worksheet S-2 Part II Date/Time Pro 8/31/2018 12	2 epared:	
		Descr	iption	Y/N	Y/N	. UZ pili	
			0	1. 00	3. 00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		<u> </u>	N N	N N	20.00	
	Report data for Other? Describe the other adjustments:						
		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	
	COMPLETED BY COST DELMBURGED AND TEEDA HOSDITALS ONLY (EVOE	DT AULI DDENG I	IOCDI TALC)		1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS F	HUSPITALS)				
	Capital Related Cost					٠	
	Have assets been relifed for Medicare purposes? If yes, see				N N	22. 0	
23.00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made dur	ing the cost	N	23. 0	
4. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entere	d into during	this cost re	porting period?	N	24. 00	
E 00	If yes, see instructions	the cost man-	sting post of	Olf voc cos	NI NI	25. 0	
25. 00	Have there been new capitalized leases entered into during instructions.	N	25.0				
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	e cost renorti	na neriod2 L	f ves see	N	26. 0	
6.00	instructions.	le cost reporti	ng perrou? r	i yes, see	IN IN	20.0	
7. 00	Has the provider's capitalization policy changed during the	cost renortir	na neriod2 lf	VAS SUMMIT	N	27. 0	
7.00	copy.	cost reportir	ig period. II	yes, submit	''	27.0	
	Interest Expense						
8. 00	Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ina the cost	reportina	N	28. 0	
	period? If yes, see instructions.						
9. 00	Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service R	Reserve Fund)	N	29. 0	
	treated as a funded depreciation account? If yes, see instructions						
0.00							
	instructions.	•	•				
1. 00	Has debt been recalled before scheduled maturity without is	suance of new	debt? If yes	s, see	N	31. 0	
	i nstructi ons.						
	Purchased Services						
2. 00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32. 0	
	arrangements with suppliers of services? If yes, see instru						
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app	lied pertainir	ng to competi	tive bidding? If	N	33. 0	
	no, see instructions.						
	Provi der-Based Physi ci ans					٠	
4.00	Are services furnished at the provider facility under an ar	rangement with	n provider-ba	ised physicians?	N	34.0	
F 00	If yes, see instructions.					0.5	
5. 00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based	N	35.0	
	physicians during the cost reporting period? If yes, see in	STRUCTIONS.	,	Y/N	Doto		
				1.00	2. 00		
					2.00		
	Home Office Costs					+	
6.00	Home Office Costs Were home office costs claimed on the cost report?					36.0	
	Were home office costs claimed on the cost report?	repared by the	home office?	Y			
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	epared by the	home office?	Y			
37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions.			Y		37. 0	
37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	ice different	from that of	Y	12/31/2017	37. 0	
37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	ice different of the home o	from that of office.	Y Y Y		37. 00 38. 00	
7. 00 8. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	ice different of the home o	from that of office.	Y Y Y		37. 0 38. 0	
7. 00 8. 00 9. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe	ice different of the home or chain compor	from that of office. nents? If yes	Y Y Y		37. 0 38. 0 39. 0	
37. 00 38. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	ice different of the home or chain compor	from that of office. nents? If yes	Y Y Y S, N		36. 00 37. 00 38. 00 39. 00 40. 00	
7. 00 8. 00 9. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	ice different of the home or chain compor	from that of office. nents? If yes	Y Y Y S, N		37. 0 38. 0 39. 0	
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	ice different of the home or chain compor home office?	from that of office. nents? If yes	Y Y Y S, N N		37. 00 38. 00 39. 00	
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	ice different of the home or chain compor home office?	from that of office. nents? If yes If yes, see	Y Y Y S, N N	12/31/2017	37. 00 38. 00 39. 00	
37. 00 38. 00 39. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	ice different of the home or chain compor home office?	from that of office. nents? If yes If yes, see	Y Y Y S, N N	12/31/2017	37. 0 38. 0 39. 0 40. 0	
37. 00 38. 00 39. 00 -0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	rice different of the home or or chain compor home office?	from that of office. nents? If yes If yes, see	Y Y Y Y N N N 2.	12/31/2017	37. 00 38. 00 39. 00	
37. 00 38. 00 39. 00 -0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	rice different of the home or or chain compor home office?	from that of office. nents? If yes If yes, see	Y Y Y Y N N N 2.	12/31/2017	37. 0 38. 0 39. 0 40. 0	
37. 00 38. 00 39. 00 -0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	rice different of the home or or chain compor home office?	from that of office. nents? If yes If yes, see	Y Y Y Y N N N 2.	12/31/2017	37. 0 38. 0 39. 0 40. 0	
37. 00 38. 00 39. 00 -0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	rice different of the home or chain compor home office?	from that of office. nents? If yes If yes, see	Y Y Y Y N N N 2.	12/31/2017	37. 0 38. 0 39. 0 40. 0	

Heal th F	Financial Systems	DUPONT	H0SP	I TAL		In Lie	u of Form C	MS-2	2552-10
HOSPI TAI	L AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provider CCN:		Peri od:	Worksheet	S-2	
						From 04/01/2017 To 03/31/2018		Droi	arod:
						10 03/31/2016	8/31/2018	12: (02 pm
				3. 00					
C	Cost Report Preparer Contact Information								
	Enter the first name, last name and the t		MAN	NAGER - REVENUE	MANAGEMEN	Т			41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,							
1	respecti vel y.								
42. 00 E	Enter the employer/company name of the co	st report							42.00
	preparer.								
	Enter the telephone number and email addr								43.00
r	report preparer in columns 1 and 2, respe	cti vel y.							

						03/31/2016	8/31/2018 12:0	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		92	33, 580	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			92	33, 580	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		10	3, 650	0. 00	1	8.00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01		29	10, 585	0.00	0	8. 01
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			131	47, 815	0.00	0	14.00
15. 00	CAH visits						0	15.00
16. 00	SUBPROVI DER - I PF	40. 00		0	0		0	16.00
17. 00	SUBPROVI DER - I RF							17.00
18. 00	SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY	44. 00		0	0		0	19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25.00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			131				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

Provider CCN: 15-0150

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 04/01/2017 Part I
To 03/31/2018 Date/Time Prepared:
8/31/2018 12:02 pm

				•		8/31/2018 12:	02 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	•
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 878	71	10, 245			1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 278	5, 162				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0				6. 00
7.00	Total Adults and Peds. (exclude observation	1, 878	71	10, 245			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	210	49				8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT	0	164	5, 906			8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		2, 169				13. 00
14. 00	Total (see instructions)	2, 088	2, 453	21, 789	0.00	593. 36	14.00
15. 00	CAH visits	0	0				15. 00
16. 00	SUBPROVI DER - I PF	0	0	0	0.00	0.00	16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	_	_	_			26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				0.00	593. 36	
28. 00	Observation Bed Days	_	0	2, 359			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30. 00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	303	875			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
00.00	outpatient days (see instructions)						00.00
33. 00	LTCH non-covered days	0					33. 00
33. UI	LTCH site neutral days and discharges	0		I	I	I	33. 01

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 04/01/2017 Part I
To 03/31/2018 Date/Time Prepared:
8/31/2018 12:02 pm

					8/31/2018 12:	02 pm	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1 00	III	11. 00	12. 00	13.00	14. 00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	554	958	4, 526	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)			0	0		2. 00
3.00	HMO IPF Subprovider			Ŭ	Ö		3. 00
4. 00	HMO IRF Subprovider				o		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	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	554	958	4, 526	
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0	0	0	0	16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00 23. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
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	Ambulance 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)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 04/01/2017 | Part II | To 03/31/2018 | Date/Time Prepared: | | Provider CCN: 15-0150

					10	03/31/2018	Date/lime Prep 8/31/2018 12:0	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	35, 891, 840	0	35, 891, 840	1, 234, 213. 00	29. 08	1. 00
1.00	instructions)	200.00	00,071,010		00,071,010		27.00	1. 00
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4 00	B Bhariai an Bant A		0			0.00	0.00	4.00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01	Physicians - Part A - Teaching		0	0	0	0.00	0. 00	
5. 00	Physician and Non Physician-Part B		0	0	0	0. 00	0. 00	5. 00
6.00	Non-physician-Part B for		0	0	0	0.00	0. 00	6. 00
	hospital-based RHC and FQHC							
7. 00	services Interns & residents (in an	21. 00	0	О	0	0.00	0. 00	7. 00
	approved program)		_	_				
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
	programs)							
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00	SNF	44. 00	-1, 025	1, 025	0	0.00	0. 00	9. 00
10.00	Excluded area salaries (see		3, 370	546, 737	550, 107	16, 276. 00	33. 80	10.00
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		393, 115	0	393, 115	7, 180. 00	54. 75	11. 00
12. 00	Care Contract Labor: Top Level		0	0	0	0. 00	0.00	12. 00
12.00	management and other		0			0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		282, 961	О	282, 961	1, 049. 00	269. 74	13. 00
	A - Administrative			_				
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0.00	14. 00
	wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		3, 304, 602	0	3, 304, 602	97, 039. 00 0. 00	34. 05 0. 00	14. 01 14. 02
15. 00	Home office: Physician Part A		0	0	0	0.00	0.00	
47.00	- Administrative		0			2.22	0.00	47.00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		7, 862, 438	0	7, 862, 438			17. 00
18. 00	Wage-related costs (other)		200, 655	0	200, 655			18. 00
19. 00	(see instructions) Excluded areas		118, 812	0	118, 812			19. 00
20. 00	Non-physician anesthetist Part		110, 612	0				20. 00
04 00	A							04.00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		Λ	0	n			22. 01
23. 00	Physician Part B		0	Ö	_			23. 00
24. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0				24. 00 25. 00
25. 00	approved program)		U		U			25.00
25. 50	Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
	wage-related (core)		0					
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)							
25. 53	Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core)							
0/ 00	OVERHEAD COSTS - DIRECT SALARIE		402.25		402.25	7.025.55	27.5	2/ 65
26. 00 27. 00	Employee Benefits Department Administrative & General	4. 00 5. 00	198, 096 5, 101, 110			7, 085. 00 155, 172. 00		26. 00 27. 00
	1		.,,			, 00		

Provider CCN: 15-0150

							8/31/2018 12: (02 pm_
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		0	0	0	0.00	0. 00	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	667, 570	0	667, 570	35, 438. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00	0. 00	31.00
32.00	Housekeepi ng	9. 00	456, 799	0	456, 799	34, 734. 00	13. 15	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 181, 313	-479, 083	702, 230	39, 227. 00	17. 90	34.00
35.00	Di etary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	479, 083	479, 083	33, 309. 00	14. 38	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	1, 701, 766	109, 406	1, 811, 172	43, 220. 00	41. 91	38.00
39.00	Central Services and Supply	14. 00	402, 691	0	402, 691	22, 143. 00	18. 19	39.00
40.00	Pharmacy	15. 00	1, 605, 950	0	1, 605, 950	32, 709. 00	49. 10	40.00
41.00	Medical Records & Medical	16. 00	317, 600	0	317, 600	18, 182. 00	17. 47	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

Heal th Financial Systems

DUPONT HOSPITAL

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0150

Period:

Worksheet S-3

Form 04 (01 (2027) Root bld.

					FI To	rom 04/01/2017 o 03/31/2018	Part III Date/Time Prep	pared:
							8/31/2018 12:0	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		35, 891, 840	0	35, 891, 840	1, 234, 213. 00	29. 08	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 345	547, 762	550, 107	16, 276. 00	33. 80	2.00
	instructions)							
3.00	Subtotal salaries (line 1		35, 889, 495	-547, 762	35, 341, 733	1, 217, 937. 00	29. 02	3.00
	minus line 2)							
4.00	Subtotal other wages & related		3, 980, 678	0	3, 980, 678	105, 268. 00	37. 81	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 063, 093	0	8, 063, 093	0.00	22. 81	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		47, 933, 266	-547, 762	47, 385, 504	1, 323, 205. 00	35. 81	6.00
7.00	Total overhead cost (see		11, 632, 895	-549, 112	11, 083, 783	421, 219. 00	26. 31	7. 00
				1			ı	

instructions)

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0150	Peri od:	Worksheet S-3	
		From 04/01/2017	Part IV Date/Time Prepared:	

	To 03/31/2018	Date/Time Prep 8/31/2018 12:0	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	659, 101	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	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)	4, 373, 571	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	11, 456	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22, 898	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	-2, 124	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	3, 341	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	286, 695	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		1
	TAXES		
17.00	FICA-Employers Portion Only	2, 029, 044	17. 00
18.00	Medicare Taxes - Employers Portion Only	474, 535	18. 00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	122, 733	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
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)	7, 981, 250	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER BENEFITS, RELOCATION EXPENSES,	200, 655	25. 00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: From 04/01/2017 To 03/31/2018	Worksheet S-3 Part V Date/Time Pre 8/31/2018 12:0	pared:	
Cost Center Description		Contract Labor	Benefit Cost		
		1. 00	2. 00		
PART V - Contract Labor and Benefit Cost					
Hearital and Hearital Deced Component Identificati	OD:				

	Cost Center Description	Contract Labor	Benefit Cost						
		1. 00	2. 00						
	PART V - Contract Labor and Benefit Cost								
	Hospital and Hospital-Based Component Identification:								
1.00	Total facility's contract labor and benefit cost	393, 115	7, 981, 250	1.00					
2.00	Hospi tal	393, 115	7, 981, 250	2.00					
3.00	Subprovi der - I PF	0	0	3.00					
4.00	Subprovi der - I RF			4. 00					
5.00	Subprovi der - (Other)	0	0	5. 00					
6.00	Swing Beds - SNF	0	0	6.00					
7.00	Swing Beds - NF	0	0	7. 00					
8.00	Hospi tal -Based SNF	0	0	8. 00					
9.00	Hospi tal -Based NF			9. 00					
10.00	Hospi tal -Based OLTC			10.00					
11.00	Hospi tal -Based HHA			11.00					
12.00	Separately Certified ASC			12.00					
13.00	Hospi tal -Based Hospi ce			13.00					
14.00	Hospital-Based Health Clinic RHC			14.00					
15.00	Hospital-Based Health Clinic FQHC			15.00					
16.00	Hospi tal -Based-CMHC			16.00					
17. 00	Renal Di al ysi s	0	0	17.00					
18.00	0ther	0	0	18.00					

10SPI	Financial Systems DUPONT HOSPITA TAL UNCOMPENSATED AND INDIGENT CARE DATA PROPERTY.	rovi der CCI	N: 15-0150	Peri od:	u of Form CMS-2 Worksheet S-10	
	THE GROOM ENGLISHED THE STATE STATE			From 04/01/2017		
				To 03/31/2018	Date/Time Pre 8/31/2018 12:	pared 02 pm
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by lin	e 202 column	n 8)	0. 145520	1. (
	Medicaid (see instructions for each line)					
. 00	Net revenue from Medicaid				14, 911, 348	
. 00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. (
. 00 . 00	If line 3 is yes, does line 2 include all DSH and/or supplementa	ai a?	Y	4. (5. (
. 00	If line 4 is no, then enter DSH and/or supplemental payments fro Medicaid charges	mi wearcard			104, 464, 358	
. 00	Medicaid cost (line 1 times line 6)		15, 201, 653	1		
. 00	Difference between net revenue and costs for Medicaid program (I	ine 7 minu	s sum of lir	nes 2 and 5: if	290, 305	1
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
. 00	Net revenue from stand-alone CHIP				0	
0.00	Stand-alone CHIP charges				0	
1.00	Stand-alone CHIP cost (line 1 times line 10)	ina 11 min	ualina O. i	f . zoro thon	0	11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (I enter zero)	ine ii min	us iine 9; i	i < zero then	U	12.
	Other state or local government indigent care program (see instr	uctions fo	r each line)			
3. 00	Net revenue from state or local indigent care program (Not inclu				13, 293	13.
4. 00	Charges for patients covered under state or local indigent care	program (N	ot included	in lines 6 or	153, 106	14.
	10)					
5. 00	State or local indigent care program cost (line 1 times line 14)				22, 280	
6. 00	Difference between net revenue and costs for state or local indi	gent care	program (lir	ne 15 minus line	8, 987	16.
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	/Local indic	ent care program	ns (see	
	instructions for each line)	and State	,	joirt dans program	.5 (555	
7. 00					0	
8. 00	Government grants, appropriations or transfers for support of ho				0	
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent c	are programs	s (sum of lines	299, 292	19.
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col. 2)	
			1. 00	2. 00	3. 00	
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	Li ±v/	4, 318, 6	10, 766	4, 329, 376	20
). 00	(see instructions)	'' Ly	4, 310, 0	10, 700	4, 327, 370	20.
1. 00	Cost of patients approved for charity care and uninsured discoun	nts (see	628, 44	10, 766	639, 210	21.
	instructions)		,			
2. 00	Payments received from patients for amounts previously written of	off as	6	75 0	675	22.
	charity care				400 505	
3. 00	Cost of charity care (line 21 minus line 22)		627, 70	59 10, 766	638, 535	23. (
					1. 00	
4. 00	Does the amount on line 20 column 2, include charges for patient	days beyo	nd a Length	of stay limit	N N	24. (
00	imposed on patients covered by Medicaid or other indigent care p		na a rongen	0. Gtay [
5. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit		care progran	n's length of	0	25.
5. 00	Total bad debt expense for the entire hospital complex (see inst	ructions)			1, 978, 256	26.
7. 00	Medicare reimbursable bad debts for the entire hospital complex		uctions)		164, 264	1
7. 01	Medicare allowable bad debts for the entire hospital complex (se	e instruct	i ons)		252, 713	27.
8. 00	Non-Medicare bad debt expense (see instructions)				1, 725, 543	
9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see i	nstructions)		339, 550	
					978, 085	30.
0.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus lin	- 20)		ŀ	1, 277, 377	

Heal th	Fi nan	cial Systems	DUPONT HOSE	PLTAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICA	TION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co	CN: 15-0150 P	eri od:	Worksheet A	
						rom 04/01/2017	5	
					T	o 03/31/2018	Date/Time Pre	
		Cost Contor Decerintian	Calarias	O+box	Total (asl 1	Dool ooo! fi oo+!	8/31/2018 12:	02 piii
		Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassified	
					+ col . 2)	ons (See A-6)	Trial Balance	
							(col. 3 +-	
		•	1.00	0.00	0.00	4.00	col . 4)	
	OFNED	AL OFFICE OF COST OFFITTED	1. 00	2. 00	3. 00	4. 00	5. 00	
		AL SERVICE COST CENTERS		4 474 040	4 474 040	4 000 447	0.004.077	
1.00		CAP REL COSTS-BLDG & FIXT		1, 474, 860			2, 804, 977	1.00
2.00		CAP REL COSTS-MVBLE EQUIP		4, 058, 042			6, 459, 550	2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	198, 096	180, 172			6, 049, 465	4. 00
5. 01		ADMITTI NG	0	0		,	2, 439, 084	5. 01
5. 02		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		,	1, 968, 663	5. 02
5. 03		OTHER ADMINISTRATIVE AND GENERAL	5, 101, 110	38, 308, 557	43, 409, 667	-13, 097, 793	30, 311, 874	5. 03
7.00		OPERATION OF PLANT	667, 570	3, 135, 825	3, 803, 395	253, 896	4, 057, 291	7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	0	400, 218	400, 218	0	400, 218	8. 00
9.00	00900	HOUSEKEEPI NG	456, 799	520, 101	976, 900	0	976, 900	9. 00
10.00	01000	DI ETARY	1, 181, 313	1, 070, 168	2, 251, 481	-1, 081, 436	1, 170, 045	10.00
11.00	01100	CAFETERI A	0	0	0	1, 077, 374	1, 077, 374	11. 00
13.00	01300	NURSING ADMINISTRATION	1, 701, 766	199, 530	1, 901, 296	107, 371	2, 008, 667	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	402, 691	12, 621, 040	13, 023, 731	-11, 301, 880	1, 721, 851	14. 00
15.00		PHARMACY	1, 605, 950	5, 013, 922			1, 842, 584	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	317, 600	689, 817			991, 783	16. 00
		ENT ROUTINE SERVICE COST CENTERS	0.77000	3077317	1,007,117	107001	7717700	
30. 00		ADULTS & PEDIATRICS	7, 966, 634	1, 948, 756	9, 915, 390	-3, 110, 612	6, 804, 778	30. 00
31. 00		INTENSIVE CARE UNIT	1, 092, 078	238, 775			1, 329, 650	
31. 01		NEONATAL INTENSIVE CARE UNIT	2, 730, 662	766, 063			3, 489, 076	
40. 00		SUBPROVI DER - I PF	2, 730, 002	700,003	101	-101	3, 407, 070	40.00
43. 00		NURSERY	104	141, 580			1, 430, 491	43. 00
	1							
44. 00		SKILLED NURSING FACILITY	-1, 025	65	-960	960	0	44. 00
EO 00		LARY SERVICE COST CENTERS OPERATING ROOM	2 200 047	4 577 004	7 0/7 021	1 742 127	0 (10 050	E0 00
50.00		RECOVERY ROOM	3, 289, 947	4, 577, 884			9, 610, 958 0	•
51.00		l l	1, 891, 611	574, 838			_	
52.00		DELIVERY ROOM & LABOR ROOM	2, 449	874, 275			2, 673, 388	•
53.00		ANESTHESI OLOGY	0	1, 984, 599			1, 984, 414	•
54.00		RADI OLOGY-DI AGNOSTI C	1, 843, 441	982, 875			2, 539, 938	•
54. 01		ULTRA SOUND	389, 903	32, 835			422, 738	•
56. 00		RADI OI SOTOPE	78, 439	136, 419			211, 708	56. 00
57. 00		CT SCAN	0	67, 567			0	57. 00
58. 00	05800		195, 306	33, 650			227, 516	
60.00		LABORATORY	1, 560, 523	1, 480, 402			2, 928, 858	
65. 00		RESPI RATORY THERAPY	991, 116	342, 612			1, 332, 690	•
66. 00		PHYSI CAL THERAPY	144, 143	11, 169			335, 152	66. 00
67. 00		OCCUPATI ONAL THERAPY	99, 036	7, 689			0	67. 00
68. 00		SPEECH PATHOLOGY	66, 378	6, 737			0	68. 00
69. 00		ELECTROCARDI OLOGY	17, 049	2, 455	19, 504	-421	19, 083	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1, 941, 891	1, 941, 891	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9, 075, 671	9, 075, 671	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0		4, 640, 385	4, 640, 385	73. 00
74.00	07400	RENAL DIALYSIS	0	122, 292	122, 292	0	122, 292	74.00
76.00	03950	SLEEP LAB	194, 681	1, 431, 274	1, 625, 955	-14, 013	1, 611, 942	76. 00
	OUTPA	TIENT SERVICE COST CENTERS						
90.00	09000	CLI NI C	349, 516	92, 596	442, 112	-900	441, 212	90.00
91.00	09100	EMERGENCY	1, 353, 584	933, 747	2, 287, 331	123, 421	2, 410, 752	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		REI MBURSABLE COST CENTERS	<u> </u>					
95.00		AMBULANCE SERVICES	2, 281	123, 691	125, 972	-125, 972	0	95. 00
		AL PURPOSE COST CENTERS	, -	-,				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35, 890, 845	84, 587, 104	120, 477, 949	-613, 040	119, 864, 909	118. 00
		MBURSABLE COST CENTERS	22/ 2/2/ 2/2		1==7 1117 111	2.070.0	,,	
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 123	3, 123	-2	3 121	190. 00
		PHYSICIANS' PRIVATE OFFICES	995	31, 432			30, 627	
		MARKETI NG	//3	31, 432		1, 500		194. 00
		PHYSICIAN RELATIONS	0	0				194. 00
		SENIOR CIRCLE		0				194. 01
		WOMENS RESOURCE CENTER		0			614, 842	
200.00		TOTAL (SUM OF LINES 118 through 199)	35, 891, 840	84, 621, 659			120, 513, 499	
200.00	ا ا	TOTAL (SOW OF LINES TO THE OUGH 199)	33, 671, 640	04, 021, 009	120, 313, 499	ı Y	120, 513, 499	₁ 200.00

				8/31/2018 12:	02 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	438, 288		•	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-116, 366			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-7, 988			4. 00
5. 01	00570 ADMI TTI NG	0	2, 439, 084		5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-629, 177	1, 339, 486		5. 02
5.03	00560 OTHER ADMINISTRATIVE AND GENERAL	-13, 900, 273	16, 411, 601		5. 03
7.00	00700 OPERATION OF PLANT	-26, 046	4, 031, 245		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	98, 281	498, 499		8. 00
9.00	00900 HOUSEKEEPI NG	0	976, 900		9. 00
10. 00	01000 DI ETARY	0	1, 170, 045		10. 00
11. 00	01100 CAFETERI A	-384, 149		1	11. 00
13.00	01300 NURSING ADMINISTRATION	-7, 249	2, 001, 418		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 721, 851		14. 00
15. 00	01500 PHARMACY	0	1, 842, 584		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-14, 514	977, 269		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDIATRICS	-683, 810		•	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	1, 329, 650	•	31. 00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	-81, 000			31. 01
40. 00	04000 SUBPROVI DER - I PF	0	0		40. 00
43.00	04300 NURSERY	0	1, 430, 491		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44. 00
	ANCILLARY SERVICE COST CENTERS				
50. 00	05000 OPERATING ROOM	0	9, 610, 958	•	50. 00
51. 00	05100 RECOVERY ROOM	0	0	I	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-399, 996	2, 273, 392		52. 00
53. 00	05300 ANESTHESI OLOGY	-1, 984, 414	0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-1, 000	2, 538, 938		54. 00
54. 01	05401 ULTRA SOUND	0	422, 738		54. 01
56. 00	05600 RADI OI SOTOPE	0	211, 708		56. 00
57. 00	05700 CT SCAN	0	0	l .	57. 00
58. 00	05800 MRI	0	227, 516		58. 00
60.00	06000 LABORATORY	0	2, 928, 858		60. 00
65. 00	06500 RESPI RATORY THERAPY	0	1, 332, 690		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	335, 152	1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	19, 083		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 941, 891		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	9, 075, 671	1	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	4, 640, 385		73. 00
74. 00	07400 RENAL DI ALYSI S	0	122, 292		74. 00
76. 00	03950 SLEEP LAB	-1, 370, 049	241, 893		76. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	441, 212		90.00
91.00	09100 EMERGENCY	-355, 104	2, 055, 648		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
05.00	OTHER REIMBURSABLE COST CENTERS				05 00
95.00	09500 AMBULANCE SERVI CES	0	0		95. 00
110 0	SPECIAL PURPOSE COST CENTERS	10 101 511	100 110 010		110 00
118.00	, ,	-19, 424, 566	100, 440, 343		118. 00
400.00	NONREI MBURSABLE COST CENTERS		0.404		400 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 121		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	30, 627	1	192.00
	07950 MARKETI NG	0	0	1	194. 00
	07951 PHYSI CI AN RELATIONS	0	0	1	194. 01
	2 07952 SENI OR CI RCLE	0	0		194. 02
	3 07953 WOMENS RESOURCE CENTER	0	614, 842		194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-19, 424, 566	101, 088, 933		200. 00

Peri od: Worksheet A-6 From 04/01/2017 To 03/31/2018 Date/Time Prepared: 9/31/2018 12:02 pm Provider CCN: 15-0150

					8/31/2018	12:02 pm
	Cook Conton	Increases	6-1	0+1		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - EMPLOYEE BENEFIT RECLASS	0.00	1.00	0.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 671, 371		1. 00
	TOTALS		0	5, 671, 371		
	B - OXYGEN COSTS					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	343		1. 00
	TOTALS	+				
	C - RENTAL AND LEASE EXPENSES		U	343		
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	ol	2, 397, 219		1.00
2. 00	NEE SOSTS IIIVBEE EQUIT	0.00	o	0		2. 00
3. 00		0.00	o	Ö		3. 00
4. 00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0. 00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
17.00	TOTALS — — — —		_ — — 🖰	2, 397, 219		17.00
	D - OTHER CAPITAL COSTS		٥	2,077,217		
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	79, 727		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	O	1, 250, 390		2. 00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4, 289		3. 00
	TOTALS			1, 334, 406		
	F - CNO SALARIES					
1.00	NURSING ADMINISTRATION	13. 00	109, 406	0		1. 00
	TOTALS		109, 406	0		
	G - MEDI CAL SUPPLIES	74 00		1 011 510		
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 941, 548		1. 00
2.00	PATIENT IMPL. DEV. CHARGED TO	72. 00	o	9, 075, 671		2. 00
2.00	PATIENTS	72.00	٥	9,075,071		2.00
	TOTALS — — —	+		11, 017, 219		
	H - DRUGS/IV SOLUTIONS		<u> </u>	11/01//21/		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	4, 640, 385		1.00
	TOTALS			4, 640, 385		
	I - MI SCELLANEOUS					
1.00	ADMI TTI NG	5. 01	2, 163, 909	275, 175		1. 00
2.00	CASHI ERI NG/ACCOUNTS	5. 02	0	1, 968, 663		2. 00
	RECEI VABLE	+				
	TOTALS		2, 163, 909	2, 243, 838		
1. 00	J - RADI OLOGY COSTS RADI OLOGY-DI AGNOSTI C	54.00	0	67, 567		1.00
1.00	TOTALS		- — — }	67, 567		1.00
	K - DIETARY		<u> </u>	07, 307		
1. 00	CAFETERI A	11.00	479, 083	598, 291		1.00
	TOTALS		479, 083	598, 291		
	L - MISC DEPT RECLASS			, , , , , , , , , , , , , , , , , , ,		
1.00	ADULTS & PEDIATRICS	30.00	0	169		1. 00
2.00	OPERATING ROOM	50. 00	1, 891, 611	575, 024		2. 00
3.00	PHYSI CAL THERAPY	66.00	165, 414	14, 426		3. 00
4.00	SKILLED NURSING FACILITY	44.00	1, 025	0		4. 00
5.00	EMERGENCY	91.00	2, 281	123, 594		5. 00
6.00	WOMENS RESOURCE CENTER	194. 03	549, 112	65, 730		6.00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8.00
9. 00	TOTALS — — — —	0.00	2, 609, 443	000		9. 00
	M - LABOR & DELIVERY COSTS		2, 007, 443	110, 743		
1.00	ADULTS & PEDIATRICS	30.00	0	22, 254		1.00
2.00	NURSERY	43. 00	1, 084, 073	204, 765		2. 00
3. 00	DELIVERY ROOM & LABOR ROOM	52.00	2, 023, 683	0		3. 00
	TOTALS		3, 107, 756	227, 019		
	N - REPAIRS & MAINTENANCE					
1.00	OPERATION OF PLANT	7. 00	0	253, 896		1. 00
2.00		0.00	0	0		2. 00
3.00	1	0.00	0	0		3. 00

Health Financial Systems RECLASSIFICATIONS DUPONT HOSPITAL In Lieu of Form CMS-2552-10 Peri od: From 04/01/2017 To 03/31/2018 Date/Time Prepared: 8/31/2018 12:02 pm Provider CCN: 15-0150

					073172010 12.02 piii
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4.00	5. 00	
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6.00
7. 00		0.00	0	0	7.00
8. 00		0.00	O	0	8.00
9. 00		0.00	O	0	9.00
10. 00		0.00	o	0	10.00
11. 00		0.00	o	0	11. 00
12. 00		0.00	o	0	12. 00
13. 00		0.00	o	0	13. 00
14. 00		0.00	o	0	14. 00
15. 00		0.00	O	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	O	0	19. 00
Ī	TOTALS			253, 896	
500.00	Grand Total: Increases		8, 469, 597	29, 230, 497	500.00

Peri od: From 04/01/2017 To 03/31/2018 Date/Ti me Prepared: 8/31/2018 12:02 pm Provider CCN: 15-0150

						8/31/2018	12: 02 pm
		Decreases	0.1	011			
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6.00 A - EMPLOYEE BENEFIT RECLASS	7. 00	8. 00	9. 00	10. 00		_
1. 00	OTHER ADMINISTRATIVE AND	5. 03	0	5, 671, 371	O		1.00
1.00	GENERAL	0.00	٩	0,071,071			1.00
	TOTALS	+		5, 671, 371			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	1400	0	343			1. 00
	TOTALS		0	343			
	C - RENTAL AND LEASE EXPENSES		ما		1 40		
1.00	EMPLOYEE BENEFITS DEPARTMENT OTHER ADMINISTRATIVE AND	4.00	0	174	1		1.00
2. 00	GENERAL	5. 03	U	917, 737	U		2. 00
3. 00	DI ETARY	10.00	0	3, 735	o		3. 00
4. 00	NURSING ADMINISTRATION	13. 00	0	1, 882	1		4. 00
5. 00	CENTRAL SERVICES & SUPPLY	14. 00	ol	300, 100	-		5. 00
6.00	PHARMACY	15. 00	O	136, 903	1		6. 00
7.00	MEDICAL RECORDS & LIBRARY	16. 00	O	15, 634	. 0		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	21, 744			8. 00
9. 00	INTENSIVE CARE UNIT	31. 00	0	55	1		9. 00
10.00	NEONATAL INTENSIVE CARE UNIT	31. 01	0	4, 762	1		10.00
11.00	OPERATING ROOM	50.00	0	540, 875			11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	335, 607			12.00
13. 00 14. 00	LABORATORY RESPIRATORY THERAPY	60. 00 65. 00	0	103, 747 144	1		13. 00 14. 00
15. 00	SLEEP LAB	76.00	0	14, 007	1		15. 00
16. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	14, 007			16. 00
10.00	CANTEEN	1 70. 00	٩	2			10.00
17. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	111	o		17. 00
	TOTALS			2, 397, 219			
	D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND	5. 03	0	1, 334, 406	12		1. 00
	GENERAL		_	_			
2.00		0.00	0	0	1 1		2. 00
3. 00	TOTALS — — — — +	0.00	0		12		3. 00
	F - CNO SALARIES		U	1, 334, 406			
1. 00	OTHER ADMINISTRATIVE AND	5. 03	109, 406	C	ol		1.00
1.00	GENERAL	3.03	107, 400				1.00
	TOTALS	+	109, 406				
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	10, 957, 908	0		1. 00
2.00	OPERATING ROOM	5000		5 <u>9, 3</u> 11			2. 00
	TOTALS		0	11, 017, 219			
4 00	H - DRUGS/IV SOLUTIONS	45.00		4 (40 005			
1. 00	TOTALS			4, 640, 385 4, 640, 385			1. 00
	I - MI SCELLANEOUS		U _I	4, 640, 385			
1. 00	OTHER ADMINISTRATIVE AND	5. 03	2, 163, 909	2, 243, 838	ol		1.00
1.00	GENERAL	0.00	2, 100, 707	2,210,000			1.00
2.00		0.00	O	C	o		2. 00
	TOTALS		2, 163, 909	2, 243, 838			
	J - RADIOLOGY COSTS						
1. 00	CT_SCAN	<u>57.</u> 00		67,567			1. 00
	TOTALS		0	67, 567			
1 00	K - DIETARY	10.00	470.000	F00, 201			1 00
1. 00	TOTALS		47 <u>9, 0</u> 83 479, 083	59 <u>8, 2</u> 91 598, 291			1. 00
	L - MISC DEPT RECLASS		4/9,003	390, 291			
1.00	OTHER ADMINISTRATIVE AND	5. 03	549, 112	65, 731	O		1.00
	GENERAL	0.00	3177112	00,70.			
2.00	ADULTS & PEDIATRICS	30.00	931	C	o		2. 00
3.00	SUBPROVI DER - I PF	40.00	94	7	0		3. 00
4.00	SKILLED NURSING FACILITY	44. 00	0	65			4. 00
5.00	RECOVERY ROOM	51.00	1, 891, 611	574, 838	1		5. 00
6.00	ANESTHESI OLOGY	53.00	0	185			6. 00
7.00	OCCUPATI ONAL THERAPY	67.00	99, 036	7, 689			7. 00
8.00	SPEECH PATHOLOGY	68.00	66, 378	6, 737	1		8. 00
9. 00	AMBULANCE SERVICES TOTALS	<u> </u>	2, 281	12 <u>3, 6</u> 91			9. 00
	M - LABOR & DELIVERY COSTS		2, 609, 443	778, 943			
1. 00	ADULTS & PEDIATRICS	30.00	3, 107, 756	C	0		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0, 107, 730	227, 019			2. 00
3. 00		0.00	ol	C	o		3. 00
	TOTALS		3, 107, 756	227, 019	T 1		1
	·	•	·		·		

Health Financial Systems RECLASSIFICATIONS DUPONT HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet A-6 | From 04/01/2017 | To 03/31/2018 | Date/Time Prepared: Provider CCN: 15-0150

						8/31/2018 1	2:02 pm_
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	N - REPAIRS & MAINTENANCE						
1.00	OTHER ADMINISTRATIVE AND	5. 03	0	42, 283	(1. 00
	GENERAL						
2.00	DI ETARY	10. 00	0	327	()	2. 00
3.00	NURSING ADMINISTRATION	13. 00	0	153	()	3. 00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	0	43, 529	(4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	2, 604	. (5. 00
6.00	INTENSIVE CARE UNIT	31.00	0	1, 148	(6. 00
7.00	NEONATAL INTENSIVE CARE UNIT	31. 01	0	2, 887	()	7. 00
8.00	NURSERY	43.00	0	31	(8. 00
9.00	OPERATING ROOM	50.00	0	123, 322	. (9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	18, 338	(10. 00
11.00	RADI OI SOTOPE	56.00	0	3, 150	(11. 00
12.00	MRI	58. 00	0	1, 440	(12. 00
13.00	LABORATORY	60.00	0	8, 320	(13. 00
14.00	RESPIRATORY THERAPY	65.00	0	894	. (14. 00
15.00	ELECTROCARDI OLOGY	69. 00	0	421	(15. 00
16.00	SLEEP LAB	76. 00	0	6	(16. 00
17. 00	CLINIC	90.00	0	900	(17. 00
18.00	EMERGENCY	91.00	O	2, 454	. (18. 00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	1, 689	(19. 00
	TOTALS	$$ $ \uparrow$	<u> </u>	253, 896			
500.00	Grand Total: Decreases		8, 469, 597	29, 230, 497		7	500. 00

					o 03/31/2018	Date/Time Prep 8/31/2018 12:	pared:
				Acqui si ti ons		0/31/2010 12.	JZ pili
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 732, 541	0	C	0	0	1.00
2.00	Land Improvements	468, 977	0	C	0	0	2.00
3.00	Buildings and Fixtures	55, 761, 046	3, 047	C	3, 047	0	3. 00
4.00	Building Improvements	4, 638, 896	2, 569, 807	C	2, 569, 807	0	4. 00
5.00	Fixed Equipment	3, 909, 841	207, 106	C	207, 106		5. 00
6.00	Movable Equipment	57, 859, 182	4, 566, 774	C	4, 566, 774	1, 760, 734	6. 00
7.00	HIT designated Assets	379, 739	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	124, 750, 222	7, 346, 734	C	7, 346, 734	2, 058, 311	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10. 00	Total (line 8 minus line 9)	124, 750, 222	7, 346, 734	C	7, 346, 734	2, 058, 311	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART 1 ANN VOLO OF OUR POST 11 AND TAL ADD	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				4 00
1.00	Land	1, 732, 541	0				1. 00
2.00	Land Improvements	468, 977	0				2. 00
3. 00	Buildings and Fixtures	55, 764, 093	0				3. 00
4.00	Building Improvements	7, 208, 703	0				4. 00
5.00	Fi xed Equipment	3, 819, 370	0				5. 00
6.00	Movable Equipment	60, 665, 222	0				6. 00
7.00	HIT designated Assets	379, 739	0				7. 00
8.00	Subtotal (sum of lines 1-7)	130, 038, 645	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	130, 038, 645	0				10. 00

Heal th	Health Financial Systems DUPONT HOSPITAL In Lieu of Form CMS-2552-10						
RECONCILIATION OF CAPITAL COSTS CENTERS		20.0	Provider CC	CN: 15-0150	Peri od: From 04/01/2017 To 03/31/2018	Worksheet A-7 Part II	pared:
			SU	JMMARY OF CAP	PITAL		
	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	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 474, 860	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 058, 042	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	5, 532, 902	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	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 474, 860				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4, 058, 042				2. 00
	1	1		I			

0 0 0

1, 474, 860 4, 058, 042 5, 532, 902

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Health Financial Systems	DUPONT HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 04/01/2017 To 03/31/2018	Worksheet A-7 Part III Date/Time Prep 8/31/2018 12:0	
	COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	65, 243, 751 64, 794, 894 130, 038, 645		65, 243, 75 64, 794, 89 130, 038, 64 CAPI TAL	0. 498274	0 0	1. 00 2. 00 3. 00
Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	f Depreciation	Lease	
DART ALL DESCRIPTION OF CARLEY COSTS OF	6.00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS	0		0 2, 047, 730	-89, 326	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 3, 672, 907 0 5, 720, 637	2, 397, 219	2. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)		Total (2) (sum of cols. 9 through 14)	
	11.00	12. 00	13. 00	14. 00	15. 00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	-45, 256 268, 769 223, 513	4, 289		0 0	6, 343, 184	1. 00 2. 00 3. 00

Provider CCN: 15-0150

	To 03/31/2							
				Expense Classification on		8/31/2018 12:0	02 pm	
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.		
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1.00	
	COSTS-BLDG & FLXT (chapter 2)							
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00	
3.00	Investment income - other (chapter 2)		0		0.00	0	3. 00	
4.00	Trade, quantity, and time		0		0. 00	0	4. 00	
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00	
<i>(</i> 00	expenses (chapter 8)		0		0.00	0	4 00	
6. 00	Rental of provider space by suppliers (chapter 8)		U		0.00	U	6. 00	
7.00	Telephone services (pay stations excluded) (chapter	Α	-52, 881	OTHER ADMINISTRATIVE AND GENERAL	5. 03	0	7. 00	
	21)		_			_		
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00	
9.00	Parking Lot (chapter 21)	4.0.2	4 001 272		0. 00	0	9.00	
10. 00	Provider-based physician adjustment	A-8-2	-4, 881, 372			0	10. 00	
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00	
12. 00	Related organization	A-8-1	-589, 535			0	12. 00	
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00	
14.00	Cafeteria-employees and guests		-384, 149	CAFETERI A	11.00	0		
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00	
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00	
47.00	patients						47.00	
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00	
18. 00	Sale of medical records and abstracts	В	-14, 514	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00	
19. 00	Nursing and allied health		0		0.00	0	19. 00	
	education (tuition, fees, books, etc.)							
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0		
21.00	interest, finance or penalty		0		0.00	U	21.00	
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00	
22.00	overpayments and borrowings to				3. 33		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	PHYSICAL 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	Α	572, 870	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00	
27. 00	Depreciation - CAP REL	А	-385, 135	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00	
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00	
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00	
50.00	therapy costs in excess of	7-0-3	U	OCCUPATIONAL THEMAT	67.00		30.00	
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99	
	instructions)	4.0.3						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00	
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00	
	Depreciation and Interest	5						
33. 00	SILVER RECOVERY	В	- 1, 000	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 00	

					03/31/2016	8/31/2018 12:0	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
	T	1.00	2. 00	3.00	4. 00	5. 00	
35. 00		В	•	CAP REL COSTS-BLDG & FIXT	1.00		
36. 00	MISC INCOME	В		OTHER ADMINISTRATIVE AND	5. 03	0	36. 00
		_		GENERAL		_	
38. 00	TRAI NI NG REVENUE	В		NURSING ADMINISTRATION	13. 00		
39. 00	PATIENT PHONE BENEFITS COST	Α	,	EMPLOYEE BENEFITS DEPARTMENT	4.00		
40. 00	PHOTO COMMISSION	В		OTHER ADMINISTRATIVE AND	5. 03	0	40. 00
44 00	DATI FAIT TV EVDENCE			GENERAL OF BLANT	7.00		44 00
41.00	PATIENT TV EXPENSE	A		OPERATION OF PLANT	7. 00		
42. 00	MARKETING EXPENSE	A		OTHER ADMINISTRATIVE AND	5. 03	0	42. 00
42 01	 MARKETING DEPARTMENT			GENERAL OTHER ADMINISTRATIVE AND	5. 03		42. 01
42. 01	WARKETING DEPARTMENT	A		GENERAL	5. 03	0	42.01
43. 00	MI NORI TY I NTEREST	A		OTHER ADMINISTRATIVE AND	5. 03	0	43. 00
43.00	WINORITITIVIEREST	_ ^		GENERAL	5.03	U	43.00
44. 00	PHYSICIAN RECRUITING	A		OTHER ADMINISTRATIVE AND	5. 03	0	44. 00
44.00	THISTOTAL REGROTTING			GENERAL	3.03		44.00
45. 00	LOBBYING EXPENSE	A		OTHER ADMINISTRATIVE AND	5. 03	0	45. 00
	Eddb 11 He E/H EHGE			GENERAL	0.00	Ĭ	10.00
45. 01	CHARI TABLE CONTRI BUTI ONS	A		OTHER ADMINISTRATIVE AND	5. 03	0	45. 01
			•	GENERAL			
45.02	MEALS & ENTERTAINMENT	A	-9, 878	OTHER ADMINISTRATIVE AND	5. 03	0	45. 02
				GENERAL			
45.03	MOB SUPPORT COSTS	A	-484, 006	OTHER ADMINISTRATIVE AND	5. 03	0	45. 03
				GENERAL			
45.04	LEGAL FEES	A	-8, 779	OTHER ADMINISTRATIVE AND	5. 03	0	45. 04
				GENERAL			
50.00	,		-19, 424, 566				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: 15-0150

Peri od: Worksheet A-8-1 From 04/01/2017

OTTTOL				Го 03/31/2018	Date/Time Pre 8/31/2018 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:				CLAI MED	
1.00		OTHER ADMINISTRATIVE AND GEN		261, 157	0	1.00
2.00	•	OTHER ADMINISTRATIVE AND GEN		439, 175	0	2.00
3.00			PASI CAPITAL COSTS	29, 824	0	3.00
4.00	•		PASI CAPITAL COSTS	8, 350	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	POOLED CAPITAL - BLDGS	47, 832	0	4. 01
4.02	2. 00	CAP REL COSTS-MVBLE EQUIP	POOLED CAPITAL - FIXTURES	298, 169	0	4. 02
4.03	5. 03	OTHER ADMINISTRATIVE AND GEN	POOLED ADMIN COSTS	2, 764, 861	0	4. 03
4.04	5. 03	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEES	0	1, 567, 743	4.04
4.05	5. 03	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	6, 403	4. 05
4.06	5. 03	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	225, 639	4.06
4.07	5. 03	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	0	2, 941, 706	4. 07
4. 15	5. 02	CASHIERING/ACCOUNTS RECEIVAB	PASI COLLECTION FEES	0	563, 813	4. 15
4. 16	5. 02	CASHIERING/ACCOUNTS RECEIVAB	PASI LIEN UNIT	0	65, 364	4. 16
4. 17	5. 03	OTHER ADMINISTRATIVE AND GEN	MALPRACTI CE	149, 469	568, 222	4. 17
4. 18	8. 00	LAUNDRY & LINEN SERVICE	LAUNDRY - OPERATING	323, 374	225, 093	4. 18
4. 19	1.00	CAP REL COSTS-BLDG & FIXT	LAUNDRY - CAPITAL	38, 425	175, 125	4. 19
4. 20	1.00	CAP REL COSTS-BLDG & FIXT	DSC BLDG LEASE SJH	627, 201	613, 413	4. 20
4. 22	5. 03	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE ALLOCATION	1, 412, 899	0	4. 22
4. 26	2. 00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	105, 729	143, 479	4. 26
5.00	TOTALS (sum of lines 1-4).			6, 506, 465	7, 096, 000	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	CHS, INC.	72. 03 CHS, INC.	72. 03	6. 00
7.00	В	HOSPITAL LAUNDR	100.00 HOSPITAL LAUNDR	100.00	7. 00
8.00	В	LUTHERAN HEALTH	100.00 LUTHERAN HEALTH	100.00	8. 00
9.00	В	PASI	100. 00 PASI	100.00	9. 00
10.00			0.00	0.00	10. 00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- $\hbox{E. Individual is director, of ficer, administrator, or key person of provider and related organization.}\\$
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

					10 03/31/2016	8/31/2018 12:02 pm	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			ENTS REQUIRED AS A RESULT OF	FRANSACTIONS WITH RELA	TED ORGANIZATIONS OR (CLAIMED	
	HOME OFFICE CO						
1. 00	261, 157					1.0	
2.00	439, 175					2. 0	
3. 00	29, 824					3. 0	
4.00	8, 350					4.0	
4. 01	47, 832					4.0	
4. 02	298, 169					4.0	
4. 03	2, 764, 861					4.0	
4.04	-1, 567, 743	1				4.0	
4. 05	-6, 403					4. 0	
4.06	-225, 639					4. 0	
4.07	-2, 941, 706					4. 0	
4. 15	-563, 813					4. 1	
4. 16	-65, 364					4. 1	
4. 17	-418, 753					4. 1	
4. 18	98, 281					4. 1	
4. 19	-136, 700					4. 1	
4. 20	13, 788					4. 2	
4. 22	1, 412, 899					4. 2	
4. 26	-37, 750					4. 2	
5.00	-589, 535					5. 0	<u>)()</u>
* The	amounts on Lin	es 1-4 (and sub	scripts as appropriate) are to	ansferred in detail to	Worksheet A. column	6 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	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOSPITAL MANAGEMENT	6.00
7.00	LAUNDRY	7.00
8.00	HOSPITAL NETWOR	8.00
9.00	DEBT COLLECTION	9.00
10.00		10.00
100.00		100.00

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

Provider CCN: 15-0150

Peri od: Worksheet A-8-2 From 04/01/2017 To 03/31/2018 Date/Time Prepared:

					8/31/2018 12:02 pm			
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00	13. 00	NURSING ADMINISTRATION	6, 999	6, 99	9 (0	0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	683, 810	683, 81	0 (0	0	2. 00
3.00	31. 01	NEONATAL INTENSIVE CARE UNIT	81, 000	81, 00	0	0	0	3. 00
4.00	52. 00	DELIVERY ROOM & LABOR ROOM	399, 996	399, 99	6 (ol o	0	4. 00
5.00	53. 00	ANESTHESI OLOGY	1, 984, 414	1, 984, 41	4	ol o	0	5. 00
6.00	76. 00	SLEEP LAB	1, 370, 049	1, 370, 04	.9	ol o	0	6. 00
7. 00		EMERGENCY	355, 104				0	7. 00
8. 00	0.00		0		0		0	8. 00
9. 00	0.00		0		0		0	9. 00
10. 00	0.00		0				0	10. 00
200.00	0.00		4, 881, 372	4, 881, 37	2	ál –	1 0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of		Provi der	Physician Cost	
	MRSt. A LITTO "	I denti fi er	Li mi t	Unadiusted RC	E Memberships &		of Malpractice	
		1 40.1111111	2	Limit	Continuing	Share of col.	Insurance	
					Education	12	l mour arroo	
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14.00	
1. 00		NURSING ADMINISTRATION	0		0 (0	1. 00
2.00		ADULTS & PEDIATRICS	0		0		0	1
3. 00	31. 01 NEONATAL INTENSIVE CARE UNIT		0		0		0	3. 00
4. 00	52. OO DELI VERY ROOM & LABOR ROOM		0		0		l o	1
5. 00		ANESTHESI OLOGY	0		0		0	5. 00
6. 00		SLEEP LAB	0				l o	
7. 00		EMERGENCY	0					7. 00
8. 00	0.00		0				0	1
9. 00	0.00							9. 00
10. 00	0.00							
200.00	0.00							200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
	WKSt. A LITIC #	I denti fi er	Component	Li mi t	Di sal I owance	Adj d3 tillerit		
		racittifici	Share of col.		Di Sai i Owanice			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		NURSING ADMINISTRATION	0		0 (1. 00
2. 00		ADULTS & PEDIATRICS	0	1	0	683, 810		2. 00
3. 00	31. 01 NEONATAL INTENSIVE CARE UNIT		0		0	81,000		3. 00
4. 00	52. OO DELI VERY ROOM & LABOR ROOM		0			399, 996		4. 00
5. 00	53. 00 ANESTHESI OLOGY				n n	1, 984, 414		5. 00
6. 00	76. 00 SLEEP LAB				o o	1, 370, 049		6.00
7. 00	91. OOISLEEF EAB					355, 104		7. 00
8. 00	0. 00					333, 104		8. 00
9. 00	0.00					il S		9.00
10. 00	0.00					il i		10.00
200.00	0.00		0		0 0	4, 881, 372		200.00
200.00	I .	l	1	1	υ _l (ار 4,001,372	1	₁ 200.00

Health Financial Systems DUPONT HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0150 Peri od: Worksheet B From 04/01/2017 Part I Date/Time Prepared: 03/31/2018 8/31/2018 12:02 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** ADMITTI NG for Cost **BENEFLTS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 3, 243, 265 3, 243, 265 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 6, 343, 184 6, 343, 184 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6,041,477 8, 377 16, 384 6, 066, 238 4.00 00570 ADMITTING 5 01 2, 439, 084 0 2, 806, 845 5 01 367, 761 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 1, 339, 486 0 0 5.02 16, 411, 601 5.03 00560 OTHER ADMINISTRATIVE AND GENERAL 109, 964 215, 068 387, 267 0 5.03 7.00 00700 OPERATION OF PLANT 4, 031, 245 905, 820 1, 771, 601 113, 455 7.00 0 00800 LAUNDRY & LINEN SERVICE 498, 499 10.151 19, 854 8 00 0 8 00 9.00 00900 HOUSEKEEPI NG 976, 900 83, 029 162, 389 77, 634 0 9.00 01000 DI ETARY 1, 170, 045 119, 345 10.00 10.00 01100 CAFETERI A 30, 774 60, 188 81, 421 11.00 693, 225 0 11.00 01300 NURSING ADMINISTRATION 2,001,418 17, 292 33, 820 307, 812 13.00 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 721, 851 10,850 21, 220 68, 438 0 14.00 01500 PHARMACY 15.00 1,842,584 272, 934 0 15.00 <u>53, 9</u>77 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 977, 269 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 120, 968 670, 532 1, 311, 429 825, 618 165, 966 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 329, 650 98, 053 191, 772 185, 601 10,098 31.00 31.01 31.01

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0150

				Т	o 03/31/2018	Date/Time Pre 8/31/2018 12:	pared:
	Cost Center Description	CASHI ERI NG/ACC	Subtotal	OTHER	OPERATION OF	LAUNDRY &	OZ PIII
		OUNTS RECEI VABLE		ADMINISTRATIVE AND GENERAL	PLANT	LINEN SERVICE	
		5. 02	5A. 02	5. 03	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS				1		
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
5. 01	00570 ADMITTING						5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 339, 486					5. 02
5. 03	00560 OTHER ADMINISTRATIVE AND GENERAL	0	17, 123, 900	17, 123, 900			5. 03
7.00	00700 OPERATION OF PLANT	0	6, 822, 121				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	528, 504	107, 784	37, 573	673, 861	8. 00
9.00	00900 HOUSEKEEPI NG	0	1, 299, 952				9. 00
10.00	01000 DI ETARY	0	1, 289, 390			-	10.00
11.00	01100 CAFETERI A	0	865, 608				11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY		2, 360, 342 1, 822, 359				13. 00 14. 00
15. 00	01500 PHARMACY		2, 115, 518				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	O	1, 031, 246				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1				•	
30.00	03000 ADULTS & PEDIATRICS	79, 211	9, 173, 724				1
31.00	03100 I NTENSI VE CARE UNI T	4, 820	1, 819, 994				31.00
31. 01 40. 00	03101 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	63, 948	4, 488, 237 0				31. 01 40. 00
43. 00	04300 NURSERY	15, 118	1, 792, 999	1	_		1
44. 00	04400 SKILLED NURSING FACILITY	0	0	000,000			44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	441, 377	13, 798, 623			155, 952	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	20 252	2 705 194	· · · · · ·		-	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	28, 252	2, 705, 184 0	551, 698		116, 471 0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	83, 886	3, 512, 487	1	-		54. 00
54. 01	05401 ULTRA SOUND	26, 886	572, 222			0	54. 01
56. 00	05600 RADI OI SOTOPE	7, 695	248, 857	50, 752	0	1	56. 00
57. 00	05700 CT SCAN	0	0	1	-	1	57. 00
58. 00 60. 00	05800 MRI 06000 LABORATORY	17, 668	315, 396			1	58. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	101, 850 19, 210	3, 583, 433 1, 560, 591		·		65.00
66. 00	06600 PHYSI CAL THERAPY	4, 551	427, 554			1	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	C	0	-	68. 00
69. 00	06900 ELECTROCARDI OLOGY	6, 897	43, 330			0	69. 00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	113, 711	2, 293, 854			0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	98, 908 150, 329	9, 381, 814 5, 105, 688			0	73.00
74. 00	07400 RENAL DIALYSIS	1, 301	126, 319				74.00
76. 00	03950 SLEEP LAB	5, 295	387, 490			8, 760	ı
	OUTPATIENT SERVICE COST CENTERS				1		
	09000 CLINIC	5, 285	516, 972				
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	63, 288	2, 824, 714 0		429, 181	69, 913	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS		0	1		L	72.00
95.00	09500 AMBULANCE SERVICES	0	0	C	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS	, ,		,	,	,	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 339, 486	99, 938, 422	16, 889, 264	7, 701, 999	673, 861	1118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 121	636	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES		55, 084				192. 00
	07950 MARKETI NG		0	, <u> ,</u> c	_	0	194. 00
	07951 PHYSICIAN RELATIONS	0	0	C	0		194. 01
	07952 SENI OR CI RCLE	0	0	000 = : :	0		194. 02
194. 03 200. 00	07953 WOMENS RESOURCE CENTER	0	1, 092, 306	222, 766	481, 018	0	194. 03 200. 00
200.00			0	0	0	0	200.00
202.00		1, 339, 486	101, 088, 933	1	-		
				•	•	•	•

Provider CCN: 15-0150

| Peri od: | Worksheet B | From 04/01/2017 | Part | To 03/31/2018 | Date/Time Prepared: | Part | Par

					Т	o 03/31/2018	Date/Time Pre 8/31/2018 12:	
		Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	<u> </u>
		·				ADMI NI STRATI ON	SERVICES &	
			9.00	10.00	11. 00	13.00	SUPPLY 14. 00	
	GENER	AL SERVICE COST CENTERS	7.00	10.00	11.00	13.00	14.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		ADMITTI NG						5. 01
5. 02	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02
5. 03 7. 00	1	OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT						5. 03 7. 00
8. 00		LAUNDRY & LINEN SERVICE						8.00
9. 00		HOUSEKEEPING	1, 872, 377					9. 00
10.00	1	DI ETARY	0	1, 552, 349				10.00
11.00	01100	CAFETERI A	27, 104	O	1, 183, 148			11. 00
13.00	1	NURSING ADMINISTRATION	15, 230	0	54, 762			13. 00
14.00		CENTRAL SERVICES & SUPPLY	9, 556	0	28, 066	1	2, 273, 306	ı
15. 00		PHARMACY	0	0	41, 453	1	26, 028	1
16. 00		MEDICAL RECORDS & LIBRARY IENT ROUTINE SERVICE COST CENTERS	U U	U	23, 033	l U	447	16. 00
30. 00		ADULTS & PEDIATRICS	590, 559	826, 461	206, 371	1, 317, 744	46, 788	30.00
31.00	03100	INTENSIVE CARE UNIT	86, 359	37, 318	41, 954	182, 152	14, 823	31. 00
31. 01	1	NEONATAL INTENSIVE CARE UNIT	124, 594	237, 310	99, 641	490, 630	58, 837	31. 01
40. 00		SUBPROVIDER - I PF	0	0	0	0	0	40. 00
43.00	1	NURSERY	39, 170	163, 090	42, 929		18, 003	1
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	0	l ol	0	44. 00
50.00		OPERATING ROOM	578, 227	O	224, 871	667, 742	374, 188	50.00
51.00	05100	RECOVERY ROOM	0	О	0	0	0	51.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	80, 219	7, 909	57, 030	1
53.00	1	ANESTHESI OLOGY	110 2/0	0	70.410	0	0	53.00
54. 00 54. 01	1	RADI OLOGY-DI AGNOSTI C ULTRA SOUND	119, 368	0	72, 418 14, 152		64, 471 482	54. 00 54. 01
56. 00	1	RADI OI SOTOPE		0	2, 978		13, 007	•
57. 00	1	CT SCAN	Ö	o	0	o	0	1
58.00	05800	MRI	o	o	7, 405	o	2, 288	58. 00
60.00	1	LABORATORY	22, 083	0	83, 197	0	104, 186	1
65. 00	1	RESPI RATORY THERAPY	0	0	39, 213	0	27, 195	1
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	7, 660	0	8, 802 0	0	160 0	66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY		0	0		0	68.00
69. 00	1	ELECTROCARDI OLOGY		ő	184	o	87	69.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	o	o	0	O	240, 478	1
72.00		IMPL. DEV. CHARGED TO PATIENTS	o	o	0	O	1, 171, 302	72. 00
		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
		RENAL DIALYSIS	0	0	0	0	0	74.00
76. 00		SLEEP LAB TIENT SERVICE COST CENTERS	28, 641	0	11, 305	l o	3, 649	76. 00
90. 00		CLI NI C	O	o	11, 253	38, 985	8, 100	90.00
		EMERGENCY	102, 127	0	62, 536			91. 00
		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
		REI MBURSABLE COST CENTERS		ما			0	05.00
		AMBULANCE SERVICES AL PURPOSE COST CENTERS	0	0	0	0	0	95. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	1, 750, 678	1, 264, 179	1, 156, 742	2, 975, 708	2, 270, 299	118. 00
	NONRE	IMBURSABLE COST CENTERS	,	,	,,	, , ,	, ,	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
		PHYSICIANS' PRIVATE OFFICES	7, 237	288, 170	53			192. 00
	1	MARKETING PHYSICIAN RELATIONS		0	5, 798 0	I		194. 00 194. 01
		SENIOR CIRCLE		0	0			194. 01
	1	WOMENS RESOURCE CENTER	114, 462	ő	20, 555	O		194. 03
200.00		Cross Foot Adjustments		ļ				200. 00
201.00		Negative Cost Centers	0	0	0	0		201. 00
202. 00	'	TOTAL (sum lines 118 through 201)	1, 872, 377	1, 552, 349	1, 183, 148	2, 975, 708	2, 273, 306	J2U2. UU

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 04/01/2017 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0150

						o 03/31/2018		pared:
		Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &	8/31/2018 12: Total	OZ PIII
		,		RECORDS &		Residents Cost		
				LI BRARY		& Post Stepdown		
						Adjustments		
			15. 00	16. 00	24. 00	25. 00	26.00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-BLDG & FTXT						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	ADMITTI NG						5. 01
5. 02	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02
5. 03	1	OTHER ADMINISTRATIVE AND GENERAL						5. 03
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00		HOUSEKEEPI NG						9. 00
10.00		DI ETARY						10.00
11.00		CAFETERI A						11.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00	1	PHARMACY	2, 614, 440					15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	1, 265, 039				16. 00
	I NPAT	ENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDI ATRI CS	0	74, 797	16, 800, 153	I .	16, 800, 153	30.00
31. 00 31. 01		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	4, 551	2, 950, 066	I I	2, 950, 066	31. 00 31. 01
40. 00		SUBPROVIDER - IPF	0	60, 385 0	7, 009, 417		7, 009, 417 0	40.00
43. 00	1	NURSERY	o	14, 275	2, 611, 491	1	2, 611, 491	43. 00
44.00		SKILLED NURSING FACILITY	0	0	C	l i	0	44. 00
		LARY SERVICE COST CENTERS						
50. 00 51. 00	1	OPERATING ROOM RECOVERY ROOM	0	416, 976 0	21, 460, 631 0	1	21, 460, 631 0	1
51.00	1	DELIVERY ROOM & LABOR ROOM	0	26, 678	3, 545, 189	- 1	3, 545, 189	•
53. 00		ANESTHESI OLOGY	o	20, 070	0, 010, 107	o o	0, 010, 107	ı
54.00		RADI OLOGY-DI AGNOSTI C	0	79, 212	5, 187, 764	0	5, 187, 764	54. 00
54. 01	1	ULTRA SOUND	0	25, 388	728, 944	I I	728, 944	1
56.00	1	RADI OI SOTOPE	0	7, 266 0	322, 860	0	322, 860	1
57. 00 58. 00	05800	CT SCAN	0	16, 684	406, 095		0 406, 095	57. 00 58. 00
60.00	1	LABORATORY	o	96, 174	4, 712, 684	I I	4, 712, 684	1
65.00	06500	RESPI RATORY THERAPY	0	18, 139	1, 963, 406	I I	1, 963, 406	1
66. 00		PHYSI CAL THERAPY	0	4, 297	567, 859		567, 859	1
67. 00		OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	0	67.00
68. 00 69. 00	1	ELECTROCARDI OLOGY	0	6, 513	58, 951		0 58, 951	68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	o	107, 375	3, 109, 518	I I	3, 109, 518	1
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	93, 396	12, 559, 849	o	12, 559, 849	72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	2, 614, 440	141, 952	8, 903, 339	I I	8, 903, 339	1
74. 00		RENAL DIALYSIS	0	1, 229	153, 310	I I	153, 310	1
76. 00		SLEEP_LAB TIENT_SERVICE_COST_CENTERS	U	5, 000	644, 232	0	644, 232	76.00
90. 00		CLINIC	0	4, 991	685, 733	o	685, 733	90.00
91.00		EMERGENCY	0	59, 761	4, 371, 581		4, 371, 581	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
05 00		REI MBURSABLE COST CENTERS	٥	ما		ا	-	05.00
95. 00		AMBULANCE SERVICES AL PURPOSE COST CENTERS	0	0	C	0	0	95. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2, 614, 440	1, 265, 039	98, 753, 072	. 0	98, 753, 072	118. 00
		IMBURSABLE COST CENTERS	, , , , , , , , , ,	, , , , , , ,	.,,	· · · · · · · · · · · · · · · · · · ·	.,,	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3, 757	I I		190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	392, 212	I I	392, 212	
		MARKETING PHYSICIAN RELATIONS	0	0	5, 798 0	1		194. 00 194. 01
		SENI OR CI RCLE	ol	0	0			194. 02
194. 03	07953	WOMENS RESOURCE CENTER	o	Ō	1, 934, 094	o	1, 934, 094	194. 03
200.00		Cross Foot Adjustments			O	=		200. 00
201.00		Negative Cost Centers	0	1 245 020	101 000 000	0		201. 00
202.00	וי	TOTAL (sum lines 118 through 201)	2, 614, 440	1, 265, 039	101, 088, 933	y 이	101, 088, 933	J2U2. UU

| Period: | Worksheet B | From 04/01/2017 | Part II | To 03/31/2018 | Date/Time Prepared: Provider CCN: 15-0150

					To	03/31/2018	Date/Time Pre	
				CAPI TAL REI	_ATED COSTS		8/31/2018 12:0	02 pm
		Cook Cooker December 1	D:+1	DIDC & FLVT	MVDLE FOULD	Culatatal	EMDL OVEE	
		Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS	0 1	1.00	2.00	2/1	4.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	8, 377	16, 384	24, 761	24, 761	2. 00 4. 00
5. 01		ADMI TTI NG	o	0,377	0	24, 701	1, 502	5. 01
5. 02		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	0	0	5. 02
5. 03 7. 00		OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	0	109, 964 905, 820	· ·	325, 032 2, 677, 421	1, 581 463	5. 03 7. 00
8. 00		LAUNDRY & LINEN SERVICE	o	10, 151		30, 005	0	8. 00
9.00		HOUSEKEEPI NG	0	83, 029		245, 418	317	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	0	0 30, 774	-	0 90, 962	487 332	10. 00 11. 00
13. 00		NURSI NG ADMI NI STRATI ON	o	17, 292		51, 112	1, 257	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	10, 850		32, 070	279	14. 00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	0		0	1, 115 220	15. 00 16. 00
16.00		IENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	J U	υ _l	220	16.00
30.00		ADULTS & PEDIATRICS	0	670, 532		1, 981, 961	3, 371	30. 00
31. 00 31. 01		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	98, 053 141, 466		289, 825 418, 145	758 1, 895	31. 00 31. 01
40. 00		SUBPROVIDER - IPF	0	141, 466	1	410, 143	1, 693	40.00
43. 00		NURSERY	0	44, 474	86, 983	131, 457	752	43. 00
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	ol	656, 527	1, 284, 037	1, 940, 564	3, 587	50. 00
51.00		RECOVERY ROOM	0	0	1	0	0	51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	1, 406	
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	135, 532	265, 073	400, 605	0 1, 279	53. 00 54. 00
54. 01		ULTRA SOUND	Ö	0	0	0	271	54. 01
56.00		RADI OI SOTOPE	0	0	0	0	54	56.00
57. 00 58. 00	05/00	CT SCAN MRI	0	0	0	0	0 136	57. 00 58. 00
60.00	1	LABORATORY	0	25, 073	49, 038	74, 111	1, 083	
65. 00	1	RESPI RATORY THERAPY	0	0	0	0	688	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	8, 697	17, 010	25, 707	215 0	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	0	0	ol	0	68. 00
69. 00	06900	ELECTROCARDI OLOGY	O	0	0	0	12	69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
74. 00		RENAL DI ALYSI S	o	0	Ö	Ö	0	74. 00
76. 00	03950	SLEEP LAB	0	32, 519	63, 602	96, 121	135	76. 00
90. 00	09000	TIENT SERVICE COST CENTERS CLINIC	ol	0	l ol	ol	243	90. 00
91. 00		EMERGENCY	0	115, 956		342, 743	941	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
95. 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	ol	0	O	o	0	95. 00
70.00	SPECIA	AL PURPOSE COST CENTERS	9					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 105, 086	6, 072, 934	9, 178, 020	24, 379	118. 00
190. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	O	ol	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	o	8, 217		24, 288		192. 00
		MARKETI NG	O	0	0	O		194. 00
		PHYSICIAN RELATIONS SENIOR CIRCLE	0	0	0	0		194. 01 194. 02
	1	WOMENS RESOURCE CENTER		129, 962	254, 179	384, 141		194. 02
200.00		Cross Foot Adjustments]			0		200. 00
201.00	1	Negative Cost Centers		2 242 245	-	0 504 440		201. 00
202.00	7	TOTAL (sum lines 118 through 201)	0	3, 243, 265	6, 343, 184	9, 586, 449	24, 761	J2U2. UU

Provider CCN: 15-0150

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 04/01/2017 | Part II |
| To 03/31/2018 | Date/Time Prepared: | 8/31/2018 | 12:02 pm

			''	0 03/31/2016	8/31/2018 12:	
Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	OPERATION OF	LAUNDRY &	
		OUNTS	ADMI NI STRATI VE	PLANT	LINEN SERVICE	
		RECEI VABLE	AND GENERAL	7.00		
CENEDAL CEDVICE COST CENTEDS	5. 01	5. 02	5. 03	7. 00	8. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-BLDG & FIXT						2. 00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00570 ADMITTING	1, 502					5. 01
5. 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 502					5. 02
5. 03 00560 OTHER ADMINISTRATIVE AND GENERAL	0	-	326, 613			5. 02
7. 00 00700 OPERATION OF PLANT	0	1	26, 538			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0		2, 056		44, 433	8. 00
9. 00 00900 HOUSEKEEPI NG	0		5, 057		0	9. 00
10. 00 01000 DI ETARY	0	l o	5, 016		0	10.00
11. 00 01100 CAFETERI A	0	l o	3, 367		0	11. 00
13.00 01300 NURSING ADMINISTRATION	0	l o	9, 182		0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	l c	7, 089	13, 222	100	14. 00
15. 00 01500 PHARMACY	0	0	8, 229	0	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	4, 012	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	80				13, 913	30.00
31.00 03100 INTENSIVE CARE UNIT	5		.,		1, 901	31. 00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	65		17, 459	172, 404	715	31. 01
40. 00 04000 SUBPROVI DER - I PF	0		0	0	0	40. 00
43. 00 04300 NURSERY	15			54, 201	709	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0) 0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	F04		F2 (/F	000 100	10. 283	FO 00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	594 0			800, 109	10, 283	50. 00 51. 00
52. OO 05200 DELIVERY ROOM & LABOR ROOM	29			0	7, 680	52. 00
53. 00 05300 ANESTHESI OLOGY	0		10, 523	0	7, 080	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	85		13, 664	165, 172	3. 944	54. 00
54. 01 05401 ULTRA SOUND	27		2, 226	· ·	0, 744	54. 01
56. 00 05600 RADI OI SOTOPE	8		968		0	56. 00
57. 00 05700 CT SCAN	0		0	0	0	57. 00
58. 00 05800 MRI	18		1, 227	o	0	58. 00
60. 00 06000 LABORATORY	103		13, 940	30, 557	0	60.00
65. 00 06500 RESPIRATORY THERAPY	19	l c	6, 071	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	5	0	1, 663	10, 599	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	7	0	169	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	115		8, 923	l .	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	100		36, 495	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	152	0	19, 861	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	1	0	491	0 (04	0	74.00
76. 00 03950 SLEEP LAB	5	0	1, 507	39, 631	578	76. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	5		2, 011	O	0	90. 00
91. 00 09100 EMERGENCY	64	l e				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	04		10, 900	141, 310	4, 610	91.00
OTHER REIMBURSABLE COST CENTERS			<u> </u>			92.00
95. 00 09500 AMBULANCE SERVICES	0	С	0	0	0	95. 00
SPECIAL PURPOSE COST CENTERS			,, ,	<u> </u>		73.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	') 1,502	С	322, 138	2, 536, 024	44, 433	118. 00
NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , , ,	,		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	12	0	0	190. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	214	10, 014	0	192. 00
194. 00 07950 MARKETI NG	0	0	0	o		194. 00
194.01 07951 PHYSICIAN RELATIONS	0	0	0	0		194. 01
194. 02 07952 SENI OR CI RCLE	0	1	0	0		194. 02
194.03 07953 WOMENS RESOURCE CENTER	0	0	4, 249	158, 384	0	194. 03
200.00 Cross Foot Adjustments			1			200. 00
201.00 Negative Cost Centers	0	0		0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 502	0	326, 613	2, 704, 422	44, 433	202. 00

| Peri od: | Worksheet B | From 04/01/2017 | Part II | To 03/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0150

					Т	o 03/31/2018	Date/Time Pre 8/31/2018 12:	
		Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	OZ PIII
			9.00	10. 00	11. 00	13.00	SUPPLY 14.00	
	GENERA	AL SERVICE COST CENTERS	7,00	10.00	11100	10.00		
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUI P						2.00
4.00	1 1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	1 1	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE						5. 01 5. 02
5. 03		OTHER ADMINISTRATIVE AND GENERAL						5. 03
7.00	1 1	OPERATION OF PLANT						7. 00
8.00		LAUNDRY & LINEN SERVICE						8. 00
9.00	1 1	HOUSEKEEPI NG	351, 980					9. 00
10.00		DI ETARY CAFETERI A	0 5, 095	5, 503	127 2/1			10.00
11. 00 13. 00		NURSI NG ADMI NI STRATI ON	2, 863	0 0	137, 261 6, 353			11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	1, 796	Ö	3, 256		57, 812	
15. 00		PHARMACY	0	O	4, 809		662	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	0	2, 672	0	11	16. 00
		ENT ROUTINE SERVICE COST CENTERS	444 000		00.040		4 400	
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	111, 020 16, 234	2, 930 123	23, 942 4, 867		1, 190 377	30. 00 31. 00
31.00		NEONATAL INTENSIVE CARE UNIT	23, 422	132 841	4, 667 11, 560		1, 496	
40. 00		SUBPROVI DER - I PF	0	0	0		0	40.00
43.00		NURSERY	7, 363	578	4, 980	0	458	
44.00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
		ARY SERVICE COST CENTERS	100 (00	ام	0.4 000		2.547	
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	108, 698	0	26, 090 0	20, 609 0	9, 516 0	50. 00 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	o	9, 306	١	1, 450	
53. 00		ANESTHESI OLOGY	Ö	o	0	0	0	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	22, 439	0	8, 401	1, 914	1, 640	54. 00
54. 01	1 1	ULTRA SOUND	0	0	1, 642		12	54. 01
56. 00		RADI OI SOTOPE	0	0	345		331	56. 00
57. 00 58. 00	05800	CT SCAN	0	0	0 859		0 58	57. 00 58. 00
60.00		LABORATORY	4, 151	0	9, 652		2, 650	60.00
65. 00	1 1	RESPI RATORY THERAPY	0	o	4, 549		692	65. 00
66.00		PHYSI CAL THERAPY	1, 440	0	1, 021	0	4	66. 00
67. 00		OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00		SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	21	0	2 6, 116	69. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	29, 785	
73. 00		DRUGS CHARGED TO PATIENTS	O	Ö	0	Ö	0	73. 00
74.00		RENAL DIALYSIS	0	0	0	0	0	74. 00
76. 00		SLEEP LAB	5, 384	0	1, 312	0	93	76. 00
90. 00		CLINIC COST CENTERS	0	ol	1, 305	1, 203	206	90. 00
		EMERGENCY	19, 198	0	7, 255		986	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	.,,.,,	Ĭ	7,200	3, 100	700	92. 00
	OTHER	REIMBURSABLE COST CENTERS						
95. 00		AMBULANCE SERVICES	0	0	0	0	0	95. 00
110 00		AL PURPOSE COST CENTERS	220 102	4 401	124 107	01 041	E7 72E	110 00
118. 00	NONREI	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	329, 103	4, 481	134, 197	91, 841	57, 735	1118.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	ol	0	o	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	1, 360	1, 022	6	0		192. 00
194.00	07950	MARKETI NG	О	О	673	0	0	194. 00
		PHYSI CI AN RELATIONS	0	0	0	0		194. 01
		SENI OR CI RCLE	0	0	0	0		194. 02
200.00	1 1	WOMENS RESOURCE CENTER Cross Foot Adjustments	21, 517	٥	2, 385	١		194. 03 200. 00
200.00		Negative Cost Centers	0	O	n	0		200.00
202.00	1 1	TOTAL (sum lines 118 through 201)	351, 980	5, 503	137, 261	91, 841	57, 812	
		-	•			,		

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 04/01/2017 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0150

						rom 04/01/2017 o 03/31/2018	Part II Date/Time Pre	
		Cost Center Description	PHARMACY	MEDI CAL RECORDS &	Subtotal	Intern & Residents Cost	8/31/2018 12: Total	OZ DIII
				LI BRARY		& Post Stepdown		
						Adjustments		
	GENER	AL SERVICE COST CENTERS	15. 00	16. 00	24. 00	25. 00	26. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	1	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE						5. 01 5. 02
5. 03		OTHER ADMINISTRATIVE AND GENERAL						5. 03
7.00	1	OPERATION OF PLANT						7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00	1	DI ETARY						10.00
11. 00	1	CAFETERI A						11. 00
13.00	1	NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	14, 815					14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	6, 915				16. 00
		IENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	401 24	3, 032, 341 446, 322		3, 032, 341	30. 00 31. 00
31.00	1	NEONATAL INTENSIVE CARE UNIT		324	663, 469		446, 322 663, 469	31.00
40. 00	1	SUBPROVI DER - I PF	o	0	C	1	0	40. 00
43.00	1	NURSERY	0	77	207, 565	1	207, 565	43. 00
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	0	0	C	0	0	44. 00
50. 00		OPERATING ROOM	0	2, 364	2, 976, 079	0	2, 976, 079	50. 00
51.00	1	RECOVERY ROOM	o	O	C		0	51. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	0	143	30, 781	0	30, 781	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C		0 425	619, 568	٦	0 619, 568	53. 00 54. 00
54. 01	1	ULTRA SOUND	Ö	136	4, 314	l l	4, 314	
56.00	1	RADI OI SOTOPE	0	39	1, 745		1, 745	
57. 00 58. 00	05/00	CT SCAN	0	0 90	2, 388	-	0 2, 388	57. 00 58. 00
60.00	1	LABORATORY		516	136, 763	l l	136, 763	60.00
65.00	1	RESPI RATORY THERAPY	o	97	12, 116		12, 116	65. 00
66. 00	1	PHYSI CAL THERAPY	0	23	40, 677		40, 677	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY		0	C	-	0	67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	Ö	35	246	Ö	246	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	576	15, 730		15, 730	
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0 14, 815	501 762	66, 881 35, 590	1	66, 881 35, 590	72. 00 73. 00
74.00		RENAL DIALYSIS	14, 813	702	499		499	
76. 00		SLEEP LAB	О	27	144, 793	0	144, 793	76. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	0	27	E 000	ا	E 000	90. 00
91.00		EMERGENCY		27 321	5, 000 534, 858		5, 000 534, 858	•
		OBSERVATION BEDS (NON-DISTINCT PART		52.	33.7 333	Ö	33.1, 333	92. 00
05.00		REIMBURSABLE COST CENTERS		a				
95. 00		AMBULANCE SERVICES AL PURPOSE COST CENTERS	0	0	C	0	0	95. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	14, 815	6, 915	8, 977, 725	0	8, 977, 725	118. 00
		IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0	12 36, 906		12 36, 906	190.00
		MARKETI NG		o	673			194. 00
194.01	07951	PHYSICIAN RELATIONS	o	Ō	C	l l	0	194. 01
		SENI OR CI RCLE	0	0	C 574 400	0		194. 02
194. 03 200. 00		WOMENS RESOURCE CENTER Cross Foot Adjustments		O	571, 133 0		571, 133 0	194. 03 200. 00
201.00		Negative Cost Centers	o	o	C	o o	0	201. 00
202. 00)	TOTAL (sum lines 118 through 201)	14, 815	6, 915	9, 586, 449	o	9, 586, 449	202. 00

| Period: | Worksheet B-1 | From 04/01/2017 | To 03/31/2018 | Date/Time Prepared: Provi der CCN: 15-0150

						o 03/31/2018		
			CAPITAL REI	ATED COSTS			8/31/2018 12:	02 pili
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMI TTI NG	CASHI ERI NG/ACC	
		cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	(GROSS CHAR	OUNTS	
					DEPARTMENT	GES)	RECEI VABLE	
					(GROSS SALARI ES)		(GROSS CHAR GES)	
			1.00	2. 00	4. 00	5. 01	5. 02	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	223, 003					1.00
2.00	1	CAP REL COSTS-BEDG & TTXT	223, 003	223, 003				2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	576	576	35, 693, 744			4. 00
5. 01 5. 02		ADMITTING CASHIERING/ACCOUNTS RECEIVABLE	0	0		678, 619, 787 0	678, 619, 787	5. 01 5. 02
5. 02	1	OTHER ADMINISTRATIVE AND GENERAL	7, 561	7, 561	`	1	0/8, 019, 787	5. 02
7.00	1	OPERATION OF PLANT	62, 283		667, 570		0	
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	698 5, 709	ł	•	0	0	8. 00 9. 00
10.00		DI ETARY	0,707	0,707			0	1
11. 00		CAFETERI A	2, 116	l			0	11. 00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	1, 189 746	l			0	13. 00 14. 00
15. 00		PHARMACY	0	0			Ö	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	0	317, 600	0	0	16. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	46, 105	46, 105	4, 857, 947	40, 127, 178	40, 127, 178	30.00
31. 00	03100	INTENSIVE CARE UNIT	6, 742		1, 092, 078	2, 441, 561	2, 441, 561	31. 00
31. 01		NEONATAL INTENSIVE CARE UNIT	9, 727	9, 727			32, 395, 193	
40. 00 43. 00		SUBPROVIDER - IPF NURSERY	0 3, 058	0 3, 058	-	_	0 7, 658, 426	
44. 00	04400	SKILLED NURSING FACILITY	0	0			0	1
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	45, 142	45, 142	E 101 EEG	222 450 204	222 450 204	50.00
51. 00		RECOVERY ROOM	45, 142	45, 142		3 223, 650, 306 0	223, 650, 306 0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2, 026, 132	14, 312, 206	14, 312, 206	1
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0 9, 319	0 9, 319	1, 843, 441	_	0 42, 495, 619	53. 00 54. 00
54. 00	1	ULTRA SOUND	9, 319	9, 319	389, 903		13, 620, 225	1
56.00		RADI OI SOTOPE	0	0	78, 439		3, 898, 303	
57. 00 58. 00	05700 05800	CT SCAN	0	0	195, 306	_	0 8, 950, 393	57. 00 58. 00
60.00		LABORATORY	1, 724	1	1		51, 595, 645	
65. 00	1	RESPI RATORY THERAPY	0	0			9, 731, 420	1
66. 00 67. 00		PHYSICAL THERAPY OCCUPATIONAL THERAPY	598 0	598 0	1		2, 305, 244 0	
68. 00		SPEECH PATHOLOGY	ő	ő		Ö	Ö	
69.00	1	ELECTROCARDI OLOGY	0	0	17, 049		3, 494, 163	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0		57, 604, 452 50, 105, 271	57, 604, 452 50, 105, 271	
73. 00		DRUGS CHARGED TO PATIENTS	Ö	Ö	d		76, 154, 376	
		RENAL DIALYSIS	0	0	104 (01	•		
76. 00		SLEEP LAB TIENT SERVICE COST CENTERS	2, 236	2, 236	194, 681	2, 682, 555	2, 682, 555	76. 00
90.00	09000	CLI NI C	0					
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	7, 973	7, 973	1, 355, 865	32, 060, 712	32, 060, 712	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS						72.00
95. 00	09500	AMBULANCE SERVICES	0	0	C	0	0	95. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	213, 502	213, 502	35, 143, 637	678, 619, 787	678, 619, 787	118 00
110.00		IMBURSABLE COST CENTERS	213,302	213,302	J 33, 143, 037	070,017,707	070,017,707	1110.00
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
		PHYSICIANS' PRIVATE OFFICES MARKETING	565	565 0	1	0		192. 00 194. 00
		PHYSICIAN RELATIONS	o o	Ö		0		194. 00
		SENI OR CI RCLE	0	0	[[0		194. 02
194. 03 200. 00		WOMENS RESOURCE CENTER Cross Foot Adjustments	8, 936	8, 936	549, 112	0	0	194. 03 200. 00
201.00	1	Negative Cost Centers						201. 00
202.00		Cost to be allocated (per Wkst. B,	3, 243, 265	6, 343, 184	6, 066, 238	2, 806, 845	1, 339, 486	202. 00
203. 00		Part Unit cost multiplier (Wkst. B, Part)	14. 543594	28. 444389	0. 169952	0. 004136	0. 001974	203. 00
204.00		Cost to be allocated (per Wkst. B,			24, 761			204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part			0. 000694	0. 000002	0. 000000	205 00
200.00					0.000092	0.00002	0.00000	203.00
						·		

Health Fina	ncial Systems	DUPONT HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provi der Co		Peri od:	Worksheet B-1	
					From 04/01/2017 To 03/31/2018		pared: 02 pm
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMI TTI NG (GROSS CHAR GES)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHAR GES)	
		1. 00	2. 00	4. 00	5. 01	5. 02	
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Provider CCN: 15-0150

	Cost Center Description	Reconciliation	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	8/31/2018 12: HOUSEKEEPI NG (SQUARE FEET)	
		FA 02	(ACCUM. COST)	,	LAUNDRY)	0.00	
	GENERAL SERVICE COST CENTERS	5A. 03	5. 03	7. 00	8. 00	9. 00	
1. 00 2. 00 4. 00 5. 01 5. 02	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE						1. 00 2. 00 4. 00 5. 01 5. 02
5. 02 5. 03 7. 00 8. 00 9. 00	00560 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	-17, 123, 900 0 0	83, 965, 033 6, 822, 121 528, 504 1, 299, 952	152, 583 698	555, 178	146, 176	5. 03 7. 00 8. 00
10. 00 11. 00 13. 00	01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	1, 289, 390 865, 608	0 2, 116	0	0 2, 116	10. 00 11. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY		2, 115, 518	746 0	1, 247	1, 189 746 0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	C	1, 031, 246	0	U	0	16. 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	C	1, 819, 994	6, 742	23, 750	46, 105 6, 742	31.00
31. 01 40. 00 43. 00	03101 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04300 NURSERY		0	0	0	9, 727 0 3, 058	40. 00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	С	0	0	0	0	44. 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	C		45, 142 0	128, 485 0	45, 142 0	51.00
52. 00 53. 00 54. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY O5400 RADI OLOGY-DI AGNOSTI C	C	2, 705, 184 0 3, 512, 487	0	95, 958 0 49, 277	0 0 9, 319	53. 00
54. 01 56. 00	05401 ULTRA SOUND 05600 RADI OI SOTOPE	C	572, 222 248, 857	. 0	0	0	54. 01 56. 00
57. 00 58. 00 60. 00	05700 CT SCAN 05800 MRI 06000 LABORATORY	0	315, 396 3, 583, 433		0	0 0 1, 724	58. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	C	1, 560, 591 427, 554	598	0	0 598	65. 00 66. 00
67. 00 68. 00 69. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	C	0 0 43, 330	0 0	0 0	0 0 0	68. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	C	2, 293, 854 9, 381, 814	0	0	0	71. 00 72. 00
73. 00 74. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03950 SLEEP LAB	0		0	0 0 7, 217	0 0 2, 236	74. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	C					90. 00 91. 00 92. 00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	C	0	0	0	0	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS						
190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3, 121	0	0	0	190. 00
192. 00 194. 00	19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING	C	55, 084 0	565 0	0	0	192. 00 194. 00
	07951 PHYSICIAN RELATIONS 07952 SENIOR CIRCLE	C		0	0		194. 01 194. 02
200.00	, ,	C	1, 092, 306	8, 936	0	8, 936	194. 03 200. 00
201. 00 202. 00			17, 123, 900	8, 213, 431	673, 861	1, 872, 377	201. 00
203. 00 204. 00			0. 203941 326, 613				
205. 00	Unit cost multiplier (Wkst. B, Part		0. 003890	17. 724268	0. 080034	2. 407919	
206. 00 207. 00	(per Wkst. B-2)						206. 00 207. 00
	Parts III and IV)						<u> </u>

In Lieu of Form CMS-2552-10 Health Financial Systems DUPONT HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0150 Peri od: Worksheet B-1 From 04/01/2017 03/31/2018 Date/Time Prepared: 8/31/2018 12:02 pm Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI ON (MEALS SERVED) (FTES) SERVICES & (COSTED **SUPPLY** REQUIS.) (NURSING FT (COSTED REQUIS.) ES) 10.00 11.00 13.00 14.00 15.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5.01 5. 01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 5.02 00560 OTHER ADMINISTRATIVE AND GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 123, 339 10.00 11.00 01100 CAFETERI A 44, 896 11.00 13.00 01300 NURSING ADMINISTRATION 0 2,078 16, 973, 196 13.00 01400 CENTRAL SERVICES & SUPPLY 1.065 17, 745, 562 14 00 0 14 00 0 1, 573 15.00 01500 PHARMACY 0 0 203, 175 4, 640, 385 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 874 0 3, 490 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 65,665 7,831 7, 516, 299 365, 228 0 30.00 03100 INTENSIVE CARE UNIT 2, 965 1, 592 1, 038, 980 115, 707 0 31.00 31.00 31.01 03101 NEONATAL INTENSIVE CARE UNIT 18, 855 3, 781 2, 798, 517 459, 283 31.01 0 04000 SUBPROVI DER - I PF 40 00 40 00 0 0 43.00 04300 NURSERY 12, 958 1,629 0 140, 533 0 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 808, 750 2, 920, 924 50.00 8, 533 0 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 3,044 45, 112 445, 178 0 52.00 0 05300 ANESTHESI OLOGY 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2.748 353.766 503, 265 0 54.00 0 05401 ULTRA SOUND 537 3, 763 54.01 54.01 C 0 05600 RADI OI SOTOPE 56.00 113 0 101, 537 56.00 57.00 05700 CT SCAN 000000000 0 57.00 0 Γ 05800 MRI 0 58 00 281 17, 860 0 58.00 06000 LABORATORY 813, 282 60.00 3, 157 60.00 65.00 06500 RESPIRATORY THERAPY 1, 488 0 212, 285 65.00 06600 PHYSI CAL THERAPY 66.00 0 66.00 334 1, 249 0 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 677 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 1, 877, 183 71.00 C Λ 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 9, 143, 263 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 640, 385 73.00 07400 RENAL DIALYSIS 0 74.00 C 0 0 74.00 03950 SLEEP LAB 76.00 429 0 28, 487 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 427 222, 367 63, 229 0 90.00 09100 EMERGENCY 0 91 00 2, 373 1.189.405 302, 487 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 95.00 95.00 0 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100, 443 43, 894 16, 973, 196 17, 722, 085 4, 640, 385 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 22,896 0 158 0 192.00 194. 00 07950 MARKETI NG 220 0 0 194.00 0 194. 01 07951 PHYSICIAN RELATIONS 0 0 0 0 194. 01 C 194. 02 07952 SENI OR CIRCLE 0 0 0 194 02 C 0 194. 03 07953 WOMENS RESOURCE CENTER 0 780 0 23, 319 0 194, 03 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 2, 975, 708 1, 552, 349 2, 273, 306 2, 614, 440 202. 00 202.00 Cost to be allocated (per Wkst. B, 1, 183, 148 Part I) Unit cost multiplier (Wkst. B, Part I) 12. 586035 0.175318 0. 128106 0. 563410 203. 00 203.00 26. 353083 204.00 Cost to be allocated (per Wkst. B, 5,503 137, 261 91, 841 57, 812 14, 815 204. 00

3 057310

0.044617

0.005411

0.003258

0.003193 205.00

206.00

205 00

206.00

Part II)

(per Wkst. B-2)

II)

Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated

Heal th Financi	al Systems	DUPONT HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATIO	ON - STATISTICAL BASIS		Provi der C		Period: From 04/01/2017	Worksheet B-1	
					To 03/31/2018	Date/Time Pre 8/31/2018 12:	
Co	ost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)	(FTES)	ADMI NI STRATI O	N SERVICES &	(COSTED	
					SUPPLY	REQUIS.)	
				(NURSING FT	(COSTED		
				ES)	REQUIS.)		
		10.00	11. 00	13.00	14. 00	15. 00	
	AHE unit cost multiplier (Wkst. D, arts III and IV)						207. 00

Health Financial Systems DUPONT HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0150 Period: Worksheet B-1

From 04/01/2017 To 03/31/2018 Date/Time Prepared: 8/31/2018 12:02 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHAR GES) 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5.01 5. 01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 5.02 00560 OTHER ADMINISTRATIVE AND GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 01000 DI ETARY 10.00 10.00 11. 00 01100 CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 678, 619, 787 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 40, 127, 178 30.00 03100 INTENSIVE CARE UNIT 2, 441, 561 31.00 31.00 31. 01 03101 NEONATAL INTENSIVE CARE UNIT 32, 395, 193 31.01 40. 00 | 04000 | SUBPROVI DER - I PF 40 00 0 43.00 04300 NURSERY 7, 658, 426 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 223, 650, 306 50 00 51.00 05100 RECOVERY ROOM 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 14, 312, 206 52.00 05300 ANESTHESI OLOGY 53.00 53.00 54. 00 | 05400 | RADI OLOGY - DI AGNOSTI C 42, 495, 619 54.00 54.01 05401 ULTRA SOUND 13, 620, 225 54.01 05600 RADI OI SOTOPE 56.00 3, 898, 303 56.00 57.00 05700 CT SCAN 57.00 8, 950, 393 05800 MRI 58 00 58 00 60.00 06000 LABORATORY 51, 595, 645 60.00 06500 RESPIRATORY THERAPY 65.00 9, 731, 420 65.00 06600 PHYSI CAL THERAPY 2, 305, 244 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 3, 494, 163 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 57, 604, 452 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 50, 105, 271 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 76, 154, 376 73.00 07400 RENAL DIALYSIS 74.00 659, 156 74.00 03950 SLEEP LAB 76.00 2, 682, 555 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 677, 383 90.00 09100 EMERGENCY 32, 060, 712 91.00 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 678, 619, 787 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 194. 00 07950 MARKETI NG 0 194.00 194. 01 07951 PHYSICIAN RELATIONS 0 194.01 0 194. 02 07952 SENI OR CIRCLE 194 02 194. 03 07953 WOMENS RESOURCE CENTER 0 194. 03 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 1, 265, 039 202.00 Cost to be allocated (per Wkst. B, 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.001864 203.00 204.00 Cost to be allocated (per Wkst. B, 6, 915 204.00 Part II) 205. 00 205 00 0.000010 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

Health Financial Systems	DUPONT HO	SPI TAL	In Lieu of Form CMS-2552-1			
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0150	Peri od: From 04/01/2017	Worksheet B-1		
				Date/Time Prepared: 8/31/2018 12:02 pm		
Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS CHAR GES) 16.00					
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207. 00		

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0150	Peri od: Worksheet C From 04/01/2017 Part I To 03/31/2018 Date/Time Prepared:

					To 03/31/2018	Date/Time Pre 8/31/2018 12:	pared: 02 pm
			Title	XVIII	Hospi tal	PPS	
			<u>'</u>		Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	16, 800, 153		16, 800, 15	3 0	16, 800, 153	30.00
31. 00	03100 I NTENSI VE CARE UNI T	2, 950, 066		2, 950, 06		2, 950, 066	
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	7, 009, 417		7, 009, 41		7, 009, 417	
40. 00	04000 SUBPROVI DER - I PF	0		.,,	0	0	1
43. 00	04300 NURSERY	2, 611, 491		2, 611, 49	1 0	2, 611, 491	1
44. 00	04400 SKILLED NURSING FACILITY	ol		, , , , ,	0	0	1
	ANCILLARY SERVICE COST CENTERS	-1			-		
50.00	05000 OPERATI NG ROOM	21, 460, 631		21, 460, 63	1 0	21, 460, 631	50.00
51. 00	05100 RECOVERY ROOM	o		,	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 545, 189		3, 545, 18	9 0	3, 545, 189	52. 00
53.00	05300 ANESTHESI OLOGY	o			0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 187, 764		5, 187, 76	4 0	5, 187, 764	54.00
54. 01	05401 ULTRA SOUND	728, 944		728, 94	4 0	728, 944	54. 01
56.00	05600 RADI OI SOTOPE	322, 860		322, 86	0 0	322, 860	56. 00
57.00	05700 CT SCAN	o			0 0	0	57. 00
58.00	05800 MRI	406, 095		406, 09	5 0	406, 095	58. 00
60.00	06000 LABORATORY	4, 712, 684		4, 712, 68	4 0	4, 712, 684	60.00
65.00	06500 RESPIRATORY THERAPY	1, 963, 406	0	1, 963, 40	6 0	1, 963, 406	65. 00
66.00	06600 PHYSI CAL THERAPY	567, 859	0	567, 85	9 0	567, 859	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	o	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	58, 951		58, 95	1 0	58, 951	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 109, 518		3, 109, 51	8 0	3, 109, 518	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	12, 559, 849		12, 559, 84	9 0	12, 559, 849	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 903, 339		8, 903, 33	9 0	8, 903, 339	73. 00
74.00	07400 RENAL DIALYSIS	153, 310		153, 31	0	153, 310	74.00
76.00	03950 SLEEP LAB	644, 232		644, 23	2 0	644, 232	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	685, 733		685, 73	3 0	685, 733	90.00
91.00	09100 EMERGENCY	4, 371, 581		4, 371, 58	1 0	4, 371, 581	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 144, 358		3, 144, 35	8	3, 144, 358	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0			0 0	0	
200.00		101, 897, 430	0	,		101, 897, 430	
201.00		3, 144, 358		3, 144, 35		3, 144, 358	
202.00	Total (see instructions)	98, 753, 072	0	98, 753, 07	2 0	98, 753, 072	202. 00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0150	Peri od: Worksheet C
		From 04/01/2017 Part I

				Т	o 03/31/2018	Date/Time Pre 8/31/2018 12:	
			Title	XVIII	Hospi tal	PPS	02 piii
			Charges	7,0111	nospi tui	110	
	Cost Center Description	Inpati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	occi contor boson pri on	i i i pa ti oii t	output. ont	+ col . 7)	Ratio	Inpatient	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	26, 316, 020		26, 316, 020			30.00
31.00	03100 INTENSIVE CARE UNIT	2, 441, 561		2, 441, 561			31. 00
31. 01	03101 NEONATAL INTENSIVE CARE UNIT	32, 395, 193		32, 395, 193			31. 01
40. 00	04000 SUBPROVI DER - I PF	0		0_, 0.10, 1.10			40.00
43. 00	04300 NURSERY	7, 658, 426		7, 658, 426	,		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		0)		44. 00
	ANCI LLARY SERVI CE COST CENTERS			-			1
50.00	05000 OPERATING ROOM	40, 493, 577	183, 156, 729	223, 650, 306	0. 095956	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0	0			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	14, 312, 206	0	14, 312, 206		0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0	0	0.000000	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 042, 708	36, 452, 911	42, 495, 619		0. 000000	
54. 01	05401 ULTRA SOUND	2, 871, 843	10, 748, 382	13, 620, 225		0. 000000	
56. 00	05600 RADI OI SOTOPE	243, 171	3, 655, 132	3, 898, 303		0. 000000	
57. 00	05700 CT SCAN	0	0,000,102	0,0,0,000		0. 000000	
58. 00	05800 MRI	536, 803	8, 413, 590	8, 950, 393		0. 000000	
60.00	06000 LABORATORY	21, 559, 363	30, 036, 282			0. 000000	
65. 00	06500 RESPI RATORY THERAPY	8, 432, 834	1, 298, 586			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	2, 009, 405	295, 839			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	2,007,100	0	2,000,211		0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0	Ö	0. 000000	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	802, 407	2, 691, 756	3, 494, 163		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 636, 271	44, 968, 181	57, 604, 452		0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	12, 731, 544	37, 373, 727	50, 105, 271		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	33, 699, 632	42, 454, 744			0. 000000	
74. 00	07400 RENAL DIALYSIS	592, 078	67, 078			0. 000000	
76. 00	03950 SLEEP LAB	38, 500	2, 644, 055			0. 000000	
70.00	OUTPATIENT SERVICE COST CENTERS	30, 300	2,044,000	2,002,000	0. 240130	0.00000	70.00
90.00	09000 CLINI C	28, 874	2, 648, 509	2, 677, 383	0. 256121	0. 000000	90.00
91. 00	09100 EMERGENCY	4, 595, 849	27, 464, 863			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 043, 975	12, 767, 183			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	1,043,773	12, 707, 103	13, 011, 130	0. 227000	0.00000	1 /2.00
95. 00	09500 AMBULANCE SERVICES		0	0	0. 000000	0. 000000	95. 00
200.00		231, 482, 240	447, 137, 547	678, 619, 787		0.000000	200. 00
200.00	, ,	251, 402, 240	777, 137, 347	370,017,707			201. 00
202.00		231, 482, 240	447, 137, 547	678, 619, 787	,		202. 00
202.00	1. otal (300 mistraotrons)	201, 402, 240	117, 137, 347	0,0,017,707	1		1-02.00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0150	Peri od: From 04/01/2017 To 03/31/2018 Date/Time Prepared: 8/31/2018 12:02 pm

				8/31/2018 12:	02 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNIT					31. 00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT					31. 01
40. 00 04000 SUBPROVI DER - I PF					40. 00
43. 00 04300 NURSERY					43. 00
44. 00 O4400 SKILLED NURSING FACILITY					44. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 095956				50. 00
51.00 05100 RECOVERY ROOM	0. 000000				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 247704				52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 122078				54. 00
54. 01 05401 ULTRA SOUND	0. 053519				54. 01
56. 00 05600 RADI 0I SOTOPE	0. 082821				56. 00
57.00 05700 CT SCAN	0. 000000				57. 00
58. 00 05800 MRI	0. 045372				58. 00
60. 00 06000 LABORATORY	0. 091339				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 201759				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 246334				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. 016871				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 053981				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 250669				72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 116912				73. 00
74. 00 07400 RENAL DI ALYSI S	0. 232585				74. 00
76. 00 03950 SLEEP LAB	0. 240156				76. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 256121				90. 00
91. 00 09100 EMERGENCY	0. 136353				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 227668				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	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0150	Period: Worksheet C From 04/01/2017 Part I
		To 03/31/2018 Date/Time Prepared

			T	o 03/31/2018	Date/Time Pre 8/31/2018 12:	
		Ti tl	e XIX	Hospi tal	PPS	02 piii
		11.61	5 //.	Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost conten boscii pti on	(from Wkst. B,	Adj.	Total oosts	Di sal I owance	10141 00313	
	Part I, col.	7.00		Di Gai i Gilanos		
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			0.00			
30. 00 03000 ADULTS & PEDI ATRI CS	16, 800, 153		16, 800, 153	ol	16, 800, 153	30.00
31. 00 03100 INTENSIVE CARE UNIT	2, 950, 066		2, 950, 066		2, 950, 066	31. 00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT	7, 009, 417		7, 009, 417		7, 009, 417	31. 01
40. 00 04000 SUBPROVI DER - I PF	0		0	ol	0	40. 00
43. 00 04300 NURSERY	2, 611, 491		2, 611, 491	ol	2, 611, 491	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	l .	0	أم	0	44. 00
ANCI LLARY SERVICE COST CENTERS				٥١		
50. 00 05000 OPERATI NG ROOM	21, 460, 631		21, 460, 631	O	21, 460, 631	50. 00
51. 00 05100 RECOVERY ROOM	0		0	ol	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 545, 189		3, 545, 189	o	3, 545, 189	52. 00
53. 00 05300 ANESTHESI OLOGY	0		0	o	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 187, 764		5, 187, 764	أم	5, 187, 764	54.00
54. 01 05401 ULTRA SOUND	728, 944		728, 944		728, 944	54. 01
56. 00 05600 RADI 0I SOTOPE	322, 860		322, 860		322, 860	56. 00
57. 00 05700 CT SCAN	0		0	o	022,000	57. 00
58. 00 05800 MRI	406, 095		406, 095	o	406, 095	58. 00
60. 00 06000 LABORATORY	4, 712, 684		4, 712, 684		4, 712, 684	
65. 00 06500 RESPIRATORY THERAPY	1, 963, 406		1, 963, 406		1, 963, 406	65. 00
66. 00 06600 PHYSI CAL THERAPY	567, 859		567, 859		567, 859	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0077007	1	007,007	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	58, 951		58, 951		58, 951	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 109, 518		3, 109, 518		3, 109, 518	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 559, 849		12, 559, 849		12, 559, 849	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 903, 339		8, 903, 339		8, 903, 339	73. 00
74. 00 07400 RENAL DI ALYSI S	153, 310		153, 310		153, 310	74. 00
76. 00 03950 SLEEP LAB	644, 232		644, 232		644, 232	76. 00
OUTPATIENT SERVICE COST CENTERS	011,202		011,202	<u> </u>	011, 202	70.00
90. 00 09000 CLINIC	685, 733		685, 733	ol	685, 733	90. 00
91. 00 09100 EMERGENCY	4, 371, 581		4, 371, 581		4, 371, 581	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 144, 358		3, 144, 358		3, 144, 358	92. 00
OTHER REIMBURSABLE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
95. 00 09500 AMBULANCE SERVI CES	0		0	0	0	95. 00
200.00 Subtotal (see instructions)	101, 897, 430	0	101, 897, 430	o	101, 897, 430	200. 00
201.00 Less Observation Beds	3, 144, 358		3, 144, 358		3, 144, 358	201. 00
202.00 Total (see instructions)	98, 753, 072	0	98, 753, 072	o	98, 753, 072	202. 00

				o 03/31/2018	Date/Time Prep 8/31/2018 12:0	pared: 02 pm
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·	+ col. 7)	Ratio	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	26, 316, 020		26, 316, 020			30. 00
31.00 03100 INTENSIVE CARE UNIT	2, 441, 561		2, 441, 561			31.00
31.01 03101 NEONATAL INTENSIVE CARE UNIT	32, 395, 193		32, 395, 193	8	 -	31. 01
40. 00 04000 SUBPROVI DER - 1 PF	0					40.00
43. 00 04300 NURSERY	7, 658, 426		7, 658, 426			43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	40, 493, 577	183, 156, 729	223, 650, 306	0. 095956	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0		0.000000	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	14, 312, 206	0	14, 312, 206	0. 247704	0.000000	52. 00
53. 00 05300 ANESTHESI OLOGY	o	0	(0. 000000	0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 042, 708	36, 452, 911	42, 495, 619	0. 122078	0.000000	54.00
54. 01 05401 ULTRA SOUND	2, 871, 843	10, 748, 382	13, 620, 225	0. 053519	0.000000	54. 01
56. 00 05600 RADI 0I SOTOPE	243, 171	3, 655, 132	3, 898, 303	0. 082821	0.000000	56. 00
57. 00 05700 CT SCAN	0	0	C	0. 000000	0.000000	57. 00
58. 00 05800 MRI	536, 803	8, 413, 590	8, 950, 393	0. 045372	0.000000	58. 00
60. 00 06000 LABORATORY	21, 559, 363	30, 036, 282	51, 595, 645	0. 091339	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	8, 432, 834	1, 298, 586	9, 731, 420	0. 201759	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 009, 405	295, 839	2, 305, 244	0. 246334	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0. 000000	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	C	0. 000000	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	802, 407	2, 691, 756	3, 494, 163	0. 016871	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 636, 271	44, 968, 181	57, 604, 452	0. 053981	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 731, 544	37, 373, 727	50, 105, 271	0. 250669	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	33, 699, 632	42, 454, 744	76, 154, 376	0. 116912	0.000000	73. 00
74.00 07400 RENAL DIALYSIS	592, 078	67, 078	659, 156	0. 232585	0.000000	74. 00
76. 00 03950 SLEEP LAB	38, 500	2, 644, 055	2, 682, 555	0. 240156	0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	28, 874	2, 648, 509	2, 677, 383	0. 256121	0.000000	90. 00
91. 00 09100 EMERGENCY	4, 595, 849	27, 464, 863	32, 060, 712	0. 136353	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 043, 975	12, 767, 183	13, 811, 158	0. 227668	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	(0.000000	0.000000	95. 00
200.00 Subtotal (see instructions)	231, 482, 240	447, 137, 547	678, 619, 787	'	ļ	200. 00
201.00 Less Observation Beds					ļ	201. 00
202.00 Total (see instructions)	231, 482, 240	447, 137, 547	678, 619, 787	'		202. 00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C From 04/01/2017 Part I To 03/31/2018 Date/Time Pre	

				8/31/2018 12:02 pm	_
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Rati o				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				30.00	
31.00 03100 INTENSIVE CARE UNIT				31.00	
31.01 03101 NEONATAL INTENSIVE CARE UNIT				31. 01	
40. 00 04000 SUBPROVI DER - PF				40.00	
43. 00 04300 NURSERY				43.00	
44.00 O4400 SKILLED NURSING FACILITY				44. 00	0
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 095956			50.00	
51.00 05100 RECOVERY ROOM	0. 000000			51. 00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 247704			52.00	
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 122078			54.00	
54. 01 05401 ULTRA SOUND	0. 053519			54. 01	
56. 00 05600 RADI 0I SOTOPE	0. 082821			56.00	
57. 00 05700 CT SCAN	0. 000000			57. 00	
58. 00 05800 MRI	0. 045372			58.00	
60. 00 06000 LABORATORY	0. 091339			60.00	
65. 00 06500 RESPIRATORY THERAPY	0. 201759			65. 00	
66. 00 06600 PHYSI CAL THERAPY	0. 246334			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. 016871			69. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 053981			71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 250669			72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 116912			73.00	
74.00 07400 RENAL DIALYSIS	0. 232585			74.00	
76. 00 03950 SLEEP LAB	0. 240156			76. 00	0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 256121			90.00	
91. 00 09100 EMERGENCY	0. 136353			91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 227668			92. 00	0
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	O

Heal th	Financial Systems	DUPONT HOS	SPI TAL	In Lie	u of Form CMS-2552-10
	ATION OF OUTPATIENT SERVICE COST ONS FOR MEDICAID ONLY	TO CHARGE RATIOS NET OF	Provider CCN: 15-0150	From 04/01/2017	Worksheet C Part II Date/Time Prepared:

				''	03/31/2016	8/31/2018 12:	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part)	Wkst. B, Part	Net of Capital	Reduction	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					1	
	05000 OPERATING ROOM	21, 460, 631	2, 976, 079	18, 484, 552	0	0	50. 00
	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	3, 545, 189	30, 781	3, 514, 408	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	5, 187, 764	619, 568		0	0	54. 00
	05401 ULTRA SOUND	728, 944	4, 314		0	0	54. 01
	05600 RADI OI SOTOPE	322, 860	1, 745	321, 115	0	0	56. 00
	05700 CT SCAN	0	0	0	0	0	57. 00
	05800 MRI	406, 095	2, 388	·	0	0	58. 00
60.00	06000 LABORATORY	4, 712, 684	136, 763	4, 575, 921	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	1, 963, 406	12, 116	1, 951, 290	0	0	65. 00
	06600 PHYSI CAL THERAPY	567, 859	40, 677	527, 182	0	0	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	58, 951	246	58, 705	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 109, 518	15, 730	3, 093, 788	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 559, 849	66, 881	12, 492, 968	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 903, 339	35, 590	8, 867, 749	0	0	73. 00
74.00	07400 RENAL DIALYSIS	153, 310	499	152, 811	0	0	74.00
76.00	03950 SLEEP LAB	644, 232	144, 793	499, 439	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	685, 733	5, 000	680, 733	0	0	90.00
91. 00	09100 EMERGENCY	4, 371, 581	534, 858	3, 836, 723	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 144, 358	567, 541	2, 576, 817	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
200.00	Subtotal (sum of lines 50 thru 199)	72, 526, 303	5, 195, 569	67, 330, 734	0	0	200. 00
201.00	Less Observation Beds	3, 144, 358	567, 541	2, 576, 817	0	0	201. 00
202.00	Total (line 200 minus line 201)	69, 381, 945	4, 628, 028		0	0	202. 00

Health Financial Systems	DUPONT HOSP	I TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST REDUCTIONS FOR MEDICALD ONLY	TO CHARGE RATIOS NET OF	Provi der CCN: 15-0150		Worksheet C Part II Date/Time Prepared:

						8/31/2018 12	2: 02 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
			(Worksheet C,				
		Operating Cost	Part I, column	Ratio (col. 6	(
		Reduction	8)	/ col . 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	21, 460, 631	223, 650, 306	0. 095956	5		50. 00
51.00	05100 RECOVERY ROOM	0	0	0. 000000)		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 545, 189	14, 312, 206	0. 24770	4		52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0. 000000)		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 187, 764	42, 495, 619	0. 122078	3		54.00
54. 01	05401 ULTRA SOUND	728, 944	13, 620, 225	0. 053519	9		54. 01
56. 00	05600 RADI 0I SOTOPE	322, 860	3, 898, 303	0. 08282	1		56.00
57. 00	05700 CT SCAN	0	0	0. 000000	O		57. 00
58. 00	05800 MRI	406, 095	8, 950, 393	0. 045372	2		58. 00
60. 00	06000 LABORATORY	4, 712, 684	51, 595, 645	0. 091339	9		60.00
65. 00	06500 RESPI RATORY THERAPY	1, 963, 406	9, 731, 420	0. 20175	9		65. 00
66. 00	06600 PHYSI CAL THERAPY	567, 859	2, 305, 244	0. 246334	4		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0. 000000	O		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0. 000000)		68. 00
69. 00	06900 ELECTROCARDI OLOGY	58, 951	3, 494, 163	0. 01687 ⁻	1		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 109, 518	57, 604, 452	0. 05398 ⁻	1		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 559, 849	50, 105, 271	0. 25066	9		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	8, 903, 339	76, 154, 376	0. 116912	2		73. 00
74. 00	07400 RENAL DIALYSIS	153, 310	659, 156	0. 23258!	5		74. 00
76. 00	03950 SLEEP LAB	644, 232	2, 682, 555	0. 24015	5		76. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	685, 733	2, 677, 383	0. 25612	1		90.00
91. 00	09100 EMERGENCY	4, 371, 581	32, 060, 712	0. 136353	3		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 144, 358	13, 811, 158	0. 227668	3		92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	0	0.000000)		95. 00
200.00	l l	72, 526, 303	609, 808, 587				200.00
201. 00		3, 144, 358	0				201. 00
202.00	l l	69, 381, 945	609, 808, 587				202. 00
	1 1 1 (1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2		, ,	1	1		,

	DUDOUT 11	2021 711			6.5. 040	
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS DUPONT HO	Provi der C		Period: From 04/01/2017 To 03/31/2018	worksheet D Part I Date/Time Pre 8/31/2018 12:	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col		Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2, 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 ADULTS & PEDIATRICS	3, 032, 341	0	0,002,01			
31. 00 I NTENSI VE CARE UNI T	446, 322	l e	446, 32			
31. 01 NEONATAL INTENSIVE CARE UNIT	663, 469		663, 46			
40. 00 SUBPROVI DER - I PF	0	0		0 0	0.00	
43. 00 NURSERY	207, 565		207, 56	5 4, 357		
44.00 SKILLED NURSING FACILITY	0			0	0.00	44. 00
200.00 Total (lines 30 through 199)	4, 349, 697		4, 349, 69	7 24, 148		200. 00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 878		•			30.00
31.00 INTENSIVE CARE UNIT	210	73, 168				31. 00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0				31. 01
40. 00 SUBPROVI DER - I PF	0	0				40. 00
43. 00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
200.00 Total (lines 30 through 199)	2, 088	524, 996				200. 00

lealth Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVIC	DUPONT H	Provider C		Period: From 04/01/2017 To 03/31/2018		pared
		Title	XVIII	Hospi tal	8/31/2018 12: PPS	UZ pm
Cost Center Description	Capi tal	Total Charges			Capital Costs	
out deliter beach per en		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col		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	2, 976, 079	223, 650, 306	0. 01330	5, 558, 789	73, 971	50.0
1.00 05100 RECOVERY ROOM	0	0	0. 00000	00	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	30, 781	14, 312, 206	0. 00215	23, 226	50	52. (
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	00	0	53. (
64. 00 05400 RADI OLOGY-DI AGNOSTI C	619, 568	42, 495, 619	0. 01458	1, 949, 951	28, 430	54. (
54. 01 05401 ULTRA SOUND	4, 314	13, 620, 225	0.0003	764, 362	242	54. (
66. 00 05600 RADI OI SOTOPE	1, 745	3, 898, 303	0. 00044	110, 644	50	56. (
7. 00 05700 CT SCAN	0		ı	00 0	0	57. (
58. 00 05800 MRI	2, 388	8, 950, 393	0. 00026	152, 500	41	58. (
50. 00 06000 LABORATORY	136, 763	51, 595, 645	0.00265	4, 081, 623	10, 820	60. (
55. 00 06500 RESPIRATORY THERAPY	12, 116	9, 731, 420	0. 00124	1, 601, 892	1, 994	65. (
66. 00 06600 PHYSI CAL THERAPY	40, 677	2, 305, 244	0. 01764		9, 620	66. (
7. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000	00 0	0	67. (
8. 00 06800 SPEECH PATHOLOGY	0	0	0. 00000	00	0	68. (
9. 00 06900 ELECTROCARDI OLOGY	246	3, 494, 163			23	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PA						
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	66, 881	50, 105, 271				
3.00 07300 DRUGS CHARGED TO PATIENTS	35, 590				3, 142	
4. 00 07400 RENAL DIALYSIS	499		1		· ·	74.
76. 00 03950 SLEEP LAB	144, 793				641	76.
OUTPATIENT SERVICE COST CENTERS	1 11,112					1
00. 00 09000 CLI NI C	5, 000	2, 677, 383	0. 00186	11, 254	21	90.
1. 00 09100 EMERGENCY	534, 858				22, 061	91.
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		13, 811, 158			· ·	92.
OTHER REIMBURSABLE COST CENTERS	, , , , , ,	,	,			1
95. 00 09500 AMBULANCE SERVICES						95.
200.00 Total (lines 50 through 199)	5, 195, 569	609, 808, 587	1	29, 130, 121	172, 034	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COS		CN: 15-0150	Period: From 04/01/2017 To 03/31/2018	Date/Time Pre 8/31/2018 12:	pared: 02 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments		Allied Healt Post-Stepdow Adjustments		Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - IPF 43. 00 04300 NURSERY	000000000000000000000000000000000000000	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	31. 00 31. 01 40. 00
44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	0			0 0		44. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)		Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
NPATI ENT ROUTINE SERVICE COST CENTERS	0	C C C C C C C C C C C C C C C C C C C	12, 66 1, 28 5, 90 4, 38	31 0.00 06 0.00 0 0.00 57 0.00 0 0.00	210 0 0 0 0	31. 00 31. 01 40. 00 43. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	000000000000000000000000000000000000000					30. 00 31. 00 31. 01 40. 00 43. 00 44. 00
200.00 Total (lines 30 through 199)						200.00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANC	LLARY SERVICE OTHER PASS Provider CCN: 15-0150	Peri od: Worksheet D		
THROUGH COSTS		From 04/01/2017 Part IV		

					1	To 03/31/2018	Date/Time Pre 8/31/2018 12:	
				Ti tl	e XVIII	Hospi tal	PPS	<u>02 p</u>
		Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		·		Post-Stepdown		Post-Stepdown		
			Cost	Adjustments		Adjustments		
			1.00	2A	2.00	3A	3. 00	
		LARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	() (0	0	50.00
51.00	05100	RECOVERY ROOM	0			0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0			0	0	52. 00
53.00	05300	ANESTHESI OLOGY	0			0	0	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0			0	0	54.00
54. 01	05401	ULTRA SOUND	0			0	0	54. 01
56.00	05600	RADI OI SOTOPE	0			0	0	56. 00
57.00	05700	CT SCAN	0			o	0	57. 00
58. 00	05800	MRI	0			o	0	58. 00
60.00	06000	LABORATORY	0			o	0	60.00
65.00	06500	RESPI RATORY THERAPY	0			o	0	65. 00
66. 00	06600	PHYSI CAL THERAPY	0			0	0	66. 00
67. 00	06700	OCCUPATI ONAL THERAPY	0			0	0	67.00
68. 00	06800	SPEECH PATHOLOGY	1 0	į (0	0	68. 00
69. 00	06900	ELECTROCARDI OLOGY	1 0	į (0	0	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	0	71. 00
72. 00	07200	IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72.00
73. 00	07300	DRUGS CHARGED TO PATIENTS	0			0	0	73. 00
74. 00	07400	RENAL DIALYSIS	0			0	0	74. 00
76. 00	03950	SLEEP LAB	0			0	0	76. 00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	0			0	0	90.00
91. 00	09100	EMERGENCY	0			0	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
00		REI MBURSABLE COST CENTERS		I		-1	<u> </u>	1 = 00
95. 00		AMBULANCE SERVICES						95. 00
200.00		Total (lines 50 through 199)	0			0	0	200. 00

Health Financial Systems	DUPONT HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider Co		Peri od:	Worksheet D	
THROUGH COSTS				From 04/01/2017 To 03/31/2018	Part IV Date/Time Pre 8/31/2018 12:	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col. 2, 3 and	8)	7)	
			4)			
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0 223, 650, 306	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0		0	0.000000	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 14, 312, 206	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		0 42, 495, 619	0. 000000	54.00
. I I			I	. 1	l	

0

0

o

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

13, 620, 225

3, 898, 303

8, 950, 393

51, 595, 645

9, 731, 420

2, 305, 244

3, 494, 163

57, 604, 452

50, 105, 271

76, 154, 376

2, 682, 555

2, 677, 383

32, 060, 712

13, 811, 158

609, 808, 587

659, 156

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

54.01

56.00

57.00

58.00

60.00

65.00

66.00

67.00

68.00

69.00

71.00

72.00

73.00

74.00

76.00

90.00

91.00

92.00

95.00

200. 00

05401 ULTRA SOUND

05600 RADI OI SOTOPE

06000 LABORATORY

06500 RESPIRATORY THERAPY

06700 OCCUPATI ONAL THERAPY

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07400 RENAL DIALYSIS

03950 SLEEP LAB

09100 EMERGENCY

09000 CLI NI C

05700 CT SCAN

05800 MRI

54.01

56.00

57.00

58.00

60.00

65.00

66.00 67.00

68.00

69.00

71.00

73.00

74.00

76.00

90.00

91.00

92.00

95.00

200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	DUPONT HOS RVI CE OTHER PASS	Provider CO		Period: From 04/01/2017 To 03/31/2018	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 8/31/2018 12:	pared:
		Title	XVIII	Hospi tal	PPS	OZ PIII
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col . 6 ÷ col .	J	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	<u> </u>					
50.00 05000 OPERATING ROOM	0. 000000	5, 558, 789		0 31, 927, 555	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	23, 226		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	1, 949, 951		0 6, 442, 832	0	54.00
54. 01 05401 ULTRA SOUND	0. 000000	764, 362		0 1, 652, 152	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	110, 644		0 788, 911	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0	0	57.00
58. 00 05800 MRI	0. 000000	152, 500		0 1, 547, 268	0	58.00
60. 00 06000 LABORATORY	0. 000000	4, 081, 623		0 3, 077, 436	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 601, 892		0 201, 956	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	545, 206		0 42, 171	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	325, 863		0 530, 966	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 058, 560		0 10, 490, 945	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 202, 475		0 8, 081, 472	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 728, 032		0 10, 261, 999	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	295, 415		0 46, 004	0	74.00
76. 00 03950 SLEEP LAB	0. 000000	11, 874		0 488, 938	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 000000	11, 254		0 645, 560	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 322, 337		0 2, 928, 940	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	386, 118		0 877, 320	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		29, 130, 121		0 80, 032, 425	0	200.00

Health Financial Systems	DUPONT HOSPITAL In Li					2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0150	Peri od:	Worksheet D	
				From 04/01/2017		
				To 03/31/2018	Date/Time Pre	
					8/31/2018 12:	02 pm_
		Title	: XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		

						0/31/2010 12.	UZ PIII
			Ti tl e	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	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.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	0. 095956	31, 927, 555	5	0 0	3, 063, 640	50. 00
51.00 0510	OO RECOVERY ROOM	0. 000000			0 0	0	51.00
52.00 0520	OO DELIVERY ROOM & LABOR ROOM	0. 247704			0 0	0	52. 00
53.00 0530	OO ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54.00 0540	OO RADI OLOGY-DI AGNOSTI C	0. 122078	6, 442, 832	2	0 0	786, 528	54.00
54. 01 0540	01 ULTRA SOUND	0. 053519		1	0	88, 422	1
56. 00 0560	00 RADI OI SOTOPE	0. 082821	788, 911		0	65, 338	
	OO CT SCAN	0. 000000		1	0	0	1
	DO MRI	0. 045372			0	70, 203	
	00 LABORATORY	0. 091339			0	281, 090	
	OO RESPIRATORY THERAPY	0. 201759		1	0	40, 746	1
	00 PHYSI CAL THERAPY	0. 246334	42, 171		0	10, 388	
	OO OCCUPATIONAL THERAPY	0. 000000			0	0	1
	OO SPEECH PATHOLOGY	0. 000000			0	0	1
	00 ELECTROCARDI OLOGY	0. 016871	530, 966		0	8, 958	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 053981	10, 490, 945	1	0	566, 312	
	00 IMPL. DEV. CHARGED TO PATIENTS	0. 250669		1	0	2, 025, 775	
	DO DRUGS CHARGED TO PATIENTS	0. 116912			0	1, 199, 751	
	OO RENAL DIALYSIS	0. 232585		1	o o	10, 700	
	50 SLEEP LAB	0. 240156			o o		
	PATIENT SERVICE COST CENTERS	0. 240130	100, 750	1	0	117, 421	70.00
	OO CLI NI C	0. 256121	645, 560	1	ol o	165, 341	90.00
	DO EMERGENCY	0. 136353			o o	399, 370	
	OO OBSERVATION BEDS (NON-DISTINCT PART	0. 227668		1	0 0		
	R REIMBURSABLE COST CENTERS	0. 227000	077, 320	′1	0 0	177, 730	72.00
	OO AMBULANCE SERVICES	0. 000000			ol		95. 00
200. 00	Subtotal (see instructions)	0.000000	80, 032, 425		0 0	9, 099, 721	
201.00	Less PBP Clinic Lab. Services-Program		00, 032, 423	Ί	0	7,077,721	201. 00
201.00	Only Charges				9		201.00
202. 00	Net Charges (line 200 - line 201)		80, 032, 425		0 0	9, 099, 721	202 00
202.00	INCL Charges (Title 200 - Title 201)		00, 032, 423	ין	u _l 0	7, 099, 721	1202.00

Health Financial Systems	DUPONT H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provi der CO	CN: 15-0150	Period: From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Pre 8/31/2018 12:	pared: 02 pm
		Title	XVIII	Hospi tal	PPS	
	Co:	sts				
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				

Services Subject To Ded. & Coin s. Cose inst.) Subject To Ded. & Coin s. Cose inst.) Subject To Subject To Ded. & Coin s. Cose inst. Ded. & Coin s.		Cost Center Description	Cost	Cost	
Subject To Ded. & Col ns. Ded. & Col ns. Csee inst.) Ded. & Col ns. Csee inst.)			Rei mbursed	Rei mbursed	
Ded. & Coins. See inst.					
See inst. (see inst.)					
ANCILLARY SERVICE COST CENTERS					
ANCILLARY SERVICE COST CENTERS					
50.00	-	ANCILLARY SERVICE COST CENTERS	0.00	7.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 53	į		0	0	50.00
53. 00 05300 ANESTHESI OLOGY 0 0 0 53 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54. 01 05401 ULTRA SOUND 0 0 0 55. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 55. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 55. 00 05500 RADI OLOGY-DI AGNOSTI C 0 0 0 57. 00 05500 RADI OLOGY-DI AGNOSTI C 0 0 0 58. 00 05800 MRI 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 66. 00 06600 PHSY CAL THERAPY 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72. 00 07300 DRIGS CHARGED TO PATI ENTS 0 0 73. 00 07300 DRIGS CHARGED TO PATI ENTS 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 75. 00 07400 RENAL DI ALYSIS 0 0 76. 00 07400 RENAL DI ALYSIS 0 0 77. 00 07400 RENAL DI ALYSIS 0 0 78. 00 09000 CLI NI C 0 0 79. 00 09000 EMERGENCY 0 0 79. 00 09100 EMERGENCY 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 70THER REI MBURSABLE COST CENTERS 95 70 00000 OS 00000 00000 00000 000000 000000		1. 00 05100 RECOVERY ROOM	0	o	51.00
54. 00	ļ	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o	52. 00
54. 01 05401 ULTRA SOUND 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 55700 CT SCAN 0 05700 CT SCAN 0 05800 MRI 0 0 0 0 0 0 558 60. 00 65000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ļ	3. 00 05300 ANESTHESI OLOGY	0	o	53. 00
56.00	į	64. 00 05400 RADI OLOGY-DI AGNOSTI C	0	o	54.00
57. 00	ļ	64. 01 05401 ULTRA SOUND	0	o	54. 01
58. 00	ļ	66. 00 05600 RADI OI SOTOPE	0	o	56. 00
60. 00	į	57. 00 05700 CT SCAN	0	o	57.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 650 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74. 00 07400 RENAL DI ALYSIS 0 0 0 76. 00 03950 SLEEP LAB 0 0 0 77. 00 09000 CLI NI C 0 0 78. 00 09000 CLI NI C 0 0 79. 00 09000 CLI RIC COST CENTERS 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 75. 00 09500 AMBULANCE SERVI CES 0 76. 00 09500 AMBULANCE SERVI CES 0 77. 00 09500 Less PBP Cli ni c Lab. Servi ces-Program 0 78. 00 00 00 00 79. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 00 70. 00 00 00 70. 00 00 00 00 70. 00 00 00 00	į	88. 00 05800 MRI	0	o	58. 00
66. 00	(0. 00 06000 LABORATORY	0	o	60.00
67. 00	(5. 00 06500 RESPIRATORY THERAPY	0	o	65. 00
68. 00	(6. 00 06600 PHYSI CAL THERAPY	0	o	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0		57. 00 06700 OCCUPATI ONAL THERAPY	0	o	67. 00
71. 00		8. 00 06800 SPEECH PATHOLOGY	0	o	68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 7300 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 7300 07400 RENAL DI ALYSI S 0 0 0 0 0 0 7400 07400 RENAL DI ALYSI S 0 0 0 0 0 0		9. 00 06900 ELECTROCARDI OLOGY	0	o	69. 00
73. 00		1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	71. 00
74. 00		2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	72. 00
76. 00	-	3.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 00 00 00 90 90 90	-	4. 00 07400 RENAL DIALYSIS	0	0	74. 00
90. 00 09000 CLINIC 0 0 0 0 900 0 910 910 910 920 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0			0	0	76. 00
91. 00					
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92 0 0 0 0 0 0 0 0 0	•		0	0	90.00
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95 200.00 Subtotal (see instructions) 0 0 200 201.00 Less PBP Clinic Lab. Services-Program 0 201			0	0	91. 00
95. 00 09500 AMBULANCE SERVICES 0 95 200. 00 Subtotal (see instructions) 0 0 0 201. 00 Less PBP Clinic Lab. Services-Program 0 201	•		0	0	92. 00
200.00 Subtotal (see instructions) 0 0 0 201.00 Less PBP Clinic Lab. Services-Program 0 201			_		
201.00 Less PBP Clinic Lab. Services-Program 0 201			0		95. 00
			0	0	200. 00
			0		201. 00
		Only Charges			
202.00 Net Charges (line 200 - line 201) 0 0 202	- :	(02.00 Net Charges (line 200 - line 201)	0	0	202. 00

	DUDON'T III	0051.711			6.5. 0110	
Health Financial Systems DUPONT HOS APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider C		Period: From 04/01/2017 To 03/31/2018	u of Form CMS-: Worksheet D Part I Date/Time Pre 8/31/2018 12:	pared:
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost		Per Diem (col. 3 / col. 4)	
	Part II, col.		(col . 1 - col	•		
	26)	2.00	2)	4.00	Г 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT	3, 032, 341 446, 322		3, 032, 34 446, 32		240. 59 348. 42	
31. 01 NEONATAL INTENSIVE CARE UNIT	663, 469		663, 46	9 5, 906	112. 34	31. 01
40. 00 SUBPROVI DER - I PF	0	l o		0 0	0.00	40.00
43. 00 NURSERY	207, 565		207, 56	5 4, 357	47. 64	43.00
44.00 SKILLED NURSING FACILITY	0	l e		0 0	0.00	44.00
200.00 Total (lines 30 through 199)	4, 349, 697		4, 349, 69	7 24, 148		200. 00
Cost Center Description	Inpatient	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	71	17, 082				30. 00
31.00 INTENSIVE CARE UNIT	49					31. 00
31.01 NEONATAL INTENSIVE CARE UNIT	164	18, 424				31. 01
40. 00 SUBPROVI DER - I PF	0	0	1			40. 00
43. 00 NURSERY	2, 169	103, 331				43. 00
44.00 SKILLED NURSING FACILITY	0		1			44. 00
200.00 Total (lines 30 through 199)	2, 453	155, 910	O			200. 00

ealth Financial Systems	DUPONT H				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	ITAL COSTS	Provider C		Peri od: From 04/01/2017 To 03/31/2018	Worksheet D Part II Date/Time Pre 8/31/2018 12:	
		Ti tI	e XIX	Hospi tal	PPS	•
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 976, 079				4, 546	
51.00 05100 RECOVERY ROOM	0		0.0000		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	30, 781	14, 312, 206			470	
53. 00 05300 ANESTHESI OLOGY	0		0.00000		0	
54. OO 05400 RADI OLOGY-DI AGNOSTI C	619, 568				1, 885	
54.01 05401 ULTRA SOUND	4, 314				28	
56. 00 05600 RADI 0I SOTOPE	1, 745	3, 898, 303			1	56.0
57.00 05700 CT SCAN	0	1	0.00000		0	
58. 00 05800 MRI	2, 388				2	58.0
50. 00 06000 LABORATORY	136, 763	51, 595, 645			1, 694	
55. 00 06500 RESPIRATORY THERAPY	12, 116				665	
66. 00 06600 PHYSI CAL THERAPY	40, 677	2, 305, 244			1, 007	66.0
57. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	00	0	67.0
58.00 06800 SPEECH PATHOLOGY	0	0	0.00000	00	0	68.0
59. 00 06900 ELECTROCARDI OLOGY	246	3, 494, 163	0.00007	70 9, 878	1	69. (
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15, 730	57, 604, 452	0.00027	73 261, 742	71	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	66, 881	50, 105, 271	0.00133	5, 781	8	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	35, 590	76, 154, 376	0. 00046	780, 464	364	73.0
74.00 07400 RENAL DIALYSIS	499	659, 156	0. 00075	8, 342	6	74.0
76.00 03950 SLEEP LAB	144, 793	2, 682, 555	0. 05397	1, 476	80	76. C
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	5, 000	2, 677, 383	0. 00186	57 0	0	90.0
91. 00 09100 EMERGENCY	534, 858	32, 060, 712	0. 01668	90, 748	1, 514	91. (
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	567, 541	13, 811, 158	0. 04109	12, 742	524	92. (
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. (
200.00 Total (lines 50 through 199)	5, 195, 569	609, 808, 587	1	3, 190, 327	12, 866	200.0

Health Financial Systems	DUPONT H		011 45 0450		u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COS	IS Provider C		Period: From 04/01/2017	Worksheet D Part III	
				To 03/31/2018	Date/Time Pre	pared:
		Ti +I	e XIX	Hospi tal	8/31/2018 12: PPS	02 pm
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
· ·	Post-Stepdown		Post-Stepdowr		Medi cal	
	Adjustments		Adjustments		Education Cost	
LANDATI ENT. DOUTLAGE OFFICE COOT OFFICE	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS			\	0 0	0	30.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	0			0	0	
31. 01 03100 TWIENSIVE CARE UNIT					0	
40. 00 04000 SUBPROVI DER - PF					0	
43. 00 04300 NURSERY	0			o o	0	
44.00 04400 SKILLED NURSING FACILITY	0			o o	_	44. 00
200.00 Total (lines 30 through 199)	0	C		0 0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	4.00	minus col. 4) 5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
30. 00 03000 ADULTS & PEDIATRICS	0	C	12, 60	4 0.00	71	30.00
31. 00 03100 INTENSIVE CARE UNIT		C	1, 28			
31.01 03101 NEONATAL INTENSIVE CARE UNIT		C	5, 90	6 0.00	164	31. 01
40. 00 04000 SUBPROVI DER - 1 PF	0	C		0.00	0	40.00
43. 00 04300 NURSERY		C	4, 35			
44.00 04400 SKILLED NURSING FACILITY		C)	0.00		
200.00 Total (lines 30 through 199)	1	C	24, 14	8	2, 453	200. 00
Cost Center Description	Inpatient Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
,	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNIT						31.00
31. 01 03101 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - IPF						31. 01 40. 00
43. 00 04300 NURSERY						43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY						44. 00
SS IS LIGOLONI EEED MONSING LAGIELLI	1	I .				1

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT AND	CILLARY SERVICE OTHER PASS Provider CCN: 15-0150	Peri od: Worksheet D		
THROUGH COSTS		From 04/01/2017 Part IV		

THROUGH 60515			Τ	o 03/31/2018	Date/Time Pre 8/31/2018 12:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING 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) c	0	0	54. 00
54. 01 05401 ULTRA SOUND	0	0	(0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	(0	0	56. 00
57. 00 05700 CT SCAN	0	0	(0	0	57.00
58. 00 05800 MRI	0	0	(0	0	58. 00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
74.00 07400 RENAL DIALYSIS	0	0	(0	0	74. 00
76. 00 03950 SLEEP LAB	0	o c	·	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	C	(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						1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	DUPONT HO	SPI TAL		In Lieu of Form CMS-255			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CO	Provider CCN: 15-0150		Worksheet D Part IV Date/Time Pre 8/31/2018 12:		
				Hospi tal	PPS		
Cost Center Description	All Other Medical Education Cost 4.00	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4) 6.00	(from Wkst. C, Part I, col.	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0		0 223, 650, 306	0.000000	50.00	

ealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	DUPONT HOS	Provi der C		Period: From 04/01/2017 To 03/31/2018	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 8/31/2018 12:	pared:
		Ti tI	e XIX	Hospi tal	PPS	•
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	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	341, 590	1	0	0	50.0
51.00 05100 RECOVERY ROOM	0. 000000	0)	0 0	0	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	218, 488		0 0	0	52.0
53. 00 05300 ANESTHESI OLOGY	0. 000000	0)	0 0	0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	129, 274		0 0	0	54.0
54. 01 05401 ULTRA SOUND	0. 000000	87, 828	1	0 0	0	54. C
66. 00 05600 RADI OI SOTOPE	0. 000000	3, 196	,	0 0	0	56. C
57.00 05700 CT SCAN	0. 000000	0)	0 0	0	57. C
58. 00 05800 MRI	0. 000000	8, 404		0 0	0	58.0
50. 00 06000 LABORATORY	0. 000000	638, 831		o o	0	60.0
55. 00 06500 RESPIRATORY THERAPY	0. 000000	534, 457		o o	0	65.0
66. 00 06600 PHYSI CAL THERAPY	0. 000000	57, 086	,	o o	0	66.0
57. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	. 0)	o o	0	67.0
8. 00 06800 SPEECH PATHOLOGY	0. 000000	0	,	0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0. 000000	9, 878		0 0	0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	261, 742		0 0	0	71.0
22.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 781		0 0	0	72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	780, 464	1	o o	0	73. C
4. 00 07400 RENAL DI ALYSI S	0. 000000	8, 342	1	o o	0	74.0
76. 00 03950 SLEEP LAB	0. 000000	1, 476		o o	0	76.0
OUTPATIENT SERVICE COST CENTERS	0.00000	., ., .	1	<u> </u>		1 .0.0
0. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.0
1. 00 09100 EMERGENCY	0. 000000	90, 748		0 0	0	
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	12, 742		0 0	0	
OTHER REIMBURSABLE COST CENTERS		,				1
95. 00 09500 AMBULANCE SERVICES						95. (
200.00 Total (lines 50 through 199)		3, 190, 327	-[0 0	0	200. 0

APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH	SERVICES AND	D VACCINE (COST	Provi der	CCN: 15-01	From 04/01/2017 To 03/31/2018	Worksheet D Part V Date/Time Pre 8/31/2018 12:	
					Ti	tle XIX	Hospi tal	PPS	

					10 03/31/2018	8/31/2018 12:	
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	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		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	0. 095956	0	(962, 036		
	100 RECOVERY ROOM	0. 000000	0	(0	0	
	200 DELIVERY ROOM & LABOR ROOM	0. 247704	0		0	0	52. 00
	300 ANESTHESI OLOGY	0. 000000	0		0	0	
	400 RADI OLOGY-DI AGNOSTI C	0. 122078	0		323, 099		
	401 ULTRA SOUND	0. 053519	0	(79, 024		54. 01
	600 RADI OI SOTOPE	0. 082821	0	(6, 340	0	56. 00
	700 CT SCAN	0. 000000	0	(0	0	57. 00
	800 MRI	0. 045372	0	(73, 319	0	58. 00
60.00 06	000 LABORATORY	0. 091339	0	(307, 757	0	60.00
65. 00 06	500 RESPI RATORY THERAPY	0. 201759	0	(7, 486	0	65. 00
66.00 06	600 PHYSI CAL THERAPY	0. 246334	0	(4, 674	0	66. 00
67. 00 06	700 OCCUPATIONAL THERAPY	0. 000000	0	(0	0	67. 00
68. 00 06	800 SPEECH PATHOLOGY	0. 000000	0	(0	0	68. 00
69. 00 06	900 ELECTROCARDI OLOGY	0. 016871	0	(24, 988	0	69. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 053981	0	(156, 746	0	71. 00
72. 00 07:	200 IMPL. DEV. CHARGED TO PATIENTS	0. 250669	0		135, 380	0	72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	0. 116912	0		138, 291	0	73. 00
74. 00 07	400 RENAL DIALYSIS	0. 232585	0		0	0	74. 00
76. 00 03	950 SLEEP LAB	0. 240156	0		89, 424	0	76. 00
OU ⁻	TPATIENT SERVICE COST CENTERS						1
90. 00 09	000 CLI NI C	0. 256121	0	(1, 063	0	90.00
91. 00 09	100 EMERGENCY	0. 136353	0		542, 093	0	91.00
92. 00 09:	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 227668	0		81, 795	0	92.00
ОТІ	HER REIMBURSABLE COST CENTERS						1
95. 00 09	500 AMBULANCE SERVICES	0. 000000	0	(95. 00
200.00	Subtotal (see instructions)		0		2, 933, 515	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		0		2, 933, 515	0	202. 00
!	1 3 (1		'		•	

Health Financial Systems	DUPONT HOSP	I TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0150	From 04/01/2017	Worksheet D Part V Date/Time Prepared: 8/31/2018 12:02 pm
		Title XIX	Hospi tal	PPS

				10 03/31/2018	8/31/2018 12:02	
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	its				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	92, 313				0. 00
51.00 05100 RECOVERY ROOM	0	0				1. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				2. 00
53. 00 05300 ANESTHESI OLOGY	0	0			53	3. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	39, 443			54	4. 00
54. 01 05401 ULTRA SOUND	0	4, 229			54	4. 01
56. 00 05600 RADI 0I SOTOPE	0	525			56	6. 00
57. 00 05700 CT SCAN	0	0			57	7. 00
58. 00 05800 MRI	0	3, 327			58	8. 00
60. 00 06000 LABORATORY	0	28, 110			60	0. 00
65. 00 06500 RESPIRATORY THERAPY	0	1, 510			65	5. 00
66. 00 06600 PHYSI CAL THERAPY	o	1, 151			66	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0			67	7. 00
68. 00 06800 SPEECH PATHOLOGY	o	0			68	8. 00
69. 00 06900 ELECTROCARDI OLOGY	o	422			69	9. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	8, 461			71	1. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	33, 936			72	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	16, 168			73	3. 00
74. 00 07400 RENAL DIALYSIS	o	0	i		74	4. 00
76. 00 03950 SLEEP LAB	o	21, 476			76	6. 00
OUTPATIENT SERVICE COST CENTERS	-1					
90. 00 09000 CLI NI C	0	272			90	0. 00
91. 00 09100 EMERGENCY	o	73, 916			91	1. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	18, 622				2. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0				95	5. 00
200.00 Subtotal (see instructions)		343, 881				0.00
201.00 Less PBP Clinic Lab. Services-Program		2 . 2 , 00 .				1. 00
Only Charges					201	
202.00 Net Charges (line 200 - line 201)		343, 881			202	2. 00
	١	3.3,001	1		1202	

Health Financial Systems	DUPONT HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0150	Peri od: From 04/01/2017	Worksheet D-1	
			Date/Time Pre 8/31/2018 12:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	

		Title XVIII	Hospi tal	PPS	JZ PIII
	Cost Center Description	THE XVIII	nospi tui	113	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	I NPATI ENT DAYS	a avaludi na nauhama)		12 (04	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed)			12, 604 12, 604	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days	12,004	3. 00
0.00	do not complete this line.	,e, yeu nave em y p	vato . oo dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		10, 245	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
,, 00	reporting period	days) till sagit bessinger	0. 0. 1 0001	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding :	swing-bed and	1, 878	9. 00
10. 00	<pre>newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or</pre>	alv (i neludi na pri vato ro	om dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		om days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ only (including private	room dovo)	0	13. 00
13.00	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)	, 3 3	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		., .	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	tne cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 21 of th	0 000+	0.00	20. 00
20.00	reporting period	s arter becember 31 or the	e cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		16, 800, 153	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 -6			22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
	7 x line 19)	•			
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)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		16, 800, 153	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			., ,	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	rges)		28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 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
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- 111le 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	rerential (line	16, 800, 153	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 332. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 503, 224	
40.00	Medically necessary private room cost applicable to the Progra	,		2 502 224	
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	l	2, 503, 224	41.00

	Financial Systems	DUPONT HO			In Lie	eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN	F	eriod: rom 04/01/2017 o 03/31/2018	Worksheet D-1 Date/Time Preps/31/2018 12:0	pared:
			Title	KVIII	Hospi tal	PPS	02 piii
	Cost Center Description	Total		Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient DaysDi	iem (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. 00	0	0	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	2.050.077	1 201	2 202 04	210	402 (17	42.00
43. 00 43. 01	INTENSIVE CARE UNIT	2, 950, 066 7, 009, 417	1, 281 5, 906	2, 302. 94 1, 186. 83	210 0	1	43. 00 43. 01
44. 00	CORONARY CARE UNIT	7,009,417	3, 400	1, 100. 63	O		44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						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 (Wks					3, 713, 124	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructions	s)		6, 699, 965	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	ationt routing	corvices (from V	Mkst D sum	of Dorte L and	524, 996	50.00
30.00		atrent routine	services (ITOIII I	VKSt. D, Suiii	or Farts I and	324, 990	30.00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (from	m Wkst. D, su	m of Parts II	172, 034	51. 00
E2 00	and IV)	50 and 51)				(07.000	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non-physi	cian anesthe	tist and	697, 030 6, 002, 935	
00.00	medical education costs (line 49 minus line 5		ratea, non physi	crair ancstric	trot, and	0,002,700	00.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (lir	ne 56 minus l	ne 53)	Ö	57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	porting period	ending 1996, upo	dated and com	bounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the mar	ket basket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines				ne amount by	0	61.00
	which operating costs (line 53) are less than		s (lines 54 x 60	D), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62.00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the d	cost reportin	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	ts after Decemb	er 31 of the cos	st reporting	period (See	0	65.00
	instructions)(title XVIII only)				(222		
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 65)	(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	December 31 of	the cost ren	orting period	0	67. 00
07.00	(line 12 x line 19)	o ocoro im ougi.	2000201	т. о осот тор	or tring port ou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of th	ne cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XLX swing-bed NF inpatient :	routine costs (line 67 + line 4	58)		0	69. 00
57.00	PART III - SKILLED NURSING FACILITY, OTHER NU]
70.00	Skilled nursing facility/other nursing facili	,					70.00
71. 00 72. 00	Adjusted general inpatient routine service co		ıne 70 ÷ line 2))			71. 00 72. 00
73. 00	Program routine service cost (line 9 x line 3 Medically necessary private room cost applications)		(line 14 x line	e 35)			73.00
74. 00	Total Program general inpatient routine servi	ice costs (line	72 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from Wor	rksheet B, Pa	rt II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	. *					77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for excess				aline 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ust iimitätion ((iiie /& Minu	s iine 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (li)				82. 00
83.00	Reasonable inpatient routine service costs (s	see instruction					83. 00
84.00	Program inpatient ancillary services (see ins		nc)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 66	PART IV - COMPUTATION OF OBSERVATION BED PASS						33. 30
87. 00	Total observation bed days (see instructions)					2, 359	1
88.00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		line 2)			1, 332. 92 3, 144, 358	
07.00	Table various bed cost (Title of A Title 00) (See					3, 144, 330	1 07.00

Health Financial Systems	DUPONT HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 04/01/2017 To 03/31/2018	Date/Time Prep 8/31/2018 12:0	oared: 02 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	3, 032, 341	16, 800, 153	0. 18049	5 3, 144, 358	567, 541	90.00
91.00 Nursing School cost	0	16, 800, 153	0.00000	0 3, 144, 358	0	91.00
92.00 Allied health cost	0	16, 800, 153	0.00000	0 3, 144, 358	0	92.00
93.00 All other Medical Education	0	16, 800, 153	0. 00000	0 3, 144, 358	0	93. 00

Health Financial Systems	DUPONT HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0150	Peri od: From 04/01/2017 To 03/31/2018	Worksheet D-1 Date/Time Pre 8/31/2018 12:	pared:
	Title XIX	Hospi tal	PPS	
Cost Center Description				
·			1. 00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				1

PART ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	PPS	
IRBMITERIA IMPS IRBMITERIA		Cost Center Description				
MARTIENT DAYS		DADT I ALL DDOVIDED COMPONENTS			1.00	
Impatient days (including private room days and saleg-bed days, excluding newborn) 12,604 1.00						
1,000 Inpatient days (including private room days, excluding swing-bed and networn days) 12,004 2,00 3,00 Private room days (excluding swing-bed and observation bed days) 17 you have only private room days. 0,300 0,000	1 00		s excluding newborn)		12 604	1 00
Private room days (excluding sking-bed and observation bed days). If you have only private room days. 4.00 do not complete this fine. 4.00 Semi-private room days (excluding sking-bed and observation bed days). 5.00 reporting period. 6.00 Interest the period state of the period of the cost period period (calendary ear, enter 0 on this line). 7.00 Total sking-bed SM type inpatient days (including private room days) through December 31 of the cost reporting period (calendary ear, enter 0 on this line). 7.00 Total sking-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period (ir calendary ear, enter 0 on this line). 7.00 Total sking-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendary ear, enter 0 on this line). 7.00 Total sking-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (calendary ear, enter 0 on this line). 7.00 Total sking-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (calendary ear, enter 0 on this line). 7.00 Sking-bed SM type inpatient days applicable to title XVIII only (including private room days). 8.00 Sking-bed MF type inpatient days applicable to title XVIII only (including private room days). 8.00 Sking-bed MF type inpatient days applicable to title XVIII only (including private room days). 8.00 Sking-bed MF type inpatient days applicable to title XVIII only (including private room days). 8.01 Sking-bed MF type inpatient days applicable to title XVIII only (including private room days). 8.01 Sking-bed MF type inpatient days applicable to title XVIII only (including private room days). 8.01 Sking-bed MF type inpatient days applicable to services through December 31 of the cost reporting period (including title XVIII). 8.01 Sking-bed MF type inpatient days applicable to services through December 31 of the cost reporting period (including title XVIII). 8.01						
Semi-private room days (excluding swing-bed And observation bed days) 10.745 4.00 5.00 Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost reporting period 7.00				vate room days,		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if call-endar year, enter 0 on this line) 7.00 reporting period (if call-endar year, enter 0 on this line) 8.01 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if call-endar year, enter 0 on this line) 9.02 Total inpatient days including private room days) after December 31 of the cost reporting period (if call-endar year, enter 0 on this line) 9.03 Total inpatient days including private room days) after December 31 of the cost reporting period (if call-endar year, enter 0 on this line) 10.04 SNF year inpatient days (and under year) enter 10 year year year year year year year year						
reporting period (1 calendar year, enter 0 on this line) 7.00 Total saving-hed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 8.00 Total saving-hed NF type inpatient days (including private room days) through December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (1 calendar year, enter 0 on this line) 10.00 Swing-hed SNF type inpatient days applicable to the Program (excluding swing-hed and newborn days) 11.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 through December 31 of the cost reporting period (see instructions) 13.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed SNF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed MF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed MF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed MF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed MF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed MF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed NF type inpatient days applicable to title XVIII only (including private room days) after 10.00 Swing-hed NF type inpatient routing after 10.00 Swing-hed Swing-hed Swing-hed Swing-hed Swing-he						
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00	5. 00]	om days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total soning-both NT type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 9.01 Total soning-both NT type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.01 Pool of through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.02 Swing-both SNT type inpatient days applicable to title XVIII only (including private room days) 9.03 Swing-both SNT type inpatient days applicable to title XVIII only (including private room days) 9.04 Swing-both SNT type inpatient days applicable to title XVIII only (including private room days) 9.05 Swing-both SNT type inpatient days applicable to title XVIII only (including private room days) 9.07 Swing-both SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.08 Swing-both SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.09 Swing-both SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.00 Swing-both SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.01 Swing-both SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.02 Swing-both SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.03 Swing-both SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.04 SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.05 SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.07 SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.08 SNT type inpatient days applicable to title XV or XIX only (including private room days) 9.08 SNT type inpatient days applic	4 00		om days) after December 3	of the cost	٥	4 00
Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost	0.00		olli days) al tel becellibel s	or or the cost	٥	0.00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SWI type Inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SWI type Inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed SWI type Inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed SWI type inpatient days applicable to titles V or XIX only (including private room days) 0 12. 00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14. 037 15. 00 16. 00 160 160 160 160 160 160 160 160 160	7.00		m davs) through December	31 of the cost	0	7. 00
reporting period (If Calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) 0.12.00 through December 31 of the cost reporting period (swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) 0.13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0.14.00 bedically necessary private room days applicable to the Program (excluding swing-bed days) 0.14.00 bedically necessary private room days applicable to the Program (excluding swing-bed days) 0.14.00 bedically necessary private room days applicable to services through December 31 of the cost of the XIX only (including private room days) 1.00 bedically necessary private room days applicable to services through December 31 of the cost 0.00 contract of the XIX only (including private room days) 1.00 bedically necessary private room days applicable to services after December 31 of the cost 0.00 contract of the XIX only (including private room days) 1.00 bedically necessary private room days applicable to services after December 31 of the cost 0.00 contract of the XIX only (including private room days) 1.00 contract of the XIX only (including private room days) 1.00 contract of the XIX only (including private room days) 1.00 contract (including private room days (including private room days) 1.00 contract of the XIX only (including private room days) 1.00 contract of		31 1 3 1	,			
10.00 Swings-bed SRF type inpatient days applicable to title XVIII only (including private room days) 0.00 10.00	8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 31	of the cost	0	8. 00
newborn days 0 10,00 1		, , , , , , , , , , , , , , , , , , , ,				
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10.00 through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 1.0	9. 00		o the Program (excluding	swing-bed and	71	9. 00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.10 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.11 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.12 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.13 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.14 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.15 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.16 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.17 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.18 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.19 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.19 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.10 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.10 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.10 Observation of the cost reporting period (if calendar year, enter 0 on this line) 1.10 Observation of the cost period (if calendar year, enter 0 on this line) 1.10 Observation of the cost period (if calendar year, enter 0 on this line) 1.11 Observation of the cost period (if calendar year, enter 0 on this line) 1.12 Observation of the cost period (if calendar year, enter 0 on this line) 1.13 Observation of the cost period	10 00		nly (including privato re	om dave)	0	10 00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) 28.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 29.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 29.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 29.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 29.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 2	10.00			Join days)	١	10.00
December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 12.00 12.00 13.00 13.00 14.00 14.00 15.00	11. 00			oom days) after	0	11. 00
through December 31 of the cost reporting period 13. 00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Total nursery days (title V or XIX only) 17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 10. 00 Total general inpatient routine service cost (see instructions) 10. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x I ine 18) 10. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x I ine 18) 10. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x I ine 18) 10. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x I ine 20) 10. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x Ine 20) 10. 00 Medicable Cost applicable to NF type service after December 31 of the cost reporting period				,		
3. 00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) and retro December 31 of the cost reporting period (if call endar year) (excluding swing-bed days) 0 14. 00	12.00		X only (including private	e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 14, 00 15.00 Total nursery days (title V or XIX only) 4, 357 15.00 2.169 16.00		1 31			_	
14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 16.00 Nursery days (title V or XIX only) 2,169 16.00 Nursery days (title V or XIX only) 2,169 16.00 Nursery days (title V or XIX only) 2,169 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 17.00 17.00 18.00 18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18.00 18.00 19.00 1	13. 00				0	13. 00
15.00 Total nursery days (title V or XIX only) 2,169 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 17.00 18.00 1	14 00				0	1/ 00
16. 00 Nursery days (title v or XIX only) 2,169 16. 00 SINING BED ADJUSTMENT			am (excluding swing-bed c	lays)	- 1	
SWING BED ADJUSTMENT 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (and care rate for swing-bed SNF services applicable to services after December 31 of the cost (and care rate for swing-bed SNF services applicable to services through December 31 of the cost (and care rate for swing-bed NF services applicable to services through December 31 of the cost (and care rate for swing-bed NF services applicable to services after December 31 of the cost (and care rate for swing-bed NF services applicable to services after December 31 of the cost (and care rate for swing-bed NF services applicable to services after December 31 of the cost (and care rate for swing-bed NF services applicable to SNF type services through December 31 of the cost reporting period (line (and care for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line (and care for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line (and care for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line (and care for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line (and care for swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line (and care for swing-bed cost (and care for swing-bed cost (line 21 minus line 26) (and care for swing-bed cost (and swing-bed cost (line 21 minus line 26) (and care for swing-bed cost (and care for swing-bed cost (line 21 minus line 26) (and care for swing-bed cost (and care for swing-bed cost (line 27 + line 28) (and care for swing-bed cost (and care for swing-bed cost (line 27 + line 28) (and care for swing-bed cost (and care for]				
reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 20. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 21. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 22. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29. 00 Private room charges (excluding swing-bed charges) 20. 00 Veriang semi-private room charges (excluding swing-bed charges) 20. 00 Very sepicable to the SWING swing-bed charges) 20. 00 Very sepicable to the SWING swing-bed cost (line 27 + line 28) 20. 00 Very sepicable to the SWING swing-bed cost and private room cost differential dire 3 x line 31) 20. 00 Very sepicable to the SWING swing-bed cost and private room cost differential (line 3 x line 35) 20. 00 Very sepicable to the SWING swing-bed cost and private						
18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 19. 0	17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 29.00 Private room charges (excluding swing-bed charges) 20.00 Average private room per diem charge (line 29 * line 3) 21.00 Average perivate room per diem charge (line 29 * line 3) 22.00 Average perivate room per diem charge (line 30 * line 4) 23.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 24.00 Average per diem private room cost differential (line 34 x line 31) 25.00 Average perivate room cost differential (line 3 x line 35) 27.00 General inpatient routine service cost per diem (see instructions) 28.00 Average per diem private room cost differential (line 3 x line 36) 29.00 Proyram general inpatient routine service cost per diem (see instructions) 29.00 Average semi-private room cost differential (line 3 x line 38) 29.00 Average per diem private room cost differential (line 3 x line 38) 29.00 Average per diem p						
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 16,800,153 21.00 22.00 23.00 23.00 24.00 25.00	18. 00		es after December 31 of t	the cost	0. 00	18. 00
reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 Private ROOM DIFFERENTIAL ADJUSTMENT 29. 00 Private room charges (excluding swing-bed charges) 29. 00 Semi-private room charges (excluding swing-bed charges) 29. 00 Semi-private room charges (excluding swing-bed charges) 29. 00 Average private room per diem charge (line 29 ± line 3) 30. 00 Average private room per diem charge (line 29 ± line 3) 30. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30 Average per diem private room cost differential (line 34 x line 35) 31. 00 General inpatient routine service cost per diem (see instructions) 32. 00 Average per diem private room cost differential (line 3 x line 35) 33. 00 Average per diem private room cost differential (line 3 x line 35) 34. 00 Program general inpatient routine service cost per diem (see instructions) 35. 00 Average per diem private room cost applicable to the Program (line 14 x line 35) 36. 00 Program general inpatient rout	10 00		s through Docombor 21 of	the cost	0.00	10 00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 1 of total general inpatient routine service cost (see instructions) 16,800,153 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 16,800,153 27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 29.00 29.00 Pri vate room charges (excluding swing-bed charges) 29.00 29	19.00		s through becember 31 of	the cost	0.00	19.00
reporting period Total general inpatient routine service cost (see instructions) 22.00 22.00 23.00 24.00 25.	20.00		s after December 31 of th	ne cost	0.00	20. 00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average perivate room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 29 + line 3) 34.00 Average per diem private room cost differential (line 30 + line 4) 35.00 Average per diem private room cost differential (line 32 x line 31) 36.00 Private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 vine 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 800, 153) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					16, 800, 153	
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32.00 Average periode more perioded more per	22. 00		er 31 of the cost reporti	ng period (line	0	22. 00
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 16,800,153 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 32.00 Average private room per diem charge (line 29 + line 3) 0.00 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 36.00 Average per diem private room cost differential (line 34 x line 35) 0.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 800, 153) 37.00 PRAT II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 1, 332.92 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22 00	,	21 of the cost reporting	noried (line 4		22 00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average per diem charge (line 29 + line 3) 31.00 Average per diem private room per diem charge (line 30 + line 4) 32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23.00		31 of the cost reporting	perrou (Trie 6	٥	23.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average semi-private room cost differential (line 30 ± line 4) 35.00 Average per diem private room cost differential (line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16,800,153) 37.00 General inpatient routine service cost per of dem (see Instructions) 38.00 Adjusted general inpatient routine service cost per of dem (see Instructions) 38.00 Adjusted general inpatient routine service cost per of dem (see Instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00		r 31 of the cost reportir	na period (line	0	24. 00
x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 800, 153) 38. 00 Agisted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 30.						
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 800, 153) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00] 3	31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 16,800,153 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room per diem charges (line 29 ± line 28) 0 0.00 Semi-private room per diem charge (line 29 ± line 28) 0 0.00 Semi-private room per diem charges (line 30 ± line 4) 0 0.00 Semi-private room per diem charges (line 30 ± line 33) 0 0.00 Semi-private room per diem charges (line 30 ± line 33) 0 0.00 Semi-private room per diem charges (line 30 ± line 33) 0 0.00 Semi-private room per diem charges (line 30 ± line 33) 0 0.00 Semi-private room charges (excluding swing-bed charges) 0 0.00 Semi-private room charges (line 30 ± line 31) 0 0.00 Semi-private room charges (line 30 ± line 31) 0 0.00 Semi-private room charges (line 30 ± line 31) 0 0.00 Semi-private room charges (line 30 ± line 31) 0 0.00 Semi-private room ch		1			ا	0, 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 94, 637 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 30. 00		, ,	(line 21 minus line 24)		- 1	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 800, 153) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 94.637 94.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 30.00	27.00		(TITIE 21 III HUS TITIE 26)		10, 800, 153	27.00
29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 33.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 34.00 Average per diem pri vate room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 16, 800, 153) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 94, 637 39.00 40.00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35) 0 30.00 30.00 29.00 30.00 0 30.00 30.00 31.00 32.00 32.00 32.00 34.00 35.00 40.00	28 00		d and observation bed cha	rraes)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 800, 153) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			a and observation bed one	11 900)		
32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 36						
33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 800, 153) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00		÷ line 28)		0. 000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0.00	
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 16, 800, 153) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 35.00 0 36.00 16, 800, 153 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 16,800,153 37.00 16,800,153 37.00 17,800,153 37.00 37.00 18,900,153 37.00 19,900,153 37.00 19,900,153 37.00 10,900,153 37.00 10,900,153 10,900,153 10,900,153 10,900,153 10,900,153 10,900,153 11,900,153 11,900,153 12,900,153 13,900,153 13,900,153 14,900,153 15,900,153 16,800,153 17,900,153				i ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 16,800,153 16,800,153 37.00 16,800,153 37.00 16,800,153 37.00 16,800,153 37.00 16,800,153 37.00		5	ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 332. 92 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	and private room cost dif	ferential (line		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 332. 92 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	57.00	,	and private room cost dir	. S. S. C. T. G. T. T. C. T. T. C.	10, 000, 103	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 332.92 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,332.92 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,332.92 38.00 94,637 39.00 40.00			JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		Adjusted general inpatient routine service cost per diem (see	instructions)			
		, , , , , , , , , , , , , , , , , , , ,	•			
41.00 Total Program general impatient routine service cost (line 39 + line 40) 94,637 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41.00	Tiotal Program general impatrent routine service cost (fine 39	+ ITTIE 40)		94, 637	41.00

	Financial Systems	DUPONT HO				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN		eriod: rom 04/01/2017 o 03/31/2018	Worksheet D-1 Date/Time Preps/31/2018 12:0	
			Title	XIX	Hospi tal	PPS	02 piii
	Cost Center Description	Total Inpatient Cost	Total Inpatient DaysDi	Average Per em (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42. 00	NURSERY (title V & XIX only)	1. 00 2, 611, 491	2. 00	3. 00 599. 38	4. 00 2, 169	5. 00 1, 300, 055	42. 00
	Intensive Care Type Inpatient Hospital Units		·		=,	1, 555, 555	
43.00	INTENSIVE CARE UNIT	2, 950, 066		2, 302. 94	49		•
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 009, 417	5, 906	1, 186. 83	164	194, 640	43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						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 (Wks			`		412, 830	48. 00
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructions	5)		2, 115, 006	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from W	Vkst. D, sum o	of Parts I and	155, 910	50. 00
51. 00	III) Pass through costs applicable to Program inpa	atient ancillar	y services (from	n Wkst. D, sum	n of Parts II	12, 866	51.00
52. 00	and IV)	50 and 51)				168, 776	52. 00
53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud		lated, non-physi	ci an anesthet	ist, and	1, 946, 230	•
	medical education costs (line 49 minus line !						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0. 00	
56.00	Target amount (line 54 x line 55)					0	56. 00
57. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (lin	ne 56 minus li	ne 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996 und	dated and comp	oounded by the	0 0. 00	58. 00 59. 00
07.00	market basket	oo. cg por ou	onaring Trion apo	aroa ana comp		0.00	07.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				o amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than					O	01.00
(2.00	amount (line 56), otherwise enter zero (see i	nstructions)				0	(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	ent (see instru	ctions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the c	cost reporting	period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the cos	st reporting p	eriod (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line 65)	(title XVIII	only) For	0	66. 00
	CAH (see instructions)	·		·			
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 of	the cost repo	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of th	ne cost report	ing period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70. 00
71. 00	Adjusted general inpatient routine service of	,		•			71.00
72. 00	Program routine service cost (line 9 x line			05)			72.00
73. 00 74. 00	Medically necessary private room cost application of the cost application of t			35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient			ksheet B, Par	t II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78.00	Inpatient routine service cost (line 74 minus		rovi den nesend-1				78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				s line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on			/		81. 00
82.00	Inpatient routine service cost limitation (li						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ins)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					2, 359	87. 00
88. 00	Adjusted general inpatient routine cost per of		line 2)			1, 332. 92	1
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				3, 144, 358	89. 00

Health Financial Systems	DUPONT HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 04/01/2017 To 03/31/2018	Date/Time Prep 8/31/2018 12:0	
		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 C	COST					
90.00 Capital -related cost	3, 032, 341	16, 800, 153	0. 18049	5 3, 144, 358	567, 541	90.00
91.00 Nursing School cost	0	16, 800, 153	0.00000	0 3, 144, 358	0	91.00
92.00 Allied health cost	0	16, 800, 153	0.00000	0 3, 144, 358	0	92.00
93.00 All other Medical Education	0	16, 800, 153	0. 00000	0 3, 144, 358	0	93. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0150	Peri od: From 04/01/2017	Worksheet D-3	
			To 03/31/2018	Date/Time Pre 8/31/2018 12:	epared 02 pm
	Ti tl e	e XVIII	Hospi tal	PPS	02 p
Cost Center Description	<u> </u>	Ratio of Cos	t Inpatient	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
LABORT FUT DOUTING OFFICE OFFICE		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	F 2/2 010		1 20 6
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT			5, 362, 910		30.0
			1, 011, 392		31.0
31. 01 03101 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF			0		31. 0
43. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVI CE COST CENTERS					43.0
50. 00 05000 OPERATI NG ROOM		0. 0959	56 5, 558, 789	533, 399	50.0
11. 00 05100 RECOVERY ROOM		0.0000		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2477		5, 753	
53. 00 05300 ANESTHESI OLOGY		0.0000		0,700	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1220		238, 046	
64. 01 05401 ULTRA SOUND		0. 0535		40, 908	
66. 00 05600 RADI OI SOTOPE		0. 0828		9, 164	56. (
57. 00 05700 CT SCAN		0.0000	00 0	0	57. (
88. 00 05800 MRI		0.0453	72 152, 500	6, 919	58. (
0. 00 06000 LABORATORY		0. 0913		372, 811	60.0
5. 00 06500 RESPI RATORY THERAPY		0. 2017		323, 196	
6. 00 06600 PHYSI CAL THERAPY		0. 2463		134, 303	
7. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
8. 00 O6800 SPEECH PATHOLOGY		0.0000		0	
99. 00 06900 ELECTROCARDI OLOGY		0. 0168	•	5, 498	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0539		111, 123	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 2506		802, 761	
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 1169		786, 588	
44.00 07400 RENAL DI ALYSI S		0. 2325		68, 709	
6.00 03950 SLEEP LAB		0. 2401	56 11, 874	2, 852	76. (
OUTPATIENT SERVICE COST CENTERS O. 00 09000 CLINIC		0. 2561	21 11, 254	2, 882	90. (
0. 00 09000 CLI NI C 1. 00 09100 EMERGENCY		0. 2561		180, 305	
12.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1363			
OTHER REIMBURSABLE COST CENTERS		0.2270	300, 110	07, 707	72.
P5. 00 09500 AMBULANCE SERVICES					95. (
200 00 Total (sum of lines 50 through 94 and 96 through 98)			29 130 121	3 713 124	

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

201. 00 202. 00

3, 713, 124 200. 00

29, 130, 121

29, 130, 121

200.00

201. 00 202. 00

Health Financial Systems	DUPONT HOSPITAL			u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 04/01/2017 To 03/31/2018	Date/Time Prep 8/31/2018 12:0	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATIENT DOUTING CEDAL OF COCT CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			513, 901		30. 00
31. 00 03100 NTENSI VE CARE UNI T			76, 292		31. 00
31. 01 03100 TNTENSIVE CARE UNIT			2, 245, 248		31.00
40. 00 04000 SUBPROVI DER - PF			2, 243, 246		40.00
43. 00 04300 NURSERY			176, 175		43.00
ANCILLARY SERVICE COST CENTERS		-	170, 173		45.00
50. 00 05000 OPERATI NG ROOM		0. 09595	341, 590	32, 778	50.00
51. 00 05100 RECOVERY ROOM		0.00000		02,770	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 24770		54, 120	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000	00 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12207	⁷⁸ 129, 274	15, 782	54.00
54. 01 05401 ULTRA SOUND		0. 05351	9 87, 828	4, 700	54. 01
56. 00 05600 RADI 0I SOTOPE		0. 08282	3, 196	265	56. 00
57. 00 05700 CT SCAN		0.00000	00	0	57. 00
58. 00 05800 MRI		0. 04537	2 8, 404	381	58. 00
60. 00 06000 LABORATORY		0. 09133		58, 350	
65. 00 06500 RESPI RATORY THERAPY		0. 20175		107, 832	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 24633	•	14, 062	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 01687	•		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 05398	•		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 25066	•	1, 449	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 11691	•	·	
74. 00 07400 RENAL DI ALYSI S		0. 23258	•	1, 940	
76. 00 03950 SLEEP LAB		0. 24015	1, 476	354	76. 00
OUTPATIENT SERVICE COST CENTERS		0.25612	01	0	90 00
OU OU HOSCIOU CLEME (/ II		

0. 256121

0.136353

0. 227668

90, 748

12, 742

3, 190, 327

3, 190, 327

0

412, 830 200. 00

12, 374

2, 901

90.00

91.00

92.00

95.00

201. 00 202. 00

09000 CLI NI C

09100 EMERGENCY

09500 AMBULANCE SERVICES

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

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

90.00

91.00

92.00

95.00

200.00

201.00

202.00

		Title XVIII	Hospi tal	8/31/2018 12: 0 PPS	02 pm
				1 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0 2, 218, 233	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring	on or after October 1	(see	2, 110, 281	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for (lischarges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for (lischarges occurring o	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			61, 926	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions	;)		0	2. 01 2. 02
3.00	Managed Care Simulated Payments	·/		Ö	3. 00
4. 00	Bed days available divided by number of days in the cost reporting Indirect Medical Education Adjustment	ng period (see instruc	ctions)	124. 54	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most re or before 12/31/1996. (see instructions)	ecent cost reporting p	eriod ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	criteria for an add-c	on to the cap	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under			0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 cost report straddles July 1, 2011 then see instructions.	CFR §412. 105(f)(1)(iv	v)(B)(2) If the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) 1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	under § 5503 of the A	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots lunder § 5506 of ACA. (see instructions)	from a closed teachin	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines ((8, 8,01 and 8,02) (s	see	0. 00	9. 00
10. 00	<pre>instructions) FTE count for allopathic and osteopathic programs in the current</pre>	year from your record	ls	0. 00	10. 00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			0.00	13. 00
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sept	ember 30, 1997,	0. 00	
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	16. 00
17. 00	Adjustment for residents displaced by program or hospital closure	;			17. 00
18. 00	Adjusted rolling average FTE count			0.00 0.000000	18.00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000	
21. 00	Enter the Lesser of Lines 19 or 20 (see instructions)			0. 000000	21. 00
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of Number of additional allopathic and osteopathic IME FTE resident		ER 412 105	0.00	23. 00
23.00	(f)(1)(iv)(C).	cap 310t3 under 42 of	K 412. 100	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the lower transfer to the lower transfer transfer to the lower transfer tra	er of line 23 or line	24 (see	0. 00	25. 00
26. 00	Instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29.00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruct	i ons)	5. 07	30. 00
31.00	Percentage of Medicaid patient days (see instructions)			34. 94	31. 00
32. 00	Sum of lines 30 and 31			40. 01	
33. 00	Allowable disproportionate share percentage (see instructions)			22. 22	33. 00
34.00	Disproportionate share adjustment (see instructions)		I	240, 449	34.00

	Financial Systems DUPONT HO	SPI TAL	In Lie	eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0150	Peri od: From 04/01/2017 To 03/31/2018	Worksheet E Part A	pared:
		Title XVIII	Hospi tal	PPS	· · · · · ·
			Prior to 10/1 1.00	On/After 10/1	
	Uncompensated Care Adjustment		1.00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		0		35. 00
35. 01	Factor 3 (see instructions)		0. 000000000		35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, entinstructions)	ter zero on this line) (se	e 1, 018, 846	1, 007, 408	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment ar	mount (see instructions)	510, 819	502, 324	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.		1, 013, 143		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary of Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46) 0		40. 00
40.00	652, 682, 683, 684 and 685 (see instructions)	g discharges for M3-DRGS			40.00
			Before 1/1	On/After 1/1	
41 00	Tatal ECDD Madianas diaghannas analysisas NC DDC- (F2 (O2	/02 /04 /05 /	1.00	1. 01	41.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	oos, oo4 an 685. (see	0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS an 685. (see instructions)	S-DRGs 652, 682, 683, 684	0	0	41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00	l l	42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, (instructions)	682, 683, 684 an 685. (see	0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0. 000000		44. 00
	days)				
45. 00 46. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line 4	•	0.00	0.00	45. 00 46. 00
47. 00	Subtotal (see instructions)	+1.01)	5, 644, 032		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)			A	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction			5, 644, 032	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			394, 444 0	50.00
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Pi Direct graduate medical education payment (from Wkst. E-4, I				51. 00 52. 00
53.00	Nursing and Allied Health Managed Care payment	,		0	53.00
54.00	Special add-on payments for new technologies			1, 036	
54. 01					54.01
	Islet isolation add-on payment	60)		0	
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in			0 0	55. 00
55. 00 56. 00 57. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.	tructions) III, column 9, lines 30 tl	nrough 35).	0	55. 00 56. 00 57. 00
55. 00 56. 00 57. 00 58. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.	tructions) III, column 9, lines 30 tl	nrough 35).	0 0	55. 00 56. 00 57. 00 58. 00
55. 00 56. 00 57. 00 58. 00 59. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introduction Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	tructions) III, column 9, lines 30 tl	nrough 35).	0 0 0 0 6, 039, 512	55. 00 56. 00 57. 00 58. 00 59. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introduction Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	tructions) III, column 9, lines 30 tl IV, col. 11 line 200)	nrough 35).	0 0	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introduction Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	tructions) III, column 9, lines 30 tl IV, col. 11 line 200)	nrough 35).	0 0 0 0 0 6, 039, 512 8, 963	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see interest Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	tructions) III, column 9, lines 30 tl IV, col. 11 line 200)	nrough 35).	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introduction Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	tructions) III, column 9, lines 30 tl IV, col. 11 line 200)	nrough 35).	0 0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see introduction Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	tructions) III, column 9, lines 30 tl IV, col. 11 line 200) us line 60)	nrough 35).	0 0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see interest Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instruction (line 61 plus line 65 minus lines 62 and 63)	tructions) III, column 9, lines 30 tl IV, col. 11 line 200) us line 60)	Ç ,	0 0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see interest notations) service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	tructions) III, column 9, lines 30 th IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (se	ee instructions)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see interpretation of physicians' services in a teaching hospital (see interpretation of physicians' services in a teaching hospital (see interpretation of physicians' service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)	tructions) III, column 9, lines 30 th IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (se	ee instructions)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705 0	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see interest not passed to the passed through costs (from Wkst. D, Pt. Ancillary service other passed through costs (from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructions) III, column 9, lines 30 th IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so	ee instructions) s)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration	tructions) III, column 9, lines 30 ti IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so). (For SCH see instructions stration) adjustment (see	ee instructions) s)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705 0 0	55. 00 56. 00 57. 00 58. 00 59. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 69. 00 70. 00 70. 50 70. 87
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see interest not pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	tructions) III, column 9, lines 30 th IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so). (For SCH see instructions stration) adjustment (see in	ee instructions) s)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705 0 0	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 62. 00 63. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 88 70. 89	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see interest not pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (\$410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	tructions) III, column 9, lines 30 th IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so). (For SCH see instructions stration) adjustment (see in	ee instructions) s)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705 0 0	55. 00 56. 00 57. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 88 70. 89
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see interest not pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see insubtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	tructions) III, column 9, lines 30 th IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so). (For SCH see instructions stration) adjustment (see in	ee instructions) s)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705 0 0	55. 00 56. 00 57. 00 58. 00 59. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 90
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVRP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	tructions) III, column 9, lines 30 th IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so). (For SCH see instructions stration) adjustment (see in	ee instructions) s)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705 0 0 0	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 70. 00 70. 87 70. 88 70. 89 70. 91 70. 92
55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 87 70. 87 70. 88 70. 89 70. 90 70. 91	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVRP adjustment amount (see instructions)	tructions) III, column 9, lines 30 th IV, col. 11 line 200) us line 60) structions) r applicable to MS-DRGs (so). (For SCH see instructions stration) adjustment (see in	ee instructions) s)	0 0 0 6, 039, 512 8, 963 6, 030, 549 560, 240 10, 199 53, 223 34, 595 41, 276 5, 494, 705 0 0 0	55. 00 56. 00 57. 00 58. 00 59. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 87 70. 88 70. 90 70. 91 70. 92 70. 93

	Financial Systems DUPONT HOSP ATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0150	Peri od: From 04/01/2017 To 03/31/2018	u of Form CMS-2 Worksheet E Part A Date/Time Pre 8/31/2018 12:	pared:
		Titl∈	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70. 9
	the corresponding federal year for the period prior to 10/1)			_	_	
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 9
0. 98	the corresponding federal year for the period ending on or aft Low Volume Payment-3	ter 10/1)			0	70. 9
0. 99	HAC adjustment amount (see instructions)				0	70. 9
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	49 & 70)			5, 487, 724	
1. 01	Sequestration adjustment (see instructions)	37 & 70)			109, 754	
1. 02	Demonstration payment adjustment amount after sequestration				107, 734	71.0
2. 00	Interim payments				5, 216, 755	
3.00	Tentative settlement (for contractor use only)				0,210,700	73.0
4. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			161, 215	
	73)					
5. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			0	75. 0
	CMS Pub. 15-2, chapter 1, §115.2					
0 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		T			
0.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	tructions)			0	
1. 00 2. 00	Capital outlier from Wkst. L, Pt. I, line 2 Operating outlier reconciliation adjustment amount (see instru	inti ana)			0	91. 0 92. 0
3. 00	Capital outlier reconciliation adjustment amount (see instruc-	,			0	1
4. 00	The rate used to calculate the time value of money (see instru	,			0.00	
5. 00	Time value of money for operating expenses (see instructions)	actions)			0.00	95. 0
6. 00	Time value of money for capital related expenses (see instructions)	tions)			0	
			1	Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
00.00	HSP bonus amount (see instructions)			0	0	100. 0
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)	`		0. 0000000000	0. 0000000000	
02.00	HVBP adjustment amount for HSP bonus payment (see instructions	5)		0	0	102. C
02 00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100 0
	HRR adjustment factor (see instructions)			0.0000	0.0000	
04.00	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr		ictmont	0	0	104. 0
00 00	Is this the first year of the current 5-year demonstration per					200. 0
00. 00	Century Cures Act? Enter "Y" for yes or "N" for no.	rod dilder t	ine 213t			200. 0
	Cost Reimbursement					1
.01. 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				201. 0
02.00	Medicare discharges (see instructions)					202. 0
03.00	Case-mix adjustment factor (see instructions)					203. 0
	Computation of Demonstration Target Amount Limitation (N/A in period)	first year	of the curre	nt 5-year demonst	ration	
04. 00	Medicare target amount					204. C
	Case-mix adjusted target amount (line 203 times line 204)					205. C
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 0
	Adjustment to Medicare Part A Inpatient Reimbursement			· '		1
~~ ~~	Program reimbursement under the \$4104 Demonstration (see inst					1207 0

207. 00

208. 00

209. 00 210. 00 211. 00

212. 00 213. 00 218. 00

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

210.00 Reserved for future use

 Heal th Financial
 Systems
 DUPONT HODITION

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

				10	0 03/31/2018	8/31/2018 12: 0	
			Title	XVIII	Hospi tal	PPS	<u> </u>
		Wkst. E, Pt.	Amt. from	Period to		Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)			·	
		0	1. 00	2. 00	3. 00	4. 00	
1.00	DRG amounts other than outlier payments	1. 00					1. 00
1.01	DRG amounts other than outlier payments for	1. 01	2, 218, 233	2, 218, 233		2, 218, 233	1. 01
	discharges occurring prior to October 1						
1.02	DRG amounts other than outlier payments for	1. 02	2, 110, 281		2, 110, 281	2, 110, 281	1. 02
	discharges occurring on or after October 1						
1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
	for Model 4 BPCI occurring prior to October						
4 04	1	4.04					4 04
1. 04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
	for Model 4 BPCI occurring on or after						
2 00	October 1	2.00	(1.00/	1 050	(0.07/	(1.00/	2 00
2. 00	Outlier payments for discharges (see instructions)	2. 00	61, 926	1, 850	60, 076	61, 926	2. 00
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
2.01	BPCI	2. 02	0	U	U	ا	2.01
3. 00	Operating outlier reconciliation	2. 01	0	0	n	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	4. 00
4.00	Indirect Medical Education Adjustment	3.00			0	0	4.00
5. 00	Amount from Worksheet E, Part A, Line 21	21. 00	0. 000000	0.000000	0. 000000		5. 00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	ol	6.00
6.01	IME payment adjustment for managed care (see	22. 01	0	0	0	o	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	instructions)						
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
0.00	care (see instructions)	20.00	_	0	0	o	9. 00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0	0	0	0	9. 00 9. 01
9.01	lines 6.01 and 8.01)	29.01	0	U	U	ا	9.01
	Disproportionate Share Adjustment		L				
10. 00	Allowable disproportionate share percentage	33.00	0. 2222	0. 2222	0. 2222		10. 00
	(see instructions)	00.00	0.2222	0.2222	0.2222		
11. 00	Di sproporti onate share adjustment (see	34.00	240, 449	123, 223	117, 226	240, 449	11.00
	instructions)						
11. 01	Uncompensated care payments	36.00	1, 013, 143	510, 819	502, 324	1, 013, 143	11. 01
	Additional payment for high percentage of ESR						
12. 00	Total ESRD additional payment (see	46. 00	0	0	0	0	12. 00
40.00	instructions)	47.00		0 054 405			40.00
13.00	Subtotal (see instructions)	47.00	5, 644, 032	2, 854, 125	2, 789, 907	5, 644, 032	
14. 00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14. 00
	and MDH, small rural hospitals only.) (see						
15. 00	instructions) Total payment for inpatient operating costs	49. 00	5, 644, 032	2. 854. 125	2, 789, 907	E 444 022	15. 00
15.00	(see instructions)	49.00	5, 644, 032	2, 854, 125	2, 789, 907	5, 644, 032	15.00
16. 00	Payment for inpatient program capital (from	50. 00	394, 444	-171, 972	566, 416	394, 444	16. 00
10.00	Wkst. L, Pt. I, if applicable)	30.00	374, 444	-1/1, 7/2	500, 410	374, 444	10.00
17. 00	Special add-on payments for new technologies	54.00	1, 036	1, 036	0	1, 036	17. 00
17. 00	Net organ acquisition cost	54.00	1,030	1,030	U	1,030	17. 00
17. 01	Credits received from manufacturers for	68. 00	n	n	n	0	
17.02	replaced devices for applicable MS-DRGs	33. 00			0		17.02
18. 00	Capital outlier reconciliation adjustment	93. 00	0	0	0	0	18. 00
	amount (see instructions)]]	
19. 00	SUBTOTAL			2, 683, 189	3, 356, 323	6, 039, 512	19. 00
	·			•		·	

Heal th	Financial Systems	DUPONT HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO	F	Period: From 04/01/2017 To 03/31/2018	Worksheet E Part A Exhibi Date/Time Pre 8/31/2018 12:	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4.00	
	Capital DRG other than outlier	1.00	347, 522	-169, 598	517, 120		20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	16, 222	8, 133	8, 089	16, 222	20. 01
21. 00	Capital DRG outlier payments	2.00	0	3, 121	-3, 121	0	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	C	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0844	0. 0844	0. 0844		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	30, 700	-13, 628	3 44, 328	30, 700	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	394, 444	-171, 972	566, 416	394, 444	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	C		0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-4, 583	12, 305	-16, 888	-4, 583	30. 00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-2, 398	-1, 553	-845	-2, 398	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	C	0	0	31. 01

0

70. 99

1.00

Υ

2.00

3. 00

0 32. 00

(Amt. to Wkst. E, Pt. A) 4.00

100.00

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 04/01/2017 Part B To 03/31/2018 Date/Ti me Prepared: 8/31/2018 12:02 pm

		10 03/31/2016	8/31/2018 12:	
-		Title XVIII Hospital	PPS	p
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	tions)	9, 099, 721	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)		8, 028, 463 157, 195	
4. 00	Outlier reconciliation amount (see instructions)		157, 143	
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	
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 acqui si ti ons		0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
12. 00	Reasonable charges Ancillary service charges		1 0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	1110 07)	0	
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for p	payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	r payment for services on a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	
18.00	Total customary charges (see instructions)	wifling 10 avagada ling 11) (asa	0	18.00
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y IT Time 18 exceeds Time II) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds line 18) (see	0	20. 00
20.00	instructions)	Ty TT TITLE TT EXCEEDES TITLE TO, (See		20.00
21. 00	Lesser of cost or charges (see instructions)		0	21. 00
22. 00	Interns and residents (see instructions)		0	22. 00
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)		8, 185, 658	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		2 022	25 00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	r CAU soo instructions)	3, 032 1, 419, 449	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p		6, 763, 177	
27.00	instructions)	or as the sam or Tries 22 and 26] (see	0,700,177	27.00
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)		6, 763, 177	
31. 00	Primary payer payments		2, 410	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CEC)	6, 760, 767	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	JES)	0	33. 00
34. 00	Allowable bad debts (see instructions)		199, 490	
35. 00	Adjusted reimbursable bad debts (see instructions)		129, 669	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	162, 725	36. 00
37. 00	Subtotal (see instructions)		6, 890, 436	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R		25	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`	0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	cod dovicos (soo instructions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see mistractions)	0	39. 99
40. 00	Subtotal (see instructions)		6, 890, 411	40. 00
40. 01	Sequestration adjustment (see instructions)		137, 808	1
40. 02	Demonstration payment adjustment amount after sequestration		0	
41.00	Interim payments		6, 762, 931	41.00
42.00	Tentative settlement (for contractors use only)		0	
43.00	Balance due provider/program (see instructions)	1.11 ONO D.1. 45 O. /	-10, 328	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR			
90. 00	Original outlier amount (see instructions)		0	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	93. 00
94.00	Total (sum of lines 91 and 93)		0	94. 00

Peri od: Worksheet E-1
From 04/01/2017
To 03/31/2018 | Date/Time Prepared: 8/31/2018 12:02 pm Provider CCN: 15-0150

					8/31/2018 12:0	02 pm
			XVIII	Hospi tal	PPS	
		I npati en			t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		5, 179, 355		6, 625, 519	1.00
2.00	Interim payments payable on individual bills, either		37, 400)	137, 412	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
0.00	amount based on subsequent revision of the interim rate					0.00
	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		0	(0	3. 02
3.03			(0	3. 03
3.04			(0	3. 04
3. 05	Durand days to Discourse		()	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM	0	(0	0	3. 50
3. 50	ADJUSTWENTS TO PROGRAW	U	(3. 50
3. 52			(0	3. 52
3. 53						3. 53
3. 54			(0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(l ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 216, 755	5	6, 762, 931	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5.02			(0	5. 02
5.03			(0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 52 5. 99
5. 99	5. 50-5. 98)		(ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		161, 215	5	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		(10, 328	6. 02
7.00	Total Medicare program liability (see instructions)		5, 377, 970)	6, 752, 603	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	(J	1. 00	2. 00	0.00
8. 00	Name of Contractor				ı l	8. 00

Heal th	Financial Systems DUPONT HOSP	PI TAL	In Lie	u of Form CMS-	2552-10
From 04/01/2017 To 03/31/2018					epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1. 00
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	1-12			2. 00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			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 l				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified 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	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00					31. 00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32. 00

Health Financial Systems	DUPONT HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0150	Peri od: From 04/01/2017 Worksheet E-3 Part VII To 03/31/2018 Date/Time Prepared: 8/31/2018 12:02 pm

			0 03/31/2018	Date/lime Pre 8/31/2018 12:	
		Title XIX	Hospi tal	PPS	<u> </u>
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			343, 881	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	343, 881	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	343, 881	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		3, 264, 439		8. 00
9.00	Ancillary service charges		3, 190, 327	2, 933, 515	1
10. 00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		6, 454, 766	2, 933, 515	12. 00
40.00	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14.00	basis			0	14 00
14. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		0	0	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0. 000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		6, 454, 766	2, 933, 515	
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	6, 454, 766	2, 589, 634	ı
17.00	line 4) (see instructions)	y 11 1111c 10 exceeds	0, 434, 700	2, 307, 034	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
	16) (see instructions)	,			
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	16)	0	343, 881	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	rs.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	343, 881	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				00.00
30.00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	343, 881	
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions) Utilization review		0	Ü	34. 00 35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 22)	0	343, 881	36.00
	ELIMINATE SETTLEMENT	1 33)	0	-343, 881	
	Subtotal (line 36 ± line 37)		0	-343, 001	
	Direct graduate medical education payments (from Wkst. E-4)		o	O	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		o	0	•
41. 00	Interim payments		0	0	•
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	o	0	•
	chapter 1, §115.2	2,	Ĭ	· ·	
			'		

Health Financial Systems DUPONT 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: 15-0150 | Period: From 04/01/2

| Period: | Worksheet G | From 04/01/2017 | To 03/31/2018 | Date/Time Prepared: 8/31/2018 | 12: 02 pm |

oni y)					8/31/2018 12:	02 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	-236, 866	1	-	0	
2.00	Temporary investments	0	0	0	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	34, 327, 863	0	0	0	
5.00	Other receivable	34, 327, 803		0		
6. 00	Allowances for uncollectible notes and accounts receivable	-4, 271, 246	Ö	0	Ö	
7. 00	Inventory	3, 687, 884	1	0	Ö	1
8.00	Prepai d expenses	1, 376, 121	1	0	0	8. 00
9.00	Other current assets	-184, 452	0	0	0	9. 00
10. 00	Due from other funds	0	_		0	
11. 00	Total current assets (sum of lines 1-10)	34, 699, 304	0	0	0	11. 00
12.00	FI XED ASSETS	1 0/0 000		0		12.00
12. 00 13. 00	Land Land improvements	1, 060, 000 629, 378	1			
14. 00	Accumulated depreciation	-378, 096		-	0	
15. 00	Bui I di ngs	63, 596, 178	1	_	o o	1
16. 00	Accumulated depreciation	-13, 710, 565	1	_	Ö	1
17.00	Leasehold improvements	6, 986, 469	1	0	0	17. 00
18. 00	Accumulated depreciation	-967, 828	0	0	0	18. 00
19. 00	Fi xed equipment	2, 122, 697	1		0	1
20.00	Accumulated depreciation	-1, 845, 874	i	_	0	
21. 00	Automobiles and trucks	24, 168	1	_	0	
22. 00 23. 00	Accumulated depreciation Major movable equipment	-7, 049 37, 834, 377	l .	_	0	
24. 00	Accumulated depreciation	-29, 002, 933	1			1
25. 00	Mi nor equipment depreciable	7, 773, 966		0	Ö	1
26. 00	Accumulated depreciation	-5, 952, 102	l .	0	Ö	1
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	0	-	0	
30. 00	Total fixed assets (sum of lines 12-29)	68, 162, 786	0	0	0	30.00
31. 00	OTHER ASSETS Investments	0	0	0	0	31.00
32.00	Deposits on Leases					1
33. 00	Due from owners/officers	0	0	0	Ö	
34. 00	Other assets	6, 451, 685	Ö	0	o o	1
35.00	Total other assets (sum of lines 31-34)	6, 451, 685	1	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	109, 313, 775	0	0	0	36. 00
	CURRENT LI ABI LI TI ES		1			
37. 00	Accounts payable	4, 416, 234	1			1
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	3, 732, 185 373, 305		0	0	
40. 00	Notes and Loans payable (short term)	412, 393	1	0		1
41. 00	Deferred income	1 412, 373		0	Ö	
42. 00	Accel erated payments	Ö				42. 00
43.00	Due to other funds	-312, 189, 033	0	0	0	43.00
44.00	Other current liabilities	1, 613, 645	0	0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	-301, 641, 271	0	0	0	45. 00
47.00	LONG TERM LIABILITIES		ı	1		1,, 00
46. 00 47. 00	Mortgage payable Notes payable	1 024 020	0		0	
48. 00	Unsecured Loans	1, 034, 829	0		0	1
49. 00	Other long term liabilities	42, 271, 712		0	Ö	1
50. 00	Total long term liabilities (sum of lines 46 thru 49)	43, 306, 541	l .	_	Ö	1
51.00	Total liabilities (sum of lines 45 and 50)	-258, 334, 730	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	367, 648, 505	1			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	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	1
55. 55	replacement, and expansion				l "	55.55
59. 00	Total fund balances (sum of lines 52 thru 58)	367, 648, 505	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	109, 313, 775	0	0	0	60.00
	[59]	l	I		l	I

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

STATEMENT OF CHANGES IN FUND BALANCES

Peri od: From 04/01/2017 03/31/2018

Worksheet G-1 Date/Time Prepared:

8/31/2018 12:02 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 338, 407, 550 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 29, 239, 213 2.00 3.00 Total (sum of line 1 and line 2) 367, 646, 763 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 367, 646, 763 0 11.00 11.00 12.00 ROUNDI NG 0 12.00 6 0 0 0 0 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 367, 646, 757 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 ROUNDI NG 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 0 19.00 Fund balance at end of period per balance 19.00 sheet (line 11 minus line 18)

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

		1	0 03/31/2018	8/31/2018 12:	
	Cost Center Description	Inpatient	Outpati ent	Total	<u> </u>
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES		<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	33, 974, 446		33, 974, 446	1.00
2.00	SUBPROVI DER - I PF	0		0	2. 00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY	0		0	7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	33, 974, 446		33, 974, 446	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	2, 441, 561		2, 441, 561	11. 00
11. 01	NEONATAL INTENSIVE CARE UNIT	32, 395, 193		32, 395, 193	11. 01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	34, 836, 754		34, 836, 754	16. 00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68, 811, 200		68, 811, 200	17. 00
18. 00	Ancillary services	157, 002, 342		561, 259, 334	18. 00
19. 00	Outpati ent servi ces	5, 668, 698	42, 880, 555	48, 549, 253	19. 00
20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVI CES	0	0	0	23. 00
24. 00	CMHC				24. 00
25. 00					25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)	0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	231, 482, 240	447, 137, 547	678, 619, 787	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		400 540 400		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		120, 513, 499		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33. 00		0			33.00
34.00		0			34.00
35. 00	T-+-1	0			35. 00
36.00	Total additions (sum of lines 30-35)	0	0		36.00
37. 00 38. 00	DEDUCT (SPECIFY)				37. 00
38.00					38. 00 39. 00
40. 00					40.00
41. 00					41. 00
41.00	Total deductions (sum of lines 37-41)		0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	ar	120, 513, 499		42.00
43.00	to Wkst. G-3, line 4)	51	120, 513, 499		43.00
	10 mcst. 0 0, 11116 4)	ı	ı I		I

Heal th	Financial Systems DUPONT HOS		In Lie	u of Form CMS-2	
STATEM			Peri od:	Worksheet G-3	
			From 04/01/2017 To 03/31/2018		
				8/31/2018 12:	U2 pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		678, 619, 787	1. 00
2.00	Less contractual allowances and discounts on patients' accounts		529, 511, 482		
3.00	Net patient revenues (line 1 minus line 2)		149, 108, 305	3. 00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		120, 513, 499	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)	,		28, 594, 806	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and 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 MI SCELLANEOUS REVENUE			644, 407	24. 00
25.00	Total other income (sum of lines 6-24)			644, 407	25. 00
26.00	Total (line 5 plus line 25)			29, 239, 213	26. 00
27 00	OTHED EVDENISES (SDECLEV)			0	27 00

0 27.00

29, 239, 213 | 29. 00

28.00

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)

27. 00 OTHER EXPENSES (SPECIFY)

Health Financial Systems DUPONT HOSPI					2552-10
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0150	Peri od: From 04/01/2017 To 03/31/2018	Worksheet L Parts I-III Date/Time Pre 8/31/2018 12:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT			0.17.500	
1.00	Capital DRG other than outlier			347, 522	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier		16, 222 0	1. 01 2. 00	
2. 00	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments		0	2.00	
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			50. 16	
4. 00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0.00	6.00
0.00	1. 01) (see instructions)	The sum of Tries I and I.o.	, corumns r and		0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			5. 07	7. 00
8.00	Percentage of Medicaid patient days to total days (see instructions)			34. 94	8.00
9.00	Sum of lines 7 and 8			40. 01	9.00
10.00	Allowable disproportionate share percentage (see instruc-	tions)		8. 44	10.00
11.00			30, 700	11.00	
12.00	Total prospective capital payments (see instructions)			394, 444	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			11.00	
1.00	Program inpatient routine capital cost (see instructions))		0	1.00
2.00	Program inpatient ancillary capital cost (see instruction			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circums	stances (see instructions)		0	1. 00 2. 00
3.00	Net program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4.00	Applicable exception percentage (see instructions)			0.00	
	Capital cost for comparison to payments (line 3 x line 4)			0.00	5.00
5 00	Percentage adjustment for extraordinary circumstances (se			0.00	
6.00			(line 6)	0	I 7 00
6. 00 7. 00	Adjustment to capital minimum payment level for extraordi		(line 6)	0	
6. 00 7. 00 8. 00	Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7)	nary circumstances (line 2 x	(line 6)	0	8. 00
6. 00 7. 00 8. 00 9. 00	Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a	nary circumstances (line 2 xapplicable)	,	0	8. 00 9. 00
5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7)	nary circumstances (line 2 x applicable) to capital payments (line 8	less line 9)	0	8. 00 9. 00 10. 00
6. 00 7. 00 8. 00 9. 00 10. 00	Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level or	nary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri	less line 9) or year	0	8. 00 9. 00 10. 00 11. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)	nary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus lin	less line 9) or year ne 11)	0 0 0	8. 00 9. 00 10. 00 11. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level on	nary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus line enter the amount on this line	less line 9) or year ne 11)	0 0 0 0	12. 00 13. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level on (if line 12 is negative, enter the amount on this line)	nary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus line enter the amount on this line ver capital payment for the f	less line 9) or year ne 11)	0 0 0 0 0	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Adjustment to capital minimum payment level for extraordicapital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital current year exception payment (if line 12 is positive, carryover of accumulated capital minimum payment level on	nary circumstances (line 2 x applicable) to capital payments (line 8 yer capital payment (from primal payments (line 10 plus line the the amount on this line yer capital payment for the fe instructions)	less line 9) or year ne 11)	0 0 0 0	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00