Health Fina	ancial Systems	DUKES MEMORIAL F	IOSPI TAL	In Lieu	ı of Form CMS-2552-10
	t is required by law (42 USC 1395g;				
	ade since the beginning of the cost				OMB NO. 0938-0050
					EXPIRES 03-31-2022
	ND HOSPITAL HEALTH CARE COMPLEX COST	REPORT CERTIFICATION	Provider CCN: 15-1318	Period: From 01/01/2021	Worksheet S Parts -
AND SEITLE	MENT SUMMARY			To 12/31/2021	Date/Time Prepared:
					5/28/2022 9:17 am
	OST REPORT STATUS				
Provi der	 [X] Electronically prepared 			Date: 5/28/202	22 Time: 9:17 am
use only	2. [] Manually prepared cost r				
	3.[0]If this is an amended re 4.[F]Medicare Utilization. En	port enter the number o ter "F" for full or "L'	of times the provider re ' for low.	esubmitted this co	ost report
Contractor		Date Received:		IPR Date:	
use only	(1) As Submitted 7.	Contractor No.	11. (Contractor's Vendo	r Code: 4
	(2) Settled without Audit 8.	[N] Final Report for [N] Final Report for	this Provider CCN 12. [0 JIT line 5, co	lumn 1 is 4: Enter
	(3) Settled with Addit		this Frovider con	number of tim	es reopened = 0-9.
	(4) Reopened				
	(5) Amended				
PART II -	CERTIFICATION BY A CHIEF FINANCIAL O	FFICER OR ADMINISTRATOR	R OR PROVIDER(S)		
	NTATION OR FALSIFICATION OF ANY INFO		· · · ·	UNISHABLE BY CRIM	INAL, CIVIL AND
ADMI NI STRA	TIVE ACTION, FINE AND/OR IMPRISONMEN	T UNDER FEDERAL LAW. F	URTHERMORE, IF SERVICES	5 IDENTIFIED IN TH	IS REPORT WERE
PROVI DED 0	R PROCURED THROUGH THE PAYMENT DIREC	TLY OR INDIRECTLY OF A	KICKBACK OR WERE OTHERW	ISE ILLEGAL, CRIM	INAL, CIVIL AND
ADMI NI STRA	TIVE ACTION, FINES AND/OR IMPRISONME	NT MAY RESULT.			
CE	RTIFICATION BY CHIEF FINANCIAL OFFIC	ER OR ADMINISTRATOR OF	PROVI DER(S)		
1	HEREBY CERTIFY that I have read the	above certification sta	atement and that I have	examined the acco	mpanvi ng
	ectronically filed or manually submi				
St	atement of Revenue and Expenses prep	ared by DUKES MEMORIAL	HOSPITAL (15-1318) fo	or the cost report	ing period
be	ginning 01/01/2021 and ending 12/31/	2021 and to the best of	f my knowledge and belie	ef, this report an	d statement
ar	e true, correct, complete and prepar	ed from the books and i	records of the provider	in accordance wit	h
	plicable instructions, except as not				
	garding the provision of health care		e services identified in	n this cost report	were
pr	ovided in compliance with such laws	and regulations.			
SI GN/	ATURE OF CHIEF FINANCIAL OFFICER OR A	ADMI NI STRATOR CHECKE	BOX	ELECTRONI C	
	1	2	SIG	NATURE STATEMENT	
1			I have read and agre	ee with the above	certification 1
			statement. I certify	/ that I intend my	el ectroni c
1			cianaturo on this co	ortification bo th	

			signature on this certification be the legally binding equivalent of my original signature.	
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-793, 426	-1, 045, 198	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-144, 586	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-938, 012	-1, 045, 198	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provi c	ler CCN: 1		Period: From 01/01/ To 12/31/	2021 2021	Workshe Part I Date/Ti	me Pre	pared:
	1.00	2.00		2.00				5/28/20	22 9:1	7 am
	1.00 Hospital and Hospital Health Care Co	2.00		3.00		2	1.00			
. 00	Street: 275 WEST 12TH STREET	PO Box:								1.00
. 00	City: PERU	State: IN	Zip Cod	e: 46970	Count	y: MLAMI				2.00
		Component Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P,	
			Number	Number	Туре	Certified	¯Т,	0, or	N)	
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
~~	Hospital and Hospital-Based Componen Hospital		151010	99915	1	07/01/10//	NI	0	Р	2.00
00 00	Subprovider - IPF	DUKES MEMORIAL HOSPITAL	151318	99915	1	07/01/1966	N	0	P	3.00
00	Subprovider - IRF									5.00
.00	Subprovider - (Other)									6.00
. 00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL	15Z318	99915		12/01/2003	Ν	0	N	7.00
	5	SB								
00	Swing Beds - NF									8.00
00	Hospital-Based SNF									9.00
0.00	Hospital-Based NF									10.00
1.00	Hospital-Based OLTC									11.00
2.00	Hospital-Based HHA									12.00
4.00	Separately Certified ASC Hospital-Based Hospice									13.00 14.00
5.00	Hospital-Based Health Clinic - RHC									15.00
6.00	Hospital -Based Health Clinic - FQHC									16.00
7.00	Hospital-Based (CMHC) I									17.00
B. 00	Renal Dialysis									18.00
9.00	Other									19.00
						From:		То		
0.00	Cast Departies Deviad (my (dd (my m))					1.00	201	2.0		20.00
	Cost Reporting Period (mm/dd/yyyy)					01/01/20	J21	12/31/	2021	20.00
1.00	Type of Control (see instructions)					4				21.00
					1.00	2.00		3. ()()	
	Inpatient PPS Information									
2.00	Does this facility qualify and is it	currently receiving pay	ments for	-	N					22.00
	disproportionate share hospital adju			2						
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		ndment							
2. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un		s for thi	c	Ν	N				22. 01
2.01	cost reporting period? Enter in colu				N.					22.0
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft									
2. 02	Is this a newly merged hospital that				Ν	N				22. 02
	payments to be determined at cost re									
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob									
	or "N" for no, for the portion of th									
	October 1.									
	Did this hospital receive a geograph	la realeccification from	urban to	o	N	N		N		22.0
2. 03		IC recrassification from								
2. 03	rural as a result of the OMB standar	ds for delineating stati	stical ar							
2. 03	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c	ds for delineating stati olumn 1, "Y" for yes or	stical ar "N" for r	10						
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	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	DSPITAL Provider CC	CN: 15-1318		eri od:	In Lie	Work	kshee	t S-2	
					Fr To	rom 01/01 0 12/31	1/2021 1/2021		e/Tim	e Prej 2 9:1	pared: 7 am
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Me el u	ut-of State di cai d i gi bl e npai d	Medica HMO da		Oth Medi da	cai d	
1 00		1.00	2.00	3.00		4.00	5.00		6.		04.00
25. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter 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-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	0				0		0		0	24.00 25.00
	HMO paid and eligible but unpaid days in column 5.					Urban/Ri	ural S	Dato	of	Cooge	
						1. 0		Date	2.00		
	Enter your standard geographic classification (not wa		at the beg	ginning of t	the		2	2			26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status ~ "2" for r cation in	ural. If ap column 2.	pplicable,			2				27.00
35.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number or	periods su	H Status Ir	1		0	1			35.00
						Begi nn		E	ndi ng	0	
36.00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb	ber	1.0	0		2.00)	36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	es.					0)			37.00
37. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo										37.01
	instructions)	or yes or	N" for no.	(see							
38.00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.	s of MDH st	atus. Ifli	ne 37 is							38.00
38.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	s of MDH st	atus. Ifli	ne 37 is		Y/I			Y/N		38.00
39. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	s of MDH st f periods i payment a), (ii), or the mileage	atus. If li n excess of djustment f (iii)? Ent requiremer	ne 37 is one and for low volu ter in columnts in	nn	<u>Y/r</u> 1.0 N	00		Y/N 2.00 N)	
39. 00 40. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii	payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y	ne 37 is one and for low volu er in colum hts in 2 "Y" for yes (" for yes o	nn es or	1.0	0		2.00 N		38. 00 39. 00 40. 00
39. 00 40. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol	payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y	ne 37 is one and for low volu er in colum hts in 2 "Y" for yes (" for yes o	nn es or	1.0 N	00 V	XVI	2.00 N	XI X	39.00
9.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol	payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y	ne 37 is one and for low volu er in colum hts in 2 "Y" for yes (" for yes o	nn es or	1.0 N	0		2.00 N		39.00
9.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	s of MDH st f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat	ne 37 is for low volu er in colum its in 2 "Y" for yes (" for yes or yes or "N" f	nn es or for acc	1.0 N N ordance	00 V 1.00 N	0 2. N	2.00 N N	XI X 3.00 N	39. 00 40. 00 45. 00
39.00 40.00 45.00 46.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	s of MDH st f periods i payment a), (ii), or the mileage i)? Enter n adjustmen ber 1. Ente (see inst nt for disp eption for t. L, Pt. I	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst	ne 37 is one and for low volu er in colum hts in ? "Y" for yes /" for yes of /" for yes or /" for yes or es share in ary circumst	nn es for acc tanc I t	1.0 N N ordance es hrough	V 1.00	0 2. N	2.00 N N	XI X 3.00	39. 00 40. 00 45. 00 46. 00
39.00 40.00 45.00 46.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment	s of MDH st f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst nt for disp eption for t. L, Pt. I capital? E	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for	ne 37 is one and for low volu er in columnts in 2 "Y" for yes (" for yes or yes or "N" for e share in ary circumst L-1, Pt. yes or "N"	mn es for acc tanc I t	1.0 N N ordance es hrough	00 V 1.00 N	0 2. 1 1	2.00 N N	XI X 3.00 N	39.00 40.00 45.00 46.00 47.00
39.00 40.00 45.00 46.00 47.00 48.00 56.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks ²⁷ Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of	s of MDH st f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to column cograms in cable CRs)	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for <u>Y" for yes</u> ME programs 1 is "Y", the prior y	ne 37 is one and for low volu- rer in column ts in 2 "Y" for yes (" for yes or yes or "N" for e share in ary circumstant c. L-1, Pt. yes or "N" or "N" for s? Enter "Y" or if this year or penu	nn es for for tanc l t ' fo no. ' fo hos ul ti	1.0 N N ordance es hrough r no. r yes or pital mate	DO V 1.00 N N N N	0 2. 1 1	2.00 N N N N N N	XI X 3.00 N N	39. OC
39.00 40.00 45.00 46.00 46.00 48.00 56.00 57.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks? Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pi year, and are you are impacted by CR 11642 (or applic	s of MDH st f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRs) umn 2. period duri r yes or "N th of this (", complet	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs 1 is "Y", the prior y MA direct C ng which re " for no ir cost report	ne 37 is one and for low volu- rer in column hts in 2 "Y" for yes (" for yes or yes or "N" for e share in ary circumstant circumstant or "N" for s? Enter "Y" or if this year or penu- SME payment esidents in n column 1. ing period?	nn es for acc tanc l t ' fo hos ul ti red app If ? E	1.0 N N ordance es hrough r no. r yes or pital mate uction? roved column 1 nter "Y"	00 1.00 N N N N N	0 2. 1 1	2.00 N N N N N N	XI X 3.00 N N	39.00 40.00 45.00 46.00 47.00 48.00 56.00
39. 00 40. 00 45. 00 46. 00 48. 00 56. 00 57. 00 58. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks? Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a nospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 2. If column 2 is "N"	s of MDH st f periods i payment a), (ii), or the mileage i)? Enter n adjustmen per 1. Ente (see inst (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved G e to column rograms in cable CRs) umn 2. period duri r yes or "N th of this (", complet j, if appli	atus. If li n excess of djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for y" for yes ME programs 1 is "Y", the prior y MA direct C ng which re " for no ir cost report e Worksheet cable. or physiciz	ne 37 is one and for low volu- er in column ts in 2 "Y" for yes (" for yes or yes or "N" for es share in ary circumst c. L-1, Pt. yes or "N" or "N" for s? Enter "Y" or if this year or penn EME payment sidents in a column 1. ing period? : E-4. If co	nn es for for acc tanc l t ' fo no. ' fo hos ulti red app If ? E blum	1.0 N N ordance es hrough r no. r yes or pital mate uction? roved column 1 nter "Y" n 2 is	00 1.00 N N N N N	0 2. 1 1	2.00 N N N N N N	XI X 3.00 N N	39.00 40.00 45.00 46.00 47.00 48.00

	Financial Systems DUKES AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		L HOSPITAL Provider C		'eri od:	worksheet S-2	
					rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	
				NAHE 413.85	Worksheet A	5/28/2022 9:1 Pass-Through	7 am
				Y/N	Line #	Qualification Criterion Code	
		(114115)		1.00	2.00	3.00	1 10 00
60.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. :R) NAHE	see If column 1	N			60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61. 03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
61.06	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 Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(1 10			1.00	2.00	3.00	4.00	(1.10
	Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 10
						1.00	-
	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which	1	62.00
	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ti ons) Teachi	ng Health Cen	ter (THC) into			62.00
63.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Setti ettings	ings during this c	ost reporting p		N	63.00
	<u>"Y" for yes or "N" for no in column 1. If yes, comple</u>		53 04 thi ough	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			INIS base year	is your cost r		
64.00	Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trair -primar all nor non-pr columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.00

OSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provider (Fi	eriod: rom 01/01/2021	Worksheet S-2 Part I	
			To	b 12/31/2021	Date/Time Pre 5/28/2022 9:1	pared: 7 am
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
-	1 00	2 00	Si te	4 00	5.00	-
5.00 Enter in column 1, if line 63		2100				65.0
trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted FTEs		Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
						-
Section 5504 of the ACA Current)	ear FTF Residents in	n Nonnrovider Settin				
beginning on or after July 1, 201	0	•				
FTEs that trained in your hospita	I. Enter in column 3	3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
-	1.00	2.00	3.00	4.00	5.00	1
7.00 Enter in column i, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)			0.00			
Image: Construction of the action o						
			tain an LDE auto			70.0
	chiathic rachity (I	FIJ, UL UUES IL CON	tarii ali IPE SUDP			70. C
1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	004? Enter "Y" for lity train residents (D)? Enter "Y" for	yes or "N" for n s in a new teach yes or "N" for n	io. (see ii ng io.	0	71.0
5.00 Is this facility an Inpatient Reh	abilitation Facility	(IRF), or does it o	contain an IRF	N		75. C
subprovi der? Enter "Y" for yes a					1 1	1

Health Financial Systems DUKES MEMORIAL	- HOSPI TAL		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	1	Period: From 01/01/2021 Fo 12/31/2021	Worksheet S- Part I Date/Time Pr	2
				5/28/2022 9: 1.00	<u>17 am</u>
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			period? Enter	N N	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)	TEFRA? Ente	r "Y" for yes	or "N" for no.	N	85.00
86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			n		86.00
87.00 Is this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified	under section	V	N	87.00
Title V and XIX Services			1.00	XI X 2.00	
90.00 Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	I services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			N	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	al certificat			N	92.00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.			N	N	94.00
 95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column. 			0. 00 N	0.00 N	95.00 96.00
 97.00 If line 96 is "Y", enter the reduction percentage in the app 98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX. 	terns and res	idents post	0. 00 Y	0. 00 Y	97.00 98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti			Y	Y	98.01
 title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o for title V, and in column 2 for title XIX. 			Y	Y	98. 02
 98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX. 			Ν	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98.04
98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c			Y	Y	98.05
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.</pre>			Y	Y	98.06
Rural Providers 105.00Does this hospital gualify as a CAH?			Y		105.00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	hod of payment	N		106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP	1. (see ins you train I&R F and/or IRF	tructions) s in an	N		107.00
Enter "Y" for yes or "N" for no in column 2. (see instruction 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	Ν		108.00
-	Physi cal 1.00	0ccupational 2.00	Speech 3.00	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Ŷ	Y	Y	N	109.00
				1.00	-
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. I	f yes,	N	110.00

Heal th Financial Systems DUKES MEMORIAL HOSPITAL			u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide		Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part I Date/Time Pr 5/28/2022 9:	epared:
		1.00		_
111.00 If this facility qualifies as a CAH, did it participate in the Frontie Health Integration Project (FCHIP) demonstration for this cost reporti "Y" for yes or "N" for no in column 1. If the response to column 1 is integration prong of the FCHIP demo in which this CAH is participating Enter all that apply: "A" for Ambulance services; "B" for additional b for tele-health services.	ng period? Enter Y, enter the g in column 2.	1.00 N	2.00	111.00
	1.00	2.00	3.00	_
112. 00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for r in column 1. If column 1 is yes, enter the method used (A, B, or E onl in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based of the definition in CMS Pub. 15-1, chapter 22, §2208.1.	y) 			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	- N			116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	er N			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter if the policy is claim-made. Enter 2 if the policy is occurrence.	- 1	1		118.00
118.01 List amounts of malpractice premiums and paid losses:	Premi ums 1.00 15,15	Losses 2. 00 2 20, 547	I nsurance	0118.01
		1.00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost center oth Administrative and General? If yes, submit supporting schedule listin and amounts contained therein.		N N	2.00	118. 02
119.00D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for Hold Harmless provision in ACA \$3121 and applicable amendments? (see i Enter in column 2, "Y" for yes or "N" for no.	"Y" for yes or or the Outpatient	Ν	Ν	119.00 120.00
 121. 00 Did this facility incur and report costs for high cost implantable dev patients? Enter "Y" for yes or "N" for no. 	vices charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", e the Worksheet A line number where these taxes are included.		N		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and	"N" for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the ce	ertification date			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the cer	tification date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the cer	tification date			128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the cert	ification date ir	n		129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the	certi fi cati on			130.00
date in column 1 and termination date, if applicable, in column 2. 131.00 f this is a Medicare certified intestinal transplant center, enter th	ne certification			131.00
date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare certified islet transplant center, enter the cer				132.00
in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the OPO numb				133. 00 134. 00
and termination date, if applicable, in column 2.				

	X IDENTIFICATION DA		HOSPI TAL Provi der CC	N: 15-131		riod: om 01/01/202 ⁻		-2
					То	12/31/2021	1 Date/Time Pr 5/28/2022 9:	
1.00		2.00				3.00	J72072022 9.	
If this facility is part of a cha	in organization, ent		nes 141 throu	ugh 143 ti	he nam		s of the	
home office and enter the home of			ntractor numbe					
41.00 Name: COMMUNITY HEALTH SYSTEMS,		lame: WPS		Contr	actor'	s Number: 522	280	141. (
42.00 Street: 4000 MERIDIAN BLVD 43.00 City: FRANKLIN	PO Box: State:	TN		Zip (`odo·	370	167	142. 0 143. 0
43. 00 city. TRANCEIN	Jtate.	111			Joue.	570		145.0
							1.00	
44.00 Are provider based physicians' co	sts included in Work	sheet A?	,				Y	144. (
					-	1.00		_
45 001 f costs for repair convisos are a	aimad on Wkst A	ino 74	and the costs	for		1.00	2.00	145 (
45.00 f costs for renal services are c inpatient services only? Enter "Y	' for ves or "N" for	no in c	ale the costs olumn 1 lf c	olump 1 i	s			145. (
no, does the dialysis facility in								
period? Enter "Y" for yes or "N"					,			
46.00 Has the cost allocation methodolog						Ν		146.
Enter "Y" for yes or "N" for no in			-2, chapter 4	0, §4020)) If			
yes, enter the approval date (mm/	uuzyyyy) in column 2							
							1.00	
47.00Was there a change in the statist	cal basis? Enter "Y	" for ye	s or "N" for	no.			N	147.
48.00Was there a change in the order o	f allocation? Enter	"Y" for	yes or "N" fo	or no.			N	148. (
49.00Was there a change to the simplif	ed cost finding met	hod? Ent					N	149. (
		-	Part A	Part		Title V	Title XIX	_
Does this facility contain a prov	idor that qualifier	for an o	1.00	2.00		3.00	4.00	-
or charges? Enter "Y" for yes or								
55. 00Hospi tal			N	N		N	N	155.
56.00 Subprovider - IPF			Ν	N		Ν	N	156.
57.00 Subprovider - IRF			Ν	N		N	N	157.
58. 00 SUBPROVI DER								158. (
59.00 SNF 60.00 HOME_HEALTH_AGENCY			N N	N N		N N	N N	159. 0 160. 0
61. 00 CMHC			IN	N		N	N	161.0
							1.00	
Multicampus								
65.00 Is this hospital part of a Multica	ampus hospital that	has one	or more campu	ises in di	fferer	nt CBSAs?	N	165.0
Enter "Y" for yes or "N" for no.	Name		County	State	Zip (Code CBSA	FTE/Campus	
			1.00		3.0			
	0			2.00		0 4.00	5.00	
56.00 fline 165 is yes, for each	0	-	1.00	2.00	5.0	00 4.00	5.00	00 166. (
66.00 If line 165 is yes, for each campus enter the name in column	0		1.00	2.00	5.0	00 4.00		00 166. (
0, county in column 1, state in	0		1.00	2.00	5.0	00 4.00		00 166. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	0		1.00	2.00	3.0	00 4.00		00 166. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	0		1.00	2.00	3.0	00 4.00		00 166. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	0		1.00	2.00	0.0	00 4.00		00 166. (
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								00 166. (
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI	T) incentive in the		n Recovery and	d Rei nves	tment		0.1	
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use	T) incentive in the r under §1886(n)? E	nter "Y"	n Recovery and for yes or "	ł Reinves N" for no	tment .	Act	0.1	167.0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10	T) incentive in the r under §1886(n)? E D5 is "Y") and is a	nter "Y" meaningf	<u>n Recovery and</u> for yes or " ful user (line	ł Reinves N" for no	tment .	Act	0.1	167.0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) reasonable cost incurred for the line	T) incentive in the r under §1886(n)? E 55 is "Y") and is a HIT assets (see inst	nter "Y" meaningf ructions	<u>n Recovery and</u> for yes or " ul user (line)	d Reinves N" for no 167 is '	tment , p. 'Y"), e	Act enter the	0.1	167. (168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 is this provider a meaningful use 68.00 if this provider is a CAH (line 1) reasonable cost incurred for the b	T) incentive in the ounder §1886(n)? E 5 is "Y") and is a HT assets (see inst not a meaningful use	nter "Y" meaningf ructions r, does	<u>n Recovery and</u> for yes or " ul user (line) this provider	<u>1 Reinves</u> N" for no e 167 is '	tment . 'Y"), e for a	Act enter the	0.1	167. (168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 68.01 If this provider is a CAH and is in exception under §413.70(a)(6)(ii)	T) incentive in the r under §1886(n)? E D5 is "Y") and is a HT assets (see inst not a meaningful use ? Enter "Y" for yes	nter "Y" meaningfi ructions r, does or "N" fo	n Recovery and for yes or " oul user (line) this provider for no. (see i	1 Reinves N" for no 167 is ' qualify nstructio	tment . 'Y"), e for a ons)	Act enter the hardship	0.1	167. (168. (168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 68.01 If this provider is a CAH and is in exception under §413.70(a)(6)(ii)	T) incentive in the r under §1886(n)? E D5 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y	nter "Y" meaningfi ructions r, does or "N" fo	n Recovery and for yes or " oul user (line) this provider for no. (see i	1 Reinves N" for no 167 is ' qualify nstructio	tment . 'Y"), e for a ons)	Act enter the hardship '), enter the	0. 1 1. 00 Y 0.	167. (168. (168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10) reasonable cost incurred for the 11 reasonable cost incurred for the 16 68.01 If this provider is a CAH and is i exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	T) incentive in the r under §1886(n)? E D5 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y	nter "Y" meaningfi ructions r, does or "N" fo	n Recovery and for yes or " oul user (line) this provider for no. (see i	1 Reinves N" for no 167 is ' qualify nstructio	tment . 'Y"), e for a ons)	Act enter the hardship '), enter the Beginning	0.1 1.00 Y 0. Endi ng	00 166. (167. (168. (168. (00 169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 01 If this provider is a meaningful to transition factor. (see instruction	T) incentive in the r under §1886(n)? E 25 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons)	nter "Y" meaningf ructions r, does or "N" f ") and i	1 Recovery and for yes or " ul user (line) this provider or no. (see i s not a CAH (<u>Reinves</u> N" for no 167 is ' qualify nstructio line 105	tment . 'Y"), e for a ons)	Act enter the hardship '), enter the	0. 1 1. 00 Y 0.	167. (168. (168. (00169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the left sprovider is a CAH and is in exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	T) incentive in the r under §1886(n)? E 25 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons)	nter "Y" meaningf ructions r, does or "N" f ") and i	1 Recovery and for yes or " ul user (line) this provider or no. (see i s not a CAH (<u>Reinves</u> N" for no 167 is ' qualify nstructio line 105	tment . 'Y"), e for a ons)	Act enter the hardship '), enter the Beginning	0.1 1.00 Y 0. Endi ng	167. (168. (168.) 00169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful to transition factor. (see instruction	T) incentive in the r under §1886(n)? E 25 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons)	nter "Y" meaningf ructions r, does or "N" f ") and i	1 Recovery and for yes or " ul user (line) this provider or no. (see i s not a CAH (<u>Reinves</u> N" for no 167 is ' qualify nstructio line 105	tment . 'Y"), e for a ons)	Act enter the hardship '), enter the Beginning	0.1 1.00 Y 0. Endi ng	167. (168. (168.) 00169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	T) incentive in the r under §1886(n)? E D5 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons) peginning date and e	nter "Y" meaningf ructions r, does or "N" f ") and i nding da	n Recovery and for yes or " ul user (line) this provider for no. (see i s not a CAH (te for the re	A Reinves N" for no 167 is ' qualify nstructio line 105	tment . 'Y"), e for a ons)	Act enter the hardship '), enter the Beginning	0.1 1.00 Y 0. Endi ng	167. (168. (168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the exception under \$413.70(a) (6) (ii) ft his provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this provider is a meaningful transition factor. (see this provider the	T) incentive in the r under §1886(n)? E D5 is "Y") and is a HIT assets (see inst not a meaningful use ? Enter "Y" for yes user (line 167 is "Y ons) peginning date and e	nter "Y" meaningf ructions or "N" f ") and i nding da	n Recovery and for yes or " ul user (line) this provider or no. (see i s not a CAH (te for the re viduals enrol	<u>d Reinves</u> N" for no e 167 is ' qualify nstruction line 105 porting	tment .). 'Y"), (for a ons) is "N'	Act enter the hardship '), enter the Beginning 1.00	0.1 1.00 Y 0. Endi ng 2.00	167. (168. (168. (00169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) reasonable cost incurred for the I exception under \$413.70(a)(6)(ii) 69.00 If this provider is a meaningful use transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	T) incentive in the or under §1886(n)? E D5 is "Y") and is a HIT assets (see inst not a meaningful use Penter "Y" for yes user (line 167 is "Y ons) Deginning date and e vider have any days reported on Wkst. S-	nter "Y" meaningfa ructions or "N" fo ") and i nding da for indi 3, Pt. I	<u>n Recovery and</u> for yes or " ul user (line) this provider or no. (see i s not a CAH (te for the re viduals enrol , line 2, col	1 Reinves N" for no 167 is ' qualify nstruction line 105 porting led in . 6? Ente	tment . Y"), e for a pns) is "N' - -	Act enter the hardship '), enter the Beginning 1.00	0.1 1.00 Y 0. Endi ng 2.00	167. 168. 168. 00169. 170.

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pro 5/28/2022 9:	epared
				Y/N	Date	
		<u> </u>		1.00	2.00	_
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ente	er all dates in t	he	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in co	lumn 2. (see	instructions)		
			Y/N	Date	V/I	_
0.0		0.1.6	1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare Pr yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, "V" for	N			2. (
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of 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)	fices, drug er or its the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		1			
. 00 . 00	Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, lable in	N			4.0
	those on the filed financial statements? If yes, submit reco					
	Approved Educational Activities			Y/N 1.00	Legal Oper. 2.00	
. 00	Column 1: Are costs claimed for a nursing program? Column 2	. If ves is	s the provide	r N		6.0
	is the legal operator of the program?					
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing programs and/or allied health programs approved		ved during the	e N		7.0
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved g	raduate medio	cal education	Ν		9. (
. 00	program in the current cost report? If yes, see instructions					,
0. 00	Was an approved Intern and Resident GME program initiated or		the current	Ν		10.0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
	reaching Program on worksneet A? IT yes, see first actrons.				Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement		*		N	14.
5.00	Did total beds available change from the prior cost reportin	<u>v</u> 1	<u>yes, see ins</u> rt A		N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
5. 00	Was the cost report prepared using the PS&R Report only? 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)	Y	03/08/2022	Y	03/08/2022	16.
7.00	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	Ν		N		17.
3. 00	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	Ν		N		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

	Financial Systems DUKES MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1318	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet S- Part II Date/Time Pro 5/28/2022 9:	2 epared:
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
D. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS I	HOSPI TALS)			
2.00 3.00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made dur	ing the cost	N N	22. 00 23. 00
4. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	d into during	this cost re	porting period?	Ν	24.0
5. 00	Have there been new capitalized leases entered into during instructions.	lfyes, see	Ν	25. 0		
5. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	f yes, see	Ν	26. 0		
7.00	Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? If	yes, submit	Ν	27.00
3. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit en	tered into du	ring the cost	reporting	N	28.0
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	Ν	29. 0
D. 00	treated as a funded depreciation account? If yes, see instru- Has existing debt been replaced prior to its scheduled matu instructions.		debt? If yes	, see	Ν	30. 0
1. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	, see	Ν	31.0
2. 00	Purchased Services Have changes or new agreements occurred in patient care services		ed through co	ntractual	N	32. 0
3. 00	arrangements with suppliers of services? If yes, see instru- If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	Ν	33. 0
1 00	Provider-Based Physicians Are services furnished at the provider facility under an ar	rangement with	n provi der-ba	sed physicians?	Y	34.0
5. 00	If yes, see instructions.	0			Y	35.0
5. 00	physicians during the cost reporting period? If yes, see in			Y/N	Date	
				1.00	2.00	_
	Home Office Costs			1.00	2.00	
	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 Y		36. C 37. C
	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	ice different	from that of		12/31/2020	38.0
9. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			, N		39.0
D. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	Ν		40.0
		1.	00	2.	00	_
1. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KUZI WA		TSI GA		41.0
2. 00	respectivel y.	COMMUNITY HEAL	_TH SYSTEMS,			42.0
		INC 615-465-3416		KUZIWA TSIGA@CI	AS NET	43.0

Heal th	Financial Systems DUKES MEMOR	I AL HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1318	Period: From 01/01/2021	Worksheet S-2 Part II			
				Date/Time Pre 5/28/2022 9:1	pared: 7 am		
		3.00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	MANAGER, REVENUE MANAGEME	NT		41.00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	ΔΙ ΠΔΤΔ	Provider CC	N· 15_1318	Peri od:	Worksheet S-3	
1105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC			SN: 13-1310	From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
1		1.00	2.00	3.00	4.00	5.00	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	21	7,60	88, 155. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF 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		21	7,60	65 88, 155. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	4	1, 40	50 17, 421. 00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	10.00					12.00
13.00	NURSERY	43.00	0.5	0.1	405 574 00	0	13.00
14.00	Total (see instructions)		25	9, 12	25 105, 576. 00	0	14.00
15.00 16.00	CAH visits SUBPROVIDER - IPF					0	15.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC – CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26. 25
27.00	Total (sum of lines 14-26)		25			_	27.00
28.00	Observation Bed Days					0	
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00 32.00	Employee discount days - IRF Labor & delivery days (see instructions)		0		0		31.00
32.00	Total ancillary labor & delivery room		0		U		32.00
JZ. UI	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges				1		33.01

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1318	Period: From 01/01/2027 To 12/31/2027		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 545	91	3, 6	73		1.00
. 00	HMO and other (see instructions)	334	710				2.00
. 00	HMO IPF Subprovider	0	0				3.00
. 00	HMO IRF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	724	0	1, 02	20		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		16	23	35		6.00
. 00	Total Adults and Peds. (exclude observation	2, 269	107	4, 92	28		7.00
	beds) (see instructions)						
. 00	INTENSIVE CARE UNIT	267	23	72	26		8.0
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL INTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		26		55		13.0
4.00	Total (see instructions)	2, 536	156	5,90	0.00	199.48	
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00 9.00	SUBPROVIDER						18. C
9.00 0.00	SKILLED NURSING FACILITY NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						20.0
2.00	HOME HEALTH AGENCY						21.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE						24.0
4. 10	HOSPICE (non-distinct part)				0		24.
5.00	CMHC - CMHC				0		25.0
6.00	RURAL HEALTH CLINIC						26.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
7.00	Total (sum of lines 14-26)		-		0.00		
8.00	Observation Bed Days		0	6'	12		28.0
9.00	Ambul ance Trips	0					29.0
0.00	Employee discount days (see instruction)				0		30.0
1.00	Employee discount days - IRF				0		31. (
2.00	Labor & delivery days (see instructions)	О	0		0		32.0
2.01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days	О					33.0
3 01	LTCH site neutral days and discharges	0					33.0

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/28/2022 9:1	pared:
		Full Time Equivalents	Di s		charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 15.00 15.00 15.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 26.00 28.00 28.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0.00	0	3	14.00 89 41 57 254 0 0 89 41	991	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 27.00 28.00 27.00 28.00 29.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.0
28.00 29.00 30.00 31.00 32.00 32.01 33.00		0.00			0 0		

	Financial Systems	DUKES MEMORIAL					u of Form CMS-2	
HOSPI T	AL WAGE RELATED COSTS		Provi der	CCN:	15-1318	Period: From 01/01/2021	Worksheet S-3 Part IV	
						To 12/31/2021		pared.
						10 12/01/2021	5/28/2022 9:1	
							Amount	
							Reported	
							1.00	
	PART IV - WAGE RELATED COSTS Part A - Core List							-
	RETIREMENT COST							-
1.00	401K Employer Contributions						222, 815	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrib	ution					0	
3.00	Nongualified Defined Benefit Plan Cost (see						0	
4.00	Qualified Defined Benefit Plan Cost (see ins						0	
	PLAN ADMINISTRATIVE COSTS (Paid to External (
5.00	401K/TSA Plan Administration fees						0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla	n					0	6.00
7.00	Employee Managed Care Program Administration						0	7.00
	HEALTH AND INSURANCE COST							1
3.00	Health Insurance (Purchased or Self Funded)						0	8.00
3. 01	Health Insurance (Self Funded without a Thir	d Party Administr	ator)				0	
3. 02	Health Insurance (Self Funded with a Third P	arty Administrato	r)				1, 738, 093	8. 02
3. 03	Health Insurance (Purchased)						0	8. 03
9.00	Prescription Drug Plan						0	
10.00	Dental, Hearing and Vision Plan							10.00
11.00	Life Insurance (If employee is owner or bene							11.00
12.00	Accident Insurance (If employee is owner or							12.00
13.00	Disability Insurance (If employee is owner o							13.00
14.00	Long-Term Care Insurance (If employee is own	er or beneficiary)				0	
15.00	'Workers' Compensation Insurance						120, 242	
16.00	Retirement Health Care Cost (Only current ye Non cumulative portion)	ar, not the extra	ordinary a	CCLUS	i require	ed by FASB 106.	0	16.00
	TAXES							
17.00	FICA-Employers Portion Only						771, 182	17 00
18.00	Medicare Taxes - Employers Portion Only						180, 357	
19.00	Unemployment Insurance							19.00
	State or Federal Unemployment Taxes						31, 331	
	OTHER							
21.00	Executive Deferred Compensation (Other Than	Retirement Cost R	eported on	line	es 1 throu	ugh 4 above. (see	0	21.00
	instructions))							
22.00	Day Care Cost and Allowances						0	22.00
23.00	Tuition Reimbursement						0	23.00
24.00							3, 085, 641	24.00
	Part B - Other than Core Related Cost							
25.00	OTHER WAGE RELATED COSTS (SPECIFY)							25.00

Heal th	Financial Systems DUKES MEMORIAL H	OSPI TAL		In Li€	eu of Form CMS-2	2552-10		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN	l: 15-1318	Period: From 01/01/2021	Worksheet S-1	0		
				To 12/31/2021	Date/Time Pre 5/28/2022 9:1			
					1.00			
	Uncompensated and indigent care cost computation				1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by line	e 202 columr	1 8)	0. 189404	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				6, 588, 899	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		с н. I.	. 10		3.00		
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr			al d ?	0	4.00 5.00		
6.00	Medicaid charges				48, 043, 551	6.00		
7.00	Medicaid cost (line 1 times line 6)		9, 099, 641	7.00				
8.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	(line 7 minus	s sum of lir	nes 2 and 5; if	2, 510, 742	8.00		
	Children's Health Insurance Program (CHIP) (see instructions for	or each line))					
9.00	Net revenue from stand-alone CHIP				0	9.00		
	Stand-alone CHIP charges				0	10.00		
	Stand-alone CHIP cost (line 1 times line 10)			с н	0	11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP (enter zero)				0	12.00		
	Other state or local government indigent care program (see inst				-			
	Net revenue from state or local indigent care program (Not incl				0	13.00 14.00		
	Charges for patients covered under state or local indigent care 10)		ot included	In Thes 6 of	_			
15.00	State or local indigent care program cost (line 1 times line 14		<i></i>		0	15.00		
16.00	Difference between net revenue and costs for state or local inc 13; if < zero then enter zero)	digent care p	program (lir	ne 15 minus line	0	16.00		
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	/local_indic	ent care progra	IIS (See			
	instructions for each line)			, pg				
	Private grants, donations, or endowment income restricted to fu				0			
	Government grants, appropriations or transfers for support of h			(<u> </u>	0	18.00		
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	Indigent ca	are programs	s (sum or lines	2, 510, 742	19.00		
			Uni nsured	Insured	Total (col. 1			
		-	patients 1.00	patients 2.00	+ col . 2) 3.00			
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00			
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	cility	2, 839, 2	50 0	2, 839, 250	20.00		
21.00	Cost of patients approved for charity care and uninsured discou instructions)	unts (see	537, 70	55 0	537, 765	21.00		
22.00	Payments received from patients for amounts previously written charity care	off as	2, 32	21 0	2, 321	22.00		
23.00	Cost of charity care (line 21 minus line 22)		535, 44	14 O	535, 444	23.00		
					1.00			
24.00	Does the amount on line 20 column 2, include charges for patier		nd a length	of stay limit	N N	24.00		
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th stay limit		care program	n's length of	0	25.00		
26.00	Total bad debt expense for the entire hospital complex (see ins	structions)			4, 507, 826	26.00		
	Medicare reimbursable bad debts for the entire hospital complex (see the		uctions)		468, 214			
	Medicare allowable bad debts for the entire hospital complex (see instructions) 720, 329 27.							
28.00	Non-Medicare bad debt expense (see instructions)		r.		3, 787, 497			
	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	bense (see in	nstructions)	1	969, 482			
	Cost of uncompensated care (line 23 column 3 plus line 29)	no 20)			1, 504, 926			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 015, 668	31.00		

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider C	CN: 15-1318	Period:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col . 3 +- col . 4)	
-	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT		1,068,389	1, 068, 38	9 961, 662	2, 030, 051	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		3, 033, 164				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	112, 741	66, 021	178, 76	2 2, 115, 353	2, 294, 115	4.00
5. 01 00570 ADMI TTI NG	0	0		0 1, 333, 403		5. 01
5. 02 00590 ADMINI STRATI VE AND GENERAL	1, 874, 549	10, 373, 936				5.02
7.00 00700 OPERATION OF PLANT	318, 798	1, 662, 448				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	81, 911				8.00
9. 00 00900 HOUSEKEEPI NG	414, 706	159, 577				9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	238, 813	160, 551 0				10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0 414, 653	0 106, 117		0 166, 275 0 -229, 815		11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	108, 898	224, 812				13.00
15. 00 01500 PHARMACY	521, 567	2, 159, 344				
16. 00 01600 MEDICAL RECORDS & LIBRARY	57, 912	275,037				
17. 00 01700 SOCI AL SERVI CE	0	0		220, 349		1
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	2, 966, 464	966, 528	3, 932, 99	2 - 296, 405	3, 636, 587	30.00
31.00 03100 I NTENSI VE CARE UNI T	583, 350	445, 907	1, 029, 25	7 -1, 978	1, 027, 279	31.00
43.00 04300 NURSERY	0	0		0 284, 291	284, 291	43.00
ANCI LLARY SERVI CE COST CENTERS				_		
50.00 O5000 OPERATING ROOM	459, 484	376, 239				50.00
51.00 05100 RECOVERY ROOM	199, 543	99, 724				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0		52.00
53. 00 05300 ANESTHESI OLOGY	0	278, 356				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	451, 780 105, 139	313, 617 55, 133				54.00 54.01
56. 00 05600 RADI OL I KASOUND	60, 967	78, 571				54.01
57. 00 05700 CT SCAN	129, 367	239, 046				57.00
58. 00 05800 MRI	89, 653	215, 071				58.00
60. 00 06000 LABORATORY	792, 205	1, 132, 240				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	59, 083				
65. 00 06500 RESPI RATORY THERAPY	724, 649	174, 999				65.00
66. 00 06600 PHYSI CAL THERAPY	0	375, 871	375, 87	1 -170	375, 701	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	159, 940	159, 94	0 0	159, 940	67.00
68.00 06800 SPEECH PATHOLOGY	0	48, 114	48, 11	4 0		68.00
69.00 06900 ELECTROCARDI OLOGY	200, 610	23, 091	223, 70			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 16, 488		1
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 32, 158		1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 947, 031		73.00
76.00 03610 SLEEP LAB	0	0		0 0	0	76.00
	102 247	12 140	114 52	4 220	114 100	00.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	103, 367 3, 515, 305	13, 169 1, 380, 189				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 515, 505	1, 300, 109	4, 075, 47	-4, 900	4, 090, 300	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	339, 186	255, 844	595, 03	0 -40, 489	554, 541	95.00
SPECIAL PURPOSE COST CENTERS	00,7100	2007011	0,0,00	10/10/	001/011	/0/00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	14, 783, 706	26,062,039	40, 845, 74	5 495	40, 846, 240	118.00
NONREI MBURSABLE COST CENTERS		.,,,				1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	314	3, 736	4, 05	0 -495	3, 555	192.00
200.00 TOTAL (SUM OF LINES 118 through 199)	14, 784, 020	26, 065, 775	40, 849, 79	5 0	40, 849, 795	200. 00

Heal tl	n Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	-2552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC	CN: 15-1318	Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pro	anarod
					10 12/31/2021	5/28/2022 9:	apareu. 17 am
	Cost Center Description	Adjustments	Net Expenses				
	·	(See A-8)	For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT	422, 230					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-596, 883					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00570 ADMI TTI NG	0	.,,				5.01
5.02 7.00	00590 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	-509, 464					5. 02 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-11, 575 0					8.00
8.00 9.00	00900 HOUSEKEEPING	0					9.00
10.00		0					10.00
11.00		-55, 387					11.00
13.00		-5, 900					13.00
14.00		0, 700					14.00
15.00		0					15.00
16.00		-285					16.00
17.00		0					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	-315, 562	3, 321, 025				30.00
31.00	03100 I NTENSI VE CARE UNI T	0	1, 027, 279				31.00
43.00		0	284, 291				43.00
	ANCILLARY SERVICE COST CENTERS		-				
50.00		0					50.00
51.00		0					51.00
52.00		0	-				52.00
53.00		-278, 356					53.00
54.00		0					54.00
54.01	05401 ULTRASOUND	0	-				54.01
56.00		0	0				56.00
57.00 58.00		0					57.00 58.00
60. 00		0	-				60.00
62.00		0					62.00
65.00		0					65.00
66.00		0					66.00
67.00		0	0,0,,0.				67.00
68.00		0					68.00
69.00		0					69.00
71.00		0					71.00
72.00		0					72.00
73.00		0					73.00
76.00	03610 SLEEP LAB	0					76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	116, 198				90.00
91.00	09100 EMERGENCY	-774, 943	4, 115, 645				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS		1				
95.00		0	554, 541				95.00
	SPECIAL PURPOSE COST CENTERS						-
118.0		-2, 126, 125	38, 720, 115				118.00
	NONREI MBURSABLE COST CENTERS	_	-				1.00.05
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0					192.00
200.0	0 TOTAL (SUM OF LINES 118 through 199)	-2, 126, 125	38, 723, 670	I			200.00

h Financial ASSIFICATION			DUKES MEMORIA	Provider CCN: 1		ri od:	u of Form CMS-2 Worksheet A-6
					To	om 01/01/2021 12/31/2021	Date/Time Prep
		Increases			I .		5/28/2022 9:17
	Cost Center	Line #	Salary	Other			
	2.00 YEE BENEFITS	3.00	4.00	5.00			
	BENEFITS DEPARTMENT	4.00	0	2, 115, 582			
0				2, 115, 582			
B - RENT	AND LEASES	I		_/			
	OSTS-BLDG & FIXT	1.00	0	464, 262			
CAP REL C	OSTS-MVBLE EQUIP	2.00	0	242, 724			
		0.00	0	0			
		0.00	0	0			
		0. 00 0. 00	0	0			
		0.00	o	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
)		0.00	0	0			
0		0.00	0	0			
		0.00	0	0			
		0. 00 0. 00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	Ö	0			
		0.00	0	0			
) <u> </u>		0.00	0	0			
0			0	706, 986			
	CAPITAL COSTS			100.000			
	OSTS-BLDG & FIXT	1.00	0	132, 230			
	OSTS-BLDG & FIXT	1.00	0	365, 170			
CAP REL C	<u>OSTS-MVBLE_EQUIP</u>		0	3 <u>0, 467</u> 527, 867			
D - CNO C	05TS		0	527,007			
	DMI NI STRATI ON	13.00	177, 436	0			
0			177, 436	ō			
	AL SUPPLIES	74.00		1 (100			
PATIENT	UPPLIES CHARGED TO	71.00	0	16, 488			
	. CHARGED TO	72.00	o	32, 158			
PATI ENTS	. CHARGED TO	72.00	0	52, 150			
	ERVICES & SUPPLY	14.00	0	13, 775			
		0.00	0	0			
0			0	62, 421			
	OF DRUGS/IV SOLUTION						
DRUGS CHA	RGED TO PATIENTS		0	1,947,031			
	DV		0	1, 947, 031			
G – NURSE NURSERY	RY	43.00	229, 673	54, 618			
O		43.00	229,673	<u>54, 618</u>			
L - MISC	DEPARTMENTS		227,073	54, 010			
ADMI TTI NG		5. 01	494, 803	838, 600			
0			494, 803	838, 600			
	RADI OLOGY						
RADI OLOGY	-DI AGNOSTI C	54.00	385, 126	101, 452			
		0.00	0	0			
		0. 00 0. 00	0	0			
0			385, 126	101, 452			
K – DIETA	RY COSTS TO CAFETERI	A	000, 120				
CAFETERI A		11.00	100, 144	66, 131			
0			100, 144	66, 131			
	RS AND MAINTENANCE						
OPERATI ON	OF PLANT	7.00	0	598, 519			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0 0			
		0. 00 0. 00	0	0			
		0.00	0	0			
		0.00	0	0			

Heal th	Financial Systems		DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider CCN: 15	5-1318	Period:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr	enared
						10 12/01/2021	5/28/2022 9:	
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
22.00		0.00		0				22.00
			0	598, 519				-
	N – CASE MANAGEMENT ADMINISTRATIVE AND GENERAL	5.02	154, 480	31, 993				1.00
	SOCIAL SERVICE							
2.00	SUCTAL SERVICE	<u>17.00</u>	<u>167, 072</u> 321, 552	5 <u>3, 277</u> 85, 270				2.00
	0 - NON CAPITALIZED EQUIPMENT	-	321, 552	85,270				-
	ADMI NI STRATI VE AND GENERAL	5.02		16, 103				1.00
2.00	ADMINI STRATIVE AND GENERAL	0, 00	0	10, 103				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
4.00 5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
0.00				- <u> </u>				0.00
500.00	Grand Total: Increases		1, 708, 734	7, 120, 580				500.00

eal th	Financial Systems		DUKES MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS	5-2552-1
ECLAS	SIFICATIONS			Provider (CCN: 15-1318	Period: From 01/01/2021	Worksheet A-	-6
						To 12/31/2021	Date/Time Pr 5/28/2022 9:	
		Decreases				· · · · · · · · · · · · · · · · · · ·		
	Cost Center 6.00	Line #	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00	<u>.</u>		
	A - EMPLOYEE BENEFITS	7.00	0.00	7.00	10.00			
00	ADMI NI STRATI VE AND GENERAL	5.02	0	<u>2, 115, 5</u> 82		<u>0</u>		1.0
			0	2, 115, 582				_
00	B - RENT AND LEASES EMPLOYEE BENEFITS DEPARTMENT	4.00	0	229	1	0		1.0
00	ADMI NI STRATI VE AND GENERAL	5.02	0	2, 130				2.0
00	OPERATION OF PLANT	7.00	0	6, 728		0		3.0
00	DI ETARY	10.00	0	230		o		4.0
00	NURSING ADMINISTRATION	13.00	0	429		0		5.0
00 00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	87, 347 64, 506				6. 0 7. 0
00	MEDICAL RECORDS & LIBRARY	16.00	0	283		0		8.0
00	ADULTS & PEDIATRICS	30.00	0	630)	o		9.0
. 00	INTENSIVE CARE UNIT	31.00	0	169		0		10.0
. 00	OPERATING ROOM	50.00	0	55, 558		0		11.0
. 00 . 00	RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	51.00 54.00	0	376 172, 075				12.0
. 00	ULTRASOUND	54.00	0	33, 243		0		14.0
. 00	CT SCAN	57.00	0	97, 655		0		15.0
. 00	MRI	58.00	0	134, 101		o		16.0
. 00	LABORATORY	60.00	0	13, 604		0		17.0
. 00		65.00	0	33, 777		0		18.0
). 00). 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	169 1, 044				19.0 20.0
. 00	CLINIC	90.00	0	338		0		20.0
2.00	EMERGENCY	91.00	Ō	437		0		22.0
8.00	AMBULANCE SERVICES	95.00	0	1, 919		o		23.0
. 00	PHYSICIANS' PRIVATE OFFICES	<u> </u>	0	9		<u>o</u>		24.0
	C - OTHER CAPITAL COSTS		0	706, 986				-
00	ADMI NI STRATI VE AND GENERAL	5.02	0	527, 867	1	2		1.0
00		0.00	0	0				2.0
00		0.00	0	0		2		3.0
	O D - CNO COSTS		0	527, 867				-
00	ADMI NI STRATI VE AND GENERAL	5.02	177, 436	0		0		1.0
	0		177, 436	0		-		
	E - MEDICAL SUPPLIES				1			
00	INTENSIVE CARE UNIT	31.00	0	1, 335		0		1.0
00 00	OPERATI NG ROOM RESPI RATORY THERAPY	50. 00 65. 00	0	60, 527 101		0		2.0 3.0
00	EMERGENCY	91.00	0	458		0		4.0
	0		o	62, 421				
00	F - COST OF DRUGS/IV SOLUTIONS			1 047 001	1			1 1 0
00	PHARMACY	<u>15.</u> 00	0	<u>1, 947, 031</u> <u>1, 947, 031</u>		0		1.0
	G - NURSERY		0	1, 717,001				
00	ADULTS & PEDIATRICS	30.00	229, 673	54, 618		0		1.0
	0		229, 673	54, 618				
00	I – MISC DEPARTMENTS ADMINISTRATIVE AND GENERAL	5.02	494, 803	838, 600		0		1.0
00		<u></u>	494,803	838, 600				1.0
	J - OTHER RADIOLOGY				1			
00	ULTRASOUND	54.01	105, 139	8, 740		0		1.0
00 00	RADI OI SOTOPE CT SCAN	56.00 57.00	60, 967 129, 367	49, 840 35, 953		0		2.0 3.0
00	MRI	58.00	89, 653	6, 919		0		4.0
	0		385, 126	101, 452		-		
	K - DIETARY COSTS TO CAFETERIA				1	-1		
00	DI ETARY	<u>10.00</u>	<u>100, 1</u> 44 100, 144	6 <u>6, 1</u> 31 66, 131		0		1.0
	M - REPAIRS AND MAINTENANCE	I	100, 144	00, 131				-
		5.02	0	88, 130		0		1.0
00	ADMI NI STRATI VE AND GENERAL		o	2, 676		o		2.0
00	HOUSEKEEPI NG	9.00						3.0
00 00	HOUSEKEEPI NG DI ETARY	10.00	0	2, 618		0		
00 00 00	HOUSEKEEPI NG DI ETARY CENTRAL SERVI CES & SUPPLY	10. 00 14. 00	0	27, 568	6	0		4.0
00 00 00 00	HOUSEKEEPI NG DI ETARY CENTRAL SERVI CES & SUPPLY PHARMACY	10. 00 14. 00 15. 00	0 0 0	27, 568 18, 554		0		4.0 5.0
00 00 00 00 00	HOUSEKEEPI NG DI ETARY CENTRAL SERVI CES & SUPPLY	10. 00 14. 00		27, 568		0		4. 0 5. 0 6. 0
00 00 00 00 00 00	HOUSEKEEPI NG DI ETARY CENTRAL SERVI CES & SUPPLY PHARMACY MEDI CAL RECORDS & LI BRARY	10. 00 14. 00 15. 00 16. 00	0 0 0 0 0	27, 568 18, 554 1		0		4.0 5.0 6.0 7.0
00 00 00 00 00 00 00 00 00	HOUSEKEEPI NG DI ETARY CENTRAL SERVI CES & SUPPLY PHARMACY MEDI CAL RECORDS & LI BRARY ADULTS & PEDI ATRI CS I NTENSI VE CARE UNI T OPERATI NG ROOM	10.00 14.00 15.00 16.00 30.00 31.00 50.00	0 0 0 0 0 0	27, 568 18, 554 11, 107 474 36, 651		0		4. 0 5. 0 6. 0 7. 0 8. 0 9. 0
00 00 00 00 00 00 00	HOUSEKEEPI NG DI ETARY CENTRAL SERVI CES & SUPPLY PHARMACY MEDI CAL RECORDS & LI BRARY ADULTS & PEDI ATRI CS I NTENSI VE CARE UNI T	10.00 14.00 15.00 16.00 30.00 31.00		27, 568 18, 554 1 11, 107 474		0		4. 0 5. 0 6. 0 7. 0 8. 0

Heal th	Financial Systems		DUKES MEMORIA	L HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider C	CN: 15-1318	Peri od:	Worksheet A-	-6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/28/2022 9:	
		Decreases						
	Cost Center	Line #	Salary		Wkst. A-7 Ref			
	6. 00	7.00	8.00	9.00	10.00			
13.00	RADI OI SOTOPE	56.00	0	28, 731		0		13.00
	CT SCAN	57.00	0	105, 438		0		14.00
15.00	MRI	58.00	0	73, 755		0		15.00
16.00	LABORATORY	60.00	0	48, 534		0		16.00
17.00	RESPI RATORY THERAPY	65.00	0	14, 489		0		17.00
18.00	PHYSI CAL THERAPY	66.00	0	1		0		18.00
19.00	ELECTROCARDI OLOGY	69.00	0	1, 288		0		19.00
20.00	EMERGENCY	91.00	0	4, 011		0		20.00
21.00	AMBULANCE SERVICES	95.00	0	38, 570		0		21.00
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	486		0		22.00
	0		0	598, 519		7		
	N – CASE MANAGEMENT							
1.00	NURSING ADMINISTRATION	13.00	321, 552	85, 270		0		1.00
2.00		0.00	0	0		o		2.00
	0		321, 552	85, 270		7		
	0 - NON CAPITALIZED EQUIPMENT					·		
1.00	OPERATION OF PLANT	7.00	0	14, 602		0		1.00
2.00	HOUSEKEEPI NG	9.00	0	380		0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	377		0		3.00
4.00	OPERATING ROOM	50.00	0	205		0		4.00
5.00	MRI	58.00	0	296		0		5.00
6.00	LABORATORY	60.00	0	243		0		6.00
	0			16, 103		1		
500.00	Grand Total: Decreases		1, 708, 734	7, 120, 580		7		500.00
			•					•

Health Financial Systems	DUKES MEMORIA	L HOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1318	Perio From To	od: 01/01/2021 12/31/2021		
				10	12/ 51/ 2021	5/28/2022 9:1	7 am
			Acqui si ti on	is			
	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 ASSE							
1.00 Land	193, 225	0		0	0	0	1.00
2.00 Land Improvements	1, 038, 384	0		0	0	0	2.00
3.00 Buildings and Fixtures	28, 885, 797	1, 136, 653		0	1, 136, 653	1, 270, 475	3.00
4.00 Building Improvements	33, 426, 837	284, 450		0	284, 450	1, 760, 995	
5.00 Fixed Equipment	0	0		0	0	0	5.00
6.00 Movable Equipment	0	0		0	0	0	6.00
7.00 HIT designated Assets	4, 602, 668	42, 391		0	42, 391	52, 130	7.00
8.00 Subtotal (sum of lines 1-7)	68, 146, 911	1, 463, 494		0	1, 463, 494	3, 083, 600	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	68, 146, 911	1, 463, 494		0	1, 463, 494	3, 083, 600	10.00
	Endi ng Bal ance	Fully					
		Depreci ated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	193, 225	0					1.00
2.00 Land Improvements	1, 038, 384	0					2.00
3.00 Buildings and Fixtures	28, 751, 975	0					3.00
4.00 Building Improvements	31, 950, 292	0					4.00
5.00 Fixed Equipment	0	0					5.00
6.00 Movable Equipment	0	0					6.00
7.00 HIT designated Assets	4, 592, 929	0					7.00
8.00 Subtotal (sum of lines 1-7)	66, 526, 805	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	66, 526, 805	0					10.00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CO	CN: 15-1318	Period: From 01/01/2021	Worksheet A-7 Part II	
					To 12/31/2021		pared:
						5/28/2022 9:1	<u>7 am</u>
			SL	JMMARY OF CAF	91 TAL		
	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 WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 068, 389	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3, 033, 164	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	4, 101, 553	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 068, 389				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 033, 164				2.00
3.00	Total (sum of lines 1-2)	0	4, 101, 553				3.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/28/2022 9:1	pared:
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col	instructions)		
			2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-				
1.00 CAP REL COSTS-BLDG & FIXT	61, 933, 876	0	61, 933, 87	6 0. 930961	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	4, 592, 929	0	4, 592, 92	9 0. 069039	0	2.00
3.00 Total (sum of lines 1-2)	66, 526, 805		66, 526, 80			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-	1			
1.00 CAP REL COSTS-BLDG & FIXT	0	, s		0 1, 444, 656		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-		0 2, 334, 074		2.00
3.00 Total (sum of lines 1-2)	0	0		0 3, 778, 730	852, 758	3.00
		Sl	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capital -Relate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1	1			
1.00 CAP REL COSTS-BLDG & FIXT	2, 136					1.00
2.00 CAP REL COSTS-MVBLE EQUIP	262			0 0	_, ,	2.00
3.00 Total (sum of lines 1-2)	2, 398	162, 697	365, 17	0 0	5, 161, 753	3.00

	Financial Systems MENTS TO EXPENSES		DUKES MEMORI		In Lie Period:	u of Form CMS-2 Worksheet A-8	
ADJUJI	MENTS TO EXTENSES			F	rom 01/01/2021 o 12/31/2021	Date/Time Prep 5/28/2022 9:1	pared [.]
				Expense Classification on		572672022 9.1	
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 0	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00	0	
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		ſ		0.00	0	
4.00	(chapter 2) Trade, quantity, and time				0.00	0	4.00
	discounts (chapter 8)						
5.00	Refunds and rebates of expenses (chapter 8)		L		0.00	0	
6.00	Rental of provider space by suppliers (chapter 8)		Ĺ		0.00	0	
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3, 665	ADMI NI STRATI VE AND GENERAL	5. 02	0	7.00
8.00	Television and radio service (chapter 21)	A	-11, 575	OPERATION OF PLANT	7.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 368, 861		0.00	0 0	
11.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-330, 484			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	(55 207	CAFETERI A	0.00 11.00	0	
15.00	Rental of quarters to employee		-55, 587		0.00	0	
16.00	and others Sale of medical and surgical supplies to other than		С		0.00	0	16. 00
17.00	patients Sale of drugs to other than		C		0.00	0	17.00
18.00	patients Sale of medical records and	В	-285	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19. 00	abstracts Nursing and allied health education (tuition, fees,		C		0.00	0	19. 00
20.00	books, etc.) Vendi ng machi nes	В	-184	ADMI NI STRATI VE AND GENERAL	5.02	0	
21.00	Income from imposition of interest, finance or penalty		C		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22. 00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	ſ	RESPI RATORY THERAPY	65.00		23.00
20100	therapy costs in excess of limitation (chapter 14)						20100
24.00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25. 00
26.00	(chapter 21) Depreciation - CAP REL	А	-1, 346	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL	А	-719, 034	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28.00
29.00 30.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see	A	C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	
33.00	Depreciation and Interest TRAINING REVENUE	В		NURSING ADMINISTRATION	13.00		33.00
55.00	THAT NE NO REVENUE	ן ט	-3,725		13.00	U	33.00

Health Financial Systems		DUKES MEMORIA	AL HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
			Expense Classification or	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Pasis (Code (2))	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
cost center bescription	1.00	2.00	3.00	4, 00	5.00	
33.01 FITNESS REVENUE	B		ADMI NI STRATI VE AND GENERAL	5.02		33.01
33. 02 MI SCELLANEOUS I NCOME	B		ADMI NI STRATI VE AND GENERAL	5. 02		33.02
33. 03 PATIENT PHONE DEPRECIATION	Ā		CAP REL COSTS-MVBLE EQUIP	2.00		33.03
33.04 PATIENT TV DEPRECIATION	А		CAP REL COSTS-MVBLE EQUIP	2.00		33.04
33.05 EMPLOYEE SELF INS DISCOUNTS	В	28, 162	ADMINISTRATIVE AND GENERAL	5.02	0	33.05
33.06 INSERVICE EDUCATION	В	-2, 175	NURSING ADMINISTRATION	13.00	0	33.06
33.07 POB CAPITAL RELATED EXPENSE	A	377, 613	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08 POB CAPITAL RELATED EXPENSE	A	20, 914	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33. 09 CHARI TABLE CONTRI BUTI ONS	A	-1, 720	ADMINISTRATIVE AND GENERAL	5.02	0	33.09
34.00 INTEREST INCOME ADD BACK	В	2, 507	ADMINISTRATIVE AND GENERAL	5.02	0	34.00
35.00 MARKETING EXPENSE	A	-31, 472	ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00 PENALTI ES	A		ADMINISTRATIVE AND GENERAL	5.02		36.00
37.00 LOBBYING EXPENSE	A		ADMINISTRATIVE AND GENERAL	5.02		37.00
40.00 PHYSICIAN RECRUITING	A		ADMINISTRATIVE AND GENERAL	5.02	0	40.00
50.00 TOTAL (sum of lines 1 thru 49)		-2, 126, 125				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	DUKES MEMOR	I AL HOSPI TAL	In Lie	eu of Form CMS-	2552-10
	STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS			Period: From 01/01/2021	Worksheet A-8	8-1
OFFICE	COSTS			To 12/31/2021	Date/Time Pre	
					5/28/2022 9:1	<u>7 am</u>
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	2.00	2.00	4.00	5.00	
		2.00 MENTS REQUIRED AS A RESULT OF		4.00		
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED UN	GANIZATIONS UK	CLAIMED	
1.00	0.00		PASI CAPITAL COSTS - BLDG &	0	0	1.00
2.00	0.00		PASI CAPITAL COSTS - MOVEABL	0	0	2.00
3.00	0.00		PASI OPERATING COSTS	0	0	3.00
3.02	0.00		SHARED SERVICE CENTER ALLOCA	0	0	3.02
3.04	0.00		NEW CAPITAL - BUILDING AND F		0	3.04
4.00			PASI Capital Costs - Bldg &	2,136	0	4.00
4.01		CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl			4.01
4.02		ADMINISTRATIVE AND GENERAL	PASI Operating Costs	181, 302		4. 02
4.03		ADMINISTRATIVE AND GENERAL	Shared Service Center Alloca			4.03
4.04			New Capital - Building & Fix			4.04
4.05			New Capital - Movable Equipm			4.05
4.06			Non-Capital Home Office Cost			4.06
4.07			Malpractice Costs	35, 699		4.07
4.08	5. 02	ADMINISTRATIVE AND GENERAL	Management Fees	0	856, 509	4.08
4.09	5. 02	ADMINISTRATIVE AND GENERAL	401K Fees	0	4, 400	4.09
4.10	5.02	ADMINISTRATIVE AND GENERAL	Audit Fees	0	21, 252	4.10
4.11	5.02	ADMINISTRATIVE AND GENERAL	Corporate Overhead Allocatio	0	438, 599	4.11
4.12	5.02	ADMINISTRATIVE AND GENERAL	HIIM Allocation	0	169, 801	4.12
4.13	5.02	ADMINISTRATIVE AND GENERAL	Contract Management	0	12, 438	4.13
4.14	5. 02	ADMINISTRATIVE AND GENERAL	PASI Lien Unit Collection Fe	0	27, 312	4.14
5.00	TOTALS (sum of lines 1-4).			2, 314, 980	2, 645, 464	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 nosted to Worksheet A columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

1103 1101	been posted to worksheet A,	corumns ranu/or z, the amou	it allowable sh	ouru be murcateu micorumin 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

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

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

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

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

 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

Health Financial Systems	DUKES MEMORIAL HOSPITAL			u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM REL OFFICE COSTS	ATED ORGANIZATIONS AND HOME	Provider CCN: 15-1318	Period: From 01/01/2021	Worksheet A-8-1
OTTICE COSTS				Date/Time Prepared:

					10 12/31/2021	5/28/2022 9:1	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
			ENTS REQUIRED AS A RESULT OF TRANS	SACTIONS WITH RELATED OF	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:					
1.00	0	0					1.00
2.00	0	0					2.00
3.00	0	0					3.00
3.02	0	0					3. 02
3.04	0	0					3. 04
4.00	2, 136						4.00
4.01	262	11					4.01
4.02	-33, 758	0					4.02
4.03	160, 255	0					4.03
4.04	43, 827	10					4.04
4.05	101, 945	10					4.05
4.06	1, 097, 829	0					4.06
4.07	-172, 669	0					4.07
4.08	-856, 509	0					4.08
4.09	-4, 400	0					4.09
4.10	-21, 252	0					4.10
4.11	-438, 599	0				1	4.11
4.12	-169, 801	0				1	4.12
4.13	-12, 438	0				1	4.13
4.14	-27, 312	0				1	4.14
5.00	-330, 484					1	5.00
* Tho	amounte on Lin	ac 1 4 (and cub	scripts as appropriate) are trapsf	Corred in datail to Wark	choot A column	(Lines es	

* 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.

Tids not been posted to worksheet	A, cordinario 1 and/or 2, the amount arrowable should be marcated in cordinaria of this part.	
Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
51		
6.00		
B. INTERRELATIONSHIP TO R	LATED 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 reimburges.

reimbursement under title XVIII.	
6.00 HOSPITAL MANAGEMENT	6.00
7.00 DEBT COLLECTION	7.00
8.00 LAUNDRY SERVICE	8.00
9.00	9.00
10. 00	10.00
100.00	100.00
(1) Use the following symbols to indicate interrelationship to related	organizations

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	DUKES MEMORI	AL HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC			Provider (Period: From 01/01/2021 To 12/31/2021		epared.
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	315, 562	315, 562	(0 0	0	1.00
2.00	53.00	ANESTHESI OLOGY	278, 356	278, 356		0 0	0	2.00
3.00	91.00	EMERGENCY	774, 943	774, 943	(0 0	0	3.00
4.00	0.00		0	0	(0 0	0	4.00
5.00	0.00		0	0	(0 0	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(o o	0	10.00
200.00			1, 368, 861	1, 368, 861	(0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		Identi fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	0		0 0	-	
2.00		ANESTHESI OLOGY	0	0		0 0		
3.00		EMERGENCY	0	0		0 0	°,	0.00
4.00	0.00		0	0		-	°,	4.00
5.00	0.00		0	0			0	
6.00	0.00		0	0		-	0	6.00
7.00	0.00		0	0	(° °	0	7.00
8.00	0.00		0	0		° °	0	0.00
9.00	0.00		0	0		-	0	9.00
10.00	0.00		0	0			-	
200.00			0	0		°	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	15.00	0				1.00
2.00		ADULTS & PEDIATRICS ANESTHESI OLOGY	0	0		278, 356		2.00
		EMERGENCY	0	0				
3.00 4.00	0.00		0	0				3.00 4.00
			0	0				
5.00	0.00		0	0		-		5.00
6.00	0.00		-			-		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
200.00			0	0	il (1, 368, 861		200. 00

	IABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CC	CN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Parts I-VI Date/Time Pre 5/28/2022 9:1	pared:
					Physical Therapy		
						1.00	
	PART I - GENERAL INFORMATION						
. 00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			0	1.00
. 00 . 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	sor or therapis	t was on provi	der site (se	e instructions)	0	
. 00	Number of unduplicated days in which therapy					0	4.00
00	nor therapist was on provider site (see instr			-+			F 00
. 00 . 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				by therapy	0	5.00 6.00
	assistant and on which supervisor and/or the						
. 00	instructions) Standard travel expense rate					0.00	7.00
. 00	Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants		Trai nees	
. 00	Total hours worked	1.00 1,173.19	2.00	3.00 1,029.	4.00 71 1,177.47	5.00 0.00	9.00
0.00	AHSEA (see instructions)	81.04	·			0.00	
1. 00	Standard travel allowance (columns 1 and 2,	40. 52	40. 52	25.	25		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
2.00	Number of travel hours (provider site)	0	0		0		12.00
2. 01	Number of travel hours (offsite)	0	0		0		12.01
3.00 3.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.01
5.01		0	0	<u> </u>			13.0
						1.00	
4.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				95, 075	14.00
5.00	Therapists (column 2, line 9 times column 2,					279, 567	
6. 00	Assistants (column 3, line 9 times column 3,	line10)				52, 000	
7.00	Subtotal allowance amount (sum of lines 14 ar others)	nd 15 for respi	ratory therapy	or lines 14	-16 for all	426, 642	17.0
3. 00	Aides (column 4, line 9 times column 4, line	10)				20, 606	18.00
9. 00	Trainees (column 5, line 9 times column 5, li					0	19.00
0. 00	Total allowance amount (sum of lines 17-19 for			es 17 and 18	for all others)	447, 248	20.00
			1	والجرار والمراجع			
	If the sum of columns 1 and 2 for respiratory occupational therapy. Line 9, is greater than				rapy, speech path	nology or	1
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	line 2, make lines 21-23.	no entries on	lines 21 and	rapy, speech path 22 and enter on	nology or line 23	
1. 00	occupational therapy, line 9, is greater thar the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra	n line 2, make <u>lines 21-23.</u> ainees (line 17	no entries on divided by su	lines 21 and	rapy, speech path 22 and enter on	nology or	
1.00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	n line 2, make <u>lines 21–23.</u> ainees (line 17 line 9 for all	no entries on divided by su others)	lines 21 and	rapy, speech path 22 and enter on	nology or line 23	21. 0
2. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	n line 2, make <u>lines 21–23.</u> ainees (line 17 line 9 for all ees (line 2 tim	no entries on divided by su others) mes line 21)	lines 21 and	rapy, speech path 22 and enter on 1 and 2, line 9	nology or line 23 0.00	21.0
2. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traina Total salary equivalency (see instructions) PART 111 - STANDARD AND OPTIONAL TRAVEL ALLOW	n line 2, make <u>lines 21–23.</u> ainees (line 17 line 9 for all ees (line 2 tim	no entries on divided by su others) mes line 21)	lines 21 and	rapy, speech path 22 and enter on 1 and 2, line 9	nology or line 23 0.00 0	21.0
2.00 3.00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	n line 2, make <u>lines 21–23.</u> ainees (line 17 line 9 for all ees (line 2 tim	no entries on divided by su others) mes line 21)	lines 21 and	rapy, speech path 22 and enter on 1 and 2, line 9	nol ogy or I i ne 23 0.00 0 447, 248	21. 00 22. 00 23. 00
2.00 3.00 4.00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traina Total salary equivalency (see instructions) PART 111 - STANDARD AND OPTIONAL TRAVEL ALLOW	n line 2, make <u>lines 21–23.</u> ainees (line 17 line 9 for all ees (line 2 tim	no entries on divided by su others) mes line 21)	lines 21 and	rapy, speech path 22 and enter on 1 and 2, line 9	nol ogy or I i ne 23 0.00 0 447, 248	21. 00 22. 00 23. 00 24. 00
2. 00 3. 00 4. 00 5. 00 5. 00	occupational therapy, line 9, is greater thar the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	n line 2, make lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2	no entries on 'divided by su others) hes line 21) L EXPENSE COMP	lines 21 and m of columns UTATION - PR	rapy, speech path 22 and enter on 1 and 2, line 9 OVIDER SITE	nol ogy or l i ne 23 0.00 0 447, 248 0 0 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
2. 00 3. 00 4. 00 5. 00 5. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traine for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	n line 2, make lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2	no entries on 'divided by su others) hes line 21) L EXPENSE COMP	lines 21 and m of columns UTATION - PR	rapy, speech path 22 and enter on 1 and 2, line 9 OVIDER SITE	nol ogy or l i ne 23 0. 00 0 447, 248 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
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2. 00 3. 00 5.	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART 111 - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.000000000000000000000000000000000000	n line 2, make lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 ar line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum NCE AND TRAVEL n of lines 5 ar Expense D1 times column	no entries on divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s a at the provid d 2, line 12) 9 and 30 for a a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU ad 6)	UTATION - PR UTATION - PR	rapy, speech path 22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	nol ogy or I i ne 23 0.00 0 447, 248 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00 22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
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2. 00 3. 00 5. 00 5. 00 5. 00 5. 00 6. 00 5.	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART 111 - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.000000000000000000000000000000000000	n line 2, make lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum expense (sum expense (sum expense ar line 5 ar Expense 01 times column a 3, line 10)	no entries on divided by su others) les line 21) L EXPENSE COMP d and 25 for a y therapy or s e at the provid d 2, line 12) 9 and 30 for a e 13 for respir e 28) of lines 27 an of lines 31 an EXPENSE COMPU ad 6) 1 2, line 10)	UTATION - PR UTATION - PR	rapy, speech path 22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	nol ogy or I i ne 23 0.00 0 447, 248 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00 22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
2. 00 3. 00 5. 00 5. 00 5. 00 5. 00 6. 00 5.	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra- for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART 111 - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard travel expense (line 7 times the sur Optional travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, 0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - 0	n line 2, make lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum expense (sum expense (sum expense of lines 5 ar Expense D1 times columns 1- m of columns 1-	no entries on divided by su others) les line 21) L EXPENSE COMP d and 25 for a y therapy or s at the provid d 2, line 12) g and 30 for a at 3 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) a, line 13.01)	UTATION - PR UTATION - PR UTATION - PR UTATION - PR UN of lines er site (sum II others) atory therap d 31) d 32) TATION - SER	rapy, speech path 22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PRC	nol ogy or I i ne 23 0.00 0 447, 248 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00 22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 31. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra- for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART 111 - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.07 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	n line 2, make lines 21-23. ainees (line 17 line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum expense (sum expense (sum expense of times 5 ar Expense 01 times columns 1- 0ffsite Service	no entries on divided by su others) les line 21) L EXPENSE COMP 4 and 25 for a y therapy or s a at the provid d 2, line 12) 9 and 30 for a a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 1 2, line 10) 3, line 13.01) s; Complete on	UTATION - PR UTATION - PR UTATION - PR UTATION - PR UTATION - PR UTATION - PR UTATION - PR d 31) d 32) TATION - SER UTATION - SER	rapy, speech path 22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PRC	nol ogy or I i ne 23 0.00 0 447, 248 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 0 22. 0 23. 0 25. 0 26. 0 27. 0 28. 0 28. 0 30. 0 30. 0 31. 0 32. 0 33. 0 33. 0 34. 0 35. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0 43. 0

alth Financial Systems EASONABLE COST DETERMINATION FOR THERAPY SERV JTSIDE SUPPLIERS	/I CES FURNI SHED BY	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Parts I-VI Date/Time Pre 5/28/2022 9:1	-3 pared:
				Physical Therapy	Cost	
					1.00	
6.00 Optional travel allowance and optional						46.00
	Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	Total	
PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00 Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.0
period (if column 5, line 47, is zero c	r					
equal to or greater than 2,080, do not						
complete lines 48-55 and enter zero in	each					
column of line 56)	0.00	0.00	0.0	0.00		40.0
3.00 Overtime rate (see instructions) 9.00 Total overtime (including base and over	0.00 0.00	0. 00 0. 00	0.0 0.0			48.0 49.0
allowance) (multiply line 47 times line		0.00	0.0	0.00		49.0
CALCULATION OF LIMIT	, 40)	I			L	1
0.00 Percentage of overtime hours by categor	y 0.00	0.00	0.0	0.00	0.00	50.0
(divide the hours in each column on lin						
by the total overtime worked - column 5	i,					
line 47)						
I. 00 Allocation of provider's standard work	year 0.00	0.00	0.0	0.00	0.00	51.0
for one full-time employee times the percentages on line 50) (see instruction	ane)					
DETERMINATION OF OVERTIME ALLOWANCE						
2.00 Adjusted hourly salary equivalency amou	int 81.04	50.50	17.5	0.00		52.0
(see instructions)						
3.00 Overtime cost limitation (line 51 times	iline 0	0		0 0		53.0
52)						
4.00 Maximum overtime cost (enter the lesser	of 0	0		0 0		54.0
5.00 Portion of overtime already included in		0		0 0		55. C
hourly computation at the AHSEA (multip		0		0 0		55.0
line 47 times line 52)						
5.00 Overtime allowance (line 54 minus line	55 - 0	0		0 0	0	56. C
if negative enter zero) (Enter in colu	imn 5					
the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 throu	igh 3					
for all others.)						
					1.00	
Part VI - COMPUTATION OF THERAPY LIMITA	TION AND EXCESS COST	ADJUSTMENT			1.00	
7.00 Salary equivalency amount (from line 23					447, 248	57.0
3.00 Travel allowance and expense - provider					0	58.0
9.00 Travel allowance and expense - Offsite		44, 45, or 46))		0	
0.00 Overtime allowance (from column 5, line	9 56)				0	
I. 00 Equipment cost (see instructions)					0	
2.00 Supplies (see instructions)					0	
3.00 Total allowance (sum of lines 57-62) 1.00 Total cost of outside supplier services	(from your records)				447, 248 374, 446	
5.00 Excess over limitation (line 64 minus l	· · · · ·	enter zero)				65.0
LINE 33 CALCULATION	The ob Th hegative,					00.0
00.00 Line 26 = line 24 for respiratory thera	py or sum of lines 24	and 25 for al	II others		0	100. (
00.01 Line 27 = line 7 times line 3 for respi	ratory therapy or sum	of lines 3 a	nd 4 for all	others		100. 0
00.02	27				0	100. C
LINE 34 CALCULATION						
01.00 Line 27 = line 7 times line 3 for respi				others		101. C
01.01 Line 31 = line 29 for respiratory thera	py or sum of lines 29	and 30 for al	II others			101.0
01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION					0	101. C
		1 00 6	LL others		0	102. C
	ny or sum of lines 20					
02.00 Line 31 = line 29 for respiratory thera				mns 1-3 line		
				mns 1-3, line		102.

	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES IE SUPPLIERS	DUKES MEMORIA FURNI SHED BY	L HOSPITAL Provider CC	F	In Lie Period: From 01/01/2021 Fo 12/31/2021 Occupational Therapy	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 5/28/2022 9:1 Cost	-3 pared:
						1.00	
	PART I - GENERAL INFORMATION						
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			0	
3.00	Number of unduplicated days in which supervis	sor or therapis	t was on provid	der site (see	instructions)	0	
4.00	Number of unduplicated days in which therapy		on provider si	te but neither	- supervi sor	0	4.00
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - super		anists (see in	structions)		0	5.00
6.00	Number of unduplicated offsite visits - there				/ therapy	0	
	assistant and on which supervisor and/or the instructions)	apist was not	present during	the visit(s))	(see		
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile		.			0.00	8.00
		Supervisors 1.00	Therapists 2.00	Assistants 3.00	Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	0.00	2, 123. 59	251.45	5 0.00	0.00	1
10.00 11.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0.00 38.41	76. 82 38. 41	50.50 25.25		0.00	10.00
11.00	one-half of column 2, line 10; column 3,	30.41	30.41	20.20			11.00
	one-half of column 3, line 10)						
12. 00 12. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0	(12.00 12.01
13.00	Number of miles driven (provider site)	0	0	(13.00
13.01	Number of miles driven (offsite)	0	0	(13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 163, 134	
16.00	Assistants (column 3, line 9 times column 3,					12, 698	
17.00	Subtotal allowance amount (sum of lines 14 and	nd 15 for respi	ratory therapy	or lines 14-1	l6 for all	175, 832	17.00
18.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	1
20.00	Total allowance amount (sum of lines 17-19 for					175, 832	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
01 00	the amount from line 20. Otherwise complete					0.00	
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,			n of columns I	and 2, line 9	0.00	21.00
22.00	Weighted allowance excluding aides and traine					0	
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE			IDED SITE	175, 832	23.00
	Standard Travel Allowance				TDER SITE		
	Therapists (line 3 times column 2, line 11)					0	1
25.00 26.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for al	(Lothers)		0	1
27.00	Standard travel expense (line 7 times line 3				and 4 for all	0	1
28.00	others) Total standard travel allowance and standard	traval ovnonco	at the provid	or sito (sum (of Linos 26 and	0	28.00
20.00	27)	traver expense				U	20.00
20.00	Optional Travel Allowance and Optional Travel		d 0 1 i ma 10)			0	1 20 00
29.00 30.00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		u z, ime iz)			0	1
31.00	Subtotal (line 29 for respiratory therapy or	sum of lines 2				0	1
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respira	atory therapy	or sum of	0	32.00
33.00	Standard travel allowance and standard travel	expense (line	28)			0	33.00
34.00	Optional travel allowance and standard travel					0	
35.00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				CES OUTSUDE PRO	0 VLDER SLTE	35.00
	Standard Travel Expense			SERVI		TIDER OF TE	
36.00	Therapists (line 5 times column 2, line 11)					0	1
37.00 38.00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	1
39.00	Standard travel expense (line 7 times the sur		d 6)			0	
40.00	Optional Travel Allowance and Optional Travel		2 line 10)				40.00
40.00	Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column		∠, ITHE IU)			0	1
41.00	Subtotal (sum of lines 40 and 41)					0	42.00
42.00							
	Optional travel expense (line 8 times the sur			and the follo	wing three line	0	43.00
42.00 43.00		offsite Service	s; Complete one			es 44, 45,	43.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider CO	CN: 15-1318	Period: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Prep 5/28/2022 9:1	-3 pared:
					Occupational Therapy	Cost	
						1.00	
45.00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see ir	nstructions)	0	45.00
46.00	Optional travel allowance and optional travel		of lines 42 an				46.00
		Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0.0	0. 00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00				48.00
49.00	Total overtime (including base and overtime	0.00	0.00	0.0	0. 00		49.00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT			<u> </u>			
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0. 00	0.00	0. (0.00	0.00	50. 00
51.00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0. (0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE			<u>.</u>			
52.00	Adjusted hourly salary equivalency amount (see instructions)	76. 82	50.50	0. (0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	O	0		0 0	0	56.00
	Tor all others.)	I					
						1.00	
57.00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	ND EXCESS COST	ADJUSTMENT			175, 832	57.00
58.00	Travel allowance and expense - provider site	(from lines 33	, 34, or 35))			0	58.00
9.00	Travel allowance and expense - Offsite servic	es (from lines	44, 45, or 46)		0	59.00
0. 00	Overtime allowance (from column 5, line 56)					0	60.00
	Equipment cost (see instructions)					0	61.00
	Supplies (see instructions) Total allowance (sum of lines 57-62)					0 175, 832	
	Total cost of outside supplier services (from	vour records)				159, 940	
	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	-	, enter zero)				65.00
00.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	II others		0	100. 00
00. 01	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others		100. 01 100. 02
01 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	thorapy or	m of lines 2 -	nd 4 for all	athors		101 00
01.01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
	Line 31 = line 29 for respiratory therapy or	cum of lines of	0 and 20 for -	II others			
	ILINE 31 = IINE 29 FOF RESPIRATORY THERAPY OF	sum of lines 2	у апо зо тог а	ii otners		0	102.00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others	13 for respira	tory therapy o	r sum of colu	umns 1-3, line	0	102. 01

	VABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	DUKES MEMORIA FURNI SHED BY	Provider CCN	: 15-1318	Period: From 01/01/2021 To 12/31/2021 Speech Patholog	Date/Time Prep 5/28/2022 9:17	-3 pared:			
						1.00				
	PART I - GENERAL INFORMATION					1.00				
1.00	Total number of weeks worked (excluding aide	s) (see instruct	tions)			0				
2.00	Line 1 multiplied by 15 hours per week					0				
3.00 4.00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy			•	,	0	3.00 4.00			
4.00	nor therapist was on provider site (see inst			e but nei ti	super vi sol	0	4.00			
5.00	Number of unduplicated offsite visits - supe	rvisors or thera				0	5.00			
6.00	Number of unduplicated offsite visits - ther					0	6.00			
	assistant and on which supervisor and/or the instructions)	rapist was not p	present during i	the visit(s	(see					
7.00	Standard travel expense rate					0.00	7.00			
8.00	Optional travel expense rate per mile		T I I I	<u> </u>	A: 1	0.00	8.00			
		Supervi sors 1.00	Therapists 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5.00				
9.00	Total hours worked	0.00	685.88		00 0.00		9.00			
10.00	AHSEA (see instructions)	0.00	73.84	0.	00 0.00	0.00	10.00			
11.00	Standard travel allowance (columns 1 and 2,	36. 92	36. 92	0.	00		11.00			
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)									
12.00	Number of travel hours (provider site)	0	0		0		12.00			
12. 01	Number of travel hours (offsite)	0	0		0		12.01			
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.01			
13.01		0	U_		0		13.01			
						1.00				
4.4.00	Part II - SALARY EQUIVALENCY COMPUTATION	1. 10)					1 4 4 9 9			
14.00 15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					50, 645	14.00 15.00			
16.00	Assistants (column 3, line 9 times column 3,					0	16.00			
17.00	Subtotal allowance amount (sum of lines 14 a		ratory therapy o	or lines 14	-16 for all	50, 645	17.00			
10 00	others)	10)					10.00			
18.00 19.00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					0	18.00 19.00			
20.00	Total allowance amount (sum of lines 17-19 f	or respiratory t	therapy or lines	s 17 and 18	for all others)	50, 645				
	If the sum of columns 1 and 2 for respirator									
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on li	nes 21 and	22 and enter on	line 23				
21.00	Weighted average rate excluding aides and tr		divided by sum	of columns	1 and 2, line 9	0.00	21.00			
	for respiratory therapy or columns 1 thru 3,									
22.00 23.00	Weighted allowance excluding aides and train	ees (line 2 time	es line 21)			0 50, 645				
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	VANCE AND TRAVEL	EXPENSE COMPUT	FATION - PR	OVIDER SITE	50, 045	23.00			
	Standard Travel Allowance									
	Therapists (line 3 times column 2, line 11)						24.00			
25.00	Subtotal (line 24 for respiratory therapy or	C 1.1 0		Assistants (line 4 times column 3, line 11)						
26 00		SUM OT LINES 74	4 and 25 for all	others)		0				
26.00 27.00	Standard travel expense (line 7 times line 3				3 and 4 for all		26.00			
27.00	Standard travel expense (line 7 times line 3 others)	for respiratory	y therapy or sum	n of lines		0 0 0	26. 00 27. 00			
	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	for respiratory	y therapy or sum	n of lines		0 0 0	26.00 27.00			
27.00	Standard travel expense (line 7 times line 3 others)	for respiratory	y therapy or sum	n of lines		0 0 0	26.00 27.00			
27.00 28.00 29.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum	for respiratory travel expense Expense of columns 1 and	y therapy or sum at the provider	n of lines			26.00 27.00 28.00 29.00			
27.00 28.00 29.00 30.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3	for respiratory travel expense Expense of columns 1 and line 12)	y therapy or sum at the provider d 2, line 12)	n of lines ⁻ site (sum			26. 00 27. 00 28. 00 29. 00 30. 00			
 27.00 28.00 29.00 30.00 31.00 	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 20	y therapy or sum at the provider d 2, line 12) 9 and 30 for all	n of lines - site (sum 	n of lines 26 and		26. 00 27. 00 28. 00 29. 00 30. 00 31. 00			
27.00 28.00 29.00 30.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3	for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 20	y therapy or sum at the provider d 2, line 12) 9 and 30 for all	n of lines - site (sum 	n of lines 26 and		26. 00 27. 00 28. 00 29. 00 30. 00 31. 00			
 27.00 28.00 29.00 30.00 31.00 32.00 33.00 	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave	for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 2 ⁶ s 1 and 2, line l expense (line	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28)	n of lines - site (sum others) tory therap	n of lines 26 and		26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00			
 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave	for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line expense (sum of	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and	n of lines - site (sum others) tory therap 31)	n of lines 26 and		26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00			
 27.00 28.00 29.00 30.00 31.00 32.00 33.00 	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave	for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 20 s 1 and 2, line l expense (line expense (sum of expense (sum of	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and		26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00			
 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense	for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 20 s 1 and 2, line l expense (line expense (sum of expense (sum of	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 30.00 31.00 32.00 33.00 33.00 34.00			
 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 20 s 1 and 2, line l expense (line expense (sum of expense (sum of	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 30.00 31.00 32.00 33.00 33.00 35.00			
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 20 s 1 and 2, line l expense (line expense (sum of expense (sum of	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and	I 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00			
 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 20 s 1 and 2, line l expense (line l expense (sum of l expense (sum of NCE AND TRAVEL	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and EXPENSE COMPUTA	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00			
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel	for respiratory travel expense of columns 1 and line 12) sum of lines 20 s 1 and 2, line expense (line expense (sum of expense (sum of NCE AND TRAVEL	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and EXPENSE COMPUTA	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00			
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.	for respiratory travel expense of columns 1 and , line 12) sum of lines 20 s 1 and 2, line l expense (line l expense (sum of expense (sum of expense (sum of lines 5 and Expense D1 times column	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and EXPENSE COMPUTA	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00			
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	for respiratory travel expense of columns 1 and , line 12) sum of lines 20 s 1 and 2, line l expense (line l expense (sum of expense (sum of expense (sum of lines 5 and Expense D1 times column	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and EXPENSE COMPUTA	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00			
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.	for respiratory travel expense of columns 1 and , line 12) sum of lines 24 s 1 and 2, line l expense (line l expense (sum of expense (sum of expense (sum of Expense 01 times column n 3, line 10)	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and EXPENSE COMPUTA d 6) 2, line 10)	n of lines - site (sum others) tory therap 31) 32)	n of lines 26 and	I 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00			
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (column 3, line 12. O1 times colum Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su Total Travel Allowance and Travel Expense - 0	for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 29 s 1 and 2, line 1 expense (line 1 expense (sum of 1 expense (sum of section)) n of columns 1-3	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 31 and EXPENSE COMPUTA d 6) 2, line 10) 3, line 13.01)	n of lines - site (sum others) tory therap 31) 32) ATION - SER	n of lines 26 and by or sum of RVICES OUTSIDE PR	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00			
27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00	Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (column 3, line 12.01 times colum Subtotal (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su	for respiratory travel expense of columns 1 and line 12) sum of lines 20 s 1 and 2, line expense (line expense (sum of expense (sum of column 1-2) offsite Services	y therapy or sum at the provider d 2, line 12) 9 and 30 for all 13 for respirat 28) of lines 27 and of lines 27 and of lines 31 and EXPENSE COMPUTA d 6) 2, line 10) 3, line 13.01) 5; Complete one	n of lines - site (sum others) tory therap 31) 32) ATION - SER	n of lines 26 and by or sum of RVICES OUTSIDE PR	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00			

ealth Financial Systems EASONABLE COST DETERMINATION FOR ⁻ UTSIDE SUPPLIERS	THERAPY SERVICES F	DUKES MEMORIAL	Provider CC		Period: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 5/28/2022 9:1	-3 pared:
					Speech Pathology		
						1.00	
6.00 Optional travel allowance ar	nd optional travel	expense (sum o	flines 42 an	d 43 - see in	structions)	0	46.0
	-	Therapists	Assistants	Aides	Trai nees	Total	
PART V - OVERTIME COMPUTATIO	N	1.00	2.00	3.00	4.00	5.00	
7.00 Overtime hours worked during		0.00	0.00	0.0	0.00	0.00	47.0
period (if column 5, line 47							
equal to or greater than 2,0							
complete lines 48-55 and ent	er zero in each						
column of line 56) 8.00 Overtime rate (see instructi	ons)	0.00	0.00	0.0	0.00		48.0
9.00 Total overtime (including ba		0.00	0.00				49.0
allowance) (multiply line 47							
CALCULATION OF LIMIT							
0.00 Percentage of overtime hours		0.00	0.00	0.0	0.00	0.00	50.0
(divide the hours in each co by the total overtime worked							
line 47)							
1.00 Allocation of provider's sta	andard work year	0.00	0.00	0.0	0.00	0.00	51.0
for one full-time employee t							
percentages on line 50) (see							
DETERMINATION OF OVERTIME AL 2.00 Adjusted hourly salary equiv		73.84	0.00	0.0	0.00		52.0
(see instructions)	anount	73.04	0.00	0.0	0.00		52.0
3.00 Overtime cost limitation (li	ne 51 times line	0	0		0 0		53.0
52)		_					
4.00 Maximum overtime cost (enter	the lesser of	0	0		0 0		54.0
5.00 Portion of overtime already	included in	0	0		0 0		55. C
hourly computation at the AF		U U	0		0		
line 47 times line 52)							
6.00 Overtime allowance (line 54	minus line 55 -	0	0		0 0	0	56. C
if negative enter zero) (Er the sum of columns 1, 3, and							
respiratory therapy and colu							
for all others.)							
						1.00	
Part VI - COMPUTATION OF THE 7.00 Salary equivalency amount (f		ND EXCESS COST A	ADJUSIMENI			50, 645	57.0
8.00 Travel allowance and expense		(from lines 33	34 or 35))			0,043	
9.00 Travel allowance and expense)		0	
0.00 Overtime allowance (from col						0	60. (
1.00 Equipment cost (see instruct	ti ons)					0	
2.00 Supplies (see instructions)	NG E7 40)					0 50, 645	
3.00 Total allowance (sum of line 4.00 Total cost of outside suppli		vour records)				50, 645 48, 115	
5.00 Excess over limitation (line			enter zero)				65.0
LINE 33 CALCULATION							
00.00 Line 26 = line 24 for respir							100. (
00.01 Line 27 = line 7 times line		therapy or sum	of lines 3 a	nd 4 for all	others		100.0
00.02 <u>Line 33 = line 28 = sum of l</u> LINE 34 CALCULATION	Thes 26 and 27					0	100. 0
01.00 Line $27 = $ Line 7 times line	3 for respiratory	therapy or sum	of lines 3 a	nd 4 for all	others	0	101.0
							101.0
01.01 Line 31 = line 29 for respir						0	101.0
01.01	nd 31						1
01.02 Line 34 = sum of lines 27 ar LINE 35 CALCULATION							
01.02 Line 34 = sum of lines 27 ar LINE 35 CALCULATION 02.00 Line 31 = line 29 for respir	ratory therapy or	sum of lines 29	and 30 for a	II others			102.
01.02 Line 34 = sum of lines 27 ar LINE 35 CALCULATION	ratory therapy or	sum of lines 29 13 for respirate	and 30 for a ory therapy o	ll others r sum of colu	mns 1-3, line		102. 102.

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/28/2022 9:1	pared: 7 am
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	ADMI TTI NG	
		0	1.00	2.00	4.00	5. 01	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	2, 452, 281	2, 452, 281	-	-		1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT	2, 432, 281		2, 709, 47	12		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 294, 115		12, 36			4.00
5.01	00570 ADMI TTI NG	1, 333, 403		19, 91		1, 449, 507	5.01
5.02	00590 ADMINISTRATIVE AND GENERAL	7, 697, 049		167, 52		0	5.02
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	2, 546, 860 81, 911		734, 57 32, 00		0	7.00 8.00
8.00 9.00	00900 HOUSEKEEPING	571, 227	28, 970			0	9.00
	01000 DI ETARY	230, 241	35, 959			0	10.00
	01100 CAFETERI A	110, 888	32, 293	35, 68		0	11.00
	01300 NURSING ADMINISTRATION	285, 055		9, 81		0	13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	232, 570		49, 83 28, 78		0	14.00 15.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	650, 820 332, 380				0	16.00
	01700 SOCIAL SERVICE	220, 349				0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	L					
	03000 ADULTS & PEDIATRICS	3, 321, 025					•
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	1, 027, 279 284, 291	43, 734 9, 500	48, 32 10, 49		19, 121 1, 554	31.00 43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	204,271	7, 300	10, 4	50,202	1, 334	43.00
50.00	05000 OPERATI NG ROOM	682, 782	164, 676	181, 94	17 72, 586	100, 722	50.00
	05100 RECOVERY ROOM	298, 574		14, 32		21, 499	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	997, 930	138, 775	153, 33	0 0 30 132, 209	0 296, 858	53.00 54.00
	05401 ULTRASOUND	0	0	100, 00	0 0	270,030	54.00
	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
	05700 CT SCAN	0	0		0 0	0	57.00
		0	0	10.00	0 0	0	58.00
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 862, 064 59, 083		43, 03 1, 65		201, 048 3, 275	•
	06500 RESPIRATORY THERAPY	851, 281				49, 284	•
66.00	06600 PHYSI CAL THERAPY	375, 701	112, 304	124, 08		18, 070	•
	06700 OCCUPATI ONAL THERAPY	159, 940		3, 37		8, 774	•
	06800 SPEECH PATHOLOGY	48, 114		F (0)	0 0	1,096	•
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	221, 369 16, 488		56, 96	58 31, 691 0 0	51, 417 30, 428	69.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	32, 158			0 0		72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 947, 031			0 0		
	03610 SLEEP LAB	0	0		0 0	0	76.00
	OUTPATIENT SERVICE COST CENTERS	11/ 100	24.475	20.00	1(220	1 0/0	
	09100 EMERGENCY	116, 198 4, 115, 645					
	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 110, 040	/ //	103, 27	000,017	221, 772	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	554, 541	32, 433	35, 83	34 53, 582	79, 582	95.00
118.00		38, 720, 115	2, 228, 497	2, 462, 21	2, 317, 613	1, 449, 507	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 970	11, 01	15 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 555		236, 23			192.00
200.00	Cross Foot Adjustments						200.00
201.00 202.00		38, 723, 670	0 2, 452, 281	2, 709, 47	0 0 72 2, 317, 663		201.00
202.00		00,720,070	1 2,702,201	1 2,707,47	L 2, 517, 003	1, 77, 307	1-02.00

Health Financial Systems	DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2021	Worksheet B Part I	
				o 12/31/2021	Date/Time Pre	pared:
Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	5/28/2022 9:1 HOUSEKEEPI NG	/ am
		AND GENERAL	PLANT	LINEN SERVICE		
GENERAL SERVICE COST CENTERS	5A. 01	5.02	7.00	8.00	9.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00570 ADMI TTI NG						5.01
5. 02 00590 ADMI NI STRATI VE AND GENERAL	8, 230, 535					5.02
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	3, 996, 637 142, 890					7.00 8.00
9. 00 00900 HOUSEKEEPING	695, 608				985, 279	
10. 00 01000 DI ETARY	327, 836				27, 182	
11. 00 01100 CAFETERI A	194, 681				24, 411	
13.00 01300 NURSING ADMINISTRATION	346, 482	93, 520	32, 355	0	6, 712	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	344, 712				34, 095	
15. 00 01500 PHARMACY	788, 052				19, 694	
16.00 01600 MEDI CAL RECORDS & LI BRARY	430, 274				31, 871	
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	269, 809	72, 825	39, 935	0	8, 284	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	4, 577, 008	1, 235, 399	1, 267, 100	226, 525	262, 848	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 230, 609				33, 060	
43.00 04300 NURSERY	342, 124				7, 181	
ANCI LLARY SERVICE COST CENTERS		1	1			
50. 00 05000 OPERATI NG ROOM	1, 202, 713				124, 482	50.00
51.00 05100 RECOVERY ROOM	378, 881				9, 799	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 719, 102	464,010	505, 704	-	104, 903	53.00 54.00
54. 01 05401 ULTRASOUND	1, 719, 102		505,704		104, 903	54.00
56. 00 05600 RADI OI SOTOPE	C		0	0	0	56.00
57.00 05700 CT SCAN	C	0 0	0	0	0	57.00
58.00 05800 MRI	C	0 0	0	0	0	58.00
60. 00 06000 LABORATORY	2, 270, 249				29, 445	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	65, 509				1, 131	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1,097,884				29, 752	
67. 00 06700 OCCUPATI ONAL THERAPY	630, 157 175, 148				84, 893 2, 311	
68. 00 06800 SPEECH PATHOLOGY	49, 210				2, 311	
69. 00 06900 ELECTROCARDI OLOGY	413,005			-	38, 975	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46, 916				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	34, 578		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 196, 646			0	0	73.00
76.00 03610 SLEEP LAB	C	0 0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	206, 356	55, 698	125, 629	0	26, 060	
90.00 09000 CLINIC 91.00 09100 EMERGENCY	5, 089, 445					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 007, 443		340, 002		70,034	92.00
OTHER REIMBURSABLE COST CENTERS		· 1	1			
95. 00 09500 AMBULANCE SERVI CES	755, 972	204, 047	118, 187	0	0	95.00
SPECIAL PURPOSE COST CENTERS		1				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	38, 249, 028	8, 102, 423	5, 039, 055	287, 027	977, 743	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	20.005	E // A	24, 220		7 50/	100.00
190. 00 19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICLANS' PRIVATE OFFICES	20, 985 453, 657			0		190. 00 192. 00
200.00 Cross Foot Adjustments	455, 657					200.00
201.00 Negative Cost Centers	C	o o	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	38, 723, 670	8, 230, 535	5, 075, 385	287, 027	985, 279	
				·		

Heal th	Financial Systems	DUKES MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/28/2022 9:1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL N SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.01	00570 ADMITTING						4.00 5.01
5.02	00590 ADMINISTRATIVE AND GENERAL						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	574, 542					10.00
11.00	01100 CAFETERI A	0	389, 318				11.00
13.00	01300 NURSING ADMINISTRATION	0	5, 558				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	6, 782		0 642, 994		14.00
15.00	01500 PHARMACY	0	13, 430		0 24, 278	1, 153, 098	
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	4, 255		0 399 0 0	0	16.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	5, 346		0 0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	479, 721	100, 927	257, 45	5 75, 431	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	94, 821	17, 419			0	31.00
43.00	04300 NURSERY	0	6, 595		0 0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	· · · ·	· · · ·	•			
50.00	05000 OPERATI NG ROOM	0	15, 691	23, 96	4 85, 423	0	50.00
51.00	05100 RECOVERY ROOM	0	5, 292	2 17, 86	4 9, 070	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	34, 573			0	54.00
54. 01 56. 00	05401 ULTRASOUND 05600 RADI OI SOTOPE	0	C		0 0	0	54.01 56.00
57.00	05700 CT SCAN	0				0	57.00
58.00	05800 MRI	0			0 0	0	58.00
60.00	06000 LABORATORY	0	39, 360			0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	Ő	C , , , , , , , , , , , , , , , , , , ,		0 26,676	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	25, 850		0 33, 499	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 558	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	7, 207		0 2,645	0	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	C		0 6, 902	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 15, 061	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 03610 SLEEP LAB	0	C C		0 0	1, 153, 098	
76.00	OUTPATIENT SERVICE COST CENTERS	0		<u>л</u>	0 0	0	76.00
90 00	09000 CLINIC	0	3, 165	i 8, 81	9 2, 525	0	90.00
	09100 EMERGENCY	0	39, 626			0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	_					92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	58, 242	2	0 35, 811	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		574, 542	389, 318	8 484, 62	7 642, 986	1, 153, 098	118.00
	NONREI MBURSABLE COST CENTERS	-		,I			400
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C	,	0 8		192.00
200.00 201.00			~				200. 00 201. 00
201.00		574, 542	389, 318	484, 62	0 0 7 642, 994		
202.00		574, 542	307, 310	404,02	1 042, 794	1, 100, 090	202.00

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCM	N: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/28/2022 9:1	pared: 7 am
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS		I I				1 1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00570 ADMITTING 5.02 00590 ADMINISTRATIVE AND GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING						1.00 2.00 4.00 5.01 5.02 7.00 8.00 9.00
10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY	736, 574					10.00 11.00 13.00 14.00 15.00 16.00
17.00 01700 SOCIAL SERVICE	0	1				17.00
INPATIENT ROUTINE SERVICE COST CENTERS	44, 400	212 (0/	0.041.7		0 041 700	1 20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	46, 620 9, 717		8, 841, 7 2, 050, 1		8, 841, 720 2, 050, 188	
43.00 04300 NURSERY	790		521, 0		521, 088	
ANCI LLARY SERVI CE COST CENTERS		i				
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	51, 185	1	2, 428, 1		2, 428, 174	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 926 0		581, 3	0 0	581, 335 0	1
53. 00 05300 ANESTHESI OLOGY	0	1		0 0	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	150, 817	0	3, 005, 8	60 0	3, 005, 860	54.00
54. 01 05401 ULTRASOUND	0			0 0	0	
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	0	1		0 0	0	
58. 00 05800 MRI	0	-		0 0	0	1
60. 00 06000 LABORATORY	102, 169	-	3, 438, 5	81 0	3, 438, 581	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 664	. 0	118, 1	16 0	118, 116	62.00
65. 00 06500 RESPI RATORY THERAPY	25, 045		1, 651, 7		1, 651, 788	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	9, 183 4, 459		1, 304, 1 240, 3		1, 304, 119 240, 332	
68. 00 06800 SPEECH PATHOLOGY	557		63, 0		63, 049	
69.00 06900 ELECTROCARDI OLOGY	26, 129		787, 3		787, 325	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15, 463		81, 9		81, 944	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	1, 230		60, 2		60, 202	
73. 00 07300 DRUGS CHARGED TO PATIENTS	126, 850	1	4, 069, 5		4, 069, 500	73.00
76. 00 03610 SLEEP LAB OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	76.00
90. 00 09000 CLINIC	642	0	428, 8	94 0	428, 894	90.00
91.00 09100 EMERGENCY	112, 686	0	7, 192, 1	26 0	7, 192, 126	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS	40 442		1 010 7	01 0	1 212 701	
95.00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	40, 442	0	1, 212, 7	01 0	1, 212, 701	95.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	736, 574	396, 199	38, 077, 0	42 0	38, 077, 042	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		70, 5			190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	576, 1		576, 113	
200.00Cross Foot Adjustments201.00Negative Cost Centers	_			0 0		200.00 201.00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	736, 574	396, 199	38, 723, 6	0 0 70 0		
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Heal th	Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1318	Period: From 01/01/2021	Worksheet B Part II	
					To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New Capital				BENEFI TS DEPARTMENT	
		Related Costs	1.00	2.00	24		
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	2A	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	11, 187	12, 36		23, 548	
5.01 5.02	00570 ADMI TTI NG 00590 ADMI NI STRATI VE AND GENERAL	0	18, 024 151, 624			794 2, 178	5. 01 5. 02
7.00	00700 OPERATION OF PLANT	0	664, 845			512	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	28, 970			0	8.00
9.00	00900 HOUSEKEEPI NG	0	27, 968	30, 90	58, 869	666	9.00
10.00	01000 DI ETARY	0	35, 959			223	10.00
11.00		0	32, 293			161	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON	0	8, 879			434	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	45, 104 26, 053			175 837	14.00 15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	42, 162	46, 58		93	16.00
17.00	01700 SOCIAL SERVICE	0	10, 959	12, 10		268	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	347, 718			4, 393	
31.00	03100 I NTENSI VE CARE UNI T	0	43, 734	48, 32		936	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	9, 500	10, 49	19, 997	369	43.00
50.00	05000 OPERATING ROOM	0	164, 676	181, 94	7 346, 623	737	50.00
51.00	05100 RECOVERY ROOM	0	12, 963	14, 32		320	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	138, 775	153, 33	0 292, 105	1, 343	
54.01	05401 ULTRASOUND	0	0		0 0	0	54.01
56.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	0		0 0	0	56.00
57.00 58.00	05800 MRI	0	0			0	57.00 58.00
60.00	06000 LABORATORY	0	38, 952	43, 03	8 81, 990	1, 271	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 497	1, 65		0	62.00
65.00	06500 RESPI RATORY THERAPY	0	39, 358			1, 163	65.00
66.00	06600 PHYSI CAL THERAPY	0	112, 304	124, 08	2 236, 386	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	3, 057	3, 37	6, 434	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	51, 560	56, 96		322	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	71.00
	07200 TMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	03610 SLEEP LAB	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS			I	-		
90.00	09000 CLI NI C	0	34, 475	38, 09	1 72, 566	166	90.00
91.00	09100 EMERGENCY	0	93, 468	103, 27	1 196, 739	5, 642	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
05 00		0	32, 433	25.02	4 (0.247	E 4 4	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	32, 433	35, 83	68, 267	544	95.00
118.00		0	2, 228, 497	2, 462, 21	9 4, 690, 716	23, 547	118.00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 970				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	213, 814	236, 23		1	192.00
200.00 201.00			0		0 0	0	200. 00 201. 00
201.00		0	8	2, 709, 47	2 5, 161, 753	23, 548	
				, ,,,,,			

Health Financial Systems	DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod:	Worksheet B	
				rom 01/01/2021 o 12/31/2021	Part II Date/Time Pre	pared:
Cost Center Description	ADMI TTI NG	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	5/28/2022 9: 1 HOUSEKEEPI NG	7 am
		AND GENERAL	PLANT	LINEN SERVICE	HOUSEREEFTING	
	5.01	5.02	7.00	8.00	9.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT		1				1.00
2.00 00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00570 ADMI TTI NG	38, 732					5.01
5. 02 00590 ADMINI STRATI VE AND GENERAL	C	321, 328				5. 02
7.00 00700 OPERATION OF PLANT	C	,				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	C	1, 506			05 000	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY		7, 330 3, 455		0	95, 822	9.00 10.00
11. 00 01100 CAFETERI A		2, 052		0	2, 644 2, 374	
13. 00 01300 NURSI NG ADMI NI STRATI ON		3, 651		0	653	
14. 00 01400 CENTRAL SERVICES & SUPPLY	C	3, 633		0	3, 316	
15. 00 01500 PHARMACY	C	8, 304		0	1, 915	
16.00 01600 MEDICAL RECORDS & LIBRARY	C	4, 534	43, 653	0	3, 100	16.00
17.00 01700 SOCIAL SERVICE	C	2, 843	11, 347	0	806	17.00
INPATIENT ROUTINE SERVICE COST CENTERS		10.000		70.007	05 5/0	
30. 00 03000 ADULTS & PEDIATRICS	2,456				25, 563	
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	512			14, 426 5, 067	3, 215 698	
ANCI LLARY SERVICE COST CENTERS	1 72	3,003	7,000	5,007	070	45.00
50. 00 05000 OPERATI NG ROOM	2,696	12, 674	170, 500	0	12, 106	50.00
51.00 05100 RECOVERY ROOM	576	3, 993	13, 421	0	953	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C			0	0	52.00
53.00 05300 ANESTHESI OLOGY	C	0	-	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7,875			0	10, 202	54.00
54. 01 05401 ULTRASOUND 56. 00 05600 RADI 0I SOTOPE		0	0	0	0	54.01 56.00
57. 00 05700 CT SCAN			0	0	0	57.00
58. 00 05800 MRI		-	-	0	0	58.00
60. 00 06000 LABORATORY	5, 382	-	, °	0	2, 864	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	88			0	110	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 319	11, 570	40, 750	0	2, 893	65.00
66. 00 06600 PHYSI CAL THERAPY	484		116, 276	0	8, 256	66.00
67.00 06700 OCCUPATI ONAL THERAPY	235			0	225	67.00
68.00 06800 SPEECH PATHOLOGY	29			0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 376			0	3, 791	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	815			0	0	71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 682			0	0	73.00
76. 00 03610 SLEEP LAB	0,002			0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	34					90.00
91. 00 09100 EMERGENCY	5, 936	53, 623	96, 774	0	6, 871	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	2,130	7, 966	33, 580	0		95.00
SPECIAL PURPOSE COST CENTERS	2, 130	1,900	33, 360	0	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	38, 732	316, 326	1, 431, 723	92, 480	95, 089	118,00
NONREI MBURSABLE COST CENTERS	1		.,	,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C			0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	4, 781	0	0	0	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	, °	0		201.00
202.00 TOTAL (sum lines 118 through 201)	38, 732	321, 328	1, 442, 045	92, 480	95, 822	1202.00

Heal th	Financial Systems	DUKES MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2021	Worksheet B Part II	
					0 12/31/2021	Date/Time Pre	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	5/28/2022 9: 1 PHARMACY	
				ADMI NI STRATI ON			
		10.00	11.00	13.00	SUPPLY 14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.01	00570 ADMITTING						4.00 5.01
5.02	00590 ADMINISTRATIVE AND GENERAL						5.02
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	119, 242	105 005				10.00
11.00		0	105, 995				11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	1, 513				13.00 14.00
14.00	01500 PHARMACY	0	1, 846 3, 656		150, 608 5, 687	102, 211	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 158		93	102, 211	16.00
17.00	01700 SOCIAL SERVICE	o	1, 455			0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-	.,	-	, -ı	-	
30.00	03000 ADULTS & PEDI ATRI CS	99, 563	27, 479	18, 134	17, 668	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	19, 679	4, 743	3, 796	2, 940	0	31.00
43.00	04300 NURSERY	0	1, 796	0	0	0	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	4, 272			0	50.00
51.00	05100 RECOVERY ROOM	0	1, 441			0	51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 413	3		0	54.00
54.01	05401 ULTRASOUND	0	,, 110	0		0	54.01
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	10, 716	1	56, 829	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	6, 248	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	7, 038	0		0	65.00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	131	0	66.00
67.00 68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	1, 962		620	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	1, 617	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3, 528	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	102, 211	73.00
76.00	03610 SLEEP LAB	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	862				90.00
	09100 EMERGENCY	0	10, 788	8, 553	10, 293	0	
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	15, 857	0	8, 388	0	95.00
95.00	SPECIAL PURPOSE COST CENTERS	0	15, 657		0, 300	0	95.00
118.00		119, 242	105, 995	34, 133	150, 606	102, 211	118.00
	NONREI MBURSABLE COST CENTERS	,	, , , , ,	, 100			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	2	0	192.00
200.00							200. 00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	119, 242	105, 995	34, 133	150, 608	102, 211	202.00

Health Financial Systems	DUKES MEMORI				u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN	N: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/28/2022 9:1	pared: 7 am
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS		I I				1 1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EOUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00570 ADMITTING GOS90 ADMINISTRATIVE AND GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING						1.00 2.00 4.00 5.01 5.02 7.00 8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	141, 376					10.00 11.00 13.00 14.00 15.00 16.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	39, 786				17.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	8, 945 1, 864 152	6, 206	1, 448, 74 208, 62 43, 74	21 0	1, 448, 741 208, 621 43, 742	31.00
ANCI LLARY SERVICE COST CENTERS	102	2,100		12 0	43, 742	45.00
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	9,821 2,096 0 0	0 0	581, 12 53, 46		581, 126 53, 469 0 0	51.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND 56. 00 05600 RADI OI SOTOPE	28, 988 0 0	3 O O	517, 79	s 5	517, 799 0 0	54.00 54.01
57. 00 05700 CT SCAN 58. 00 05800 MRI 60. 00 06000 LABORATORY	0 0 19, 603	0 0 0 0	242, 9	0 0 0 0	0 0 242, 910	57.00 58.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	319 4, 805 1, 762	0	12, 15 160, 22 369, 93	29 0 36 0	12, 156 160, 229 369, 936	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	856 107 5, 013	0 8 0	12, 76 65 179, 34	55 O 48 O	12, 761 655 179, 348	68.00 69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 76.00 03610 SLEEP LAB	2, 967 236 24, 338 0	0 0	5, 89 4, 19 156, 37	93 0	5, 893 4, 193 156, 379	72.00
OUTPATIENT SERVICE COST CENTERS	0			0 0	0	70.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	123 21, 621		115, 36 416, 84		115, 366 416, 840	
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES	7, 760		144, 49		144, 492	1
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	141, 376	39, 786	4, 674, 65	56 0	4, 674, 656	118. 00
190.0019000GIFT, FLOWER, COFFEE SHOP & CANTEEN192.0019200PHYSICIANS' PRIVATE OFFICES200.00Cross Foot Adjustments	0 0		32, 26 454, 83	36 0 0 0	454, 836 0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 141, 376	0 0 39, 786	5, 161, 75	0 0 53 0	0 5, 161, 753	201. 00 202. 00

	Financial Systems LLOCATION – STATISTICAL BASIS	DUKES MEMORIA	AL HOSPITAL Provider CC	CN: 15-1318	Period:	eu of Form CMS-: Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/28/2022 9:1	
		CAPI TAL REI	LATED COSTS			1 37 207 2022 7. 1	
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMI TTI NG (GROSS CHARGES)	Reconci I i ati on	
		1.00	2.00	4.00	5. 01	5A. 02	
	GENERAL SERVICE COST CENTERS	400.007					1 1 00
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	193, 337	193, 337				1.00 2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	882		14, 671, 279			4.00
	00570 ADMI TTI NG	1, 421		494, 803			5.01
	00590 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	11, 954 52, 416		1, 356, 790 318, 798		-8, 230, 535	5.02 7.00
	00800 LAUNDRY & LINEN SERVICE	2, 284		510,790		0	•
9.00	00900 HOUSEKEEPI NG	2, 205	2, 205	414, 706	0	0	9.00
	01000 DI ETARY	2,835		138, 669		0	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	2, 546 700		100, 144 270, 537		0	11.00
	01400 CENTRAL SERVICES & SUPPLY	3, 556		108, 898		0	14.00
	01500 PHARMACY	2, 054		521, 567		0	15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 324 864		57, 912 167, 072			16.00 17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	004	004	107,072	0	0	17.00
	03000 ADULTS & PEDIATRICS	27, 414				0	•
	03100 I NTENSI VE CARE UNI T	3, 448		583, 350		0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	/49	///////////////////////////////////////	229, 673	215, 567	0	43.00
	05000 OPERATI NG ROOM	12, 983	12, 983	459, 484	13, 969, 756	0	50.00
	05100 RECOVERY ROOM	1, 022		199, 543	2, 981, 876		51.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0			0	52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C	10, 941	10, 941	836, 906	41, 167, 604	0	54.00
	05401 ULTRASOUND	0	0	C	0 0	0	54.01
	05600 RADI OI SOTOPE 05700 CT SCAN	0	0		0	0	56.00 57.00
	05700 CT SCAN 05800 MRI		0			0	57.00
	06000 LABORATORY	3, 071	3, 071	792, 205	27, 884, 663	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	118			454, 271	0	62.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 103 8, 854		724, 649	6, 835, 531 2, 506, 256	0	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	241		C			67.00
	06800 SPEECH PATHOLOGY	0		0	151, 979		68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	4,065		200, 610		0	69.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	-	C			
73.00	07300 DRUGS CHARGED TO PATIENTS	0		C			•
	03610 SLEEP LAB OUTPATI ENT SERVICE COST CENTERS	0	0	C	0 0	0	76.00
90.00	09000 CLI NI C	2, 718	2, 718	103, 367	175, 147	0	90.00
	09100 EMERGENCY	7, 369				0	91.00
	09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	2, 557	2, 557	339, 186	11, 037, 752	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	175, 694	175, 694	14, 670, 965	201, 035, 873	-8, 230, 535	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	786	786	C	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	16, 857		314			192.00
200.00	5						200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 452, 281	2, 709, 472	2, 317, 663	1, 449, 507		201.00 202.00
202.00	Part I)	2, 402, 201	2,107,472	2, 317, 000	1, 47, 507		202.00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	12. 683972	14. 014245	0. 157973 23, 548			203. 00 204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part			0. 001605	0. 000193		205.00
206.00	II) NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						207.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2021	Worksheet B-1	
			T		Date/Time Pre	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/28/2022 9: 1 DI ETARY	7 am
	AND GENERAL	PLANT	LINEN SERVICE			
	(ACCUMULATED COST)	(SQUARE FEET)	(TOTAL PATIENT DAYS)			
	5. 02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00570 ADMI TTI NG						5.01
5. 02 00590 ADMINI STRATI VE AND GENERAL	30, 493, 135					5.02
7.00 00700 OPERATION OF PLANT	3, 996, 637	109, 807				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	142, 890 695, 608	2, 284 2, 205		102, 761		8.00 9.00
10. 00 01000 DI ETARY	327,836	2, 203		2, 835	4, 399	
11. 00 01100 CAFETERI A	194, 681	2, 546		2, 546	0	11.00
13.00 01300 NURSING ADMINISTRATION	346, 482	700	0	700	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	344, 712	3, 556		3, 556	0	14.00
	788, 052	2,054		2,054	0	15.00 16.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	430, 274 269, 809	3, 324 864		3, 324 864	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	207,007		<u> </u>	001		17.00
30. 00 03000 ADULTS & PEDI ATRI CS	4, 577, 008			27, 414	3, 673	
31. 00 03100 I NTENSI VE CARE UNI T	1, 230, 609	3, 448		3, 448	726	31.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	342, 124	749	255	749	0	43.00
50. 00 05000 OPERATI NG ROOM	1, 202, 713	12, 983	0	12, 983	0	50.00
51.00 05100 RECOVERY ROOM	378, 881	1, 022		1, 022	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	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	1, 719, 102	10, 941	0	10, 941	0	54.00
54. 01 05401 ULTRASOUND 56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	54.01 56.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58. 00 05800 MRI	0	0	0	0	0	58.00
60. 00 06000 LABORATORY	2, 270, 249	3, 071		3, 071	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	65, 509	118		118	0	62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 097, 884 630, 157	3, 103 8, 854		3, 103 8, 854	0	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	175, 148	241		241	0	67.00
68.00 06800 SPEECH PATHOLOGY	49, 210	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	413, 005	4, 065	0	4, 065	0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	46, 916	0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	34, 578 2, 196, 646	0	0	0	0	72.00 73.00
76. 00 03610 SLEEP LAB	2, 190, 040	0		0	0	
OUTPATIENT SERVICE COST CENTERS			, <u> </u>			/ 01 00
90. 00 09000 CLINIC	206, 356			2, 718	0	1
91.00 09100 EMERGENCY	5, 089, 445	7, 369	0	7, 369	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	755, 972	2, 557	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	30, 018, 493	109, 021	4, 654	101, 975	4, 399	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	20, 985	786	0	786	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	453, 657	0	0	0		192.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	8, 230, 535	5, 075, 385	287, 027	985, 279	574, 542	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 269914	46. 220960	61.673184	9, 588064	130. 607411	203.00
204.00 Cost to be allocated (per Wkst. B,	321, 328	1, 442, 045		95, 822	119, 242	
Part II)	_					
205.00 Unit cost multiplier (Wkst. B, Part	0. 010538	13. 132542	19.871079	0. 932474	27.106615	205.00
206.00 NAHE adjustment amount to be allocated						206.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lieu	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		eriod: rom 01/01/2021	Worksheet B-1	
				o 12/31/2021	Date/Time Pre	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/28/2022 9:1 MEDI CAL	7 am
cost center bescription	(FTES)	ADMI NI STRATI ON		(COSTED REQ)	RECORDS &	
			SUPPLY		LI BRARY	
		(NURSING	(COSTED REQ)		(GROSS	
	11.00	SALARI ES) 13.00	14.00	15.00	CHARGES) 16.00	
GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00570 ADMITTING						4.00 5.01
5. 02 00590 ADMINISTRATIVE AND GENERAL						5.01
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	14 (20					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	14, 639					11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	255		1, 424, 151			14.00
15. 00 01500 PHARMACY	505		53, 772			15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	160	0	883		201, 035, 873	16.00
17.00 01700 SOCIAL SERVICE	201	0	0	0	0	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 705		1(7.070	0	12, 723, 822	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNIT	3, 795				2, 651, 999	30.00 31.00
43. 00 04300 NURSERY	248		0		215, 567	43.00
ANCI LLARY SERVI CE COST CENTERS		1				
50.00 05000 OPERATI NG ROOM	590				13, 969, 756	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM	199 C		20, 090		2, 981, 876 0	51.00
53. 00 05300 ANESTHESI OLOGY					0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 300		56, 661	0	41, 167, 604	54.00
54. 01 05401 ULTRASOUND	C	0	0	0	0	54.01
56. 00 05600 RADI OI SOTOPE	C	-	0	0	0	56.00
57. 00 05700 CT SCAN	0	-	0	0	0	57.00
58. 00 05800 MRI 60. 00 06000 LABORATORY	1, 480			0	0 27, 884, 663	58.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL					454, 271	62.00
65. 00 06500 RESPI RATORY THERAPY	972	0	74, 197	0	6, 835, 531	65.00
66. 00 06600 PHYSI CAL THERAPY	C		1, 235		2, 506, 256	1
67. 00 06700 OCCUPATI ONAL THERAPY			0		1, 216, 936	1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	271		5, 859	-	151, 979 7, 131, 290	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			15, 288		4, 220, 271	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	33, 358		335, 697	
73.00 07300 DRUGS CHARGED TO PATIENTS	C		-		34, 620, 605	1
76.00 03610 SLEEP LAB	C	0 0	0	0	0	76.00
90. 00 09000 CLINIC	119	96, 345	5, 592	0	175, 147	90.00
91. 00 09100 EMERGENCY	1, 490				30, 754, 851	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS		-		-1 -1		
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	2, 190	0	79, 316	0	11, 037, 752	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 14,639	5, 294, 202	1, 424, 134	1, 947, 031	201, 035, 873	118.00
NONREI MBURSABLE COST CENTERS	11/00/	0,2,1,202	1, 12 1, 10 1	17717001	2011 0001 010	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	17	0	0	192.00
200.00Cross Foot Adjustments201.00Negative Cost Centers						200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	389, 318	484, 627	642, 994	1, 153, 098	736, 574	
Part I)	007,010	101,027	012,771	1, 100, 070	700,071	202.00
203.00 Unit cost multiplier (Wkst. B, Part	I) 26. 594576	0. 091539	0. 451493	0. 592234	0.003664	203.00
204.00 Cost to be allocated (per Wkst. B,	105, 995	34, 133	150, 608	102, 211	141, 376	204.00
Part II) 205 00 Unit cost multiplier (West B Part	7 240500	0 004447	0 105753	0.052404	0 000703	205 00
205.00 Unit cost multiplier (Wkst. B, Part	7. 240590	0. 006447	0. 105753	0. 052496	0.000703	203.00
206.00 NAHE adjustment amount to be alloca	ted					206.00
(per Wkst. B-2)						007 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
	I	I	I	I I		1

	Financial Systems	DUKES MEMORIA			of Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 15-1318	From 01/01/2021	orksheet B-1
				To 12/31/2021 D	ate/Time Prepared: /28/2022 9:17 am
	Cost Center Description	SOCI AL SERVI CE			
		(TOTAL PATIENT			
		DAYS)			
	GENERAL SERVICE COST CENTERS	17.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01 5. 02	00570 ADMI TTI NG 00590 ADMI NI STRATI VE AND GENERAL				5. 01 5. 02
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A				10.00
	01300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	01500 PHARMACY				15.00
	01600 MEDICAL RECORDS & LIBRARY	4 454			16.00
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	4,654			17.00
30.00	03000 ADULTS & PEDI ATRI CS	3, 673			30.00
	03100 I NTENSI VE CARE UNI T	726			31.00
43.00		255			43.00
50, 00	ANCI LLARY SERVICE COST CENTERS	0			50.00
	05100 RECOVERY ROOM	0			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0			52.00
53.00	05300 ANESTHESI OLOGY	0			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0			54.00
	05401 ULTRASOUND 05600 RADI OI SOTOPE	0			54. 01 56. 00
	05700 CT SCAN	0			57.00
	05800 MRI	0			58.00
	06000 LABORATORY	0			60.00
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	0			62.00 65.00
66.00	06600 PHYSI CAL THERAPY	0			66.00
	06700 OCCUPATIONAL THERAPY	0			67.00
	06800 SPEECH PATHOLOGY	0			68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			69.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0			73.00
76.00	03610 SLEEP LAB	0			76.00
00.00					
	09000 CLINIC 09100 EMERGENCY	0			90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	Ŭ			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0			95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	4,654			118.00
110.00	NONREIMBURSABLE COST CENTERS	4,034			118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
200.00 201.00					200. 00 201. 00
201.00		396, 199			201.00
	Part I)				
203.00		85. 130855			203.00
204.00		39, 786			204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	8. 548775			205.00
_00.00		0.010770			200.00
206.00					206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,				207.00
207.00	Parts III and IV)				207.00
	· · · · · · · · · · · · · · · · · · ·	1 I			1

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider COX: 15-1318 Period: From 01/01/2021 Worksheet C bits/Time Prepared: 5/28/2029 -177 am (5/28/2029	Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
Title XVIII Hospital Cost Cost Center Description Total Cost Total Costs Costs Cost Center Description Total Costs Total Costs Costs Total Costs Total Costs Costs Impart Ent Routine Service Cost Centers 30.00 Cost Centers AnctLLARY SERVICE COST CENTERS 30.00 Cost Centers AnctLLARY SERVICE COST CENTERS 521,088 Cost 6 AnctLLARY SERVICE COST CENTERS 521,088 Cost 521,088 Cost Cost Centers Cost Cost Centers Cost Cost Centers Costan	COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1318	From 01/01/2021	Part I Date/Time Pre	pared: 7 am
Cost Center Description Total Cost (Part 1, col. 26) Total Cost Adj. Total Costs Total Costs Cost C				Title	× XVIII	Hospi tal		
Impart ENT ROUTI NE SERVICE COST CENTERS Âdj. Pi sal I owance 30.00 03000 ADULTS & PEDIATRI CS 8.841,720 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 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						Costs		
INPATIENT ROUTINE SERVICE COST CENTERS Image: Control of Content of Contentered of Control of Control of Control of Control o		Cost Center Description	(from Wkst. B, Part I, col. 26)	Ădj .		Di sal I owance		
30:00 ADULTS & PEDIATRICS 8, 841, 720 0 0 30.00 31:00 03100 INTENSIVE CARE UNIT 2, 050, 188 2, 050, 188 0 0 ANCILLARY SERVICE COST CENTERS 521, 088 521, 088 0 0 43.00 ANCILLARY SERVICE COST CENTERS 521, 088 0 0 0 0 0 0 0 51:00 05000 (0PERATING ROM 2, 428, 174 2, 428, 174 0 0 50.00 50.00 51:00 05000 (0PERATING ROM 2, 428, 174 0 0 0 51.00 52:00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 53:00 05300 ANESTHESI OLOGY 3, 005, 860 3, 005, 860 0 54.00 54:01 05400 RADI OLOGY-DI AGNOSTIC 3, 005, 860 0 0 0 0 54.00 56:00 05000 CTSCAN 0 0 0 0 58.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 </td <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>			1.00	2.00	3.00	4.00	5.00	
31:00 03100 INTENSIVE CARE UNIT 2,050,188 0 0 31.00 43:00 04300 NURELERY 521,088 0 0 43.00 ANCILLARY SERVICE COST CENTERS 521,088 0 0 50.00 0 50.00 0 50.00 0 0 0 50.00 51.00 51.00 51.00 51.00 51.00 51.00 52.00 0 0 0 0 52.00 0 0 0 0 52.00 0 0 0 0 52.00 0 53.00 53.00 54.00 0 0 0 0 54.00 54.00 0 0 0 0 54.00 56.00 51.00 55.00 55.00 0 0 0 0 54.00 0 0 0 0 54.00 0 0 0 55.00 55.00 55.00 55.00 0 0 0 55.00 55.00 0 0 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 <t< td=""><td></td><td></td><td>0.044.700</td><td></td><td>0.044.74</td><td></td><td></td><td></td></t<>			0.044.700		0.044.74			
43.00 04300 NURSERY 521,088 521,088 0 43.00 ANCILLARY SERVICE COST CENTERS							-	
ANCILLARY SERVICE COST CENTERS							-	
50.00 DFERATI NG ROOM 2, 428, 174 2, 428, 174 0 0 50.00 51.00 D5200 DEL VERY ROOM & LABOR ROOM 0 0 0 52.00 0 0 0 0 0 0 0 0 0 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 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 0 0 0 0 0 0 0 0 0 0 0			521,088		521, 08	38 0	0	43.00
51.00 OS100 RECOVERY ROOM 581,335 581,335 0 0 51.00 52.00 OS200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 53.00 OS300 ANESTHESI OLOCY 0 0 0 0 0 53.00 54.00 OS400 RADI OLOCY-DI AGNOSTI C 3,005,860 3,005,860 0 0 0 54.00 54.01 OS400 RADI OLOCY-DI AGNOSTI C 3,005,860 3,005,860 0 0 0 56.00 57.00 OS500 RADI OLOCY-DI AGNOSTI C 0 0 0 0 56.00 58.00 OS600 RADI OLOCY-DI AGNOSTI C 3,005,860 0 0 0 0 56.00 60.00 OS600 RADI OLOCY-DI AGNOSTI C 3,438,581 3,438,581 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 0 <			0 100 171		0.400.47			
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 53.00 05300 ARSTHESI OLOGY 0 0 0 0 0 53.00 54.00 05400 RADI LOGY-DI AGNOSTI C 3,005,860 3,005,860 0 0 0 0 54.00 54.01 05401 ULTRASOUND 0 0 0 0 0 0 54.01 56.00 05500 RADI OLOGY-DI AGNOSTI C 3,005,860 0 0 0 0 0 55.00 57.00 05700 CT SCAN 0 0 0 0 0 56.00 60.00 06500 RESPI RATORY THERAPY 3,438,581 3,438,581 0 66.00 66.00 65.00 06500 RESPI RATORY THERAPY 1,651,788 1,651,788 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 66.00 67.00 66.00 67.00 68.00 66.00 67.00 68.00 66.00 67.00 69.00 71.00 6							-	
53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,005,860 3,005,860 0 0 54.01 54.01 015400 RADI ASOUND 0 0 0 0 54.01 54.01 015600 RADI OLOGY-DI AGNOSTI C 3,005,860 0 0 0 54.01 55.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 56.00 68.00 05200 MRI 0 0 0 0 60.00 62.00 06200 HADOR ATORY 3,438,581 3,438,581 0 62.00 65.00 06500 RESPIRATORY THERAPY 1,651,788 1,651,788 0 65.00 65.00 06600 PHEXINTERAPY 1,304,119 0 66.00 67.00 66.00 06900 ELECTROCARDI OLOGY 787,325 787,325 0 69.00 71.00 07100<			581, 335		581, 33	35 0	-	
54.00 05400 RADI OLOGY-DI AGNOSTI C 3,005,860 0 0 0 54.00 54.01 05401 ULTRASOUND 0 0 0 0 54.01 55.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 55.00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 54.01 56.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 MRI 0 0 0 0 58.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 118,116 118,116 0 62.00 65.00 06500 RESPI RATORY THERAPY 1,304,119 0 1,651,788 0 66.00 60.00 06500 SPECH PATHOLOGY 63,049 0 63.049 0 67.00 68.00 05900 ELECTROCARDI OLOGY 787,325 787,325 0 69.00 69.00 69.00 0 71.00 73.00 73.00 73.00 73.00 73.00 73.00 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td>0 0</td><td>-</td><td></td></t<>			0			0 0	-	
54. 01 05401 ULTRASOUND 0 0 0 54. 01 56. 00 05600 RADI 01 SOTOPE 0 0 0 56. 00 57. 00 05700 CT SCAN 0 0 0 57. 00 60. 00 06000 LABORATORY 3, 438, 581 0 0 0 62. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 118, 116 118, 116 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 1, 651, 788 0 1, 651, 788 0 65. 00 066. 00 06000 PHYSI CAL THERAPY 1, 304, 119 0 1, 304, 119 0 66. 00 66. 00 06000 PHYSI CAL THERAPY 240, 332 0 67. 00 68. 00 68. 00 68. 00 68. 00 69. 00 67. 00 68. 00 69. 00 67. 00 68. 00 69. 00 71. 00 71. 00 72. 00 69. 00 67. 00 68. 00 69. 00 72. 00 69. 00 72. 00 69. 00 72. 00 69. 00 73. 00 72. 00 60. 00			0			0 0	-	1
56.00 05600 RADI 0I SOTOPE 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MRI 0 0 0 58.00 60.00 06000 LABORATORY 3,438,581 3,438,581 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 118,116 118,116 0 62.00 65.00 06500 RESPI RATORY THERAPY 1,651,788 0 1,651,788 0 66.00 64.00 06700 OCCUPATI ONAL THERAPY 1,304,119 0 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 240,332 0 240,332 0 67.00 68.00 SPEECH PATHOLOGY 63,049 0 63.049 0 67.00 71.00 OTOO MELI CAL SUPPLIES CHARGED TO PATI ENT 81,944 81,944 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI			3, 005, 860		3, 005, 86	0 0	-	
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62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 118, 116 118, 116 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 1, 651, 788 0 1, 651, 788 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 304, 119 0 1, 304, 119 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 240, 332 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 63, 049 0 63, 049 0 68.00 69.00 06900 ELECTROCARDI OLOGY 787, 325 787, 325 0 0 69.00 71.00 MDI CAL SUPPLIES CHARGED TO PATI ENT 81, 944 81, 944 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 60, 202 0 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 90.00 0 73.00 0 90.00 91.00 91.00 92.00 91.00 91.00 92.00			0			0 0	-	1
65.00 06500 RESPIRATORY THERAPY 1,651,788 0 1,651,788 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,304,119 0 1,304,119 0 66.00 67.00 0CCUPATI ONAL THERAPY 240,332 0 240,332 0 67.00 68.00 06800 SPEECH PATHOLOGY 63,049 0 63,049 0 68.00 69.00 06900 ELECTROCARDI OLOGY 787,325 787,325 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 81,944 81,944 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 60,202 60,202 0 73.00 73.00 73.00 73.00 0 0 0 0 73.00 73.00 73.00 73.00 0 74.069,500 4,069,500 0 0 0 70.00 73.00 73.00 70.00 90.00 0 0 90.00 0 90.00 0 90.00 0 90.00 91.00 91.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>							-	
66.00 06600 PHYSI CAL THERAPY 1, 304, 119 0 1, 304, 119 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 240, 332 0 240, 332 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 63, 049 0 63, 049 0 68.00 69.00 06900 ELECTROCARDIOLOGY 787, 325 787, 325 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 81, 944 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 60, 202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 4, 069, 500 4, 069, 500 0 0 73.00 76.00 03610 SLEEP LAB 0 0 0 0 0 0 90.00 0 0 0 0 0 91.00 91.00 09100 EMERGENCY 7, 192, 126 7, 192, 126 0 0 92.00 92.00 92.00 09200 OBSERVAT							-	
67.00 06700 OCCUPATIONAL THERAPY 240, 332 0 240, 332 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 63, 049 0 63, 049 0 68.00 69.00 06900 ELECTROCARDIOLOGY 787, 325 787, 325 0 0 69.00 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 81, 944 81, 944 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 60, 202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 069, 500 4, 069, 500 0 0 73.00 0.0010 DIGS CHARGED TO PATIENTS 4, 069, 500 0 0 0 0 0 73.00 0.0101 DUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 90.00 90.00 91.00 92.00 90.00 O9100 EMERGENCY 7, 192, 126 7, 192, 126 0 0 92.00 91.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 1, 0							-	1
68.00 06800 SPEECH PATHOLOGY 63,049 0 63,049 0 68.00 69.00 06900 ELECTROCARDIOLOGY 787,325 787,325 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 81,944 81,944 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 60,202 60,202 0 0 72.00 73.00 07300 RUGS CHARGED TO PATIENTS 4,069,500 4,069,500 0 0 0 0 73.00 76.00 03610 SLEEP LAB 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 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 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>							-	
69.00 06900 ELECTROCARDIOLOGY 787,325 787,325 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 81,944 81,944 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 60,202 60,202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 60,202 60,202 0 0 73.00 76.00 03610 SLEEP LAB 0 0 0 0 76.00 0000 CLINIC 428,894 428,894 0 0 90.00 90.00 09000 CLINIC 428,894 428,894 0 91.00 91.00 09100 EMERGENCY 7,192,126 7,192,126 92.00 92.00 92.00 09200 DSERVATION BEDS (NON-DI STINCT PART 1,020,008 1,212,701 92.00 92.00 95.00 09500 AMBULANCE SERVICES 1,212,701 0 95.00 95.00 200.00 Less Observation Beds 1,020,008 1,020,008 0 200.00							0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 81,944 81,944 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 60,202 60,202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4,069,500 4,069,500 0 0 73.00 76.00 03610 SLEEP LAB 0 0 0 0 76.00 0000 CLINIC 428,894 428,894 0 0 90.00 90.00 09100 EMERGENCY 7,192,126 7,192,126 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 1,020,008 1,020,008 0 92.00 95.00 09500 AMBULANCE SERVICES 1,212,701 1,212,701 0 95.00 200.00 Subtotal (see instructions) 39,097,050 0 39,097,050 0 200.00 201.00 Less Observation Beds 1,020,008 1,020,008 0 201.00			63, 049	0	63, 04	19 0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 60,202 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4,069,500 4,069,500 0 0 73.00 76.00 03610 SLEEP LAB 0 0 0 0 0 76.00 0000 CLINIC 428,894 428,894 0 0 90.00 90.00 09100 EMERGENCY 7,192,126 7,192,126 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1,020,008 1,020,008 92.00 00000 09500 AMBULANCE SERVICES 1,212,701 1,212,701 0 0 95.00 200.00 Subtotal (see instructions) 39,097,050 0 39,097,050 0 200.00 200.00 201.00 Less Observation Beds 1,020,008 1,020,008 0 201.00 0 201.00							0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 4,069,500 0 0 73.00 76.00 03610 SLEEP LAB 0 0 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 70.00 90.00 09000 CLINIC 428,894 428,894 0 0 90.00 91.00 09200 DBERVATION BEDS (NON-DISTINCT PART 1,020,008 1,020,008 0 92.00 92.00 OPSCOV OBSERVATION SEDS (NON-DISTINCT PART 1,212,701 0 0 92.00 95.00 09500 AMBULANCE SERVICES 1,212,701 1,212,701 0 0 200.00 Subtotal (see instructions) 39,097,050 0 39,097,050 0 200.00 201.00 Less Observation Beds 1,020,008 1,020,008 0 201.00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 944		81, 94	4 0	0	71.00
76.00 03610 SLEEP LAB 0 0 0 0 0 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 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 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 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 0 0 0 0 0 0 0 0 0 0 0 0			60, 202		60, 20	02 0	0	72.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 428,894 428,894 0 90.00 91.00 09100 EMERGENCY 7,192,126 7,192,126 0 91.00 92.00 09200 DBSERVATION BEDS (NON-DI STINCT PART 1,020,008 1,020,008 0 92.00 95.00 09500 AMBULANCE SERVICES 1,212,701 0 0 95.00 200.00 Subtotal (see instructions) 39,097,050 0 39,097,050 0 200.00 201.00 Less Observation Beds 1,020,008 1,020,008 0 201.00			4,069,500		4, 069, 50	0 0	0	73.00
90.00 09000 CLINIC 428,894 428,894 0 0 90.00 91.00 09100 EMERGENCY 7,192,126 7,192,126 0 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 1,020,008 1,020,008 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 95.00 09500 AMBULANCE SERVICES 1,212,701 0 0 95.00 200.00 Subtotal (see instructions) 39,097,050 0 39,097,050 0 200.00 201.00 Less Observation Beds 1,020,008 1,020,008 0 201.00	76.00	03610 SLEEP LAB	0			0 0	0	76.00
91. 00 92. 00 09100 09200 EMERGENCY 0BSERVATION BEDS (NON-DISTINCT PART) 7, 192, 126 1, 020, 008 7, 192, 126 1, 020, 008 0 91. 00 92. 00 95. 00 09500 AMBULANCE SERVICES 1, 212, 701 0 0 95. 00 200. 00 Subtotal (see instructions) 39, 097, 050 0 39, 097, 050 0 200. 00 200. 00 201. 00 Less Observation Beds 1, 020, 008 1, 020, 008 0 201. 00								
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 1,020,008 1,020,008 0 92. 00 0THER REIMBURSABLE COST CENTERS 0 0 95. 00 09500 AMBULANCE SERVICES 1,212,701 0 0 95. 00 200. 00 Subtotal (see instructions) 39,097,050 0 39,097,050 0 200. 00 200. 00 201. 00 0 201. 00 0 201. 00 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 0 0 0 0 0	90.00	09000 CLINIC	428, 894		428, 89	04 0	0	90.00
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 212, 701 0 0 95.00 200.00 Subtotal (see instructions) 39, 097, 050 0 39, 097, 050 0 200.00 201.00 Less Observation Beds 1, 020, 008 1, 020, 008 0 201.00	91.00	09100 EMERGENCY	7, 192, 126		7, 192, 12	26 0	0	91.00
95.00 09500 AMBULANCE SERVICES 1, 212, 701 0 0 95.00 200.00 Subtotal (see instructions) 39, 097, 050 0 39, 097, 050 0 200.00 200.00 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 200.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 0 201.00 0 0 201.00 0 0 201.00 0 0 0 201.00 0 0 201.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1,020,008		1, 020, 00)8	0	92.00
200.00 Subtotal (see instructions) 39,097,050 0 39,097,050 0 200.00 201.00 Less Observation Beds 1,020,008 1,020,008 0 201.00			1		1	- 1		
201.00 Less Observation Beds 1,020,008 1,020,008 0 201.00								
202.00 Total (see instructions) 38,077,042 0 38,077,042 0 0 202.00								
	202.00	Total (see instructions)	38, 077, 042	0	38, 077, 04	2 0	0	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	DUKES MEMORIA	Provider CO	CN: 15-1318	Peri od:	u of Form CMS-: Worksheet C	2002 1
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre	
		Title	XVIII	Hospi tal	5/28/2022 9:1 Cost	/ am
		Charges			0031	
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
			· · · ·		Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	10, 980, 314		10, 980, 31	4		30.0
31.00 03100 INTENSIVE CARE UNIT	2, 651, 999		2, 651, 99	99		31.0
43. 00 04300 NURSERY	215, 567		215, 56	57		43.0
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 201, 352	10, 768, 404	13, 969, 75		0.000000	50.0
51.00 05100 RECOVERY ROOM	558, 934	2, 422, 942	2, 981, 87	0. 194956	0.000000	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.000000	52.0
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0. 000000	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 988, 485	33, 179, 119	41, 167, 60	0. 073015	0.000000	54. C
54. 01 05401 ULTRASOUND	0	0		0 0.000000	0.000000	54.0
56. 00 05600 RADI OI SOTOPE	0	0		0 0.000000	0.000000	56.0
57.00 05700 CT SCAN	0	0		0 0.000000	0.000000	57.0
58. 00 05800 MRI	0	0		0 0.000000	0.000000	58.0
60. 00 06000 LABORATORY	8, 994, 958	18, 889, 705	27, 884, 66		0.000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	266, 676	187, 595			0.000000	
65. 00 06500 RESPI RATORY THERAPY	6,001,862	833, 669	6, 835, 53		0.000000	
56. 00 06600 PHYSI CAL THERAPY	1,074,406	1, 431, 850	2, 506, 25		0, 000000	
67.00 06700 OCCUPATI ONAL THERAPY	885, 317	331, 619			0. 000000	
68. 00 06800 SPEECH PATHOLOGY	70, 068	81, 911	151, 97		0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	2,041,895	5, 089, 395	7, 131, 29		0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 420, 596	1, 799, 675	4, 220, 27		0.000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	63, 751	271, 946	335, 69		0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	20, 457, 452	14, 163, 153	34, 620, 60			
76. 00 03610 SLEEP LAB	20, 437, 432	14, 103, 133	34, 020, 00	0 0.000000	0.000000	
OUTPATIENT SERVICE COST CENTERS	0	0		0 0.00000	0.000000	70.0
20. 00 09000 CLINIC	37, 417	137, 730	175, 14	2. 448766	0.00000	90.0
91. 00 09100 EMERGENCY	4, 234, 920	26, 519, 931	30, 754, 85		0.000000	
092.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	602, 166	1, 141, 342	1, 743, 50	0. 585032	0. 000000	92.0
95. 00 09500 AMBULANCE SERVICES	0	11,037,752	11, 037, 75	0. 109868	0. 000000	95. C
					0.000000	
200.00 Subtotal (see instructions)	72, 748, 135	128, 287, 738	201, 035, 87	3		200.0
201.00 Less Observation Beds	70 740 405	100 007 700	201 025 03	10		
202.00 Total (see instructions)	72, 748, 135	128, 287, 738	201, 035, 87	13		202.0

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1318	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/28/2022 9:	epared: 17 am
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	I I				_
30.00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 I NTENSI VE CARE UNI T					31.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					_
50.00 05000 OPERATING ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 01 05401 ULTRASOUND	0. 000000				54.01
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
57.00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MRI	0. 000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00 03610 SLEEP LAB	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000				05.00
95.00 09500 AMBULANCE SERVICES	0. 000000				95.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/28/2022 9:1	epared: 7 am
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.044.700				0.044.700	
30. 00 03000 ADULTS & PEDIATRICS	8, 841, 720		8, 841, 7		8, 841, 720	•
31.00 03100 INTENSIVE CARE UNIT	2,050,188		2,050,1		2, 050, 188	
43.00 04300 NURSERY	521, 088		521, 0	88 0	521, 088	43.00
ANCI LLARY SERVICE COST CENTERS	0 400 174		0 400 1	7.4	2 420 174	50.00
50. 00 O5000 OPERATI NG ROOM	2, 428, 174		2, 428, 1		2, 428, 174	
51.00 O5100 RECOVERY ROOM	581, 335		581, 3		581, 335	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	2 005 0(0		2 005 0	v v	2 005 940	
54. 01 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	3, 005, 860		3, 005, 8	0 0	3, 005, 860 0	
56. 00 05600 RADI 0I SOTOPE	0			0 0	0	
57. 00 05700 CT SCAN	0			0 0	0	
58. 00 05800 MRI	0			0 0	0	
60. 00 06000 LABORATORY	3, 438, 581		3, 438, 5	81 0	3, 438, 581	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	118, 116		118, 1		118, 116	
65. 00 06500 RESPI RATORY THERAPY	1, 651, 788				1, 651, 788	
66. 00 06600 PHYSI CAL THERAPY	1, 304, 119		1, 304, 1		1, 304, 119	
67. 00 06700 OCCUPATI ONAL THERAPY	240, 332		240, 3		240, 332	
68.00 06800 SPEECH PATHOLOGY	63, 049		63, 0		63, 049	
69.00 06900 ELECTROCARDI OLOGY	787, 325		787, 3		787, 325	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 944		81, 9		81, 944	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	60, 202		60, 2	02 0	60, 202	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,069,500		4, 069, 5	0 00	4, 069, 500	
76.00 03610 SLEEP LAB	0			0 0	0	
OUTPATIENT SERVICE COST CENTERS	-					1
90. 00 09000 CLINIC	428, 894		428, 8	94 0	428, 894	90.00
91.00 09100 EMERGENCY	7, 192, 126		7, 192, 1	26 0	7, 192, 126	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 020, 008		1, 020, 0	08	1, 020, 008	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	1, 212, 701		1, 212, 7		1, 212, 701	
200.00 Subtotal (see instructions)	39, 097, 050				39, 097, 050	
201.00 Less Observation Beds	1, 020, 008		1, 020, 0		1, 020, 008	
202.00 Total (see instructions)	38, 077, 042	0	38, 077, 0	42 0	38, 077, 042	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	DUKES MEMORIA	Provi der C	CN: 15-1318	Peri od:	u of Form CMS-: Worksheet C	
			. 10 1010	From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre	pared:
					5/28/2022 9:1	7 am
		Charges	e XIX	Hospi tal	PPS	
Cost Center Description	Inpatient	Outpati ent	Total (col	6 Cost or Other	TEFRA	
oust center bescription	inpatrent	outpatront	+ col. 7)	Ratio	Inpatient	
				Natio	Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	10, 980, 314		10, 980, 31	14		30.0
31.00 03100 I NTENSI VE CARE UNI T	2,651,999		2, 651, 99	99		31.0
43. 00 04300 NURSERY	215, 567		215, 56	57		43.0
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	3, 201, 352	10, 768, 404	13, 969, 75	. 0. 173816 56	0.00000	50.0
51.00 05100 RECOVERY ROOM	558, 934	2, 422, 942	2, 981, 87	76 0. 194956	0.00000	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.00000	52.0
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000	0.00000	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 988, 485	33, 179, 119	41, 167, 60		0.00000	
54. 01 05401 ULTRASOUND	0	0		0 0.000000	0.00000	54.0
56. 00 05600 RADI OI SOTOPE	0	0		0 0.000000	0.00000	
57.00 05700 CT SCAN	0	0		0 0.000000	0.00000	57.0
58. 00 05800 MRI	0	0		0 0.000000	0.00000	
60. 00 06000 LABORATORY	8, 994, 958	18, 889, 705			0.00000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	266, 676	187, 595			0.00000	
65. 00 06500 RESPI RATORY THERAPY	6, 001, 862	833, 669			0.00000	65.0
66. 00 06600 PHYSI CAL THERAPY	1,074,406	1, 431, 850			0.00000	
67.00 06700 OCCUPATIONAL THERAPY	885, 317	331, 619			0.000000	
68.00 06800 SPEECH PATHOLOGY	70, 068	81, 911	151, 97		0.000000	
69. 00 06900 ELECTROCARDI OLOGY	2, 041, 895	5, 089, 395			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 420, 596	1, 799, 675			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	63, 751	271, 946			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 457, 452	14, 163, 153			0.000000	
76. 00 03610 SLEEP LAB	0	0		0 0.000000	0. 000000	76.0
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	37, 417	137, 730			0.000000	
91. 00 09100 EMERGENCY	4, 234, 920	26, 519, 931	30, 754, 85		0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	602, 166	1, 141, 342	1, 743, 50	0. 585032	0.000000	92.0
OTHER REIMBURSABLE COST CENTERS	-1	44 007	44.005.55		0.000	1
95. 00 09500 AMBULANCE SERVI CES	0	11,037,752			0.000000	
200.00 Subtotal (see instructions)	72, 748, 135	128, 287, 738	201, 035, 87	/3		200.0
201.00 Less Observation Beds						201.0
202.00 Total (see instructions)	72, 748, 135	128, 287, 738	201, 035, 87	/3		202.0

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1318	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/28/2022 9:1	pared: 7 am
		Title XIX	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 UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	0.47004/				50.00
50. 00 05000 OPERATI NG ROOM	0. 173816				50.00
51.00 05100 RECOVERY ROOM	0. 194956				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.00000				52.00
53. 00 05300 ANESTHESI OLOGY	0.00000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 073015				54.00
54. 01 05401 ULTRASOUND	0. 000000				54.01
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
57. 00 05700 CT SCAN	0. 000000				57.00
58. 00 05800 MRI	0. 000000				58.00
60. 00 06000 LABORATORY	0. 123314				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 260012				62.00
65. 00 06500 RESPI RATORY THERAPY	0. 241647				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 520345				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 197489				67.00
68.00 06800 SPEECH PATHOLOGY	0. 414853				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 110404				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 019417				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 179334				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 117546				73.00
76.00 03610 SLEEP LAB	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	2. 448766				90.00
91.00 09100 EMERGENCY	0. 233853				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 585032				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0. 109868				95.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS	
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY Part II To 12/31/2021 Date/Time Provider CCN: 15-1318 Period: From 01/01/2021 Part II Date/Time Provider CCN: 15-1318 Period: From 01/01/2021 Piriod: From 01/01/2021 Piriod: From 01/01/2021 Piriod: From 01/01/2021 Piriod: From	
Title XIX Hospital PPS	
Cost Center Description Total Cost Capital Cost Operating Cost Capital Operating Cost	t
(Wkst. B, Part(Wkst. B, PartNet of Capital Reduction Reduction	
I, col. 26) II col. 26) Cost (col. 1 - Amount	
<u>1.00</u> <u>2.00</u> <u>3.00</u> <u>4.00</u> <u>5.00</u>	
ANCI LLARY SERVI CE COST CENTERS	
	50.00
	51.00
	52.00
	53.00
	54.00
	54.01
	56.00
	57.00
58.00 05800 MRI 0 0 0 0	58.00
60. 00 06000 LABORATORY 3, 438, 581 242, 910 3, 195, 671 0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 118, 116 12, 156 105, 960 0	62.00
65. 00 06500 RESPI RATORY THERAPY 1, 651, 788 160, 229 1, 491, 559 0	0 65.00
66. 00 06600 PHYSI CAL THERAPY 1, 304, 119 369, 936 934, 183 0	0 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 240, 332 12, 761 227, 571 0	67.00
68. 00 06800 SPEECH PATHOLOGY 63, 049 655 62, 394 0	68.00
69. 00 06900 ELECTROCARDI OLOGY 787, 325 179, 348 607, 977 0	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 81, 944 5, 893 76, 051 0	71.00
	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 069, 500 156, 379 3, 913, 121 0	73.00
76.00 03610 SLEEP LAB 0 0 0 0	76.00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 428, 894 115, 366 313, 528 0	90.00
91. 00 09100 EMERGENCY 7, 192, 126 416, 840 6, 775, 286 0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1, 020, 008 167, 131 852, 877 0	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVICES 1, 212, 701 144, 492 1, 068, 209 0	95.00
	200.00
	201.00
202.00 Total (line 200 minus line 201) 26,664,046 2,973,552 23,690,494 0	202.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Li	eu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RAREDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2021 To 12/31/2021	I Date/Time Prepared: 5/28/2022 9:17 am
			e XIX	Hospi tal	PPS
Cost Center Description		Total Charges			
	Capital and	(Worksheet C,			
	Operating Cost			6	
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS			1	1	
50.00 05000 OPERATI NG ROOM	2, 428, 174				50.00
51.00 05100 RECOVERY ROOM	581, 335	2, 981, 876			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 005, 860	41, 167, 604			54.00
54. 01 05401 ULTRASOUND	0	0	0.0000		54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.0000		56.00
57.00 05700 CT SCAN	0	0	0.0000	00	57.00
58. 00 05800 MRI	0	0	0.0000	00	58.00
60. 00 06000 LABORATORY	3, 438, 581	27, 884, 663	0. 1233	14	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	118, 116	454, 271	0. 2600	12	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 651, 788	6, 835, 531	0. 2416	47	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 304, 119	2, 506, 256	0. 5203	45	66.00
67.00 06700 OCCUPATI ONAL THERAPY	240, 332	1, 216, 936	0. 1974	89	67.00
68.00 06800 SPEECH PATHOLOGY	63, 049	151, 979	0. 4148	53	68.00
69. 00 06900 ELECTROCARDI OLOGY	787, 325	7, 131, 290	0. 1104	04	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 944	4, 220, 271		17	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	60, 202	335, 697		34	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4,069,500	34, 620, 605	0. 1175	46	73.00
76.00 03610 SLEEP LAB	0	0			76.00
OUTPATIENT SERVICE COST CENTERS					
90, 00 09000 CLINIC	428, 894	175, 147	2, 4487	66	90.00
91. 00 09100 EMERGENCY	7, 192, 126	30, 754, 851			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,020,008	1, 743, 508			92.00
OTHER REIMBURSABLE COST CENTERS	1, 020, 000	1, 7 10, 000	0.0000	~~	,2.00
95. 00 09500 AMBULANCE SERVICES	1, 212, 701	11, 037, 752	0. 1098	68	95.00
200.00 Subtotal (sum of lines 50 thru 199)	27, 684, 054			~~	200.00
201.00 Less Observation Beds	1,020,008	0, 107, 779			201.00
202.00 Total (line 200 minus line 201)	26, 664, 046	-			202.00
	20,004,040	107, 107, 773	I	I.	1202.00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-1318	Peri od:	Worksheet D	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/28/2022 9:1	pared: 7 am
		Title	× XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		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	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 OPERATI NG ROOM	581, 126					
51.00 05100 RECOVERY ROOM	53, 469	2, 981, 876				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	517, 799	41, 167, 604			35, 108	
54. 01 05401 ULTRASOUND	0	0	0.0000		0	
56. 00 05600 RADI OI SOTOPE	0	0	0.0000		0	56.00
57.00 05700 CT SCAN	0	0	0.0000		0	57.00
58. 00 05800 MRI	0	0	0.0000		0	58.00
60. 00 06000 LABORATORY	242, 910	27, 884, 663	0.0087	2, 877, 857	25, 069	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	12, 156	454, 271	0. 02675	59 140, 545	3, 761	62.00
65. 00 06500 RESPI RATORY THERAPY	160, 229	6, 835, 531	0. 02344	1, 855, 044	43, 484	65.00
66. 00 06600 PHYSI CAL THERAPY	369, 936		0. 14760	306, 186	45, 195	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 761	1, 216, 936	0. 01048	36 258, 516	2, 711	67.00
68.00 06800 SPEECH PATHOLOGY	655	151, 979	0.0043	10 30, 427	131	68.00
69. 00 06900 ELECTROCARDI OLOGY	179, 348	7, 131, 290	0. 02514	19 776, 532	19, 529	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 893	4, 220, 271	0.00139	705, 041	984	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 193	335, 697	0. 01249	90 18, 160	227	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	156, 379	34, 620, 605	0.0045	6, 433, 738	29, 061	73.00
76.00 03610 SLEEP LAB	0	0	0.0000	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	115, 366	175, 147	0. 65868	31 0	0	90.00
91. 00 09100 EMERGENCY	416, 840					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	167, 131	1, 743, 508	0. 0958	59 14, 552	1, 395	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 996, 191	176, 150, 241		16, 949, 513	234, 039	200. 00

Health Financial Systems	DUKES MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CC	CN: 15-1318	Period: From 01/01/2021	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2021	Date/Time Pre	pared:
					5/28/2022 9:1	7 am
		Title		Hospi tal	Cost	
Cost Center Description	Non Physician Anesthetist	Nursi ng Program	Nursi ng Program	Allied Health Post-Stepdown	Allied Health	
		Program Post-Stepdown	Program	Adj ustments		
	0031	Adj ustments		Aujustilientis		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 MRI	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65.00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATIONAL 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	0	0		0 0	0	69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03610 SLEEP LAB	0	0			0	73.00 76.00
00100000000000000000000000000000000000	0	0		0 0	0	76.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 00 109000 CETNIC 91. 00 109100 EMERGENCY	0	0		0 0	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0			<u>ч</u>	0	/2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00
		-1			-	

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-1318	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	nared
				10 12/31/2021	5/28/2022 9:1	
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS				0 13, 969, 756	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0			0 13, 969, 750		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0 2, 901, 870	0.000000	1
53. 00 05300 ANESTHESI OLOGY	0				0.000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 41, 167, 604		
54. 01 05401 ULTRASOUND				0 41, 107, 004	0.000000	
56. 00 05600 RADI OI SOTOPE					0.000000	1
57. 00 05700 CT SCAN					0.000000	
58. 00 05800 MRI	0				0.000000	1
60. 00 06000 LABORATORY	0			0 27, 884, 663		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 454, 271	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	0			0 6, 835, 531		1
66. 00 06600 PHYSI CAL THERAPY	0			0 2, 506, 256		
67.00 06700 OCCUPATI ONAL THERAPY	0	l d		0 1, 216, 936		
68.00 06800 SPEECH PATHOLOGY	0	C)	0 151,979		
69. 00 06900 ELECTROCARDI OLOGY	0	c		0 7, 131, 290	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 4, 220, 271	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 335, 697	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 34, 620, 605	0. 000000	73.00
76.00 03610 SLEEP LAB	0	0		0 0	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS					_	
90. 00 09000 CLI NI C	0	C		0 175, 147	0.000000	90.00
91. 00 09100 EMERGENCY	0	0		0 30, 754, 851		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 1, 743, 508	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS	1	1				
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 176, 150, 241		200. 00

APPORT IOMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CON: 15-1318 Period: For 12/3/12021 Period: To 12/3/12021 Worksheet D Part IV Date Time Prepared: 5/28/2022 (9:17 am Cost Center Description Worksheet D Part IV Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. Inpatient Program Charges Inpatient Program Charges Untpatient Program Charges Outpatient Program Charges 50: 00 05000 0FECHERY ROOM 0.000000 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <th>Health Financial Systems</th> <th>DUKES MEMORIAL</th> <th>HOSPI TAL</th> <th></th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Health Financial Systems	DUKES MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
Interview To 12/31/2021 Date/Time Prepared: 5/28/2022 9:17 am (2022 9:17 am biology 2022 9:17 am biolog		RVICE OTHER PASS	Provider C	CN: 15-1318				
Cost Center Description Outpatient Ratio of Cost (col. 6 + col. 7) Inpatient Program Charges (col. 6 + col. 7) Inpatient Program Charges (col. 6 + col. 7) Unpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges 50.00 05000 0PERATING ROM 0.00000 10.00 11.00 12.00 13.00 50.00 05000 0PERATING ROM 0.000000 00 0 0 51.00 51.00 05100 REDOVERY ROM 0.000000 0 0 0 51.00 52.00 05200 DELIVERY ROM & LABOR ROM 0.000000 0 0 0 51.00 54.00 54.01 0.54.00 0 0 0 53.00 53.00 56.00 05000 RADI 0150PE 0.000000 0 0 0 54.00 56.00 06000 RADI 0126Y-DI ARNOSTI C 0.000000 0 0 0 55.00 57.00 05700 CT SCAN 0.000000 0 0 0 55.00 57.00 05700 CT SCAN 0.000000 0	THROUGH COSTS							narod
Cost Center Description Utpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges (col. 6 + col. 7) Hospital Inpatient Program Charges Outpatient Program Costs (col. 8 Hospital Program Pass-Through Costs (col. 8 Obstal ent Program Charges Program Charges ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 OPERATING ROM 0.000000 602,374 0 0 0 51.00 52.00 05000 ARD PLOKY NOM 0.000000 602,374 0 0 0 51.00 53.00 05300 ARSTHESI OLGY 0.000000 0 0 0 53.00 54.00 05401 ULTRASUND 0.000000 0 0 0 54.00 56.00 05600 RADI OLGOX PLAKONSTIC 0.000000 0 0 0 55.00 57.00 05000 CLVERY NOM 0.0000000 0 0 0 0 56.00 6600 ORADI OLGOX PLAKONSTIC 0.000000 0 0 0 0 0 56.00 56.00 <td< td=""><td></td><td></td><td></td><td></td><td>10</td><td>12/ 31/ 2021</td><td>5/28/2022 9:1</td><td>7 am</td></td<>					10	12/ 31/ 2021	5/28/2022 9:1	7 am
Ratio of Cost to Charges (col. 6 + col. 7) Program (charges 7) Pr			Title	XVIII		Hospi tal		
to to Charges (col. Charges 7) Charges Pass-Through (col. Charges (col. Pass-Through (col. Charges (col. Pass-Through (col. Pass-Through (col. Charges (col. Pass-Through (col. Pass-Through (col. Pass-Through (col. Pass-Through (col. Pass-Through (col. Passtrime Passtrimasthethethethethethethethethethet	Cost Center Description		Inpati ent	I npati ent		Outpati ent	Outpati ent	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$		Ratio of Cost	Program			Program		
Product Y) x col. 10) x col. 12) ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 OPERATING ROOM 0.000000 602,374 0 0 0 0 50.00 51.00 05000 DPERATING ROOM 0.000000 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 52.00 53.00 05300 ANESTHESI 0LOGY 0.000000 0 0 0 53.00 54.00 54.00 54.00 0.000000 0 0 0 54.00 54.01 05400 RADIOSTOPE 0.000000 0 0 0 54.00 56.00 05700 CTSAN 0.000000 0 0 0 57.00 58.00 05800 MRI 0.000000 0 0 0 65.00 60.00 06500 RADRATORY			Charges			Charges		
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57.00 05700 CT SCAN 0.000000 0 0 0 57.00 58.00 05800 MRI 0.000000 0 0 0 58.00 60.00 06000 LABORATORY 0.000000 2,877,857 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 140,545 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0.000000 1,855,044 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 306,186 0 0 66.00 67.00 06700 CCUPATI ONAL THERAPY 0.000000 258,516 0 0 66.00 68.00 SPEECH PATHOLOGY 0.000000 76,532 0 0 68.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 76,041 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 76,041 0 0 73.00 73.00 07300 DUGS CHARGED TO PATI	54. 01 05401 ULTRASOUND	0. 000000	0		0	0	0	54.01
58.00 05800 MRI 0.000000 0 0 0 0 0 58.00 60.00 06000 LABORATORY 0.000000 2,877,857 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 140,545 0 0 0 65.00 65.00 06500 RESPI RATORY THERAPY 0.000000 1,855,044 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 306,186 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 258,516 0 0 66.00 68.00 69.00 06800 SPEECH PATHOLOGY 0.000000 30,427 0 0 68.00 69.00 68.00 69.00 68.00 69.00 69.00 69.00 69.00 0 0 71.00 0 0 71.00 71.00 71.00 0 0 73.00 73.00 73.00 0 0 73.00 73.00 73.00 73.00 70.00 <td< td=""><td></td><td>0. 000000</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>56.00</td></td<>		0. 000000	0		0	0	0	56.00
60.00 06000 LABORATORY 0.00000 2,877,857 0 0 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 140,545 0 0 0 62.00 65.00 06500 RESPIRATORY THERAPY 0.000000 140,545 0 0 0 65.00 66.00 06600 PHYSICAL THERAPY 0.000000 306,186 0 0 0 66.00 67.00 06700 0CCUPATIONAL THERAPY 0.000000 258,516 0 0 0 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 30,427 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 776,532 0 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 78,160 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 18,160 0 0 73.00 73.00 76.00 0 0 0 72.00 74.00 <td>57.00 05700 CT SCAN</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>57.00</td>	57.00 05700 CT SCAN	0. 000000	0		0	0	0	57.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.00000 140,545 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0.000000 1,855,044 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 306,186 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0.000000 258,516 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 30,427 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 776,532 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 785,041 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 18,160 0 0 73.00 0.3610 SLEEP LAB 0.000000 0 0 0 0 73.00 0.40000 09100 EMERGENCY 0.000000 0 0 0 90.00	58.00 05800 MRI	0. 000000	0		0	0	0	58.00
65.00 06500 RESPI RATORY THERAPY 0.00000 1,855,044 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 306,186 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 258,516 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 30,427 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 776,532 0 0 0 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 776,532 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 18,160 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 0.3610 SLEP LAB 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60. 00 06000 LABORATORY	0. 000000	2, 877, 857		0	0	0	60.00
66.00 06600 PHYSI CAL THERAPY 0.00000 306, 186 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 258, 516 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 30, 427 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 776, 532 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 776, 532 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 18, 160 0 0 72.00 73.00 03610 SLEEP LAB 0.000000 0 0 0 73.00 76.00 03610 SLEEP LAB 0.000000 0 0 0 90.00 90.00 09100 EMERGENCY 0.000000 0 0 0 90.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 39, 286 0 0 0	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	140, 545		0	0	0	62.00
67.00 06700 0CCUPATI ONAL THERAPY 0.000000 258,516 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 30,427 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 776,532 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 776,532 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 18,160 0 0 0 73.00 73.00 03610 SLEEP LAB 0.000000 6,433,738 0 0 0 73.00 00000 03610 SLEEP LAB 0.000000 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 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 855, 044		0	0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0.000000 30,427 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 776,532 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 705,041 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 18,160 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 6,433,738 0 0 0 73.00 76.00 03610 SLEEP LAB 0.000000 0 0 0 0 76.00 09000 CLI NI C 0.000000 0 0 0 0 90.00 91.00 09000 CLI NI C 0.000000 39,286 0 0 91.00 92.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 14,552 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 950.0 950.0	66. 00 06600 PHYSI CAL THERAPY	0. 000000	306, 186		0	0	0	66.00
69.00 06900 ELECTROCARDI OLOGY 0.00000 776,532 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 705,041 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 18,160 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 6,433,738 0 0 0 73.00 76.00 03610 SLEEP LAB 0.000000 0 0 0 0 76.00 00TPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 90.00 90.00 09100 EMERGENCY 0.000000 39,286 0 0 91.00 91.00 92.00 92.00 0 92.00 0 92.00 92.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	258, 516		0	0	0	67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 705,041 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 18,160 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 6,433,738 0 0 0 73.00 76.00 03610 SLEEP LAB 0.000000 0 0 0 0 76.00 004TPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 76.00 90.00 09000 CLINIC 0.000000 39,286 0 0 90.00 91.00 92.00 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 0 92.00 92.00 92.00 92.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00	68.00 06800 SPEECH PATHOLOGY	0. 000000	30, 427		0	0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 18,160 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 6,433,738 0 0 0 73.00 76.00 03610 SLEEP LAB 0.000000 0 0 0 0 73.00 76.00 03610 SLEEP LAB 0.000000 0 0 0 0 76.00 00TPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 90.00 90.00 09100 EMERGENCY 0.000000 39,286 0 0 91.00 92.00 9200 058ERVATION BEDS (NON-DI STINCT PART 0.000000 14,552 0 0 92.00 92.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	776, 532		0	0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 6,433,738 0 0 0 73.00 76.00 03610 SLEEP LAB 0.000000 0 0 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 76.00 90.00 09000 CLINIC 0.000000 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 39,286 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 14,552 0 0 0 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	705, 041		0	0	0	71.00
76.00 03610 SLEEP LAB 0.00000 0 0 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0.000000 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 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0<	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	18, 160		0	0	0	72.00
76.00 03610 SLEEP LAB 0.00000 0 0 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0.000000 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 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0<	73.00 07300 DRUGS CHARGED TO PATIENTS	0, 000000	6, 433, 738		0	0	0	73.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 39,286 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.000000 14,552 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00 95.00					0	0	0	
90.00 09000 CLINIC 0.00000 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 39,286 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.000000 14,552 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	OUTPATIENT SERVICE COST CENTERS	· ·		•				
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.000000 14, 552 0 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 950. 00 950. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 <t< td=""><td></td><td>0. 000000</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>90.00</td></t<>		0. 000000	0		0	0	0	90.00
OTHER REI MBURSABLE COST CENTERS OTHER SERVICES 95.00	91. 00 09100 EMERGENCY	0. 000000	39, 286		0	0	0	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	14, 552		0	0	0	92.00
						-		
200.00 Total (lines 50 through 199) 16, 949, 513 0 0 0 200.00	95. 00 09500 AMBULANCE SERVI CES							95.00
	200.00 Total (lines 50 through 199)		16, 949, 513		0	0	0	200.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/28/2022 9:1	pared: 7 am
		Title	XVIII	Hospi tal	Cost	
			Charges	•	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 173816	0	2, 023, 91	5 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 194956	0	498, 37	5 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 073015	0	8, 856, 39	4 0	0	54.00
54. 01 05401 ULTRASOUND	0. 000000	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58. 00 05800 MRI	0.00000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 123314	0	4, 294, 11	9 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 260012		57, 33		0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 241647	0	192, 97		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 520345	0	183, 11		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 197489		21, 75		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 414853		8, 13		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 110404	0	1, 624, 91		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 019417	0	183, 27		0	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 179334		60, 17		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 117546				0	
76. 00 03610 SLEEP LAB	0. 000000			0 0	0	1
OUTPATIENT SERVICE COST CENTERS	0100000		1	<u> </u>		/ 0/ 00
90. 00 09000 CLINIC	2. 448766	0	12, 52	8 48, 029	0	90.00
91. 00 09100 EMERGENCY	0. 233853				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 585032				0	
OTHER REIMBURSABLE COST CENTERS	01000002		170/20	<u> </u>		/2/00
95. 00 09500 AMBULANCE SERVICES	0, 109868			0		95.00
200.00 Subtotal (see instructions)	01107000	0	29, 792, 66	9 48, 525	0	200.00
201.00 Less PBP Clinic Lab. Services-Program		l	2.,	0 0	Ű	201.00
Only Charges				-		
202.00 Net Charges (line 200 - line 201)		0	29, 792, 66	9 48, 525	0	202.00

leal th	Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1318	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/28/2022 9:2	epared: 17 am
				XVIII	Hospi tal	Cost	
			sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)				
	ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				-
	05000 OPERATING ROOM	351, 789	0				50.00
	05100 RECOVERY ROOM	97, 161					50.00
	05200 DELIVERY ROOM & LABOR ROOM	97, 161					51.00
	05200 ANESTHESI OLOGY	0					52.00
	05400 RADI OLOGY-DI AGNOSTI C	646, 650					53.00
		646, 650					
	05401 ULTRASOUND 05600 RADI OI SOTOPE	0					54.01
		0					56.00
	05700 CT SCAN 05800 MRI	0	0				57.00
	06000 LABORATORY	529, 525					60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	14, 906					
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY						62.00
	06600 PHYSI CAL THERAPY	46, 631 95, 282					66.00
	06700 OCCUPATIONAL THERAPY	4, 296					67.00
	06800 SPEECH PATHOLOGY	3, 374					68.00
	06900 ELECTROCARDI OLOGY	179, 397					69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 559					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 791					72.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	595, 360	58				73.00
	03610 SLEEP LAB	0 393, 300	0				76.00
	OUTPATIENT SERVICE COST CENTERS	0	0				70.00
	09000 CLINIC	30, 678	117, 612				90.00
	09100 EMERGENCY	1, 452, 819	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	291, 485	0				92.00
	OTHER REIMBURSABLE COST CENTERS	271,403	0	1			/2.00
	09500 AMBULANCE SERVICES	0					95.00
200.00		4, 353, 703	117, 670				200.00
200.00		4, 333, 703					201.00
	Only Charges						
202.00		4, 353, 703	117, 670				202.00

Health Financial Systems	DUKES MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	_ COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/28/2022 9:1	pared:
		Ti +1	e XIX	Hospi tal	PPS	/ dlll
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
cost center bescription	Rel ated Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	Aujustment	Related Cost			
	Part II, col.		(col, 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	1, 448, 741	278, 552	1, 170, 18	9 4, 285	273.09	30.00
31.00 INTENSIVE CARE UNIT	208, 621		208, 62			31.00
43.00 NURSERY	43, 742		43, 74			•
200.00 Total (lines 30 through 199)	1, 701, 104		1, 422, 55			200.00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS					-	
30. 00 ADULTS & PEDIATRICS	91	24, 851				30.00
31.00 INTENSIVE CARE UNIT	23					31.00
43.00 NURSERY	26	4, 460				43.00
200.00 Total (lines 30 through 199)	140	35, 920				200.00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1318	Peri od:	Worksheet D	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/28/2022 9:1	pared: 7 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
·	Related Cost	(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	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50. 00 05000 OPERATI NG ROOM	581, 126					
51.00 05100 RECOVERY ROOM	53, 469	2, 981, 876			610	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	517, 799	41, 167, 604	0. 01257	/8 193, 546	2, 434	54.00
54. 01 05401 ULTRASOUND	0	0	0.0000	0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0	0.0000	0 0	0	56.00
57.00 05700 CT SCAN	0	0	0.0000	0 0	0	57.00
58.00 05800 MRI	0	0	0.0000	0 0	0	58.00
60. 00 06000 LABORATORY	242, 910	27, 884, 663	0.0087	1 228, 736	1, 993	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	12, 156	454, 271	0. 02675	9 12, 652	339	62.00
65. 00 06500 RESPI RATORY THERAPY	160, 229	6, 835, 531	0. 02344	1 91, 925	2, 155	65.00
66. 00 06600 PHYSI CAL THERAPY	369, 936	2, 506, 256	0. 14760	9, 638	1, 423	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 761	1, 216, 936	0. 01048	2, 459	26	67.00
68.00 06800 SPEECH PATHOLOGY	655	151, 979	0.00431	0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	179, 348	7, 131, 290	0. 02514	9 15, 647	394	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5, 893	4, 220, 271	0.00139	6 112, 165	157	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 193	335, 697	0. 01249	972	12	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	156, 379	34, 620, 605	0. 00451	7 538, 868	2, 434	73.00
76.00 03610 SLEEP LAB	0	0	0.0000	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	115, 366	175, 147	0. 65868	3, 389	2, 232	90.00
91.00 09100 EMERGENCY	416, 840	30, 754, 851	0. 01355	93, 391	1, 266	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	167, 131	1, 743, 508	0. 09585	i9 15, 342	1, 471	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 996, 191	176, 150, 241		1, 588, 141	26, 739	200. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1318 Period: From 01/01/2021 To 12/31/2021 Worksheet D Proprom 01/2021 To 12/31/2021 Worksheet D Proprom 01/2021 SZ/2022 9:17 an SZ/2022 9:17 an SZ/2022 9:17 an Post-Stepdown Adjustments Impatient Routine Service Cost Center Description Nursing Program Adjustments Nursing Program Adjustments Nursing Program Adjustments Nursing Program Adjustments Provider CN: 15-1318 Period: From 01/01/2021 Period: SZ/2022 9:17 an SZ/2022 9:17 an SZ/2022 9:17 an Program INPATIENT ROUTINE SERVICE COST CENTERS Nursing Program Adjustments Nursing Program Program Program Program	Health Financial Systems	DUKES MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-	2552-10
Cost Center Description Nursing Program Ost-Stepdown Adjustments Nursing Program Adjustments Nursing Program Adjustments Allied Health Adjustments Allied Health Cost Allied Health Medical Education Cost 30 00 03000 ADULTS & PEDIATRICS 0 24 2.00 3.00 31.00 03000 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 30.00 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 0 200.00 10tal Costs instructions) Total Costs instructions) 5.00 6.00 7.00 8.00 30.00 03000 ADULTS & PEDIATICS instructions) 0 0 0 0 20.00 2.25 0.00 2.3 31.00 30.00 03000 ADULTS & PEDIATICS instructions) 0 2.26 0.00 2.26 140 200.00 200.00 Total (lines 30 through 199) <td>APPORTIONMENT OF INPATIENT ROUTINE SERVIC</td> <td>CE OTHER PASS THROUGH COSTS</td> <td></td> <td>-</td> <td>From 01/01/2021 To 12/31/2021</td> <td>Part III Date/Time Pre 5/28/2022 9:1</td> <td>epared: 7 am</td>	APPORTIONMENT OF INPATIENT ROUTINE SERVIC	CE OTHER PASS THROUGH COSTS		-	From 01/01/2021 To 12/31/2021	Part III Date/Time Pre 5/28/2022 9:1	epared: 7 am
Program Post-Stepdown Adj ustments Program Adj ustments Program Adj ustments Post-Stepdown Adj ustments Cost Medical Education Cost 30.00 03000 ADULTS & PEDIATRICS 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 30.00 30.00 03000 ADULTS & PEDIATRICS 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td></td><td></td><td>Titl</td><td>e XIX</td><td>Hospi tal</td><td>PPS</td><td></td></td<>			Titl	e XIX	Hospi tal	PPS	
Post-STepdown Adjustments Adjustments Education Cost 30.00 03000 ADULTS & PEDIATRICS 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 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 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 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 0 0 0 0 0 0 0 0 0	Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
Post-Stepdown Adj ustments Adj ustments Educati on Cost 0.00 30.00 ADULTS & PEDIATRICS 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 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 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Program	Program	Post-Stepdown	Cost	Medi cal	
Adj ustments Adj ustment Adj ustments Adj ustments Adj ustments Adj ustments Adj ustment Dags Dags Dags Dags Dags Dags Dags Dags Dag		Post-Stepdown	5	Adiustments		Education Cost	
INPATI ENT ROUTI NE SERVICE COST CENTERS 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 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 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 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							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 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 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 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 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			1 00	2A	2 00	3 00	
31.00 03100 INTENSIVE CARE UNIT 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 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 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 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 0 0 0 0 0 0 0 0 0 0	INPATIENT ROUTINE SERVICE COST CEN			2/1	2.00	0100	
43.00 04300 NURSERY 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 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 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 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	30. 00 03000 ADULTS & PEDIATRICS	0	0	(0 C	0	30.00
43.00 04300 NURSERY 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 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 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 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	0		0	0	31 00
200.00 Total (lines 30 through 199) 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 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 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 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	0		- - 0		
Cost Center Description Swing-Bed Adjustment Adjustment Amount (see instructions) Total Costs (sum of cols. 1 through 3, instructions) Total Patient Days Per Diem (col. 5 ÷ col. 6) Inpatient Program Days 1NPATIENT ROUTINE SERVICE COST CENTERS 0 6.00 7.00 8.00 0.00 03000 ADULTS & PEDIATRICS 0 0 4.285 0.00 91 30.00 031.00 03100 INTENSIVE CARE UNIT 0 726 0.00 223 31.00 200.00 Total (lines 30 through 199) 1 0 255 0.00 26 43.00 200.00 Total (lines 30 through 199) 1 1 Program Pass-Through Cost (col. 7 x 7 7 7 7 7 7 30.00 03000 ADULTS & PEDIATRICS 9.00 9 9 7 30.00 30.00 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		0	0			,	
Adjustment Amount (see instructions) Days 5 ÷ col. 6) Program Days 1 through 3, in nus col. 4) 1 through 3, in nus col. 4) 0 5 ÷ col. 6) Program Days 30.00 03000 ADULTS & PEDI ATRICS 0 0 4.00 5.00 6.00 7.00 8.00 31.00 03100 INTENSIVE CARE UNIT 0 726 0.00 23 31.00 200.00 Total (tines 30 through 199) 0 255 0.00 264 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 1 30.00 30.00 03000 ADULTS & PEDI ATRICS 0 30.00 30.00 30.00 03000 ADULTS & PEDI ATRICS 0 31.00 30.00 200.00 Total (tines 30 through 199) Inpatient Program Pass-Through Cost (col. 7 x col. 8) 30.00 30.00 30.00 03000 ADULTS & PEDI ATRICS 0 30.00 31.00 31.00 03000 ADULTS & PEDI ATRICS 0 31.00 31.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00		Swipg_Bed	Total Costs	Total Dationt	Per Diem (col		200.00
Amount (see instructions) 1 through 3, minus col. 4) 3 3 3 3 3 30.00 03000 ADULTS & PEDIATRICS 0 0 4.00 5.00 6.00 7.00 8.00 31.00 03000 ADULTS & PEDIATRICS 0 0 4.285 0.00 91 30.00 31.00 03100 INTENSIVE CARE UNIT 0 726 0.00 23 31.00 43.00 04300 NURSERY 0 5.266 140 200.00 Cost Center Description Inpati ent Program Pass-Through Cost (col. 7 x cot (col. 7 x	cost center bescription						
INPATIENT ROUTINE SERVICE COST CENTERS 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 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 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 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				Days	5 ÷ COI. 0)	FIOGLAIII Days	
INPATI ENT ROUTINE SERVICE COST CENTERS 0 6.00 7.00 8.00 30.00 03000 ADULTS & PEDIATRICS 0 0 4,285 0.00 91 30.00 31.00 03100 INTENSI VE CARE UNI T 0 0 726 0.00 23 31.00 43.00 04300 NURSERY 0 0 255 0.00 26 43.00 200.00 Total (Lines 30 through 199) Inpati ent Program Pass-Through Cost (col. 7 x col. 8) 9.00 9.00 200.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 31.00 31.00 31.00 31.00 31.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 0 4, 285 0. 00 91 30. 00 31. 00 03100 INTENSI VE CARE UNI T 0 726 0. 00 23 31. 00 43. 00 04300 NURSERY 0 255 0. 00 26 43. 00 200. 00 Total (lines 30 through 199) 0 5, 266 140 200. 00 Cost Center Description Inpati ent Program Pass-Through Cost (col. 7 x col. 8) 9. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 30. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31				6 00	7 00	8.00	
30. 00 03000 ADULTS & PEDIATRICS 0 0 4, 285 0.00 91 30. 00 31. 00 03100 INTENSIVE CARE UNIT 0 726 0.00 23 31. 00 43. 00 04300 NURSERY 0 255 0. 00 26 43. 00 200. 00 Total (Lines 30 through 199) 0 5, 266 140 200. 00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	INDATIENT DOUTINE SEDVICE COST CEN	1	5.00	0.00	7.00	0.00	
31.00 03100 INTENSIVE CARE UNIT 0 726 0.00 23 31.00 43.00 04300 NURSERY 0 255 0.00 26 43.00 200.00 Total (lines 30 through 199) 0 5,266 140 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			0	4 20	E 0.00	01	20.00
43.00 04300 NURSERY 0 255 0.00 26 43.00 200.00 Total (lines 30 through 199) 0 5,266 140 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 0 30.00 30.00 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 43.00 04300 NURSERY 0		0	0				
200.00 Total (lines 30 through 199) 0 5, 266 140 200.00 Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			0				
Cost Center Description Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 03000 ADULTS & PEDIATRICS 0 0 31.00 31.00 03100 VINENSIVE CARE UNIT 0 0 43.00 04300			0				
INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 0 31.00 31.00 31.00 31.00 43.00 04300 NURSERY 0 43.00 0			0	5, 26	6	140	200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30.00 03000 ADULTS & PEDI ATRI CS 0 30.00 31.00 1NTENSI VE CARE UNI T 0 31.00 43.00 04300 NURSERY 0 43.00	Cost Center Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00 31. 00 43. 00 04300 NURSERY 0 43. 00 04300 NURSERY 0 43. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 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 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
col. 8) 9.00 30.00 03000 ADULTS & PEDI ATRI CS 0 31.00 03100 INTENSI VE CARE UNI T 0 43.00 04300 NURSERY 0							
9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 43.00 04300 NURSERY 0 43.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00 31. 00 03100 INTENSI VE CARE UNI T 0 31. 00 43. 00 04300 NURSERY 0 43. 00							
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 03100 INTENSIVE CARE UNIT 0 31. 00 43. 00 04300 NURSERY 0 43. 00							
31.00 03100 INTENSIVE CARE UNIT 0 31.00 43.00 04300 NURSERY 0 43.00							
43. 00 04300 NURSERY 0 43. 00		0					30.00
	31.00 03100 INTENSIVE CARE UNIT	0					31.00
200.00 Total (lines 30 through 199) 0 200.00	43.00 04300 NURSERY	0					43.00
	200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	DUKES MEMORIAI	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/28/2022 9:1	pared: 7 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Nursi ng Program Post-Stepdown Adj ustments	Nursing Program	Allied Health Post-Stepdown Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 ULTRASOUND	0	0		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	0		0 0	0	57.00 58.00
	0	0		0 0	0	
	0	0		0 0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPI RATORY THERAPY	0	0		0 0		62.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 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	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03610 SLEEP LAB	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		/ 0/ 00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			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	0	200. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	VICE OTHER PASS	S Provider C	CN: 15-1318	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	narad.
				10 12/31/2021	5/28/2022 9:1	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	1.00	F 00	(00	7.00	instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	0	0	1	0 13, 969, 756	0.00000	50.00
51. 00 05100 RECOVERY ROOM	0	0		0 13, 969, 756 0 2, 981, 876		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		2, 981, 876	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 41, 167, 604		54.00
54. 01 05401 ULTRASOUND	0			0 41, 107, 004	0.000000	
56. 00 05600 RADI 0I SOTOPE	0				0.000000	56.00
57. 00 05700 CT SCAN	0				0.000000	57.00
58. 00 05800 MRI	0				0.000000	58.00
60. 00 06000 LABORATORY	0			0 27, 884, 663		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 454, 271	0. 000000	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 6, 835, 531		
66.00 06600 PHYSI CAL THERAPY	0	0		0 2, 506, 256		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 216, 936		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 151, 979		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 7, 131, 290		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 4, 220, 271	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 335, 697	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 34, 620, 605	0. 000000	73.00
76.00 03610 SLEEP LAB	0	0		0 0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 175, 147		90.00
91. 00 09100 EMERGENCY	0	0		0 30, 754, 851		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 1, 743, 508	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS	1		1			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 176, 150, 241		200. 00

Health Financial Systems	DUKES MEMORIAL	. HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-1318	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021		nared
				10 12/31/2021	5/28/2022 9:1	
			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-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1		1		1	
50.00 05000 OPERATI NG ROOM	0. 000000	235, 408		0 0	-	50.00
51.00 05100 RECOVERY ROOM	0. 000000	34, 003		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0 0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0 0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	193, 546		0 0	0 0	54.00
54. 01 05401 ULTRASOUND	0. 000000	0		0 0	0 0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0 0	56.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0 0	57.00
58.00 05800 MRI	0. 000000	0		0 0	0 0	58.00
60. 00 06000 LABORATORY	0. 000000	228, 736		0 0	0 0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	12, 652		0 0	0 0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	91, 925		0 0	0 0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	9, 638		0 0	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 459		0 0	o o	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	o o	68.00
69. 00 06900 ELECTROCARDI OLOGY	0, 000000	15, 647		0 0	ol o	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0, 000000	112, 165		0 0	ol o	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	972		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	538, 868		0 0	0	73.00
76.00 03610 SLEEP LAB	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			1		1 .	
90. 00 09000 CLINIC	0. 000000	3, 389		0 0	0 0	90.00
91.00 09100 EMERGENCY	0, 000000	93, 391		0 0	o l	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	15, 342		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)		1, 588, 141		0 0	0 0	200.00
			•			

Health Financial Systems	DUKES MEMORIA				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider C	CN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/28/2022 9:1	pared:
		Titl	e XIX	Hospi tal	PPS	
			Charges	noopritai	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9	í í	Subject To	Subject To		
			Ded. & Coi ns			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS			•			
50.00 05000 OPERATI NG ROOM	0. 173816	0		0 75, 227	0	50.00
51.00 05100 RECOVERY ROOM	0. 194956	0		0 16, 328	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 073015	0		0 822, 779	0	54.00
54. 01 05401 ULTRASOUND	0, 000000	l o		0 0	0	54.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	l o		0 0	0	57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 123314	0		0 576, 130	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	S 0. 260012	0		0 5, 362	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 241647	0		0 17, 931	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 520345	0		0 14, 347	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 197489	0		0 2,527	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 414853	0		0 1, 715	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 110404	0		0 87, 477	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 019417	0		0 17, 341	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 179334	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 117546	0		0 345, 248	0	73.00
76.00 03610 SLEEP LAB	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		•				
90. 00 09000 CLI NI C	2. 448766	0	I	0 2, 417	0	90.00
91.00 09100 EMERGENCY	0. 233853	0		0 1, 064, 996	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 585032	0		0 52, 294	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 109868	0		0		95.00
200.00 Subtotal (see instructions)		0		0 3, 102, 119	0	200.00
201.00 Less PBP Clinic Lab. Services-Progr	am			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 3, 102, 119	0	202.00

Heal th Financia		DUKES MEMORI				u of Form CMS-2	2552-10
APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prep 5/28/2022 9:17	
			Ti tl	e XIX	Hospi tal	PPS	
			sts	1			
Со	ost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.) 6.00	(see inst.) 7.00	-			
	RY SERVICE COST CENTERS	0.00	7.00				
	PERATING ROOM	0	13,076				50.00
	COVERY ROOM		3, 183				50.00
	LIVERY ROOM & LABOR ROOM	0	3, 103 C	•			52.00
	IESTHESI OLOGY	0					52.00
	ADI OLOGY – DI AGNOSTI C	0	60, 075				53.00
	TRASOUND	0	00,075				54. 0
	ADI OI SOTOPE	0		1			56.00
57.00 05700 CT		0					57.0
58.00 05800 MR		0					57.00
	ABORATORY	0	71, 045				60.00
	IOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 394				62.00
	SPIRATORY THERAPY	0	4, 333				65.00
	IYSI CAL THERAPY		7, 465				66.0
	CCUPATIONAL THERAPY		499				67.0
	PEECH PATHOLOGY		711				68.00
	ECTROCARDI OLOGY		9,658				69.0
	DICAL SUPPLIES CHARGED TO PATIENT		337				71.00
	IPL. DEV. CHARGED TO PATIENTS		007	1			72.0
	RUGS CHARGED TO PATIENTS	0	40, 583	1			73.0
76.00 03610 SL		0	10,000				76.00
	ENT SERVICE COST CENTERS			1			, 0, 0,
90.00 09000 CL		0	5, 919				90.00
91.00 09100 EM		0					91.00
	SERVATION BEDS (NON-DISTINCT PART	0	30, 594				92.00
	EIMBURSABLE COST CENTERS						
	IBULANCE SERVI CES	0					95.00
200.00 Su	ıbtotal (see instructions)	0	497, 925			2	200. 00
	ess PBP Clinic Lab. Services-Program	0				2	201.00
	ly Charges						
	et Charges (line 200 - line 201)	0	497, 925			2	202.00

MPUT	ATION OF INPATIENT OPERATING COST Pro	ovider CCN: 15-1318	Period: From 01/01/2021	Worksheet D-1	
		Title XVIII	To 12/31/2021 Hospi tal	Date/Time Prep 5/28/2022 9:17 Cost	
	Cost Center Description		- nospi tai		
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, e			5, 540	1
00	Inpatient days (including private room days, excluding swing-bed			4, 285	2
00	Private room days (excluding swing-bed and observation bed days).	lf you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed d	avs)		3, 673	4
00	Total swing-bed SNF type inpatient days (including private room d		er 31 of the cost	1, 020	
00	reporting period Total swing-bed SNF type inpatient days (including private room d	avs) after December	31 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)	ays) arter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private room da	ys) through December	31 of the cost	235	7
00	reporting period Total swing-bed NF type inpatient days (including private room da	uvs) after December 3	1 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total inpatient days including private room days applicable to th newborn days) (see instructions)	e Program (excluding	swing-bed and	1, 545	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private r	room days)	724	10
~~	through December 31 of the cost reporting period (see instruction				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, enter		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX on		e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX on	ly (including privat	a room day(c)	0	1 1 2
. 00	after December 31 of the cost reporting period (if calendar year,			U	13
00	Medically necessary private room days applicable to the Program (excluding swing-bed	days)	0	
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16
. 00	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to services t	hrough December 31 c	of the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services a	fter December 31 of	the cost		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services th	rough December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services af	ter December 31 of t	he cost	0.00	20
	reporting period				
. 00 . 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 3	1 of the cost report	ing period (line)	8, 841, 720	21
. 00	5 x line 17)	T OF the cost report	ing period (inte	0	
. 00	Swing-bed cost applicable to SNF type services after December 31 x line 18)	of the cost reportin	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 31	of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 o	of the cost reportinc	period (line 8	0	25
	x line 20)				
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (lin	ne 21 minus line 26)		1, 700, 014 7, 141, 706	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			7, 141, 700	2
	General inpatient routine service charges (excluding swing-bed an	d observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27 ÷ li	ne 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	- /		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minus		ctions)	0.00	
	Average per diem private room cost differential (line 34 x line 3 Private room cost differential adjustment (line 3 x line 35)	1)		0.00	35 36
. 00	private room cost uniterential augustment (THE 3 X THE 33)	privato room cost di	fferential (line	7, 141, 706	
. 00	General inpatient routine service cost net of swing-bed cost and	private room cost ur	inoronal (innor		I
. 00 . 00	27 minus line 36)				
. 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	·			
00 00 00	27 minus line 36)	ENTS		1, 666. 68	
. 00 . 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTM	ENTS Etructions)		1, 666. 68 2, 575, 021 0	

OMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1318	Period: From 01/01/2021	Worksheet D-1	
					To 12/31/2021	Date/Time Pre	
			Title	xviii	Hospi tal	5/28/2022 9:1 Cost	7 аш
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	1.0
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00000	0	42
. 00	INTENSIVE CARE UNIT	2, 050, 188	726	2, 823. 9	267	753, 995	43
. 00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	
	Program inpatient ancillary service cost (Wks					2, 267, 333	
. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)(s	see instructio	ins)		5, 596, 349	49
. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sun	of Parts I and	0	50
	111)						
. 00	Pass through costs applicable to Program inpa	atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	0	51
. 00	and IV) Total Program excludable cost (sum of lines {	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclud		ated, non-phy	sician anesth	netist, and	0	
	medical education costs (line 49 minus line 5	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	borting period e	enaling 1996, u	ipdated and co	pmpounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, upo	lated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
2.00	Relief payment (see instructions)	listi ucti olis)				0	62
	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST			++!		1 00/ /7/	
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Decen	nder 31 of the	cost reporti	ng period (see	1, 206, 676	64
5.00	Medicare swing-bed SNF inpatient routine cost	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65
00	instructions)(title XVIII only)		4 ml 1			1 00/ /7/	
o. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (Tine a	64 prus rine 6	5)(title XVII	I ONLY). FOR	1, 206, 676	60
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	porting period	0	67
	(line 12 x line 19)	0					
3. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68
9.00	Total title V or XIX swing-bed NF inpatient i	outine costs (I	ine 67 + line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU	IRSING FACILITY,	AND ICF/IID	ONLY		-	
	Skilled nursing facility/other nursing facili	5		• • • •			70
	Adjusted general inpatient routine service of		ne 70 ÷ líne	2)			71
	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
. 00	Capital-related cost allocated to inpatient i	routine service	costs (from W	lorksheet B, F	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	2)					
	Program capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
	Inpatient routine service cost (line 74 minus						78
. 00	Aggregate charges to beneficiaries for excess	s costs (from pr					79
00	Total Program routine service costs for compa		ost limitation	ı (line 78 mir	nus line 79)		80
	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li						81
	Reasonable inpatient routine service cost film tation (in	,					82
	Program inpatient ancillary services (see ins		/				84
. 00	Utilization review - physician compensation	(see instruction					85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					612	87
	Adjusted general inpatient routine cost per d		line 2)			1, 666. 68	
3.00							

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	1, 448, 741	8, 841, 720	0. 16385	3 1, 020, 008	167, 131	90.00
91.00 Nursing Program cost	0	8, 841, 720	0.00000	1, 020, 008	0	91.00
92.00 Allied health cost	0	8, 841, 720	0.00000	1, 020, 008	0	92.00
93.00 All other Medical Education	0	8, 841, 720	0.00000	1, 020, 008	0	93.00

			u of Form CMS-2 Worksheet D-1 Date/Time Prep	
		spi tal	5/28/2022 9:11 PPS	
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)		5, 540	1
00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4, 285	2
00	Private room days (excluding swing-bed and observation bed days). If you have only private r do not complete this line.	oom days,	0	3
00	Semi-private room days (excluding swing-bed and observation bed days)		3, 673	4
00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of	the cost	1, 020	5
00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of t	he cost	0	6
	reporting period (if calendar year, enter 0 on this line)			
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of	the cost	235	7
00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of th	e cost	0	8
	reporting period (if calendar year, enter 0 on this line)			
00	Total inpatient days including private room days applicable to the Program (excluding swing- newborn days) (see instructions)	bed and	91	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room day	rs)	0	10
	through December 31 of the cost reporting period (see instructions)			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room day December 31 of the cost reporting period (if calendar year, enter 0 on this line)	s) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room	days)	0	12
00	through December 31 of the cost reporting period			1.1
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	days)	0	13
. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			14
. 00	Total nursery days (title V or XIX only)		255 26	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		26	16
. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the c	ost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cos	t		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the co reporting period	st	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20
. 00	Total general inpatient routine service cost (see instructions)		8, 841, 720	
. 00		iod (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting perio x line 18)	d (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting peri	od (line	О	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period	l (line 8	0	25
~~	x line 20)		4 700 014	
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1, 700, 014 7, 141, 706	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 - '
	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)		0	
. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	31
			0.00	
. 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00 0.00	
	Average per diem private room cost differential (line 34 x line 31)		0.00	35
. 00	Private room cost differential adjustment (line 3 x line 35)		0	36
. 00	27 minus Line 36)	ial (line	7, 141, 706	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			-
. 00	Adjusted general inpatient routine service cost per diem (see instructions)		1, 666. 68	38
. 00 . 00 . 00			1, 666. 68 151, 668 0	

COMPUTATION OF INPATIENT	DPERATING COST		<u>HOSPITAL</u> Provider CC		eri od:	eu of Form CMS- Worksheet D-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/28/2022 9:1	
				e XIX	Hospi tal	PPS	
Cost Center D	escription	Total Inpatient Costl	Total npatient Daysl	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V &		521, 088	255	2, 043. 48	3 26	53, 130	42.0
	Inpatient Hospital Unit		70/	0.000.00		(4.054	1
3.00 INTENSIVE CARE UNI 4.00 CORONARY CARE UNIT		2, 050, 188	726	2, 823. 95	23	64, 951	43.0
5. 00 BURN INTENSIVE CARE							44.0
6. 00 SURGI CAL INTENSI VE							46.0
7.00 OTHER SPECIAL CARE	(SPECI FY)						47.0
Cost Center D	escription					1.00	
8.00 Program inpatient a	ncillary service cost (V	West D=3 col 3	Line 200)			1.00 227,425	48.0
	ient costs (sum of lines			ıs)		497, 174	
PASS THROUGH COST A		3 7 1				-	
Ũ	applicable to Program in	npatient routine s	ervices (from	Wkst. D, sum	of Parts I and	35, 920	50.0
III) 51.00 Pass through costs	applicable to Program ir	nationt ancillary	sorvicos (fr	m What D a	m of Parts II	26, 739	51.0
and IV)	appricable to Flogram II	ipatrent and riary	Services (III	JIII WKST. D, SC	m of Farts II	20, 734	1 51.0
2.00 Total Program exclu	udable cost (sum of lines					62, 659	52.0
	ient operating cost excl		ated, non-phys	sician anesthe	tist, and	434, 515	53.0
TARGET AMOUNT AND L	costs (line 49 minus line	e 52)					
4.00 Program discharges						C	54.0
5.00 Target amount per d	li scharge						55.
6.00 Target amount (line						0	56.
	adjusted inpatient opera	ating cost and tar	get amount (li	ne 56 minus l	ine 53)	C	
8.00 Bonus payment (see		concerting posted a	nding 100/	dated and can	nounded by the	0	
9.00 Lesser of lines 53, market basket	'54 or 55 from the cost r	eporting period e	inding 1996, up	buated and com	pounded by the	0.00	59.
	'54 or 55 from prior year	r cost report, upd	lated by the ma	arket basket		0.00	60.
	ess than the lower of lir					0	61. (
	sts (line 53) are less th otherwise enter zero (see		6 (lines 54 x 6	50), or 1% of	the target		
52.00 Relief payment (see		e filsti ucti olis)				c c	62.0
	cost plus incentive pay	yment (see instruc	tions)			C	
	OUTINE SWING BED COST						
04.00 Medicare swing-bed instructions)(title	SNF inpatient routine co	osts through Decem	iber 31 of the	cost reportir	g period (See	C	64.0
	SNF inpatient routine co	osts after Decembe	er 31 of the co	ost reportina	period (See	l c	65.0
instructions)(title				5		-	
	ig-bed SNF inpatient rout	tine costs (line 6	4 plus line 65	5)(title XVIII	only). For	0	66. 0
CAH (see instruction 7.00 Title V or XIX swin	ons) Ng-bed NF inpatient routi	ne costs through	December 31 of	f the cost rer	orting period	l c	67.0
(line 12 x line 19)		ne costs through	becchiber 51 01		or tring period		
	ng-bed NF inpatient routi	ne costs after De	ecember 31 of 1	the cost repor	ting period	0	68.0
(line 13 x line 20)		t rautina aaata (l	ing (7 , ling	(0)			
9.00 Total title V or XI PART III - SKILLED	NURSING FACILITY, OTHER			,		0	69.0
	ility/other nursing faci						70. (
3	patient routine service		ne 70 ÷ line 2	2)			71.0
	vice cost (line 9 x line			25)			72.
	/private room cost appli al inpatient routine ser			ne 35)			73. 74.
5 5	at allocated to inpatient	•	,	orksheet B. Pa	rt II. column		75.
26, line 45)					,		
	elated costs (line 75 ÷ l						76.
ů i	ated costs (line 9 x lir						77.
	ervice cost (line 74 mir o beneficiaries for exce	,	ovider records	3)			78.
55 5 5	ne service costs for con			· .	s line 79)		80.
5	ervice cost per diem lin	•			,		81.
	ervice cost limitation (• • • •					82.
	t routine service costs	•	.)				83.
	ncillary services (see i - physician compensatior		s)				84. 85.
	ient operating costs (su						86.
<u> </u>	ON OF OBSERVATION BED PA						
37.00 Total observation I	ed days (see instruction	ıs)				612	
5	patient routine cost per st (line 87 x line 88) (s	•	line 2)			1, 666. 68 1, 020, 008	
0 00 lobconvotion had							

Health Financial Systems	DUKES MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 448, 741	8, 841, 720	0. 16385	3 1, 020, 008	167, 131	90.00
91.00 Nursing Program cost	0	8, 841, 720	0. 00000	0 1, 020, 008	0	91.00
92.00 Allied health cost	0	8, 841, 720	0. 00000	0 1, 020, 008	0	92.00
93.00 All other Medical Education	0	8, 841, 720	0. 00000	0 1, 020, 008	0	93.00

ealth Financial Systems DUKES MEMOR NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	AL HOSPITAL Provider C	CN: 15-1318	Peri od:	u of Form CMS-2 Worksheet D-3	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	0.57(.000		
0. 00 03000 ADULTS & PEDIATRICS			3, 576, 030		30.
1. 00 03100 I NTENSI VE CARE UNI T			939, 648		31.
3. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.
0.00 05000 OPERATING ROOM		0. 1738	16 602, 374	104, 702	50.0
1. 00 05100 RECOVERY ROOM		0. 1738			
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 1949			51.
3. 00 05300 ANESTHESI OLOGY		0.0000		0	52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0000		-	54.
4. 00 105400 RADIOLOGI-DIAGNOSTIC 4. 01 105401 ULTRASOUND		0.0730			54.
6. 00 05600 RADI OI SOTOPE		0.0000		0	56.
7. 00 05700 CT SCAN		0.0000			57.
8. 00 05800 MRI		0.0000		0	57.
0. 00 06000 LABORATORY		0. 1233			
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2600			
5. 00 06500 RESPI RATORY THERAPY		0. 2000			
6. 00 06600 PHYSI CAL THERAPY		0. 5203			66.
7. 00 06700 OCCUPATI ONAL THERAPY		0. 1974			
8. 00 06800 SPEECH PATHOLOGY		0. 4148			
9. 00 06900 ELECTROCARDI OLOGY		0. 1104			
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0194			
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1793			
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1175			
6. 00 03610 SLEEP LAB		0.0000			76.
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	. · · · ·	/0.
0. 00 09000 CLINIC		2. 4487	66 0	0	90.
1. 00 09100 EMERGENCY		0. 2338			
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 5850			
OTHER REIMBURSABLE COST CENTERS		0.0000	,, 002	5,010	1
5. 00 09500 AMBULANCE SERVICES					95.
00.00 Total (sum of lines 50 through 94 and 96 through 98)			16, 949, 513	2, 267, 333	
01.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		0	_,, 000	201.
02.00 Net charges (line 200 minus line 201)	3. (51)		16, 949, 513		202.

ealth Financial Systems DUKES MEMORIA NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1318	Peri od:	eu of Form CMS-2 Worksheet D-3	
NI ATTENT ANGLEART SERVICE COST ATTORTONNENT	i i ovider c	CN. 13-1310	From 01/01/2021	worksneet D-5	,
	Component	CCN: 15-Z318	To 12/31/2021	Date/Time Pre	parec
				5/28/2022 9:1	7 am
	litle	XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs (col. 1 x col.	
			Charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS				1	30.
11. 00 03100 I NTENSI VE CARE UNI T					31.
13. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS		1		1	-
0. 00 05000 OPERATI NG ROOM		0. 1738	16 0	0	50.
1.00 05100 RECOVERY ROOM		0. 1949	56 2, 435	475	51.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			52.
3. 00 05300 ANESTHESI OLOGY		0.0000		0	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0730		2, 379	54.
4. 01 05401 ULTRASOUND		0.0000			54.
6. 00 05600 RADI 0I SOTOPE		0.0000		0	
7. 00 05700 CT SCAN		0.0000	00 0	0	57.
8. 00 05800 MRI		0.0000	00 0	0	58.
0. 00 06000 LABORATORY		0. 1233	14 283, 051	34, 904	60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2600	12 12, 816	3, 332	62.
5. 00 06500 RESPI RATORY THERAPY		0. 2416	47 515, 777	124, 636	65.
6. 00 06600 PHYSI CAL THERAPY		0. 5203	45 243, 922	126, 924	66.
7. 00 06700 OCCUPATI ONAL THERAPY		0. 1974	89 220, 945	43, 634	67.
8.00 06800 SPEECH PATHOLOGY		0. 4148	53 18, 981	7, 874	68.
9. 00 06900 ELECTROCARDI OLOGY		0. 1104	04 6, 160	680	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0194	17 140, 577	2, 730	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1793	34 0	0	72.
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1175	46 906, 161	106, 516	73.
6.00 03610 SLEEP LAB		0.0000	00 0	0	76.
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLINIC		2.4487		0	90.
1.00 09100 EMERGENCY		0. 2338			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 5850	32 0	0	92.
OTHER REIMBURSABLE COST CENTERS		1		1	
5. 00 09500 AMBULANCE SERVICES					95.
00.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 383, 409	454, 084	
01.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.
202.00 Net charges (line 200 minus line 201)			2, 383, 409		202.

Health Financial Systems DUKES MEMORI	Provi der C	CN: 15-1318	Peri od:	u of Form CMS-2 Worksheet D-3	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre	
	T: +1	e XIX	Hospi tal	5/28/2022 9:1 PPS	/ am
Cost Center Description		Ratio of Cos		Inpati ent	
cost center bescription		To Charges		Program Costs	
			Charges	$(col \cdot 1 \times col \cdot 1)$	
			ondriges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				•	
30. 00 03000 ADULTS & PEDI ATRI CS			264, 765		30.0
31. 00 03100 INTENSIVE CARE UNIT			105, 329		31.0
43. 00 04300 NURSERY			24, 330		43.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1738			
51.00 05100 RECOVERY ROOM		0. 1949		6, 629	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	52.0
53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0730		14, 132	54.0
54. 01 05401 ULTRASOUND		0.0000		0	54.0
56. 00 05600 RADI 0I SOTOPE		0.0000		0	
57.00 05700 CT SCAN		0.0000		0	57.0
58. 00 05800 MRI		0.0000		0	
60. 00 06000 LABORATORY		0. 1233			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2600			
65. 00 06500 RESPI RATORY THERAPY		0. 2416			
56. 00 06600 PHYSI CAL THERAPY		0. 5203			
67.00 06700 OCCUPATI ONAL THERAPY		0. 1974			
68.00 06800 SPEECH PATHOLOGY		0. 4148		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 1104		1, 727	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0194			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1793			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1175			
76.00 03610 SLEEP LAB		0.0000	00 0	0	76.0
OUTPATIENT SERVICE COST CENTERS					
20. 00 09000 CLINIC		2. 4487			
91.00 09100 EMERGENCY		0.2338			
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0. 5850	32 15, 342	8, 976	92.0
OTHER REI MBURSABLE COST CENTERS		1			
95.00 09500 AMBULANCE SERVICES			1 500 444	207 405	95.0
Total (sum of lines 50 through 94 and 96 through 98)	(1: (1)		1, 588, 141	227, 425	
201.00 Less PBP Clinic Laboratory Services-Program only char	ges (IIne 61)		1 500 444		201.0
202.00 Net charges (line 200 minus line 201)		1	1, 588, 141		202.0

	Financial Systems DUKES MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1318	Peri od:	u of Form CMS-2 Worksheet E	2002-1
			From 01/01/2021 To 12/31/2021	Part B Date/Time Pre	pared
		Title XVIII	Hospi tal	5/28/2022 9:1 Cost	7 am
			nooprear		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
	Medical and other services (see instructions)	+:)		4, 471, 373	
	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		0 5, 968, 178	2. C 3. C
	Outlier payment (see instructions)			0	4.0
	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru-	ctions)		0.000	
0	Line 2 times line 5	· · · · ,		0	6.0
	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
0	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.1
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 4, 471, 373	10.
	COMPUTATION OF LESSER OF COST OR CHARGES			.,, ••	
	Reasonable charges Ancillary service charges			0	12. (
00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, 1	ine 69)		0	13. (
	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.0
00	Aggregate amount actually collected from patients liable for			0	
	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(1 5	on a chargebasi s	0	16. (
00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0. 000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	lvifline 18 exceeds li	ne 11) (see	0	18. 19.
	instructions)	5			
	Excess of reasonable cost over customary charges (complete on instructions)	ly if line 11 exceeds li	ne 18) (see	0	20.
00	Lesser of cost or charges (see instructions)			4, 516, 087	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22. 23.
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			5, 968, 178	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction:	s)		25, 409	25.
00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see inst		4, 567, 042	26. (
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2.	z and z3j (see	-76, 364	27.
	Direct graduate medical education payments (from Wkst. E-4, 1)	ine 50)		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			-76, 364	
	Primary payer payments			1, 789	
00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)		-78, 153	32.
00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			625, 988 406, 892	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		534, 704	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			328, 739 0	37. 38.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
	Pioneer ACO demonstration payment adjustment (see instruction: Demonstration payment adjustment amount before sequestration	S)		0	39. 39.
98	Partial or full credits received from manufacturers for replace	ced devices (see instru	ctions)	0	39.
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 328, 739	39. 40.
01	Sequestration adjustment (see instructions)			0	40.
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 40.
00	Interim payments			1, 373, 937	41.
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 42.
01	Tentative settlement-PARHM (for contractor use only)				42.
	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-1, 045, 198	43. 43.
00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub. 15-2,	chapter 1,	0	
	§115.2 TO BE COMPLETED BY CONTRACTOR				
00	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
00	Time Value of Money (see instructions)			0	93.
00	Total (sum of lines 91 and 93)			0	94.

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet E-1 Part I Date/Time Prep 5/28/2022 9:17	pared
		Title		Hospi tal	Cost	
		Inpati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		6, 101, 937		1, 373, 937	1. (
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		C, 127, 127		0	2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
	Program to Provider	I				
01	ADJUSTMENTS TO PROVIDER		C		0	3.0
02 03			C		0	3. 3.
03					0	3.
05			C		0	3.
	Provider to Program	II	-	I	-	
50	ADJUSTMENTS TO PROGRAM		C		0	3.
51			C		0	3.
52			C		0	3.
53 54			C		0	3. 3.
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines				0	3. 3.
77	3. 50-3. 98)		C		0	J.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6, 101, 937		1, 373, 937	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER		C		0	5.
22			C		0	5.
03			C		0	5.
	Provider to Program					
50	TENTATI VE TO PROGRAM		C		0	5.
51 52			C		0	5. 5.
o∠ 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines		(0	5
	5. 50-5. 98)				0	
00 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		ſ		0	6. 6.
)1)2	SETTLEMENT TO PROVIDER		793, 426		0 1, 045, 198	6. 6.
)2)0	Total Medicare program liability (see instructions)		5, 308, 511		328, 739	7.
			0,000,011	Contractor Number	NPR Date (Mo/Day/Yr)	,.
		C		1.00	2.00	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-1318 CCN: 15-Z318	Period: From 01/01/2021 To 12/31/2021		pared
		Title	XVIII	Swing Beds - SN		/ dili
		Inpatien			rt B	
		mm/dd/yyyy	Amount		Amount	
		1.00	2.00	3. 00	4.00	
00	Total interim payments paid to provider		1, 807, 6	70	0	1.0
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
	Program to Provider				1	
01	ADJUSTMENTS TO PROVIDER			0	0	3. (
02				0	0	
03				0	0	
04 05				0	0	
05	Provider to Program			0	0	J. J.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 807, 6	70	0	4.
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
0.4	Program to Provider			0		
01 02	TENTATI VE TO PROVI DER			0	0	
02				0	0	
	Provider to Program			-		
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
-	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER			0	0	
)2)0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		144, 5 1, 663, 0		0	
50			1, 003, 0	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems DUKES MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1318	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Pre 5/28/2022 9:1	pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				
1.00	Total hospital discharges as defined in AARA §4102 from Wks				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, ar		for cost		2.00
0.00	reporting periods beginning on or after 10/01/2013, line 32	2)			0.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of line		plus for cost		4.00
F 00	reporting periods beginning on or after 10/01/2013, line 32	2)			F 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				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HII 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	on (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	lline 31) (see instructior	ıs)		32.00

ALCULA	Financial Systems DUKES MEMORIAL HOS TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pr	SPITAL rovider CCN: 15-1318	Peri od:	u of Form CMS-2 Worksheet E-2	
	Ca	omponent CCN: 15-Z318	From 01/01/2021 To 12/31/2021	Date/Time Prep 5/28/2022 9:1	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A 1.00	Part B 2.00	
C	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	Inpatient routine services - swing bed-SNF (see instructions)		1, 218, 743	0	1.
	Inpatient routine services - swing bed-NF (see instructions)				2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A			0	3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing- instructions)	bed pass-through, see			
	Nursing and allied health payment-PARHM (see instructions)				3.
	Per diem cost for interns and residents not in approved teaching	program (see		0.00	4.
	instructions)		704	0	-
	Program days Interns and residents not in approved teaching program (see inst	ructions)	724	0	5. 6.
	Jtilization review - physician compensation - SNF optional metho		0	0	7.
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	5	1, 677, 368	0	8.
	Primary payer payments (see instructions)		0	0	
	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applicab	lo to physician	1, 677, 368	0	10. 11.
	professional services)	ire to physician	0	0	11.
	Subtotal (line 10 minus line 11)		1, 677, 368	0	12.
	Coinsurance billed to program patients (from provider records) (excl ude coi nsurance	14, 284	0	13.
	for physician professional services)				
	80% of Part B costs (line 12 x 80%) Subtotal (see instructions)		1, 663, 084	0	14. 15.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		1, 003, 004	0	
	Pioneer ACO demonstration payment adjustment (see instructions)				16
	Rural community hospital demonstration project (§410A Demonstrat	ion) payment	0		16
	adjustment (see instructions)		0	0	16
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	17
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	-
	Total (see instructions)		1, 663, 084	0	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration)		0	0	
	Sequestration adjustment-PARHM pass-throughs		0	0	19
	Sequestration for non-claims based amounts (see instructions)		0	0	
	Interim payments		1, 807, 670	0	
	Interim payments-PARHM		0	0	20
	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		0	0	21
	Balance due provider/program (line 19 minus lines 19.01, 19.02,	19.25.20. and 21)	-144, 586	0	
	Balance due provider/program-PARHM (see instructions)				22.
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23.
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstrat	ion) Adjustment			
	Is this the first year of the current 5-year demonstration perio				200.
(Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				0.01
	Medicare swing-bed SNF inpatient routine service costs (from Wks 66 (title XVIII hospital))	st. D-1, Pt. II, line			201.
	Medicare swing-bed SNF inpatient ancillary service costs (from W	/kst. D-3. col. 3. lin	e		202.
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.
	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fi	rst year of the curre	nt 5-vear demonst	ration	204.
	period)				
5.00	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time				206.
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem Program reimbursement under the §410A Demonstration (see instruc				207.
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	-	1		207
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209.
	Reserved for future use				210.
	Comparision of PPS versus Cost Reimbursement	plus line 210) (see			

leal th Financial Systems DUKES MEMORIAL CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1318	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Pre 5/28/2022 9:1	epar
		Title XVIII	Hospi tal	Cost	
				1 00	-
				1.00	-
. 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAN Inpatient services	RE PART A SERVICES - COST	KETWOUKSEWENT	5, 596, 349	1
. 00	Nursing and Allied Health Managed Care payment (see instruc	tions)		5, 590, 349	
. 00	Organ acquisition	trons)		0	
. 00	Subtotal (sum of lines 1 through 3)			5, 596, 349	-
. 00	Primary payer payments			0, 370, 347	
. 00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 652, 312	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES			0,002,012	1
	Reasonabl e charges				
. 00	Routine service charges			0	7
. 00	Ancillary service charges			0	
. 00	Organ acquisition charges, net of revenue			0	9
0. 00	Total reasonable charges			0	10
	Customary charges				
1.00	Aggregate amount actually collected from patients liable fo	r payment for services on	a charge basis	0	11
2.00	Amounts that would have been realized from patients liable	for payment for services of	on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.13	(e)			
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13
4.00	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	15
	instructions)				
6.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lir	ne 14) (see	0	16
7.00	instructions)	structions)		0	17
7.00	Cost of physicians' services in a teaching hospital (see in: COMPUTATION OF REIMBURSEMENT SETTLEMENT	structions)		0	4 ''
8.00	Direct graduate medical education payments (from Worksheet	E-4 line 49)		0	18
9.00	Cost of covered services (sum of lines 6, 17 and 18)			5, 652, 312	
0.00	Deductibles (exclude professional component)			404, 752	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			5, 247, 560	22
3.00	Coinsurance			371	23
4.00	Subtotal (line 22 minus line 23)			5, 247, 189	24
5.00	Allowable bad debts (exclude bad debts for professional ser	vices) (see instructions)		94, 341	25
5.00	Adjusted reimbursable bad debts (see instructions)			61, 322	26
7.00	Allowable bad debts for dual eligible beneficiaries (see in:	structions)		54, 567	27
3.00	Subtotal (sum of lines 24 and 25, or line 26)			5, 308, 511	28
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29
9. 98	Recovery of accelerated depreciation.			0	
9. 99	Demonstration payment adjustment amount before sequestration	n		0	
0.00	Subtotal (see instructions)			5, 308, 511	
). 01	Sequestration adjustment (see instructions)			0	
0. 02	Demonstration payment adjustment amount after sequestration			0	
0.03				/ 101 007	30
. 00	Interim payments			6, 101, 937	
1.01	Interim payments-PARHM			~	31
2.00	Tentative settlement (for contractor use only)			0	
	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 30 minus lines 30.01, 30	(0, 2, 2, 1) and $(2, 2)$		702 424	32
2.01		. UZ. 31. ANO 32)		-793, 426	33
3.00			and 22 011		1 00
	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, Protested amounts (nonallowable cost report items) in accorr	minus lines 30.03, 31.01,		0	33

CALCUI	Financial Systems DUKES MEMORIAL H ATION OF REIMBURSEMENT SETTLEMENT	Peri od:	2552-10		
		Provider CCN: 15-1318	From 01/01/2021	Worksheet E-3 Part VII	
			To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
		Title XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	VICES FOR TITLES V OR X	IX SERVICES		
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			497, 925	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	497, 925	
5.00	Inpatient primary payer payments		0	_	5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		0	497, 925	7.00
	Reasonable Charges				
8.00	Routi ne servi ce charges		394, 424		8.00
9.00	Ancillary service charges		1, 588, 141	3, 102, 119	
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)		1, 982, 565	3, 102, 119	12.00
12 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	convisor on a charge	0	0	13.00
13.00	basis	services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for	payment for services o	n O	0	14.00
	a charge basis had such payment been made in accordance with 4				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
16.00	Total customary charges (see instructions)		1, 982, 565	3, 102, 119	
17.00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	1, 982, 565	2, 604, 194	17.00
18.00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	vifling 4 avecade lin		0	18.00
18.00	16) (see instructions)	y II IIIe 4 exceeds III	e 0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1		0	497, 925	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be a	completed for PPS provi			
22.00	Other than outlier payments		0	0	22.00
23.00 24.00	Outlier payments		0	0	23.00 24.00
24.00	Program capital payments Capital exception payments (see instructions)		0		24.00
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	28.00	
29.00	Titles V or XIX (sum of lines 21 and 27)		0	497, 925	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00 32.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	497, 925	
	Deducti bl es Coi nsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review	0		35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	0	497, 925		
37.00	REMOVE SETTLEMENT	0	-497, 925		
38.00	Subtotal (line 36 ± line 37)			0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4) 0				39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0		
41.00 42.00	Interim payments		0	0	
	Balance due provider/program (line 40 minus line 41)	0	0		
42.00	Protested amounts (nonallowable cost report items) in accordance	co with CMS Dub 15 0	0	0	43.00

	Financial Systems DUKES MEMORIA E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2021	u of Form CMS-: Worksheet G	
y)	ype accounting records, comprete the General Fund corumn			To 12/31/2021	Date/Time Pre 5/28/2022 9:1	epare 7 an
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	-138, 898	(0	0	1 1
00	Temporary investments	0	(0 0	0	
00	Notes receivable	0	(0 0	0	3
00	Accounts receivable	9, 684, 548	(0 0	0	
00	Other receivable	0	(0	0	
00	Allowances for uncollectible notes and accounts receivable	-4, 703, 527		0	0	
00 00	Inventory Prepaid expenses	888, 998 339, 415			0	
00	Other current assets	13, 420			0	
00	Due from other funds	0			0	
	Total current assets (sum of lines 1-10)	6, 083, 956			0	
	FIXED ASSETS			· I		
00	Land	500, 000	(0 0	0	12
00	Land improvements	246, 545	(0	
00	Accumulated depreciation	-149, 655	(0	
	Buildings	10, 619, 283	(0	
00	Accumulated depreciation	-4, 477, 644		-	0	
00	Leasehold improvements	10, 928, 313 -5, 271, 933			0	
	Accumulated depreciation Fixed equipment	3, 112, 251			0	
	Accumulated depreciation	-1, 901, 374			0	
	Automobiles and trucks	583, 590			0	
	Accumulated depreciation	-583, 590	(0	0	
00	Major movable equipment	6, 394, 101		0 0	0	23
00	Accumulated depreciation	-5, 236, 705	(0 0	0	
	Minor equipment depreciable	4, 327, 142	(0	1
	Accumulated depreciation	-3, 043, 402	(0	
	HIT designated Assets	0			0	
	Accumulated depreciation Minor equipment-nondepreciable				0	1
	Total fixed assets (sum of lines 12-29)	16, 046, 922			0	
00	OTHER ASSETS	10,010,722				
00	Investments	0	(0 0	0	31
00	Deposits on Leases	0	(0 0	0	32
00	Due from owners/officers	0	(0 0	0	33
	Other assets	9, 128, 369			0	
	Total other assets (sum of lines 31-34)	9, 128, 369			0	
00	Total assets (sum of lines 11, 30, and 35)	31, 259, 247	(0 0	0	36
00	CURRENT LIABILITIES Accounts payable	2, 085, 578	(0	37
00	Salaries, wages, and fees payable	1, 737, 401			0	
	Payrol I taxes payable	-8			0	
	Notes and Loans payable (short term)	254, 186	(0	0	
	Deferred income	0	(0 0	0	
00	Accelerated payments	0				42
00	Due to other funds	-32, 832, 802	(0	
00	Other current liabilities	360, 913	(0	
00	Total current liabilities (sum of lines 37 thru 44)	-28, 394, 732	(0 0	0	45
00	LONG TERM LIABILITIES Mortgage payable	0	(0	46
00	Notes payable	319, 695			0	
00	Unsecured Loans	0,7,0,0			0	
00	Other long term liabilities	0		o o	0	
00	Total long term liabilities (sum of lines 46 thru 49)	319, 695	(0	0	
00	Total liabilities (sum of lines 45 and 50)	-28, 075, 037		0 0	0	51
	CAPI TAL ACCOUNTS			1		
00	General fund balance	59, 334, 284				52
00	Specific purpose fund)		53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant			0	0	
00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
00	Total fund balances (sum of lines 52 thru 58)	59, 334, 284	(0 0	0	59
00						60

ial Systems CHANGES IN FUND BALANCES	DUKES MEMORIAL	Provider CC	CN: 15-1318	Period: From 01/01/2021	worksheet G-1	
	General			To 12/31/2021	Date/Time Pre 5/28/2022 9:1	
		Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	1 00
alances at beginning of period come (loss) (from Wkst. G-3, line 29) (sum of line 1 and line 2) ons (credit adjustments) (specify) additions (sum of line 4-9) al (line 3 plus line 10) ions (debit adjustments) (specify) deductions (sum of lines 12-17) alance at end of period per balance	0 0 0 0 0 0 0 0 0 0 0 0 0 0	51, 128, 580 8, 205, 704 59, 334, 284 0 59, 334, 284 0 59, 334, 284			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
(line 11 minus line 18)	Endowment Fund	PI ant	Fund			
alances at boginning of poriod		7.00	8.00	0		1.00
come (loss) (from Wkst. G-3, line 29) (sum of line 1 and line 2) ons (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
additions (sum of line 4-9) al (line 3 plus line 10) ions (debit adjustments) (specify) deductions (sum of lines 12-17) alance at end of period per balance	0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	dditions (sum of line 4-9) I (line 3 plus line 10) ons (debit adjustments) (specify) eductions (sum of lines 12-17) lance at end of period per balance line 11 minus line 18) lances at beginning of period ome (loss) (from Wkst. G-3, line 29) sum of line 1 and line 2) ns (credit adjustments) (specify) dditions (sum of line 4-9) I (line 3 plus line 10) ons (debit adjustments) (specify) eductions (sum of lines 12-17)	dditions (sum of line 4-9) 0 1 (line 3 plus line 10) 0 ons (debit adjustments) (specify) 0 eductions (sum of lines 12-17) 0 lance at end of period per balance 0 line 11 minus line 18) Endowment Fund ances at beginning of period 0 ome (loss) (from Wkst. G-3, line 29) 0 sum of line 1 and line 2) 0 ns (credit adjustments) (specify) 0 dditions (sum of line 4-9) 0 l (line 3 plus line 10) 0 ons (debit adjustments) (specify) 0 eductions (sum of lines 12-17) 0 lance at end of period per balance 0	dditions (sum of line 4-9) 0 1 (line 3 plus line 10) 59, 334, 284 ons (debit adjustments) (specify) 0 eductions (sum of lines 12-17) 0 lance at end of period per balance 59, 334, 284 line 11 minus line 18) Endowment Fund Plant 6.00 ons (debit adjustments) (specify) 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0 o 0	dditions (sum of line 4-9) 0 1 (line 3 plus line 10) 59, 334, 284 ons (debit adjustments) (specify) 0 eductions (sum of lines 12-17) 0 lance at end of period per balance 59, 334, 284 line 11 minus line 18) Endowment Fund Plant Fund 6.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td>dditions (sum of line 4-9) 0 0 0 l (line 3 plus line 10) 59, 334, 284 0 ons (debit adjustments) (specify) 0 0 0 eductions (sum of lines 12-17) 0 0 0 lance at end of period per balance 59, 334, 284 0 ine 11 minus line 18) Endowment Fund Plant Fund eductions (sum of lines 12-17) 0 0 sum of line 1 and line 2) 0 0 ns (credit adjustments) (specify) 0 0 dditions (sum of line 4-9) 0 0 l (line 3 plus line 10) 0 0 ons (debit adjustments) (specify) 0 0 dditions (sum of line 4-9) 0 0 l (line 3 plus line 10) 0 0 ons (debit adjustments) (specify) 0 0 eductions (sum of lines 12-17) 0 0 l ance at end of period per balance 0 0</td> <td>dditions (sum of line 4-9) 0 0 0 1 (line 3 plus line 10) 59, 334, 284 0 ons (debit adjustments) (specify) 0 0 eductions (sum of lines 12-17) 0 59, 334, 284 0 lance at end of period per balance 59, 334, 284 0 lances at beginning of period 6.00 7.00 8.00 lances at beginning of period 0 0 sum of line 1 and line 2) 0 0 ns (credit adjustments) (specify) 0 0 dditions (sum of line 4-9) 0 0 1 (line 3 plus line 10) 0 0 ons (debit adjustments) (specify) 0 0 dditions (sum of line 4-9) 0 0 1 (line 3 plus line 10) 0 0 ons (debit adjustments) (specify) 0 0</td>	dditions (sum of line 4-9) 0 0 0 l (line 3 plus line 10) 59, 334, 284 0 ons (debit adjustments) (specify) 0 0 0 eductions (sum of lines 12-17) 0 0 0 lance at end of period per balance 59, 334, 284 0 ine 11 minus line 18) Endowment Fund Plant Fund eductions (sum of lines 12-17) 0 0 sum of line 1 and line 2) 0 0 ns (credit adjustments) (specify) 0 0 dditions (sum of line 4-9) 0 0 l (line 3 plus line 10) 0 0 ons (debit adjustments) (specify) 0 0 dditions (sum of line 4-9) 0 0 l (line 3 plus line 10) 0 0 ons (debit adjustments) (specify) 0 0 eductions (sum of lines 12-17) 0 0 l ance at end of period per balance 0 0	dditions (sum of line 4-9) 0 0 0 1 (line 3 plus line 10) 59, 334, 284 0 ons (debit adjustments) (specify) 0 0 eductions (sum of lines 12-17) 0 59, 334, 284 0 lance at end of period per balance 59, 334, 284 0 lances at beginning of period 6.00 7.00 8.00 lances at beginning of period 0 0 sum of line 1 and line 2) 0 0 ns (credit adjustments) (specify) 0 0 dditions (sum of line 4-9) 0 0 1 (line 3 plus line 10) 0 0 ons (debit adjustments) (specify) 0 0 dditions (sum of line 4-9) 0 0 1 (line 3 plus line 10) 0 0 ons (debit adjustments) (specify) 0 0

1.00 2.00 3.00 4.00 5.00 6.00 7.00	Cost Center Description PART I - PATIENT REVENUES			To 12/31/2021	Date/Time Prep 5/28/2022 9:1	
1.00 2.00 3.00 4.00 5.00 6.00 7.00	PART I - PATIENT REVENUES		Inpati ent	Outpati ent	Total	
1.00 2.00 3.00 4.00 5.00 6.00 7.00	PART I – PATIENT REVENUES		1.00	2.00	3.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00						1
2.00 3.00 4.00 5.00 6.00 7.00	General Inpatient Routine Services					
3.00 4.00 5.00 6.00 7.00	Hospi tal		11, 195, 8	31	11, 195, 881	1.00
4.00 5.00 6.00 7.00	SUBPROVIDER - IPF					2.00
5.00 6.00 7.00	SUBPROVIDER - IRF					3.00
6.00 7.00	SUBPROVIDER					4.00
7.00	Swing bed - SNF			0	0	5.00
	Swing bed - NF			0	0	6.00
8 00 1	SKILLED NURSING FACILITY					7.00
	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
	Total general inpatient care services (sum of lines 1-9)		11, 195, 8	31	11, 195, 881	10.00
	Intensive Care Type Inpatient Hospital Services					
	INTENSIVE CARE UNIT		2, 651, 9	99	2, 651, 999	
	CORONARY CARE UNIT					12.00
	BURN INTENSIVE CARE UNIT					13.00
	SURGI CAL INTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	2, 651, 9	99	2, 651, 999	16.00
	11-15)					
	Total inpatient routine care services (sum of lines 10 and 16)		13, 847, 8		13, 847, 880	
	Ancillary services		54, 025, 7		143, 476, 735	
	Outpatient services		4, 874, 50	03 27, 799, 003		
	RURAL HEALTH CLINIC			0 0	0	20.00
	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
	HOME HEALTH AGENCY					22.00
	AMBULANCE SERVICES			0 11, 037, 752	11, 037, 752	
	CMHC					24.00
	AMBULATORY SURGICAL CENTER (D. P.)					25.00
	HOSPICE					26.00
	OTHER (SPECIFY)			0 0	0	27.00
	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	72, 748, 13	35 128, 287, 738	201, 035, 873	28.00
	G-3, line 1)					1
	PART II - OPERATING EXPENSES					
	Operating expenses (per Wkst. A, column 3, line 200)			40, 849, 795		29.00
	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.0
33.00				0		33.0
34.00				0		34.00
35.00				0		35.00
	Total additions (sum of lines 30-35)			0		36.0
	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.0
39.00				0		39.00
40.00				0		40.0
41.00				0		41.0
	Total deductions (sum of lines 37-41)			0		42.00
	Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4)	2)(transfer		40, 849, 795		43.00

Heal th	alth Financial Systems DUKES MEMORIAL HOSPITAL In Lie				u of Form CMS-2	552-10		
STATE	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1318 Period:			Worksheet G-3				
From 01/01/2021 To 12/31/2021						Date/Time Prep	arod	
	10 12/31/2021							
	1.00							
1.00	Total patient revenues (from Wkst. G-2, Part	201, 035, 873	1.00					
2.00	Less contractual allowances and discounts on	patients' accoun	ts			154, 084, 995	2.00	
3.00	Net patient revenues (line 1 minus line 2)		(2)			46, 950, 878	3.00	
4.00	Less total operating expenses (from Wkst. G-		43)			40, 849, 795	4.00	
5.00	Net income from service to patients (line 3	minus line 4)				6, 101, 083	5.00	
6.00	OTHER INCOME Contributions, donations, bequests, etc					0	6.00	
8.00 7.00	Income from investments					0	7.00	
8.00	Revenues from telephone and other miscellane	ous communication	sarvi cas			0	8.00	
9,00	Revenue from tel evision and radio service		361 11 663			0	9,00	
10.00	Purchase di scounts					0	10.00	
11.00	Rebates and refunds of expenses					0	11.00	
12.00						o	12.00	
13.00	Revenue from Laundry and Linen service					0	13.00	
14.00		sts				0	14.00	
15.00	Revenue from rental of living quarters					0	15.00	
16.00	Revenue from sale of medical and surgical su	pplies to other th	han patients			0	16.00	
17.00	Revenue from sale of drugs to other than pat	ients				0	17.00	
18.00	Revenue from sale of medical records and abs	tracts				0	18.00	
	Tuition (fees, sale of textbooks, uniforms,	,				0	19.00	
	Revenue from gifts, flowers, coffee shops, a	nd canteen				0	20.00	
	Rental of vending machines					0	21.00	
22.00						0	22.00	
23.00						0	23.00	
24.00						52, 449	24.00	
	COVI D-19 PHE Funding					2,052,172	24.50	
	Total other income (sum of lines 6-24)					2, 104, 621	25.00	
	Total (line 5 plus line 25)					8, 205, 704	26.00	
	OTHER EXPENSES (SPECIFY) Total other expenses (sum of line 27 and sub	scrints)				0	27.00 28.00	
	Net income (or loss) for the period (line 26					8, 205, 704		
27.00	Iner medile (or ross) for the period (The 20	minus inne 20)			I	0, 200, 704	27.00	