Heal th Financia	al Systems	DUKES MEMORIAL HO	SPI TAL	In Lie	u of Form CMS-2552-10	
	,	1395g; 42 CFR 413.20(b)). Failu	•			
payments made	since the beginning of th	e cost reporting period being o	deemed overpayments ((42 USC 1395g).	OMB NO. 0938-0050	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 151318 Period: WARD SETTLEMENT SUMMARY PROVIDER CCN: 151318 P						
AND SETTLEMENT	SUMMARY			To 12/31/2015		
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically fi	led cost report		Date: 5/31/20	16 Time: 9:11 am	
use only	2. [] Manually submitte	d cost report				
	3. [0] If this is an ame 4. [F] Medicare Utilizat	nded report enter the number o ion. Enter "F" for full or "L"	f times the provider for low.	resubmitted this c	ost report	
Contractor use only	5. [1]Cost Report Statu (1) As Submitted (2) Settled without Au (3) Settled with Audit (4) Reopened	7. Contractor No. dit 8. [N] Initial Report for	this Provider CCN 12			

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUKES MEMORIAL HOSPITAL (151318) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			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	-458, 093	-1, 152, 540	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	-41, 066	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	-499, 159	-1, 152, 540	0	0	200. 00

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

Health Financial Systems DUKES MEMORIAL HOSPITAL HOSPITAL IN Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151318 Period: Worksheet S-2

	TAL AND HOSPITAL HEALTH CARE COMPLEX		ATA		der CCN:		Period: From 01/01/	V	Vorkshe Part I		2552-10
							To 12/31/	2015	Date/Ti 5/31/20		
	1.00		. 00		3. 00			1. 00			
1. 00	Hospital and Hospital Health Care Co Street: 275 WEST 12TH STREET	PO Box:									1. 00
2.00	City: PERU	State: I			e: 46970		y: MLAMI	-			2. 00
		Component Na		CCN Number	CBSA Number	Provi der Type	Date Certified		t Systo 0, or		
						. , , , ,		V	XVIII	XI X	
	Hospital and Hospital-Based Componen	1.00		2.00	3. 00	4.00	5. 00	6. 00	7. 00	8. 00	
3.00	Hospi tal	DUKES MEMORIAL H		151318	99915	1	07/01/1966	N	0	Р	3. 00
4. 00 E. 00	Subprovi der - IPF Subprovi der - IRF										4. 00 5. 00
5. 00 6. 00	Subprovider - (Other)										6. 00
7. 00	Swing Beds - SNF	DUKES MEMORIAL H	OSPI TAL	15Z318	99915		12/01/2003	N	0	N	7. 00
8. 00	Swing Beds - NF	SB									8. 00
9.00	Hospi tal -Based SNF										9. 00
10. 00 11. 00	Hospi tal -Based NF Hospi tal -Based OLTC										10. 00 11. 00
12.00	Hospi tal -Based HHA										12. 00
13. 00 14. 00	Separately Certified ASC Hospital-Based Hospice										13. 00 14. 00
15. 00	Hospital-Based Health Clinic - RHC										15. 00
16. 00 17. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16. 00 17. 00
18. 00	Renal Dialysis										18. 00
19. 00	Other								To		19. 00
							1.00		2. C		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2	ŀ	12/31/	2015	20.00
21. 00	Type of Control (see instructions) Inpatient PPS Information							4			21. 00
22. 00	Does this facility qualify and is it						N				22. 00
	share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle										
22 01	amendment hospital?) In column 2, en				a aaat m	nontina	N.		N		22 01
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y						N		N		22. 01
	reporting period occurring prior to										
	for no for the portion of the cost r (see instructions)	eportring perrou t	occur i riig	011 01 2	itei octo	bbei i.					
22. 02	Is this a newly merged hospital that						N		N		22. 02
	determined at cost report settlement or "N" for no, for the portion of th						'				
	in column 2, "Y" for yes or "N" for	no, for the porti	ion of the	cost r	eporti ng	period or	1				
22. 03	or after October 1. Did this hospital receive a geograph	ic reclassificati	ion from ι	ırban to	rural as	s a result	: N		N		22. 03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						,				
	cost reporting period occurring on o hospital contain at least 100 but no		•		,						
	42 CFR 412.105)? Enter in column 3,				ili accord	dance with	'				
23. 00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							3	N		23. 00
	method of identifying the days in th	is cost reporting	g period d	li fferer	t from th	ne method					
	used in the prior cost reporting per	iod? In column 2	2, enter " In-State			<u>N" for no.</u> ut-of	Out-of N	ledi cai d	1 01	her	
			Medi cai d	Medi	caid S	State	State F	MO days		i cai d	
			paid day	s elig unp			ledi cai d I i gi bl e		d	ays	
				da			unpai d				
24 00	If this provider is an IPPS hospital	ontor the	1.00	0 2.	00 :	3. 00	4. 00	5. 00	0 6	. 00	24. 00
24.00	in-state Medicaid paid days in colum			٩		٩	o _l			U	24.00
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in										
25. 00	If this provider is an IRF, enter th			0	О	О	О		0		25. 00
	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column	3, out-of-state									
	Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day										
	pinno para ana erigibie but unpara day	3 III COLUMNI 9.	I	I	ı	I	ı		ı		

care or general surgery. (see instructions)

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151318 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 8:44 am Program Code Unweighted IME Program Name Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of

unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions)

ealth Financial Systems		MORIAL HOSPITAL				u of Form CMS	
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENIIFICATION DATA	Provi dei	CCN: 151318	From O	: 1/01/2015 2/31/2015	Worksheet S- Part I Date/Time Pr 5/31/2016 8:	epared:
					1. 00	2.00	\dashv
All Providers						2.00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	" for no in column 1	. If yes, and hom	e office cos		Y	449008	140. 0
1.00		2. 00			3.00	6.11	
If this facility is part of a chain home office and enter the home offi			9	e name and	a address	or the	
41.00 Name: CHS/COMMUNITY HEALTH SYSTEMS				ctor's Nu	mber: 0500)1	141. 0
INC. 42.00 Street: 4000 MERIDIAN BLVD	PO Box:						142. 0
43. OO City: FRANKLIN	State:	TN	Zip Co	de:	3706	7	143. 0
44.00 Are provider based physicians' cost	s included in Worksh	pet Δ?				1. 00 Y	144. 0
14. OOM C provider based physicians cost	3 THE LUCE THE WOLKSTO	cot A:				'	177.0
45 001.6		7.4			1. 00	2. 00	4.45.0
45.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for no ude Medicare utiliza	o in column 1. If	column 1 is	;	Υ		145. 0
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	column 1. (See CMS P			If	N		146. 0
						1.00	
7.00 Was there a change in the statistic						N	147. (
H8.00 Was there a change in the order of H9.00 Was there a change to the simplifie				for no		N N	148. (
47. Oolwas there a change to the shiphine	d cost finding methor	Part A	Part E		itle V	Title XIX	147. (
-		1.00	2.00		3.00	4. 00	
Does this facility contain a provid or charges? Enter "Y" for yes or "N							
55.00 Hospi tal	1 101 110 101 00011 00	N	N N	J. (300 12	N N	N N	155. (
56.00 Subprovi der - IPF		N	N		N	N	156.
57.00 Subprovi der - IRF 58.00 SUBPROVI DER		N	N		N	N	157. (158. (
59. 00 SNF		N	N		N	N	159.
50.00 HOME HEALTH AGENCY		N	N		N	N	160.
51. 00 CMHC			N N		N	N	161.
						1.00	
Multicampus 55.00 s this hospital part of a Multicam	inus hosnital that ha	s one or more cam	nuses in dif	ferent CE	RSAs?	l N	165. (
Enter "Y" for yes or "N" for no.	ipus nospi tai that na	3 One of more cam	puses III ul i	Terent CL	JON3 :	IN IN	103. (
	Name	County		Zip Code		FTE/Campus	
66.00 If line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 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 column 5 (see instructions)							
Health Information Technology (HIT)	incentive in the Am	erican Recovery	nd Rei nyesti	nent Act		1. 00	
o7.00 s this provider a meaningful user				HOIT ACL		Υ	167. (
58.00 If this provider is a CAH (line 105			ne 167 is "\	"), enter	the		0168.0
reasonable cost incurred for the HI 08.01 If this provider is a CAH and is no			er qualify f	or a hard	lshi p		168. (
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or	"N" for no. (see	instruction	ıs)	·		
69.00 If this provider is a meaningful us		and is not a CAH	(line 105 i	s "N"), e	enter the	0.0	00169. (
trancition factor (ass instruction						İ	
transition factor. (see instruction					gi nni ng	Endi ng	
transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR be		ing data for th	nonost!		gi nni ng 1. 00 /01/2015	Endi ng 2. 00 12/31/2015	170.

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu o						2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN:	151318	From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/31/2016 8:4	
					1.00	
171.00 If line 167 is "Y", does this provide	der have any days for individ	duals enrolled	in secti	on 1876	N	171. 00
Medicare cost plans reported on Wks	t. S-3, Pt. I, line 2, col. 6	6? Enter "Y" fo	or yes ar	nd "N" for no.		
(see instructions)						

the other adjustments:

Health Financial Systems DUKES MEMORIAL HOSPITAL Systems In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 151318 Period: Worksheet S-2

From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/31/2016 8:44 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Υ 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position PARRI SH 41.00 LLSA held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report COMMUNITY HEALTH SYSTEMS, 42.00 42.00 preparer. I NC 43.00 Enter the telephone number and email address of the cost 615-465-7554 LI SA_PARRI SH@CHS. NET 43.00

report preparer in columns 1 and 2, respectively.

1103111	TE AND HOST THE HEALTH SAKE KETHOSTOLINETT GOL	orr on with the	Trovide:	55N. 151515	From 01/01/2015 To 12/31/2015	Part II Date/Time Prep 5/31/2016 8:44	
	·	Part B					
		Date					
		4. 00					
-	PS&R Data						
16. 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)	05/19/2016					16. 00
17. 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 in columns 2 and 4. (see instructions)						17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						18. 00
19. 00	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.						19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21. 00
		_	3. 0	00			
	Cost Report Preparer Contact Information		5. 0				
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		ANAGER				41. 00
42. 00	Enter the employer/company name of the cost r	report					42. 00
43. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43. 00

 Heal th Financial
 Systems
 DUKES M

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					To	12/31/2015	Date/Time Prep 5/31/2016 8:44	
							I/P Days / 0/P	T GIII
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		21	7, 665	71, 592. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3. 00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			21	7, 665	71, 592. 00	0	7. 00
	beds) (see instructions)						_	
8.00	INTENSIVE CARE UNIT	31. 00		4	1, 460	10, 872. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00 11. 00	BURN INTENSIVE CARE UNIT							10. 00 11. 00
12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)	43.00		25	9, 125	82, 464. 00	Ö	14. 00
15. 00	CAH visits			20	7, 120	02, 1011 00	0	15. 00
16. 00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17.00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE							23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			25				27. 00
28.00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
33 00	outpatient days (see instructions) LTCH non-covered days							33. 00
33.00	LIGH Hon-covered days		l					33.00

Provider CCN: 151318

				•		5/31/2016 8: 4	4 am	
		I/P Days	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On		
				Pati ents	& Residents	Payrol I		
		6. 00	7. 00	8. 00	9. 00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 560	109	2, 983			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)	297	0				2. 00	
3.00	HMO IPF Subprovider	0	0				3. 00	
4.00	HMO IRF Subprovider	0	0				4. 00	
5. 00	Hospital Adults & Peds. Swing Bed SNF	148	0	•			5. 00	
6.00	Hospital Adults & Peds. Swing Bed NF		0	1			6. 00	
7.00	Total Adults and Peds. (exclude observation	1, 708	109	3, 148			7. 00	
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	298	0	453			8. 00	
9.00	CORONARY CARE UNIT						9. 00	
10. 00	BURN INTENSIVE CARE UNIT						10. 00	
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00	
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00	
13.00	NURSERY		0	400			13. 00	
14.00	Total (see instructions)	2, 006	109	4, 001	0.00	194. 54	14. 00	
15.00	CAH visits	0	0	0			15. 00	
16.00	SUBPROVI DER - I PF						16. 00	
17. 00	SUBPROVI DER - I RF						17. 00	
18.00	SUBPROVI DER						18. 00	
19.00	SKILLED NURSING FACILITY						19. 00	
20.00	NURSING FACILITY						20. 00	
21.00	OTHER LONG TERM CARE						21. 00	
22.00	HOME HEALTH AGENCY						22. 00	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00	
24.00	HOSPI CE						24. 00	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10	
25.00	CMHC - CMHC						25. 00	
26.00	RURAL HEALTH CLINIC						26. 00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25	
27.00	Total (sum of lines 14-26)				0.00	194. 54	27. 00	
28.00	Observation Bed Days		0	723			28. 00	
29.00	Ambul ance Tri ps	0					29. 00	
30.00	Employee discount days (see instruction)			0			30. 00	
31.00	Employee discount days - IRF			0			31.00	
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00	
32. 01	Total ancillary labor & delivery room			0			32. 01	
	outpatient days (see instructions)							
33.00	LTCH non-covered days	0					33. 00	
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 Heal th Financial
 Systems
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 151318

Full Time Discharges Equivalents Nonpaid Workers Title V Title XVIII Title XIX Patients Total All Patients Nonpaid Workers Title V Title XVIII Patients Patients Title XIX Patients Patients Title XIX Total All Patients Title XIX Total All Patients Title XIX Patients Title XIX Patients Title XIX Total All Title XIX Total All Title XIX Total All Total All Total XIX Total					10) 12/31/2015	5/31/2016 8: 4	
Nonpaid Title V					Di sch	arges		
Norkers		C		T: +1 - \/	T: +1 - V(// 1.1	T: +1 - VIV	T-+-1 All	
10.0 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) 1,127 1,00 2,00 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,127 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,		Component		iitie v	little XVIII	little xix		
1.00				12 00	13.00	14 00		
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1 00	Hospital Adults & Peds (columns 5 6 7 and	11.00					1 00
Hospi ce days) (see instructions for col. 2 7 7 7 7 7 7 7 7 7				· ·		.,,	.,,	
2.00 HMC and other (see instructions) 3.00 HMC IPF Subprovider 4.00 4.00 4.00 4.00 5.00 HMC IPF Subprovider 6.00 6.00 HMC IRF Subprovider 7.00 Hospital Adult s& Peds. Swing Bed SNF 6.00 6.00 Hospital Adult s& Peds. Swing Bed SNF 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 1.00 BURN INTENSIVE CARE UNIT 9.00 1.00 BURN INTENSIVE CARE UNIT 1.10 00 1.00 SURGICAL INTENSIVE CARE UNIT 1.10 00 1.00 OTHER SPECIAL CARE (SPECIFY) 1.30 00 TOtal (see instructions) 1.01 00 SUBPROVIDER - IPF 1.127 14.00 1.00 SUBPROVIDER - IPF 1.10 00 CAH visits 1.10 00 SUBPROVIDER - IRF 1.10 00 SUBPROVIDER - IRF 1.10 00 OTHER LONG TERM CARE 1.10 00 OTHER LONG TER								
3. 00		for the portion of LDP room available beds)						
4. 00	2.00	HMO and other (see instructions)			0	0		
5.00						0		
6. 00 Hospital Adults & Peds. Swing Bed NF 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00						0		
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33.00 LICH non-covered days 33.00								
	33. 00	LICH non-covered days						33. 00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Provider CCN: 151318

Non-physician nussthetist Part						T	12/31/2015	Date/Time Pre 5/31/2016 8:4	pared: 4 am
Note 1								Average Hourly	
Part Wolf DATA			Line Number	Reported					
Mart 1 State Part					,			COI . 3)	
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12.00 Contract labor: Top level management and other management and administrative services	11.00			C	0	0	0.00	0.00	11.00
nanagement and administrative	12.00			C	0	0	0.00	0.00	12. 00
Services									
13.00 Contract labor: Physician-Part									
14. 00 Home office salaries & 0 0 0 0 0 0 0 0 0	13. 00	1		C	0	0	0.00	0. 00	13. 00
wage-related costs	14 00					0	0.00	0.00	14 00
15.00 Home office: Physician Part A 0 0 0 0 0.00 0.00 0.00 15.00	14.00			C) 	0	0.00	0.00	14.00
16.00 Home office and Contract	15. 00	Home office: Physician Part A		C	0	0	0. 00	0. 00	15. 00
Physicians Part A - Teaching	14 00					0	0.00	0.00	14 00
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20.00 Non-physician anesthetist Part A D D D D D D D D D	40.00								10.00
21.00 Non-physician anesthetist Part B		1		C	0	0			1
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Administrative Physician Part A - Teaching 0	21. 00	Non-physician anesthetist Part		C	0	0			21. 00
Administrative Physician Part A - Teaching 0	22. 00	Physician Part A -		C	0	0			22. 00
23.00 Physician Part B 0 0 0 0 24.00 24.00 24.00 Wage-related costs (RHC/FQHC) 0 0 0 0 0 24.00 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 25.00 25.00 0 0 0 0 0 0 0 0 0		Admi ni strati ve							
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28. 00 Administrative & General under contract (see inst.)									
29.00 Maintenance & Repairs 6.00 0 0 0 0.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 230,938 753 231,691 0.00 0.00 30.00 31.00 Laundry & Linen Service 8.00 0 0 0 0.00 0.00 0.00 31.00 32.00 Housekeeping 9.00 229,964 0 229,964 0 0.00 0.00 0.00 32.00 33.00 Housekeeping under contract (see instructions) 10.00 205,298 -126,284 79,014 0.00 0.00 33.00 35.00 Di etary under contract (see instructions) 0 0 0 0 0.00 0.00 0.00 0.00 35.00 36.00 Cafeteria 11.00 0 126,284 126,284 0.00 0.00 0.00 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	28. 00			C	0	0	0.00	0. 00	28. 00
30. 00 Operation of Plant 7. 00 230, 938 753 231, 691 0. 00 0. 00 30. 00 31. 00 31. 00 Laundry & Linen Service 8. 00 0 0 0 0 0. 00 0. 00 31. 00 32. 00 Housekeeping 9. 00 229, 964 0 229, 964 0. 00 0. 00 32. 00 33. 00 Housekeeping under contract (see instructions) 10. 00 205, 298 -126, 284 79, 014 0. 00 0. 00 33. 00 0. 00 33. 00 0. 00 0. 00 34. 00 0. 00 0. 00 35. 00 0. 00 0. 00 0. 00 0. 00 35. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 0	29 00		6 00	C		0	0.00	0.00	29 00
32. 00 Housekeeping				230, 938	753	231, 691			
33. 00 Housekeeping under contract (see instructions) 34. 00 Di etary 35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 37. 00 Maintenance of Personnel 38. 00 Nursing Administration 39. 00 Central Services and Supply 30 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				C	0	0		l .	1
(see instructions) 34.00 Di etary Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursing Administration 13.00 297, 568 -185, 526 112, 042 0.00 0.00 33.00 0.00 38.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 39.00 0.00 0			9. 00	229, 964	0	229, 964			
34. 00 Di etary Under contract (see instructions) 36. 00 Cafeteria 37. 00 Maintenance of Personnel 38. 00 Nursi ng Administration 39. 00 Central Services and Supply 31. 00 Di etary under contract (see instructions) 32. 00 Di etary under contract (see instructions) 32. 00 Di etary under contract (see instructions) 34. 00 Di etary under contract (see instructions) 35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 31. 00 Di etary under contract (see instructions) 31. 00 Di etary under contract (see instructions) 32. 00 Di etary under contract (see instructions) 34. 00 Di etary under contract (see instructions) 35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 37. 00 Di etary under contract (see instructions) 38. 00 Di etary under contract (see instructions) 38. 00 Di etary under contract (see instructions) 39. 00 Cafeteria 31. 00 Di etary under contract (see instructions) 31. 00 Di etary under contract (see instructions) 32. 00 Di etary under contract (see instructions) 34. 00 Di etary under contract (see instructions) 36. 00 Di etary under contract (see instructions) 36. 00 Di etary under contract (see instructions) 36. 00 Di etary under contract (see instructions) 37. 00 Di etary under contract (see instructions) 38. 00 Di etary under contract (see instructions) 39. 00 Di etary under contract (see instructions) 30. 00 Di etary under contract (see instructions) 30. 00 Di etary under contract (see instructions) 30. 00 Di etary under contract	33.00			C	,	0	0.00	0.00	33.00
instructions) 36.00 Cafeteria	34.00	Di etary	10. 00	205, 298	-126, 284	79, 014	0. 00	0. 00	34. 00
36. 00 Cafeteria 11. 00 0 126, 284 126, 284 0. 00 0. 00 36. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0. 00 0. 00 37. 00 38. 00 Nursing Administration 13. 00 297, 568 -185, 526 112, 042 0. 00 0. 00 0. 00 38. 00 39. 00 Central Services and Supply 14. 00 75, 696 0 75, 696 0. 00 0. 00 0. 00 0. 00 39. 00	35. 00			C	0	0	0. 00	0.00	35. 00
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 37. 00 38. 00 Nursing Administration 13. 00 297, 568 -185, 526 112, 042 0. 00 0. 00 38. 00 39. 00 Central Services and Supply 14. 00 75, 696 0 75, 696 0 0. 00 0. 00 0. 00 39. 00	36. 00		11. 00	C	126. 284	126. 284	0. 00	0. 00	36. 00
39.00 Central Services and Supply 14.00 75,696 0 75,696 0.00 0.00 39.00	37. 00	1	12. 00	C	0	0	0.00	0.00	37. 00
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Heal th	Financial Systems		DUKES MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI 7	TAL WAGE INDEX INFORMATION			Provi der	CCN: 151318	Peri od:	Worksheet S-3		
						From 01/01/2015			
					[To 12/31/2015			
							5/31/2016 8: 4		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3. 00	4. 00	5. 00	6. 00		
41.00	Medical Records & Medical	16. 00	143, 612	77, 142	220, 75	0.00	0. 00	41. 00	
	Records Li brary								
42.00	Soci al Servi ce	17. 00	0	0		0.00	0. 00	42.00	
43.00	Other General Service	18. 00	0	0		0.00	0. 00	43.00	

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 151318 Peri od: From 01/01/2015 To 12/31/2015 5/31/2016 8:44 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . Salaries in col. 5) (from Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 4.00 5.00 6.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 11, 680, 318 11, 680, 318 0.00 0. 00 1.00 instructions) 2.00 Excluded area salaries (see 200, 027 74, 328 274, 355 0.00 0.00 2.00 instructions)

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-74, 328

-74, 328

-74, 328

C

11, 405, 963

11, 405, 963

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11, 480, 291

11, 480, 291

3, 451, 101

3.00

4.00

5.00

6.00

7.00

Subtotal salaries (line 1

Subtotal other wages & related

Subtotal wage-related costs

Total overhead cost (see

Total (sum of lines 3 thru 5)

minus line 2)

(see inst.)

instructions)

costs (see inst.)

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 151318	
		From 01/01/2015 Part IV

	To 12/31/2015	Date/Time Pre 5/31/2016 8:4	
		Amount	
		Reported	
		1.00	
•	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	-388	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pensi on Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1, 216, 458	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	15, 731	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	8, 333	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	8, 875	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	190, 640	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17. 00		563, 261	17. 00
18.00	Medicare Taxes - Employers Portion Only	131, 730	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	42, 316	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	0	22. 00
23. 00		0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2, 176, 956	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	10, 014	25. 00

Heal th	Financial Systems DUKES MEMORIAL HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI 7	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151318	Peri od:	Worksheet S-10	0
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/31/2016 8:4	
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by Li	ne 202 colum	າ 8)	0. 185391	1.00
1.00	Medicaid (see instructions for each line)	ded by iii	ic 202 cor uiii	1 0)	0. 103371	1.00
2. 00	Net revenue from Medicaid				2, 621, 693	2.00
3. 00	Did you receive DSH or supplemental payments from Medicaid?				Υ Υ	3.00
4. 00	If line 3 is "yes", does line 2 include all DSH or supplemental	pavments	from Medicai	d?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from				2, 541, 263	5.00
6.00	Medi cai d charges				28, 582, 044	6.00
7.00	Medicaid cost (line 1 times line 6)				5, 298, 854	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	ine 7 minu	us sum of li	nes 2 and 5; if	135, 898	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	9. 00
10.00	Stand-alone SCHIP charges				0	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand-alone SCHIP (enter zero)	line 11 mi	inus line 9;	if < zero then	0	12. 00
	Other state or local government indigent care program (see instr	uctions fo	or each line)		
13.00	Net revenue from state or local indigent care program (Not inclu	ded on li	nes 2, 5 or	9)	222, 859	13. 00
14. 00	Charges for patients covered under state or local indigent care 10)	program (I	Not included	in lines 6 or	1, 008, 275	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14)				186, 925	15. 00
16. 00	Difference between net revenue and costs for state or local indi 13; if < zero then enter zero)	gent care	program (li	ne 15 minus line	0	16. 00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fun	di ng chari	tv care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of ho				0	18. 00
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and local			ms (sum of lines	135, 898	19. 00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	-		1. 00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (charges excluding non-reimbursable cost centers) for the entire		29, 6	75 846	30, 521	20. 00
21. 00	Cost of initial obligation of patients approved for charity care		5, 5	01 157	5, 658	21. 00
22. 00	times line 20) Partial payment by patients approved for charity care			0 44	44	22. 00
	Cost of charity care (line 21 minus line 22)		5. 5	-		23. 00
23.00	cost of charty care (fine 21 millus fine 22)		3, 3	01 113	3, 014	23.00
24.00	Deep the amount in line 20 celumn 2 include charges for notices	daya baya	ad a langth	of atou limit	1. 00	24.00
24. 00	Does the amount in line 20 column 2 include charges for patient imposed on patients covered by Medicaid or other indigent care p		iu a rength i	or Stay ITMIT		24. 00
25. 00	If line 24 is "yes," charges for patient days beyond an indigen		ogram's Leng	th of stav limit	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see inst		5		5, 213, 986	
27. 00	Medicare bad debts for the entire hospital complex (see instruct	,			877, 196	ı
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (lin	e 26 minus	s line 27)		4, 336, 790	1
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (line	1 times line	e 28)	804, 002	29. 00
30. 00	Cost of uncompensated care (line 23 column 3 plus line 29)				809, 616	
21 00	Total unreimbursed and uncompensated care cost (line 19 plus lin	e 30)			945, 514	I 31. 00

Heal th	n Financial Systems	DUKES MEMORIAL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANC	E OF EXPENSES	Provi der	CCN: 151318 P	eri od:	Worksheet A	
				T		Date/Time Prep 5/31/2016 8:44	
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				,	, , (, , , , , , , , , , , , , , , , ,	(col. 3 +-	
		1.00				col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		722, 471	722, 471	402, 991	1, 125, 462	1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		1, 636, 705		339, 279	1, 975, 984	2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	95, 212	40, 465		1, 616, 116	1, 751, 793	4. 00
5.01	00570 ADMITTING	o	0	0	1, 594, 036	1, 594, 036	5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL	1, 763, 655	6, 515, 012	8, 278, 667	-3, 735, 862	4, 542, 805	5. 02
7.00	00700 OPERATION OF PLANT	230, 938	1, 265, 499		5, 386	1, 501, 823	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	91, 728		0	91, 728	8. 00
9.00	00900 HOUSEKEEPI NG	229, 964	65, 076		l .	295, 040	9. 00
10.00	01000 DI ETARY 01100 CAFETERI A	205, 298	169, 440 0	374, 738 0		130, 355	10. 00 11. 00
11. 00 13. 00	01300 NURSING ADMINISTRATION	297, 568	35, 516		243, 328 -219, 270	243, 328 113, 814	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	75, 696	329, 087	404, 783		185, 022	14. 00
15. 00	01500 PHARMACY	409, 158	949, 636	· ·	-772, 388	586, 406	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	143, 612	139, 592			362, 751	16. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS				, , , , , ,		
30.00	03000 ADULTS & PEDIATRICS	1, 421, 277	727, 845	2, 149, 122	-145, 140	2, 003, 982	30. 00
31.00	03100 INTENSIVE CARE UNIT	320, 843	38, 470		-1, 206	358, 107	31. 00
43.00	04300 NURSERY	0	0	0	132, 655	132, 655	43.00
	ANCILLARY SERVICE COST CENTERS	440.045	1 105 010		507 70/	4 000 040	
50.00	05000 OPERATING ROOM	460, 915	1, 435, 249		-507, 796	1, 388, 368	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	285, 701	39, 543 0		-1, 120 0	324, 124 0	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	537, 439	193, 426		-	1, 277, 173	
54. 00	05401 ULTRASOUND	79, 852	12, 440		-92, 292	1, 277, 173	54. 00
56. 00		81, 365	100, 595			0	56. 00
57. 00	05700 CT SCAN	61, 457	131, 993			0	57. 00
58.00	05800 MRI	46, 703	94, 336			0	58. 00
60.00	06000 LABORATORY	633, 708	761, 492	1, 395, 200	-49, 804	1, 345, 396	60.00
65.00	06500 RESPI RATORY THERAPY	311, 339	55, 566	366, 905	-2, 083	364, 822	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 099	493, 134			493, 789	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	175, 587		0	175, 587	67. 00
68. 00		250.740	14, 826			14, 826	
69. 00 71. 00		259, 749	33, 700		-1, 055	292, 394	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	202, 856 464, 848	202, 856 464, 848	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	708, 928	708, 928	73. 00
76. 00	03610 SLEEP LAB	75, 586	16, 191	91, 777	-1, 268	90, 509	76. 00
	OUTPATIENT SERVICE COST CENTERS	15/555			., ====		
90.00	09000 CLI NI C	248, 928	55, 782	304, 710	-3, 283	301, 427	90. 00
91.00	09100 EMERGENCY	3, 202, 229	891, 878	4, 094, 107	-3, 454	4, 090, 653	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	199, 273	147, 710	346, 983	-3, 958	343, 025	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	11, 679, 564	17, 379, 990	20 050 554	-185, 738	20 072 014	110 00
118.00	NONREI MBURSABLE COST CENTERS	11, 079, 304	17, 379, 990	29, 059, 554	- 185, 738	28, 873, 816	118.00
190 00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	n	190. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	754	17, 259		_		192. 00
	007950 OTHER NRCC	0	0	0	0		194. 00
	1 07951 MARKETI NG	0	0	0	203, 751	203, 751	194. 01
	2 07952 SENIOR CIRCLE	0	-964	-964	o	-964	194. 02
	3 07953 FREE MEALS	0	0	0	0		194. 03
200.00	O TOTAL (SUM OF LINES 118-199)	11, 680, 318	17, 396, 285	29, 076, 603	0	29, 076, 603	200. 00

Provi der CCN: 151318

Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/31/2016 8: 44 am

SIMPLES SERVICE ORST CONTESS SAMPLE PROPERS					10 12/31/2013	5/31/2016 8: 4	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLUG & FIXT 256, 038 1,381,500 1.00 00100 CAP REL COSTS-BLUG & FIXT 256, 038 1,381,500 1.00 00400 ENRICOYFE BENEFITS DEPARTMENT -1,573 1,750,220 4.00 00400 ENRICOYFE BENEFITS DEPARTMENT -1,573 1,750,220 4.00 00400 ENRICOYFE BENEFITS DEPARTMENT -1,573 1,750,220 4.00 0.00 00500 ENRICOYFE BENEFITS DEPARTMENT -1,573 1,750,220 4.00 7.00 0.00 00500 DEPARTMENT -13,414 4.888,409 7.00 0.00 00500 DEPARTMENT -31,414 4.888,409 7.00 0.00 00500 DEPARTMENT -31,414 4.888,409 7.00 0.00 00500 DEPARTMENT -31,414 4.888,409 7.00 0.00 00500 DEPARTMENT -3,414 4.888,409 7.00 0.00 0.00 DEPARTMENT -3,414 -4,33,547 8.00 0.00 0.00 DEPARTMENT -3,414 -4,33,547 8.00 0.00 0.00 DEPARTMENT -3,414 -4,33,547 1.00 0.00 0.00 DEPARTMENT -3,414 -4,33,547 1.00 0.00 0.00 DEPARTMENT -3,414 -4,34,648 -3,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4,40 -4		Cost Center Description	Adjustments	Net Expenses			
ENRERAL SERVICE COST CENTERS			(See A-8)	For Allocation			
1.00			6. 00	7. 00			
2.00 002000 CAP PECL COSTS-IMBLE COUIP 331, 406 1,644, 578 2,00 4.00 00400 EMPLYVEE BERKEP ITS DEPARTMENT -1,573 1,750,220 4.00 00570 ADMI ITT INS 399,377 1,504,659 5.01 5.01 00570 ADMI ITT INS 7.00 6.00 00500 ADMI ISTRATI VE AND GENERAL -505,062 4,037,723 5.02 00590 ADMI ISTRATI VE AND GENERAL -13,414 1,488,409 7.00 00700 OPERATI TO 0 FILANT -13,414 1,488,409 7.00 00900 HOUSEKEFFING 0.00 00500 HOUSEKEFFING 0.00 00500 DI ELARAY 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0			,				
4.00							
5.01 00570 ARM ITTING							
5.0 0.00590 ADMINISTRATIVE AND GENERAL -505, 082 4, 037, 723 5.0 0.00500 DEPATION OF PLAIT -134, 414 1, 488, 409 7.00 0.00500 LAUNDRY & LINEN SERVICE -53, 181 38, 547 8.0 0.00 0.00500 LAUNDRY & LINEN SERVICE -53, 181 38, 547 8.0 0.00 0.00500 LOUSEKEEPING 0.00 2.55, 040 9.00 0.00500 LOUSEKEEPING 0.00 2.55, 040 9.00 0.00500 LOUSEKEEPING 0.00 130, 355 11.00 0.00 1.00 0.00500 LOUETARY 0.00 130, 355 11.00 0.00 0.00500 CAFETERI & -63, 639 179, 689 111.00 13.00 0.1300 NURSING ADMINISTRATION -60 113, 754 13.00 0.00 0.00500 LOUETAR SERVICES & SUPPLY 0.00 185, 022 144, 00.00 1.00 0.00500 LOUETAR SERVICES & SUPPLY 0.00 180, 022 144, 00.00 1.00 0.00500 LOUETAR SERVICE COST CENTERS -141, 177 348, 574 15.00 0.00 0.00500 LOUETAR SERVICE COST CENTERS -141, 177 348, 574 16.00 0.00 0.00500 ADMINISTRATION 0.00 0.00 0.00500 ADMINISTRATION 0.00500 0.00500 ADMINISTRATION 0.005000 0.00500 ADMINISTRATION 0.0050000 0.00500 ADMINISTRATION 0.00500000 0.00500 ADMINISTRATION 0.00500000 0.00500 ADMINISTRATION 0.00							
7. 00 00700 0PERTION OF PLANT							1
8. 00 00800 LAUNRY & LINEN SERVICE							
9, 00 000900 1005EKEEPI NG							
10.00 01000 01EARY 0			-53, 181				1
11.00 01100 CAFERRIA			1				
13. 00 01300 AURSIN & ADMINI STRATION -60 113, 754 113, 00 114, 00 10400 CENTRAL SERVICES & SUPPLY 0 586, 406 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15.			1				1
14. 00	11. 00 01	I 100 CAFETERI A	-63, 639	179, 689			11. 00
15. 00			-60	113, 754			
16. 00 01600 MEDICAL RECORDS & LIBRARY -14, 177 348, 574 16. 00	14. 00 01	1400 CENTRAL SERVICES & SUPPLY	0	185, 022			
INPATI ENT ROUTI NE SERVICE COST CENTERS 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 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 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 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 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 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 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 3	15. 00 01	1500 PHARMACY	0	586, 406			15. 00
30.00 03000 ADULTS & PEDIATRICS -417, 889 1,586, 093 31,00 043.00 043.00 043.00 NURSERY 0 388,107 31,00 043.00 NURSERY 0 388,107 31,00 043.00 NURSERY 0 388,107 31,00 043.00 NURSERY 0 043.00 NURSERY 0 324,124 51,00 051.00 05100 RECOVERY ROOM 0 0 0 0 0 052.00 05200 DELIVERY ROOM LABOR ROOM 0 0 0 0 0 0 0 0 0	16. 00 01	1600 MEDICAL RECORDS & LIBRARY	-14, 177	348, 574			16. 00
31.00 03100 INTERSIVE CARE UNIT 0 358, 107							
43. 00 04300 NURSERY			-417, 889	1, 586, 093			30.00
ANCILLARY SERVICE COST CENTERS 50.00	31.00 03	3100 INTENSIVE CARE UNIT		358, 107			31. 00
50.00 05000 05000 05000 05000 05000 05000 0500 0500 0500 0500 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 050000 05000 050000 05000 05000 05000 05000 05000 05000 05000 050000 05000			0	132, 655			43. 00
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 324, 124 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 05400 RADIO LOGY-DIAGNOSTI C 0 1, 277, 173 54.00 05400 RADIO LOGY-DIAGNOSTI C 0 1, 277, 173 54.01 05401 ULTRASOUND 0 0 0 554.01 05401 ULTRASOUND 0 0 0 0 0 0 0 0 0							
52.00 05200 DEL I VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0							
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 1, 277, 173 54. 00 54. 01 05401 ULTRASOUND 0 0 0 0 55. 00 05600 RADI OLSOTOPE 0 0 0 0 0 0 0 0 0			1	324, 124			
54. 01 05401 ULTRASQUND 0 0 0 0 55. 00				0			
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1, 277, 173			
57, 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0			0	0			
58. 00			0	0			
60. 00 06000 LABORATORY 0 1, 345, 396 66. 00 06500 RESPI RATORY THERAPY 0 364, 822 65. 00 06500 RESPI RATORY THERAPY 0 493, 789 66. 00 06600 PHYSI CAL THERAPY 0 493, 789 66. 00 06700 0CCUPATI ONAL THERAPY 0 175, 587 67. 00 06800 SPECH PATHOLOGY 0 14, 826 68. 00 06800 SPECH PATHOLOGY -3, 078 289, 316 69, 00 06900 ELECTROCARDI OLOGY -3, 078 289, 316 69, 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 202, 856 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 464, 848 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 708, 228 73. 00 07300 PRUSC CHARGED TO PATIENTS 0 708, 228 73. 00 076, 00 0000 CLI N C 0 0000 CLI N C 0 0000 CLI N C 0 0000 0000 CLI N C 0 0000 0000 CLI N C 0 0 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 0000 00			0	0			
65. 00 06500 RESPIRATORY THERAPY 0 364, 822 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 493, 789 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 175, 587 67. 00 68. 00 06800 SPECH PATHOLOGY 0 14, 826 68. 00 69. 00 06900 ELECTROCARDI OLOGY -3, 078 289, 316 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 202, 856 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 464, 848 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 464, 848 72. 00 76. 00 03610 SLEEP LAB -5, 700 84, 809 76. 00 001TPATI ENT SERVICE COST CENTERS 0 4, 090, 653 97. 00 92. 00 09000 CLI NI C 0 301, 427 99. 00 92. 00 09100 BMERGENCY 0 4, 090, 653 99. 00 92. 00 09200 DRISSERVATI ON BEDS (NON-DI STI NCT PART 99. 00 95. 00 09500 AMBULANCE SERVI CES 0 343, 025 95. 00 97. 00 09500 AMBULANCE SERVI CES 0 343, 025 95. 00 98. 00 09500 AMBULANCE SERVI CES 0 343, 025 95. 00 99. 00 09500 AMBULANCE SERVI CES 0 343, 025 95. 00 99. 00 09500 OFFICE SHOP & CANTEEN 99. 00 99. 00 09500 OFFICE SHOP & CANTEEN 99. 00 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFICE SHOP & CANTEEN 0 0 99. 00 09500 OFFIC				0			
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73. 00							1
76. 00 03610 SLEEP LAB -5,700 84,809 76. 00	72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	464, 848			72. 00
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 301, 427 90. 00 91. 00 09100 EMERGENCY 0 4, 090, 653 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 OTHER MBURSABLE COST CENTERS 95. 00 OTHER MBURSABLE COST CENTERS 95. 00 OTHER MBURSABLE COST CENTERS OTHER MS	73. 00 07	7300 DRUGS CHARGED TO PATIENTS	0	708, 928			73. 00
90. 00 09000 CLI NI C 0 301, 427 90. 00 91. 00 991.00 69200 09SERVATI ON BEDS (NON-DI STI NCT PART 92. 00 09500 AMBULANCE SERVI CES 0 343, 025 95. 00 09500 AMBULANCE SERVI CES 5PECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1-117) -1, 695, 800 27, 178, 016 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 194. 00 194. 00 197950 MARKETI NG 0 203, 751 194. 00 194. 00 194. 03 07953 FREE MEALS 0 0 0 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194			-5, 700	84, 809			76. 00
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92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS OSDO AMBULANCE SERVI CES OSDO AMBULANCE SERVI CES OSDO OSDO AMBULANCE SERVI CES OSDO							
OTHER REI MBURSABLE COST CENTERS 95. 00 95.00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 192. 00 192. 00 192. 00 194. 00 195. 00 196. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 00 197. 0			0	4, 090, 653			
95. 00 09500 AMBULANCE SERVI CES 0 343, 025 95. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1-117) -1, 695, 800 27, 178, 016 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 192. 00 192. 00 192. 00 192. 00 192. 00 194. 01 07950 OTHER NRCC 0 0 0 194. 02 194. 02 07952 SENI OR CI RCLE 3, 464 2, 500 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03							92. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) -1,695,800 27,178,016 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 192.00 19200 19200 19200 19200 19200 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300 19300							
118. 00 SUBTOTALS (SUM OF LINES 1-117) -1, 695, 800 27, 178, 016 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 00 194. 00 07950 OTHER NRCC 0 0 0 194. 01 07951 MARKETI NG 0 203, 751 194. 01 194. 02 07952 SENI OR CI RCLE 3, 464 2, 500 194. 03 07953 FREE MEALS 0 0 0 194. 03			0	343, 025			95. 00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 00 194. 00 07950 OTHER NRCC 0 0 0 194. 00 194. 00 194. 01 07951 MARKETI NG 0 203, 751 194. 01 194. 02 07952 SENI OR CI RCLE 3, 464 2, 500 194. 02 194. 03 07953 FREE MEALS 0 0 0 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194. 03 194.							ļ
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 192. 00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 1			-1, 695, 800	27, 178, 016			1118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES				=1			100 00
194. 00 07950 OTHER NRCC			-	-1			
194. 01 07951 MARKETI NG 0 203, 751 194. 01 194. 02 07952 SENI OR CI RCLE 3, 464 2, 500 194. 03 07953 FREE MEALS 0 0 0 194. 03							
194. 02 07952 SENI OR CI RCLE 3, 464 2, 500 194. 03 07953 FREE MEALS 0 0 194. 03			1	9			
194. 03 07953 FREE MEALS 0 0 194. 03			١				
			1				1
200. 00 TOTAL (SUM OF LINES 118-199) -1, 692, 336 27, 384, 267			1	9			
	200.00	TUTAL (SUM OF LINES TI8-199)	- 1, 692, 336	27, 384, 267			J200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 151318

					To 12/31/2018	5/31/2016 8:44 am
	Cost Center	Increases Li ne #	Sal ary	Other		
	2. 00	3.00	4. 00	5. 00		
	A - EMPLOYEE BENEFITS	0.00		0.00		
0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 617, 236		1.
	TOTALS B - RECLASS OXYGEN COSTS		0	1, 617, 236		
0	MEDICAL SUPPLIES CHARGED TO	71. 00	O	32, 606		1.
	PATI ENT	,		02, 000		
	TOTALS		0	32, 606		
	C - RECLASS RENT AND LEASES	2 00	ما	211 0/5		
0 0	CAP REL COSTS-MVBLE EQUIP PHYSICIANS' PRIVATE OFFICES	2. 00 192. 00	0	311, 965 370		1.
0	FITTSTCTANS FREVATE OFFICES	0.00	o	0		3.
0		0.00	o	0		4.
0		0.00	0	0		5.
0		0. 00	0	0		6.
0		0.00	0	0		7.
0		0. 00 0. 00	0	0		8. 9.
00		0.00	0	0		10.
00		0.00	o	Ö		11.
00		0.00	o	0		12.
00		0.00	0	0		13.
00		0.00	0	0		14.
00		0. 00 0. 00	0	0		15. 16.
00		0.00	0	0		17.
00		0.00	o	Ö		18.
00		0.00	О	0		19.
00		0.00	0	0		20.
00		0.00	0	0		21.
00	TOTAL C — — — —		0	0		22.
	TOTALS D - RECLASS OTHER CAPITAL COST	rs I	U _I	312, 335		
0	CAP REL COSTS-BLDG & FIXT	1.00	0	74, 406		1.
0	CAP REL COSTS-BLDG & FIXT	1.00	0	328, 585		2.
0	CAP REL COSTS-MVBLE EQUIP		0	27, 314		3.
	TOTALS E - RECLASS MARKETING DEPT		0	430, 305		
0	MARKETING DEPT	194. 01	75, 081	128, 670		1.
•	TOTALS	— — 171. 01	75, 081	128, 670		''
	F - RECLASS CNO COSTS					
0	NURSING ADMINISTRATION	1300	11 <u>0, 4</u> 45	<u>0</u>		1.
	TOTALS		110, 445	0		
0	G - RECLASS MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	170, 250		1.
J	PATI ENT	71.00	٥	170, 230		'
C	IMPL. DEV. CHARGED TO	72.00	О	464, 848		2.
	PATI ENTS					
	TOTALS	COLUET ONC	0	635, 098		
0	H - RECLASS COST OF DRUGS/IV S DRUGS CHARGED TO PATIENTS	73. 00	ol	708, 928		1.
)	DROGS CHARGED TO PATTENTS	0.00	o	0		2.
	TOTALS			708, 928		
	I - RECLASS LABOR AND DELIVERY	/				
)	NURSERY	4300	112, 023	20, 632		1.
	TOTALS		112, 023	20, 632		
0	J - RECLASS NURSING ADMIN COST ADMINISTRATIVE AND GENERAL	5. 02	218, 829	24, 143		1.
	MEDI CAL RECORDS & LI BRARY	16. 00	77, 142	6, 884		2.
	TOTALS		295, 971	31, 027		
	K - RECLASS MISC DEPARTMENTS					
)	ADMITTING		465, 864	1, 128, 172		1.
	TOTALS		465, 864	1, 128, 172		
)	L - RECLASS OTHER RADIOLOGY RADIOLOGY-DIAGNOSTIC	54.00	269, 377	338, 906		1.
)	INDI OLOGI -DI AGNUSTI C	0.00	269, 377	338, 906		2.
)		0.00	ol	0		3.
)		0.00	0	0		4.
	TOTALS		269, 377	338, 906		
	M - RECLASS DIETARY COSTS TO C	CAFETERI A 11. 00	126, 284	44		
0				117, 044		1.

Heal th	Financial Systems		DUKES MEMORI	AL HOSF	PI TAL		In Lie	u of Form CMS-	-2552-10
RECLASS	SIFICATIONS			F	rovi der	CCN: 151318	Peri od: From 01/01/2015	Worksheet A-	6
							To 12/31/2015	Date/Time Pro 5/31/2016 8:4	epared: 44 am
		Increases							
	Cost Center	Li ne #	Sal ary	Oth	ner				
	2. 00	3. 00	4. 00	5.	00				
	N - RECLASS PHYSICIAN PRACTIC	ES COSTS							
1.00	OPERATION OF PLANT	7. 00	753		17, 630				1. 00
	TOTALS		753		17, 630				
500.00	Grand Total: Increases		1, 455, 798	5,	518, 589				500.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-0 From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/31/2016 8:44 am Provider CCN: 151318

							5/31/2016 8:44 am
		Decreases				1	
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.	_	
	6.00 A - EMPLOYEE BENEFITS	7. 00	8. 00	9. 00	10. 00		
. 00	ADMINISTRATIVE AND GENERAL	5. 02	٥	1, 617, 236	C		1. 0
. 00	TOTALS			1, 617, 236		7	1.0
	B - RECLASS OXYGEN COSTS		<u> </u>	1,017,230			
. 00	CENTRAL SERVICES & SUPPLY	14.00	0	32, 606	(1.0
	TOTALS			32, 606			
	C - RECLASS RENT AND LEASES						
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 120	10		1.0
. 00	ADMINISTRATIVE AND GENERAL	5. 02	0	23, 061			2. 00
. 00	OPERATION OF PLANT	7. 00	0	12, 997			3.0
. 00	DIETARY	10.00	0	1, 055			4.0
. 00	NURSI NG ADMI NI STRATI ON	13.00	0	2, 717		1	5. 0
. 00 . 00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00	O O	1, 282		-	6.0
. 00	MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	63, 460 4, 479		1	7. 0 8. 0
. 00	ADULTS & PEDIATRICS	30.00	0	12, 485		-	9. 0
0. 00	INTENSIVE CARE UNIT	31.00	0	1, 206			10. 0
1. 00	OPERATING ROOM	50.00	Ö	58, 571			11.0
2. 00	RECOVERY ROOM	51. 00	o	1, 120	d		12. 0
3. 00	RADI OLOGY-DI AGNOSTI C	54.00	О	61, 975	C		13. 0
4. 00	MRI	58. 00	0	458	C		14. 0
5. 00	LABORATORY	60.00	0	49, 804	C		15. 00
6. 00	RESPIRATORY THERAPY	65. 00	0	2, 083	C		16. 0
7. 00	PHYSI CAL THERAPY	66. 00	0	1, 444			17. 0
8. 00	ELECTROCARDI OLOGY	69. 00	0	1, 055			18.0
9. 00	SLEEP LAB	76. 00	0	1, 268			19. 0
0.00	CLINIC	90.00	0	3, 283		- 1	20. 0
1.00	EMERGENCY	91.00	0	3, 454			21. 0
2. 00	AMBULANCE SERVICES TOTALS	95.00		<u>3, 9</u> 58 312, 335		4	22. 0
	D - RECLASS OTHER CAPITAL COST	TS	U _I	312, 333			
. 00	ADMINISTRATIVE AND GENERAL	5. 02	0	430, 305	12		1. 0
. 00	AND SENERAL	0.00	Ö	0			2. 00
. 00		0.00	o	0	12		3.00
	TOTALS		0	430, 305		1	
	E - RECLASS MARKETING DEPT		•				
. 00	ADMI NI STRATI VE AND GENERAL	5.02	75, 081	12 <u>8, 6</u> 70		D	1. 00
	TOTALS		75, 081	128, 670			
	F - RECLASS CNO COSTS				т	.T	
. 00	ADMI NI STRATI VE AND GENERAL		110, 445	$ \frac{0}{0}$	<u></u>	의 의	1.00
	TOTALS G - RECLASS MEDICAL SUPPLIES		110, 445	0			
. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	185, 873			1. 00
. 00	OPERATING ROOM	50.00	0	449, 225			2. 00
. 00	TOTALS	= = = = = = = = = = = = = = = = = =	- — — ŏ	635, 098		1	2. 0
	H - RECLASS COST OF DRUGS/IV	SOLUTI ONS		220, 212			
. 00		0.00	0	0	C		1.0
. 00	PHARMACY	15. 00	0	708, 928		D	2. 00
	TOTALS		0	708, 928			
	I - RECLASS LABOR AND DELIVERY						
. 00	ADULTS & PEDIATRICS	3000	112, 023	20, 632		<u> </u>	1.0
	TOTALS		112, 023	20, 632			
00	J - RECLASS NURSING ADMIN COS		205 074	24 027		J	1.00
. 00	NURSING ADMINISTRATION	13.00	295, 971	31, 027		1	1.00
. 00	TOTALS — — — —		00 295, 971	31, 027	<u></u>	2	2. 0
	K - RECLASS MISC DEPARTMENTS		273, 771	31,027			
. 00	ADMINISTRATIVE AND GENERAL	5. 02	465, 864	1, 128, 172	C		1. 0
	TOTALS		465, 864	1, 128, 172			''-
	L - RECLASS OTHER RADIOLOGY				<u>'</u>		
. 00	ULTRASOUND	54. 01	79, 852	12, 440	C		1. 0
. 00	RADI OI SOTOPE	56. 00	81, 365	100, 595	(2. 0
. 00	CT SCAN	57. 00	61, 457	131, 993			3. 0
. 00	MRI	<u>58.</u> 00	46, 703	93, 878		<u> </u>	4. 0
	TOTALS		269, 377	338, 906			
0.0	M - RECLASS DIETARY COSTS TO (401 00:1	447.0::			
(1()	DI ETARY		126, 284	117, 044		4	1.0
. 00	TOTALS	EC COCTC	126, 284	117, 044			
. 00	N DECLACE DUVELCUAN DRACTION						
	N - RECLASS PHYSICIAN PRACTICI		75.0	17 / 20	_	1	1 0
. 00	N - RECLASS PHYSICIAN PRACTICI PHYSICIANS' PRIVATE OFFICES TOTALS	192.00		1 <u>7, 630</u>			1.00

2.00 Land Improvements 938,654 0 0 0 0 3.00 Buildings and Fixtures 30,242,257 493,711 0 493,711 0	^ed:
Beginning Purchases Donation Total Disposals and Retirements	am
Balances Retirements 1.00 2.00 3.00 4.00 5.00	
1.00 2.00 3.00 4.00 5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land Land	
1.00 Land 193,225 0 0 0 0 2.00 Land Improvements 938,654 0 0 0 0 3.00 Buildings and Fixtures 30,242,257 493,711 0 493,711 0	
2.00 Land Improvements 938,654 0 0 0 0 3.00 Buildings and Fixtures 30,242,257 493,711 0 493,711 0	
3.00 Buildings and Fixtures 30, 242, 257 493, 711 0 493, 711 0	1. 00
	2. 00
4.00 Building Improvements 16,095,396 667,389 0 667,389 21,362	3. 00
	4. 00
	5. 00
6.00 Movable Equipment 0 0 0 0	6. 00
7.00 HIT designated Assets 2,294,361 147,609 0 147,609 0	7. 00
8.00 Subtotal (sum of lines 1-7) 49,763,893 1,308,709 0 1,308,709 21,362	8. 00
9.00 Reconciling I tems 0 0 0 0	9. 00
10.00 Total (line 8 minus line 9) 49,763,893 1,308,709 0 1,308,709 21,362 1	0. 00
Ending Balance Fully	
Depreciated	
Assets	
6.00 7.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	
1. 00 Land 193, 225 0	1. 00
2.00 Land Improvements 938,654 0	2.00
3.00 Buildings and Fixtures 30,735,968 0	3. 00
4.00 Building Improvements 16,741,423 0	4.00
5.00 Fixed Equipment 0 0	5. 00
6.00 Movable Equipment 0 0	6. 00
	7. 00
8.00 Subtotal (sum of lines 1-7) 51,051,240 0	8. 00
	9. 00
	0. 00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151318	Peri od: From 01/01/2015	Worksheet A-7	
					To 12/31/2015		pared:
						5/31/2016 8: 4	4 am
			Sl	JMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
						instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0)	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0)	0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	0 1 0 1 5 11	011	T 1 1 (4) (
	Cost Center Description		Total (1) (sum	1			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00				
		14.00	15.00	L			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK						
1. 00	CAP REL COSTS-BLDG & FLXT	722, 471	l	1			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 636, 705	1, 636, 705				2. 00
3.00	Total (sum of lines 1-2)	2, 359, 176	2, 359, 176	,			3. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		anad.
				To 12/31/2015	5/31/2016 8: 44	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C			0.00	11.00	0.00	
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0 1.000000		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000		2.00
3.00 Total (sum of lines 1-2)	0	0		0 1.000000		3. 00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	6.00	d Costs 7.00	through 7) 8.00	9, 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	9.00	10.00	
1. 00 CAP REL COSTS-BLDG & FLXT	0	0		0 261, 526	-14, 985	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	o		0 -380, 129		2.00
3.00 Total (sum of lines 1-2)	0	0		0 -118, 603	336, 400	3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Relate		
				d Costs (see	through 14)	
	11. 00	12.00	13. 00	instructions)	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	15.00	
1. 00 CAP REL COSTS-BLDG & FLXT	7, 316	74, 406	328, 58	5 724, 652	1, 381, 500	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	1, 069			0 1, 644, 939		2. 00
3.00 Total (sum of lines 1-2)	8, 385	101, 720	328, 58	5 2, 369, 591	3, 026, 078	3.00

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151318
 Period: From 01/01/2015
 Worksheet A-8

 From 01/01/2015
 To 12/31/2015
 Date/Time Prepared

				T	rom 01/01/2015 o 12/31/2015	Date/Time Prep	
				Expense Classification on		5/31/2016 8: 44	4 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL CUSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)		0		0.00		
6. 00	Rental of provider space by suppliers (chapter 8)		Ü		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter	А	-30, 839	ADMINISTRATIVE AND GENERAL	5. 02	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce		0		0. 00	0	8. 00
	(chapter 21)		0			J	
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-914, 765		0. 00	0	9. 00 10. 00
	adj ustment	7. 0 2			0.00		
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-204, 484			0	12. 00
13. 00	Laundry and linen service		0		0. 00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-63, 639 0	CAFETERI A	11. 00 0. 00	0	
	and others		0				
16. 00	Sale of medical and surgical supplies to other than		Ü		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
	patients		14 177	MEDICAL DECODDS & LIDDADY			
18. 00	Sale of medical records and abstracts	В	-14, 1//	MEDICAL RECORDS & LIBRARY	16. 00	0	
19. 00	Nursing school (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00	Vending machines	В	-2, 091	ADMINISTRATIVE AND GENERAL	5. 02	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		O		0.00	J	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT	A	261, 526	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	Depreciation - CAP REL	A	6, 315	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	4.0.2	0	OCCUPATIONAL THERADY	0.00	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for	A	_277 <i>1</i> 72	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32. 00
	Depreciation and Interest						
33. 00 35. 00	RENTAL I NCOME TRAINING REVENUE	B B		CAP REL COSTS-BLDG & FIXT NURSING ADMINISTRATION	1. 00 13. 00		33. 00 35. 00
	1	- 1				٩	

				T	o 12/31/2015	Date/Time Pre 5/31/2016 8:4	
				Expense Classification on	Worksheet A	37 3 17 20 10 0. 4	T GIII
				To/From Which the Amount is			
				To, i i om min on the famount i o	to bo haj dotod		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
36. 00	FI TNESS REVENUE	В	-440	ADMINISTRATIVE AND GENERAL	5. 02	0	36. 00
37.00	OTHER MISC REVENUE - HOSPITAL	В	-14, 354	ADMINISTRATIVE AND GENERAL	5. 02	0	37. 00
38.00	PATIENT PHONES BENEFITS COST	A	-1, 573	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38. 00
40.00	PATIENT PHONES DEPRECIATION	A	-6, 205	CAP REL COSTS-MVBLE EQUIP	2. 00	9	40. 00
	COST						
41.00	PATIENT TV SERVICE COST	A	-15, 796	OPERATION OF PLANT	7. 00	0	41. 00
42.00	PATIENT TV DEPRECIATION	A	-2, 767	CAP REL COSTS-MVBLE EQUIP	2. 00	9	42. 00
43.00	MARKETING EXPENSE	A	-197, 927	ADMINISTRATIVE AND GENERAL	5. 02	9	43.00
44.00	PENALTI ES	A	-37	ADMINISTRATIVE AND GENERAL	5. 02	0	44. 00
44. 01	LOBBYING EXPENSE IN	A	-2, 320	ADMINISTRATIVE AND GENERAL	5. 02	9	44. 01
	ASSOCIATION DUES						
45.00	CHARI TABLE CONTRI BUTI ONS	A	· ·	ADMINISTRATIVE AND GENERAL	5. 02	l	45. 00
45. 01	PHYSICIAN RECRUITING	A	· ·	ADMINISTRATIVE AND GENERAL	5. 02	l e	45. 01
45. 02	POB UTILITIES	A	· ·	OPERATION OF PLANT	7. 00		45. 02
45. 03	POB PROPERTY TAX	A	-	CAP REL COSTS-BLDG & FIXT	1.00	14	45. 03
45.04	OTHER NON-ALLOWABLE COST	A	-1, 520	ADMINISTRATIVE AND GENERAL	5. 02	0	45. 04
45. 05	LEGAL FEES	A	-14, 269	ADMINISTRATIVE AND GENERAL	5. 02	0	45. 05
45.06	ELIMINATE NEGATIVE COST CENTER	A	3, 464	SENIOR CIRCLE	194. 02	0	45. 06
45. 07	MEALS AND ENTERTAINMENT	A	' '	ADMINISTRATIVE AND GENERAL	5. 02	0	
50.00	TOTAL (sum of lines 1 thru 49)		-1, 692, 336				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.

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

B. Amount Received - if cost cannot be determined.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 151318

OFFICE COSTS

Period: Worksheet A-8-1 From 01/01/2015 To 12/31/2015 Date/Time Prepa

				To 12/31/2015	Date/Time Pre 5/31/2016 8:4	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			'	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			PASI Capital Costs - Bldg &	7, 316	0	1.00
2.00		CAP REL COSTS-MVBLE EQUIP	PASI Capital Costs - Moveabl	1, 069		2.00
3.00		ADMITTI NG	PASI Operating Costs	114, 510	0	3.00
3. 01	1.00	CAP REL COSTS-BLDG & FIXT	Pre-Acq Legacy Capital Costs	1, 394	0	3. 01
3.02		CAP REL COSTS-MVBLE EQUIP	Pre-Acq Legacy Capital Costs	8, 234	0	3. 02
3.03	5. 02	ADMINISTRATIVE AND GENERAL	Pre-Acq Period Non-Capital A	85, 549	0	3. 03
3.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING AND F	5, 911	0	3. 04
4.00	2. 00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	39, 420	0	4.00
4.01	5. 02	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	566, 116	0	4. 01
4.02	5. 02	ADMINISTRATIVE AND GENERAL	MALPRACTICE ALLOCATIONS (PER	124, 859	151, 108	4. 02
4.03	5. 02	ADMINISTRATIVE AND GENERAL	CIG LEASED EQUIPMENT (PER EX	9, 537	14, 258	4.03
4. 05	8. 00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICES (F	107, 289	160, 470	4. 05
4.06	5. 02	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	277, 218	4.06
4.07	5. 02	ADMINISTRATIVE AND GENERAL	401K FEES	0	1, 349	4.07
4. 08	5. 02	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	19, 027	4. 08
4. 09	5. 02	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD FEES	0	428, 691	4. 09
4. 10	5. 02	ADMINISTRATIVE AND GENERAL	PPSI FEES	0	19, 680	4. 10
4. 11	5. 01	ADMITTING	PASI COLLECTION FEES	0	165, 912	4. 11
4. 12	5. 01	ADMITTING	EBOS FEES	0	6, 829	4. 12
4. 13	5. 01	ADMITTING	PASI LIEN UNIT COLLECTION FE	0	31, 146	4. 13
4. 14	0.00			0	0	4. 14
4. 15	0.00			0	o	4. 15
4. 16	0.00			0	o	4. 16
4. 17	0.00			0	o	4. 17
4. 18	0.00			0	o	4. 18
4. 19	0.00			0	o	4. 19
4. 20	0.00			0	0	4. 20
5.00	TOTALS (sum of lines 1-4).			1, 071, 204	1, 275, 688	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

6.00	В	0.00 COMMUNITY HEALTH SYTEMS 100	.00 6.	. 00
7.00	В	0. 00 PASI 100	.00 7.	. 00
8.00	В	0.00 HOSPITAL LAUNDRY SERVICE 100	.00 8.	. 00
9.00		0.00	00 9.	. 00
10.00		0.00	00 10.	. 00
100.00	G. Other (financial or		100.	. 00
	non-financial) specify:			

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

					To 12/31/2015	Date/Time Pre 5/31/2016 8:4	pared: 4 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			ENTS REQUIRED AS A RESULT OF TRANS	ACTIONS WITH RELATED OF	RGANIZATIONS OR C	CLAI MED	
	HOME OFFICE CO						
1.00	7, 316						1. 00
2.00	1, 069						2. 00
3.00	114, 510						3. 00
3. 01	1, 394						3. 01
3. 02	8, 234						3. 02
3. 03	85, 549						3. 03
3. 04	5, 911						3. 04
4.00	39, 420						4. 00
4. 01	566, 116	1					4. 01
4. 02	-26, 249						4. 02
4.03	-4, 721						4. 03
4. 05	-53, 181						4. 05
4.06	-277, 218						4. 06
4. 07	-1, 349						4. 07
4. 08	-19, 027						4. 08
4. 09	-428, 691						4. 09
4. 10	-19, 680						4. 10
4. 11	-165, 912						4. 11
4. 12	-6, 829						4. 12
4. 13	-31, 146						4. 13
4. 14	0	1					4. 14
4. 15	0	1					4. 15
4. 16	0	-					4. 16
4. 17	0	1					4. 17
4. 18	0	1					4. 18
4. 19	0						4. 19
4. 20	_	1					4. 20
5. 00	-204, 484						5. 00

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

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

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

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

	Comonic undor the tro mining	
6.00	HOSPITAL MANAGEMENT	6. 00
7.00	DEBT COLLECTION	7. 00
8.00	LAUNDRY SERVICE	8. 00
9.00		9. 00
10.00		10.00
100.00		100.00

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

						To 12/31/2015	Date/Time Pre 5/31/2016 8:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
					'		Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 02	ADMINISTRATIVE AND GENERAL	34, 836	34, 836	0	0	0	1. 00
2.00		ADULTS & PEDIATRICS	417, 889	417, 889	0	0	0	2. 00
3.00	50.00	OPERATING ROOM	453, 262		0	0	0	3. 00
4.00	69. 00	ELECTROCARDI OLOGY	3, 078	3, 078	0	0	0	4.00
5.00	76. 00	SLEEP LAB	5, 700	5, 700	0	0	0	5. 00
6.00	91. 00	EMERGENCY	2, 338, 567	0	2, 338, 567	0	0	6. 00
7.00	95. 00	AMBULANCE SERVICES	1, 284	0	1, 284	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10. 00
200.00			3, 254, 616	914, 765	2, 339, 851		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				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		ADMINISTRATIVE AND GENERAL	0	0	_	_	_	
2.00		ADULTS & PEDIATRICS	0	0	_		1	2. 00
3.00		OPERATING ROOM	0	0	0	_	1	3. 00
4.00		ELECTROCARDI OLOGY	0	0	0	0	1	4. 00
5.00		SLEEP LAB	0	0	0	0	1	5. 00
6.00		EMERGENCY	0	0	0	0	Ĭ	6. 00
7.00		AMBULANCE SERVICES	0	0	0	0	1	7. 00
8.00	0. 00		0	0	0	0		8. 00
9. 00	0. 00		0	0	0	0	1	9. 00
10.00	0. 00		0	0	0	0		10. 00
200.00		0 1 0 1 (8)	0	0	0	0	0	200. 00
	Wkst. A Line #	J	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti 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		ADMINISTRATIVE AND GENERAL	13.00	10.00				1. 00
2. 00		ADULTS & PEDIATRICS		Ö			•	2. 00
3.00		OPERATING ROOM	1 0	0		,		3. 00
4. 00		ELECTROCARDI OLOGY	1 0	0	_	3, 078		4. 00
5. 00		SLEEP LAB	1 0	0	_	5, 700		5. 00
6. 00		EMERGENCY	1 0	١		0,700	1	6. 00
7. 00		AMBULANCE SERVICES		0		0	1	7. 00
8. 00	0.00			0	_	0		8. 00
9. 00	0.00			0				9. 00
10. 00	0.00							10. 00
200.00	0.00			Ö		914, 765		200.00
200.00	ı	I	1			, , , , , , , , ,	I	200.00

	Financial Systems	DUKES MEMORIA				u of Form CMS-2	
	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151318	Peri od: From 01/01/2015 To 12/31/2015	Worksheet A-8- Parts I-VI Date/Time Prep 5/31/2016 8:44	pared:
					Physical Therapy		
						1. 00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides	s) (see instruct	tions)			52	1.00
. 00 . 00 . 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy	assistant was o				780 0 0	2. 00 3. 00 4. 00
. 00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera	rvisors or thera apy assistants (include only	visits made l		0	5. 00 6. 00
	assistant and on which supervisor and/or ther instructions)	apist was not p	oresent during	the visit(s)) (see		
7. 00	Standard travel expense rate					0.00	7.00
3. 00	Optional travel expense rate per mile		TI			5. 19	8. 00
		Supervi sors 1.00	Therapi sts 2.00	Assi stants 3.00	4. 00	Trai nees 5. 00	
. 00	Total hours worked	0. 00	3, 739. 00	3, 166.	3, 682. 00	0.00	9. 0
	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 39. 02	78. 03 39. 02	57. 28.		0.00	10. 00 11. 00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)			28.			
	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12. 0 12. 0
	Number of miles driven (provider site)	0	0		0		13. 0
	Number of miles driven (offsite)	0	0		0		13. 0
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
4. 00 5. 00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0	14. 00 15. 00
6. 00	Assistants (column 3, line 9 times column 3,					291, 754 180, 589	16. 0
7. 00	Subtotal allowance amount (sum of lines 14 ar others)	nd 15 for respir	ratory therapy	or lines 14	-16 for all	472, 343	
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					139, 990 0	18. 0 19. 0
0. 00	Total allowance amount (sum of lines 17-19 fo	or respiratory t	therapy or Lin	es 17 and 18	for all others)	612, 333	
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than	therapy or col	umns 1-3 for	physical the	rapy, speech path	nology or	
	the amount from line 20. Otherwise complete		io entires on	rines zi and	zz and enter on	TITIE 23	
	Weighted average rate excluding aides and tra	ainees (line 17		m of columns	1 and 2, line 9	0.00	21.0
2. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trains					o	22. 0
	Total salary equivalency (see instructions)					612, 333	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMP	UTATION - PRO	OVI DER SITE		
4. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24. 0
5. 00	Assistants (line 4 times column 3, line 11)					0	25. 0
6. 00 7. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3			,	3 and 4 for all	0	26. 0 27. 0
,. 00	others)	ioi respiratory	, инстару от S	um or FINES	anu + IVI dll		21.0
8. 00	Total standard travel allowance and standard 27)	· .	at the provid	er site (sum	of lines 26 and	0	28. 0
9. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		1 2 line 12 \			0	29. 0
0. 00	Assistants (column 3, line 10 times column 3,		, , , , , , , , , , , , , , , , , , ,			0	30.0
	Subtotal (line 29 for respiratory therapy or	sum of lines 29			_	0	31.0
2. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respir	atory therap	y or sum of	0	32. 0
3. 00	Standard travel allowance and standard travel	expense (line	28)			0	33. 0
4. 00	Optional travel allowance and standard travel	expense (sum o	of lines 27 an			0	34.0
5. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				/I CES OUTSI DE DO	0 NUMED SLITE	35. 00
	Standard Travel Expense	INCL AND TRAVEL	EAFLINGE COMPU	TATION - SER	TIGES OUTSTDE PRO	OVIDER SITE	
36. 00	Therapists (line 5 times column 2, line 11)						36.0

	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29. 00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	32.00
	columns 1-3, line 13 for all others)		1
33.00	Standard travel allowance and standard travel expense (line 28)	0	33. 00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PRO	OVIDER SITE	
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36. 00
37.00	Assistants (line 6 times column 3, line 11)	0	37. 00
38. 00	Subtotal (sum of lines 36 and 37)	0	38. 00
39. 00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39. 00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40. 00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42. 00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43. 00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line	es 44, 45,	
	or 46, as appropriate.		
	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		44. 00
45. 00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45. 00
MODIFO	0.004500		
MCRIF3	2 - 8.8.159.0		

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In lie	eu of Form CMS-2	2552-10
REASON	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS				Period: From 01/01/2015 To 12/31/2015	Worksheet A-8 Parts I-VI	-3 pared:
				F	hysical Therapy		
						1. 00	
46. 00	Optional travel allowance and optional travel	expense (sum	of lines 42 and	d 43 - see ins	structions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
		1.00	2. 00	3. 00	4. 00	5. 00	
47. 00	PART V - OVERTIME COMPUTATION 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	0. 00	0.00	0.00	0.00	0.00	47. 00
	column of line 56)						
48. 00	Overtime rate (see instructions)	0. 00	0.00				48. 00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0. 00	0.00	0.00		49. 00
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0. 00	0. 00	0.00	0.00	50. 00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0. 00	0.00	0. 00	0.00	0.00	51. 00
52. 00	Adjusted hourly salary equivalency amount	78. 03	57.04	38. 0	2 0.00		52. 00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0	(0		53. 00
54. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	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		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	0	0	(0	0	56. 00
	for all others.)					1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FXCESS COST	ADJUSTMENT			1.00	
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servid Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	(from lines 33 ces (from lines	, 34, or 35)) 44, 45, or 46)		612, 333 0 0 0 0 0 0 612, 333	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or		•	II others		0	65. 00 100. 00
100. 02	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					0	100. 01 100. 02
101.01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				mns 1-3, line		102. 00 102. 01

0 102. 02

13 for all others 102.02 Line 35 = sum of lines 31 and 32

Description Content		ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CCN: 15	1318 Period: From 01/01/201! To 12/31/201!		pare
PART 1 - CEREAL INFORMATION 1 1 1 1 1 1 1 1 1							
PART 1 - CEREAL INFORMATION 1 1 1 1 1 1 1 1 1						1. 00	
10 International process							
Description Number of unduplicated offsite visits - supervisors or theraplasts (see instructions) 0 1 2 2 2 2 2 2 2 2 2	. 00 . 00 . 00 . 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	sor or therapist v	was on provider sit		0	2. 3.
10 Standard travel expense rate 0.00 0 0 0 0 0 0 0 0	00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther	rvisors or therapi apy assistants (ir	nclude only visits	made by therapy	1	5. 6.
Supervisors Therapists Assistants Aldes Trainees	00 00	Standard travel expense rate				•	
10 Total hours worked	00	optional travel expense rate per mire	Supervi sors T	herapists Assis	stants Ai des		0.
DATE SEA (See Instructions) Column 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10) Column 3, one-half of column 4, line 10 Column 3, line 10 Column 4, line 10 Column 5, line 9 times column 1, line 10) Column 5, line 9 times column 3, line 10) Column 5, line 9 times column 3, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 9 times column 5, line 10) Column 5, line 10, line 11, line 10,							
100 Number of travel hours (provider site) 0 0 0 1 1 1 1 1 1 1	. 00 0. 00 1. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	0. 00	73. 96	54. 06 0. 0	•	
Part II - SALARY EQUIVALENCY COMPUTATION Supervi sors (column 1, line 9 times column 2, line 10) Therapists (column 3, line 9 times column 2, line 10) Assistants (column 3, line 9 times column 3, line 10) Assistants (column 3, line 9 times column 3, line 10) Assistants (column 4, line 9 times column 4, line 10) Trainees (column 4, line 9 times column 4, line 10) Trainees (column 4, line 9 times column 4, line 10) Trainees (column 4, line 9 times column 4, line 10) Trainees (column 5, line 9 times column 5, line 10) Trainees (column 6, line 9 times column 4, line 10) Trainees (column 7, line 9 times column 4, line 10) Trainees (column 7, line 9 times column 5, line 10) Trainees (column 8, line 9 times column 6, line 10) Trainees (column 8, line 9 times column 6, line 10) Trainees (column 8, line 9 times column 6, line 10) Trainees (column 8, line 9 times column 6, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 10) Trainees (column 8, line 10) Trainees (column 8, line 9 times column 8, line 10) Trainees (column 8, line 10) Trainee	. 01 . 00	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site)	0	0	0		12. 12. 13. 13.
Part II - SALARY EQUIVALENCY COMPUTATION 0 10 157, 017 10 16 17, 017 17 17 17 17 17 17 17	. 01	manuscr of mires arriver (error te)	<u> </u>	<u> </u>		1.00	10
Subtraits (column 1, line 9 times column 2, line 10) 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017 157, 017		Part II - SALARY EQUIVALENCY COMPUTATION				1.00	
00 Assistants (column 3, line 9 times column 3, line 10) 01 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 172, 857 or 172,	. 00	Supervisors (column 1, line 9 times column 1,					1
DS Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 172,857 1 others) DA Ai des (column 4, line 9 times column 5, line 10) 0 1 Trainees (column 5, line 9 times column 6, line 10) 0 1 Trainees (column 6, line 9 times column 6, line 10) 0 1 Trainees (column 6, line 9 times column 7, life the sum of columns 1 and 2 for respiratory therapy or clines 17 and 18 for all others) 172,857 20 1 Trainees (column 6, line 9 times column 1 and 2 for respiratory therapy or clines 17 and 18 for all others) 1 Tray 857 20 1 Trainees (column 6, line 17 times 11 line 17 divided by sum of columns 1 and 2, line 9 or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. Description of the amount from line 20. Otherwise complete lines 21-23. Weighted average rate excluding aides and trainees (line 2 times line 21) 0 1 0 1 0 1 0 1 0 1 0 1 0 1 1 1 0 1 1 0 1 0 1 0 1 0 1 0 1 1 0 1 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1						•	
O Aldes (column 4, line 9 times column 4, line 10) O Aldes (column 5, line 9 times column 5, line 10) O Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 of for respiratory therapy or columns 1 thru 3, line 9 for all others) Weighted allowance excluding aides and trainees (line 2 times line 21) O Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance O Therapists (line 3 times column 2, line 11) Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) O Total standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) O Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27) Optional Travel Allowance and optional Travel Expense O Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) O Subtotal (line 24 for respiratory therapy or sum of lines 29 and 30 for all others) O Subtotal (line 20 for respiratory therapy or sum of lines 29 and 30 for all others) O Subtotal (line 20 for respiratory therapy or sum of lines 29 and 30 for all others) O Subtotal (line 20 for respiratory therapy or sum of lines 29 and 30 for all others) O Subtotal (line 20 for respiratory therapy or sum of lines 29 and 30 for all others) O Subtotal (line 20 for respiratory therapy or sum of lines 29 and 30 for all others) O Subtotal (line 20 for respiratory therapy or sum of lines 29 and 30 for all others) O Subtotal (line 20 for respiratory therapy or sum of line				ory therapy or lir	nes 14-16 for all		
00 Trainees (column 5, line 9 times column 5, line 10) 10 Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 172, 857 17 the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. 00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thur, 3, line 9 for all others) 10 Weighted allowance excluding aides and trainees (line 2 times line 21) 11 Total sal arry equival ency (see instructions) 11 Total sal arry equival ency (see instructions) 12 Assistants (line 4 times column 2, line 11) 10 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 10 Total standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 10 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 50 tothers) 11 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 50 tothers) 12 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 50 tothers) 12 Total standard travel allowance and standard travel expense (line 12) 12 Total standard travel allowance and standard travel expense (line 12) 13 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 14 Subject of the sum of times the sum of columns 1 and 2, line 13 for respiratory therapy or sum of lines 26 and 50 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 15 Standard travel expense (line 8 times column 3, line 12) 16 Subtotal (sum of lines 36 and 37) 17 Standard travel expense (line 8 times column 3, line 10) 18 Standard travel allowance and optional travel expense	. 00		id 15 for respirat	ory therapy or its	10 10 101 411	172,007	' '
100 Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 172,857 20 1F the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 100 Weighted average rate excluding aid des and trainees (line 17 divided by sum of columns 1 and 2, line 9 101 for respiratory therapy or columns 1 thru 3, line 9 for all others) 0 0 2 1 172,857 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						0	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others) Weighted allowance excluding aides and trainees (line 2 times line 21)							
Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 0.00 2	. 00	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than	therapy or colum I line 2, make no	ns 1-3 for physica	al therapy, speech pat	thology or] 20
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00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) 0 4:	. 00	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 columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWARD 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 sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	of columns 1 and 2 line 12) sum of lines 29 as 1 and 2, line 13 expense (line 28 expense (sum of expense (sum of NNCE AND TRAVEL EX m of lines 5 and 6 Expense Of times column 2,	and 30 for all others for respiratory to the second state of the s	therapy or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30 311 32 33 34 35 36 37 38 39
	00 00 00 00 00 00 00 00 00 00	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 columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWASTANDARD TRAVEL STANDARD AND OPTIONAL TRAVEL ALLOWASTANDARD (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column	of columns 1 and 2 line 12) sum of lines 29 as 1 and 2, line 13 expense (line 28 expense (sum of expense (sum of NNCE AND TRAVEL EX m of lines 5 and 6 Expense Of times column 2,	and 30 for all others for respiratory to the second state of the s	therapy or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30 31 32 33 34 35 36 37 38 39
	00 00 00 00 00 00 00 00 00	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 columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Standard Travel AND OPTIONAL TRAVEL ALLOWASTANDARD AND OPTIONAL TRAVEL ALLOWASTANDARD 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 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)	of columns 1 and 2 line 12) sum of lines 29 a s 1 and 2, line 13 expense (line 28 expense (sum of expense (sum of expense (sum of expense 5 and 6 Expense 01 times column 2, n 3, line 10)	and 30 for all others for respiratory for the second secon	therapy or sum of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30 31 32 33 34 35 36 37 38 39 40 41 42

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151318	Peri od: From 01/01/2015 To 12/31/2015		pared:
					Occupati onal Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 ar	nd 42 - see in	nstructions)	0	
6. 00	Optional travel allowance and optional travel		of lines 42 ar				46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4. 00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	0.00	1. 00	0.00	
7. 00	Overtime hours worked during reporting 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
8. 00	Overtime rate (see instructions)	0. 00	0.00	1			48.00
9. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0.00	0.0	0.00		49.00
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0. 00	0.0	0.00	0.00	50.00
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
2. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	73. 96	54.06	0.0	0.00		52. 00
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0 00		0 0		53.00
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	O		0 0		54. 00
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	О		0 0		55. 00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	С		0 0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	AD JUSTMENT			1. 00	
7. 00	Salary equivalency amount (from line 23)	EXCESS COST	710303TIMEITT			172, 857	57.00
8. 00						0	58.00
9. 00 0. 00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46) Overtime allowance (from column 5, line 56)					0 0	59. 00 60. 00
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
3. 00	Total allowance (sum of lines 57-62)					172, 857	
4. 00						0	
	Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION .00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	65. 00 100. 00
10.00 Line 27 = Time 24 for respiratory therapy of sum of Times 24 and 23 for all others 10.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 10.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION						0	100. 01 100. 02
01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						0	101. 00 101. 01 101. 02
02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 02.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line							102. 00 102. 01
13 for all others 02.02 Line 35 = sum of lines 31 and 32						0	102. 02

<u>Heal th</u>	Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu				552-10
REASON				Worksheet A-8-	-3
OUTSLE	OUTSIDE SUPPLIERS From 01/01/2015				
	To 12/31/2015		Date/Time Prep 5/31/2016 8:44		
					l am
			Speech Pathology	Cost	
				1. 00	
	PART I - GENERAL INFORMATION				
1.00	Total number of weeks worked (excluding aides) (see instructi	ons)		52	1.00
2.00	Line 1 multiplied by 15 hours per week			780	2.00
3.00	Number of unduplicated days in which supervisor or therapist	was on provider site (se	e instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on	provider site but neith	er supervisor	o	4.00
	nor therapist was on provider site (see instructions)	•	'		
5.00	Number of unduplicated offsite visits - supervisors or therap	ists (see instructions)		0	5. 00
6.00	Number of unduplicated offsite visits - therapy assistants (i		by therapy	o	6.00
	assistant and on which supervisor and/or therapist was not pr				
	instructions)	occur during the viert(c	,,, (555		
7. 00	Standard travel expense rate			5. 19	7. 00
8. 00	Optional travel expense rate per mile			0.00	8. 00
0.00	Topti onal travel expense rate per illire			0.00	0.00

8.00	loptional travel expense rate per mile		0.00	8.00			
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
		1. 00	2.00	3. 00	4. 00	5. 00	
9.00	Total hours worked	0.00	209. 00	3. 00	0.00	0.00	9. 00
10.00	AHSEA (see instructions)	0.00	71. 08	71. 08	0.00	0.00	10.00
11. 00	Standard travel allowance (columns 1 and 2,	35. 54	35. 54	35. 54			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	Number of miles driven (provider site)	0	0	0			13.00
13. 01	Number of miles driven (offsite)	0	0	0			13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1,	, line 10)				0	14.00
45 00	T	1.1 40)				44.05/	45 00

14.00 Supervisors (column 1, line 9 times column 2, line 10) 14.00 16.00 Assistants (column 2, line 9 times column 3, line10) 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.0		Part II - SALARY EQUIVALENCY COMPUTATION		
16.00 Assistants (column 3, line 9 times column 3, line 10) 71.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.0	14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
16.00 Assistants (column 3, line 9 times column 3, line 10 18.00 17.00 21.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00			14, 856	15. 00
17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 15,069 17.00 18.00 Aldes (column 4, line 9 times column 5, line 10) 0 18.00 100 Tariness (column 5, line 9 times column 5, line 10) 15,069 17.00 100 Tariness (column 5, line 9 times column 5, line 10) 15,069 17.00 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100	16.00	Assistants (column 3, line 9 times column 3, line10)	213	16.00
Others 18. 00 Aldes (column 4, line 9 times column 4, line 10)	17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all	15, 069	17. 00
19.00 Trainees (column 5, line 9 times column 5, line 10) 17.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00				
20.00 Total allowance amount (sum of lines 17-19 for respiratory therapy or clumes 1 and 18 for all others) 15,069 16 fite sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 10.00 10 10 10 10 10 10	18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.	19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
Decupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. The amount from line 20. Otherwise complete lines 21-23.	20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	15, 069	20.00
the amount from line 20. Otherwise complete lines 21-23. 1.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9				
21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 71.08 21.00 for respiratory therapy or columns 1 thru 3. line 9 for all others) 55, 442 22.00 70 70 70 70 70 70 70			line 23	
For respiratory therapy or columns 1 thru 3, line 9 for all others) 55, 442 22, 00				
22.00 Weighted allowance excluding aides and trainees (line 2 times line 21) 55, 442 22.00	21. 00		71. 08	21. 00
23. 00 Total salary equivalency (see instructions) 55, 442 23. 00				
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance 24. 00 Therapists (line 3 times column 2, line 11) 25. 00 Assistants (line 4 times column 3, line 11) 26. 00 Stototal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 27. 00 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all objects) 28. 00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27) Divide the standard travel allowance and optional Travel Expense 29. 00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 31. 00 31. 00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 32. 00 33. 00 34. 00 35. 00 Standard travel allowance and standard travel expense (line 8 times column 3, line 12) 35. 00 Standard travel allowance and standard travel expense (sum of lines 27 and 31) 36. 00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 37. 00 Standard travel allowance and optional travel expense (sum of lines 31 and 32) 38. 00 Spit onal travel Expense 39. 00 Standard travel Expense 39. 00 Standard travel Expense 39. 00 Subtotal (line 6 times column 3, line 11) 39. 00 Subtotal (sum of lines 36 and 37) 39. 00 Subtotal (sum of lines 36 and 37) 39. 00 Subtotal (sum of lines 30 and 37) 39. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41) 30. 00 Subtotal (sum of lines 40 and 41)		, , ,		
Standard Travel Allowance Therapists (line 3 times column 2, line 11)	23. 00		55, 442	23. 00
24.00 Therapists (line 3 times column 2, line 11) 24.00 Assistants (line 4 times column 3, line 11) 25.00 Assistants (line 4 times column 3, line 11) 26.00 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) 27.00 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others) 28.00 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27) 29.00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 30.00 Assistants (column 3, line 10 times column 3, line 12) 30.00 Optional travel expense (line 8 times column 3, line 13 for respiratory therapy or sum of columns 1-3, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) 30.00 Standard travel allowance and standard travel expense (line 28) 30.00 Optional travel allowance and standard travel expense (sum of lines 27 and 31) 30.00 Optional travel allowance and standard travel expense (sum of lines 31 and 32) 30.00 Optional travel allowance and optional travel expense (sum of lines 31 and 32) 30.00 Optional travel Expense 30.00 Therapists (line 5 times column 2, line 11) 30.00 Optional travel expense (line 28) 30.00 Optional travel expense (line 30 and 37) 30.00 Optional travel expense (line 31 and 32) 30.00 Optional travel expense (line 30 and 37) 30.00 Optional travel expense (line 7 times the sum of lines 5 and 6) 30.00 Optional travel expense (line 7 times the sum of lines 5 and 6) 30.00 Optional travel allowance and Optional Travel Expense 30.00 Optional travel expense (line 7 times the sum of lines 5 and 6) 30.00 Optional travel expense (line 8 times column 3, line 10) 40.00 Optional travel expense (line 8 times column 3, line 10) 40.00 Optional travel expense (line 8 times column 3, line 10) 40.00 Optional travel expense (line 8 times column 3, line 10) 40.00 Optional travel expense (line 8 times column 3, line 10) 40.00 Optional travel expense (line 8 times column 3				
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45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	45.00	Uptional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	ا ۱	45.00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
REASON	ABLE COST DETERMINATION FOR THERAPY SERVICES F SE SUPPLIERS	FURNI SHED BY	Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
					Speech Pathology		
						1.00	
46, 00	Optional travel allowance and optional travel	expense (sum	of lines 42 an	d 43 - see in	structions)		46. 00
10.00		Therapi sts	Assi stants	Ai des	Trai nees	Total	
		1. 00	2. 00	3. 00	4. 00	5. 00	
47.00	PART V - OVERTIME COMPUTATION	0.00	0.00	0.0	0.00	0.00	47.00
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	0. 0	0.00		48. 00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0. 00	0.0	0.00		49. 00
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50. 00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
52. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	71. 08	71. 08	0.0	0.00		52. 00
02.00	(see instructions)	, 55	, 55	0.0	0.00		02.00
53. 00	Overtime cost limitation (line 51 times line	0	0		0		53.00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	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		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	0	0		0	0	56. 00
	for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23)					55, 442	1
58.00	• •			`		0	
59. 00 60. 00	Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56)	es (from lines	44, 45, OF 46)		0	
	Equipment cost (see instructions)						
	Supplies (see instructions)						62.00
	Total allowance (sum of lines 57-62)					l	63.00
	Total cost of outside supplier services (from	your records)				0	1
65. 00	65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION						65. 00
100.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	II others		•	100. 00
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	therapy or su	m of lines 3 a	nd 4 for all	others	l	100. 01 100. 02
101 00	LINE 34 CALCULATION	. +bonon:: -:-	m of 1: 2	nd 4 fe:= -!!	a+bana		101 00
101.01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				otners	0	101. 00
101.02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION					0	101. 02

LINE 34 = SUM OF TITIES 27 and 31

LINE 35 CALCULATION

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

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

0 102. 00 0 102. 01

0 102. 02

13 for all others 102.02 Line 35 = sum of lines 31 and 32 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151318 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 8:44 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** ADMITTI NG for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 5. 01 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 381, 500 1, 381, 500 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 1, 644, 578 1, 644, 578 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 750, 220 9,749 11,653 1, 771, 622 4.00 00570 ADMITTING 14, 833 5 01 1, 504, 659 17, 731 1, 608, 464 5 01 71, 241 00590 ADMINISTRATIVE AND GENERAL 5.02 4, 037, 723 70, 335 84, 072 203, 554 0 5.02 7.00 00700 OPERATION OF PLANT 1, 488, 409 408, 816 488, 666 35, 431 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 38, 547 16, 050 19, 185 8.00 0 00900 HOUSEKEEPI NG 35, 167 9 00 295.040 13, 288 15, 883 9 00 0 10.00 01000 DI ETARY 130, 355 33, 548 40, 101 12,083 0 10.00 01100 CAFETERI A 179, 689 21, 547 25, 756 19, 312 11.00 11.00 01300 NURSING ADMINISTRATION 113, 754 7, 490 17, 134 13.00 13.00 6, 266 0 39, 306 01400 CENTRAL SERVICES & SUPPLY 32, 884 14.00 185.022 11, 576 0 14.00 15.00 01500 PHARMACY 586, 406 15, 351 18, 349 62, 569 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 348, 574 27, 744 33, 162 33, 758 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1 586 093 230, 285 275, 262 200 214 80 245 30.00 03100 INTENSIVE CARE UNIT 358, 107 31, 900 49, 064 31.00 26, 688 10,665 31.00 43.00 04300 NURSERY 132, 655 5, 280 6, 311 17, 131 4, 893 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 935, 106 105, 799 126, 463 70 484 197, 539 50.00 324, 124 43, 690 05100 RECOVERY ROOM 9, 104 51.00 7,616 34, 496 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 277, 173 88.945 123, 380 344, 416 54.00 74.412 54.01 05401 ULTRASOUND C 0 54.01 C 05600 RADI OI SOTOPE 56.00 0 0 0 0 56.00 57.00 05700 CT SCAN 0 Ω 0 0 57.00 0 58.00 05800 MRI 0 0 0 Λ 58 00 06000 LABORATORY 1, 345, 396 96, 908 60.00 29, 751 35, 561 234, 343 60.00 65.00 06500 RESPIRATORY THERAPY 364, 822 12, 770 15, 264 47.611 21, 399 65.00 06600 PHYSI CAL THERAPY 493.789 20.949 31, 798 66,00 17.526 321 66,00 67.00 06700 OCCUPATIONAL THERAPY 175, 587 5, 735 6,855 11, 310 67.00 0 06800 SPEECH PATHOLOGY 68.00 14,826 231 276 728 68.00 06900 ELECTROCARDI OLOGY 289, 316 39, 721 69.00 69.00 8, 665 10.357 55.154 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 202, 856 55, 108 71.00 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 464, 848 C 0 0 40,081 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 708, 928 174, 916 73.00 C 03610 SLEEP LAB 84, 809 11, 559 76 00 12, 372 14.788 9, 286 76 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 301, 427 8, 043 9, 613 38, 067 6, 750 90.00 91.00 09100 EMERGENCY 4, 090, 653 51, 249 61, 259 489, 692 227, 167 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 343, 025 30, 473 68, 170 95.00 95.00 20, 638 24, 669 SPECIAL PURPOSE COST CENTERS 27, 178, 016 1, 608, 464 118. 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 1, 287, 471 1, 538, 930 1, 760, 140 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 5, 644 192.00 19200 PHYSICIANS' PRIVATE OFFICES 88, 385 105, 648 0 0 192.00 0 194.00|07950|OTHER_NRCC 0 194 00 0 C 0 0 194. 01 07951 MARKETI NG 203, 751 0 0 194. 01 11, 482 194. 02 07952 SENI OR CIRCLE 0 0 194. 02 2,500 Ω 0 194.03 07953 FREE MEALS 0 0 194 03 Ω C 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00

27, 384, 267

1.381.500

1.644.578

1. 771. 622

1, 608, 464 202. 00

202.00

TOTAL (sum lines 118-201)

				''	0 12/31/2015	5/31/2016 8: 4	
	Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			AND GENERAL	PLANT	LINEN SERVICE		
		5A. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00570 ADMI TTI NG						5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL	4, 395, 684	4, 395, 684				5. 02
7.00	00700 OPERATION OF PLANT	2, 421, 322	462, 986	2, 884, 308			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	73, 782	14, 108	52, 741	140, 631		8. 00
9.00	00900 HOUSEKEEPI NG	359, 378	68, 717	43, 663	0	471, 758	9. 00
10.00	01000 DI ETARY	216, 087	41, 318	110, 238	0	18, 654	10. 00
11.00	01100 CAFETERI A	246, 304	47, 096	70, 804	0	11, 981	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	144, 644	27, 658	20, 591	0	3, 484	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	268, 788	51, 395	108, 055	0	18, 285	14. 00
15.00	01500 PHARMACY	682, 675	130, 536	50, 443	0	8, 536	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	443, 238	1				1
	INPATIENT ROUTINE SERVICE COST CENTERS			· · ·			
30.00	03000 ADULTS & PEDI ATRI CS	2, 372, 099	453, 574	756, 709	55, 828	128, 048	30.00
31.00	03100 INTENSIVE CARE UNIT	476, 424	1				1
43.00	04300 NURSERY	166, 270					1
	ANCILLARY SERVICE COST CENTERS			<u> </u>			
50.00	05000 OPERATI NG ROOM	1, 435, 391	274, 464	347, 652	23, 336	58, 828	50.00
51.00	05100 RECOVERY ROOM	419, 030	80, 124	25, 026	0	4, 235	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 908, 326	364, 895	244, 515	15, 891	41, 376	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	1, 741, 959	333, 083	97, 760	230	16, 543	60. 00
65.00	06500 RESPI RATORY THERAPY	461, 866	88, 314	41, 963	0	7, 101	65. 00
66.00	06600 PHYSI CAL THERAPY	564, 383	107, 917	57, 590	0	9, 745	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	199, 487	38, 144	18, 844	0	3, 189	67. 00
68.00	06800 SPEECH PATHOLOGY	16, 061	3, 071	758	0	128	68. 00
69.00	06900 ELECTROCARDI OLOGY	403, 213	77, 099	28, 473	0	4, 818	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	257, 964	49, 326	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	504, 929	96, 548	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	883, 844	169, 002	0	0	0	73. 00
76.00	03610 SLEEP LAB	132, 814	25, 396	40, 653	3, 521	6, 879	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	363, 900	69, 582	26, 428	0	4, 472	90. 00
91.00	09100 EMERGENCY	4, 920, 020	940, 760	168, 403	38, 402	28, 496	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	486, 975	93, 115	67, 816	0	11, 476	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	26, 966, 857	4, 315, 871	2, 575, 333	140, 631	419, 475	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 644					190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	194, 033	37, 101	290, 430	0		192. 00
	07950 OTHER NRCC	0	0	0	0		194. 00
	07951 MARKETI NG	215, 233	41, 155	0	0		194. 01
194. 02	07952 SENI OR CIRCLE	2, 500	478	0	0		194. 02
194. 03	07953 FREE MEALS	0	0	0	0	0	194. 03
200.00		0					200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	27, 384, 267	4, 395, 684	2, 884, 308	140, 631	471, 758	202. 00

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151318
 Period: Worksheet B From 01/01/2015 Part I To 12/31/2015 Part I Date/Time Prepared: 12/31/2016 Part I Pre

				To	12/31/2015	Date/Time Pre 5/31/2016 8:4	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	4 alli
				ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
	Ta	10. 00	11. 00	13. 00	14. 00	15. 00	
4 00	GENERAL SERVICE COST CENTERS						4 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 ADMITTING						5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT						5. 02
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY	386, 297					10.00
11. 00	01100 CAFETERI A	300, 277	376, 185				11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON		2, 037	1			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY		6, 241		452, 764		14. 00
15. 00	01500 PHARMACY		13, 109		9, 983	895, 282	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		14, 414	1	598	070, 202	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		<u> </u>			10.00
30. 00	03000 ADULTS & PEDIATRICS	257, 275	64, 108	31, 969	26, 387	0	30. 00
31. 00	03100 NTENSI VE CARE UNI T	33, 485	13, 239		2, 920	0	31. 00
43.00	04300 NURSERY	0	4, 961	1	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	21, 804	12, 824	87, 356	0	50. 00
51.00	05100 RECOVERY ROOM	0	11, 673	7, 949	3, 638	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	39, 587	22, 447	22, 236	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	42, 617	17, 631	91, 791	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	15, 093	0	8, 399	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	157	0	1, 365	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	17, 522	0	1, 060	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	49, 204	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	110, 808	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	895, 282	73. 00
76. 00	03610 SLEEP LAB	0	3, 447	0	720	0	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0.740		7 000		00.00
90.00	09000 CLINIC	0	9, 740		7, 223	0	90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 709	78, 184	89, 094	17, 369	0	91.00
92. 00	OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	O	15, 511	0	11, 411	0	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	13, 311] 0	11, 411		73.00
118.00		301, 469	373, 444	198, 414	452, 468	895, 282	118 00
	NONREI MBURSABLE COST CENTERS	3317 137	370, 111	1707 111	1027 100	0,0,202	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	104	0	64		192. 00
194.00	07950 OTHER NRCC	0	0	0	0	0	194. 00
194.01	07951 MARKETI NG	0	2, 637	0	232	0	194. 01
	07952 SENI OR CIRCLE	0	0	0	0		194. 02
	07953 FREE MEALS	84, 828	0	0	0		194. 03
200.00	1						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	386, 297	376, 185	198, 414	452, 764	895, 282	202. 00

Heal th F	Financial Systems	DUKES MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
					From 01/01/2015 To 12/31/2015	Part Date/Time Pre	narodi
					To 12/31/2015	5/31/2016 8: 4	
	Cost Center Description	MEDI CAL	Subtotal	Intern &	Total		
	·	RECORDS &		Residents Cos	t		
		LI BRARY		& Post			
				Stepdown			
				Adjustments			
	SENERAL OFFICE OFFICE	16. 00	24. 00	25. 00	26. 00		
	SENERAL SERVICE COST CENTERS			I			1 00
1	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQULP						1.00
							2. 00 4. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING						5. 01
	00590 ADMINISTRATIVE AND GENERAL						5. 02
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPING						9. 00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13. 00
	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY	649, 592					16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		•	'		
	03000 ADULTS & PEDIATRICS	32, 407	4, 178, 404		0 4, 178, 404		30.00
31.00	03100 INTENSIVE CARE UNIT	4, 307	736, 355		736, 355		31. 00
43.00	04300 NURSERY	1, 976	232, 860		0 232, 860		43.00
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	79, 776	2, 341, 431	1	0 2, 341, 431		50.00
	05100 RECOVERY ROOM	13, 931	565, 606	1	0 565, 606		51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 0		52. 00
	D5400 RADI OLOGY-DI AGNOSTI C	139, 109	2, 798, 382	1	0 2, 798, 382		54.00
	D5401 ULTRASOUND	0	0	1	0 0		54. 01
1	D5600 RADI OI SOTOPE	0	0	1	0 0		56.00
	05700 CT SCAN	0	0	1	0 0		57. 00
1	05800 MRI	0 0	0 407 050	1	0 0		58.00
	06000 LABORATORY	94, 639	2, 436, 253	1	0 2, 436, 253		60.00
	06500 RESPI RATORY THERAPY	8, 642	631, 378		0 631, 378		65. 00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	12, 842	753, 999 264, 232		0 753, 999 0 264, 232		66. 00 67. 00
	06800 SPEECH PATHOLOGY	4, 568 294	20, 312	1	0 20, 312		68.00
	06900 ELECTROCARDI OLOGY	22, 274	554, 459	1	0 554, 459		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	22, 255	378, 749		0 378, 749		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	16, 186	728, 471		728, 471		72.00
	07300 DRUGS CHARGED TO PATIENTS	70, 639	2, 018, 767		2, 018, 767		73.00
	03610 SLEEP LAB	3, 750	217, 180		0 217, 180		76. 00
	OUTPATIENT SERVICE COST CENTERS		,		,		
90.00	09000 CLI NI C	2, 726	484, 071		0 484, 071		90.00
91.00	99100 EMERGENCY	91, 741	6, 383, 178		0 6, 383, 178		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
0	THER REIMBURSABLE COST CENTERS						
95. 00 <u>0</u>	99500 AMBULANCE SERVICES	27, 530	713, 834		0 713, 834		95. 00
	PECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1-117)	649, 592	26, 437, 921		0 26, 437, 921		118. 00
	IONREI MBURSABLE COST CENTERS			1			
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28, 406	1	0 28, 406		190. 00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	570, 877	ı	570, 877		192. 00
	07950 OTHER NRCC	0	0	l .	0 0		194. 00
	07951 MARKETI NG	0	259, 257		0 259, 257		194. 01
1	07952 SENI OR CI RCLE		2, 978		0 2, 978 0 84, 828		194. 02
200. 00	07953 FREE MEALS Cross Foot Adjustments	"	84, 828 0	1	II		194. 03 200. 00
200.00	Negative Cost Centers		0				200.00
202.00	TOTAL (sum lines 118-201)	649, 592	27, 384, 267		0 27, 384, 267		202.00
202.00	TOTAL (Sum TITIES TTO-201)	047, 372	21,304,201	I .	27, 304, 207	l	1202.00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	ITION OF CAPITAL RELATED COSTS		Provi der		reriod: from 01/01/2015 fo 12/31/2015	Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		5/31/2016 8: 4	4 alli
	Cost Center Description	Di rectly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS		1,00	2.00		1, 00	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	9, 749	11, 653	21, 402	21, 402	1
5. 01	00570 ADMITTING	0	14, 833			860	
5. 02	00590 ADMINISTRATIVE AND GENERAL	0	70, 335		·	2, 459	
7.00	00700 OPERATION OF PLANT	0	408, 816			428	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	16, 050	19, 185	35, 235	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	13, 288	15, 883	29, 171	425	9. 00
10.00	01000 DI ETARY	0	33, 548	40, 101	73, 649	146	10.00
11. 00	01100 CAFETERI A	0	21, 547	25, 756	47, 303	233	11.00
13.00	01300 NURSING ADMINISTRATION	0	6, 266	7, 490	13, 756	207	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	32, 884				
15. 00	01500 PHARMACY	0	15, 351				
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	27, 744	33, 162	60, 906	408	16. 00
30. 00	03000 ADULTS & PEDIATRICS	0	230, 285	275, 262	505, 547	2, 418	30.00
31. 00	03100 NTENSI VE CARE UNI T	0	1				1
43. 00	04300 NURSERY	0	l			207	
	ANCILLARY SERVICE COST CENTERS		,		,		
50.00	05000 OPERATI NG ROOM	0	105, 799	126, 463	232, 262	851	50.00
51.00	05100 RECOVERY ROOM	0	7, 616	9, 104	16, 720	528	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	74, 412	88, 945	163, 357	1, 490	54.00
54. 01	05401 ULTRASOUND	0	0	C	0	0	
56. 00	05600 RADI OI SOTOPE	0	0	C	0	0	
57. 00	05700 CT SCAN	0	0	C	0	0	
58. 00	05800 MRI	0	0	0 0	0	0	
60.00	06000 LABORATORY	0	29, 751				
65. 00	06500 RESPIRATORY THERAPY	0	12, 770			575	
66. 00 67. 00	06600 PHYSI CAL THERAPY	0	17, 526			4	
68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	5, 735 231				
69. 00	06900 ELECTROCARDI OLOGY	0	8, 665			480	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0,000	10, 337	17,022	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	Ö	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	٥	l o	0	0	
76. 00	03610 SLEEP LAB	0	12, 372	14, 788	27, 160	-	
	OUTPATIENT SERVICE COST CENTERS	_	,,				1
90.00	09000 CLI NI C	0	8, 043	9, 613	17, 656	460	90.00
91.00	09100 EMERGENCY	0	51, 249	61, 259	112, 508	5, 917	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	20, 638	24, 669	45, 307	368	95. 00
	SPECIAL PURPOSE COST CENTERS						1
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	1, 287, 471	1, 538, 930	2, 826, 401	21, 263	118. 00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	5, 644		5, 644	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1				190.00
	07950 OTHER NRCC	0	00, 303	100, 040	174, 033 N) n	194. 00
	07951 MARKETI NG			"	0		194. 01
	07952 SENI OR CI RCLE		Ö	Ö	n o		194. 02
	07953 FREE MEALS		٥				194. 03
200.00				1	0		200.00
201.00	Negative Cost Centers		0	l o	o o	0	201. 00

1, 381, 500

0 201.00 21, 402 202. 00

3, 026, 078

201.00

202.00

Negative Cost Centers TOTAL (sum lines 118-201)

| Peri od: | Worksheet B | From 01/01/2015 | Part II | Date/Time Prepared: | 5/31/2016 | 8:44 am |

				'	0 12/31/2013	5/31/2016 8: 4	4 am
	Cost Center Description	ADMI TTI NG	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·		AND GENERAL	PLANT	LINEN SERVICE		
		5. 01	5. 02	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.01	00570 ADMITTING	33, 424					5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL	0	156, 866				5. 02
7.00	00700 OPERATION OF PLANT	0	16, 523	914, 433			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	503		52, 459		8. 00
9.00	00900 HOUSEKEEPI NG	0	2, 452	13, 843	0	45, 891	9. 00
10.00	01000 DI ETARY	0	1, 475		0	1, 815	10.00
11. 00	01100 CAFETERI A	0	1, 681	22, 447	0	1, 165	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	987	6, 528	0	339	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 834	34, 258	0	1, 779	14. 00
15. 00	01500 PHARMACY	0	l		0	830	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	3, 025	28, 903	0	1, 501	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0,020	20, 700	<u> </u>	1,001	10.00
30.00	03000 ADULTS & PEDIATRICS	1, 665	16, 187	239, 904	20, 824	12, 455	30.00
31. 00	03100 INTENSIVE CARE UNIT	221	3, 251	27, 802		1, 444	31. 00
43. 00	04300 NURSERY	102	1, 135		0	286	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	102	1, 133	3, 301	٥	200	43.00
50.00	05000 OPERATING ROOM	4, 098	9, 795	110, 219	8, 705	5, 723	50.00
51. 00	05100 RECOVERY ROOM	716	2, 859			412	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	2,037	7, 754	0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 198	13, 022	77, 520	5, 928	4, 025	54. 00
54. 01	05401 ULTRASOUND	7, 170	13,022	77, 320	3, 720	4, 023	54. 01
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0		0	57. 00
58. 00	05800 MRI	0	0		0	0	58.00
60.00	06000 LABORATORY	4, 862	11, 887	30, 994	86	1, 609	60.00
	06500 RESPI RATORY THERAPY		l		00		
65. 00		444	3, 152		0	691	65. 00
66. 00	06600 PHYSI CAL THERAPY	660		18, 258	١	948	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	235	1, 361	5, 974	0	310	67. 00
68. 00	06800 SPEECH PATHOLOGY	15			0	12	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 144	2, 752	9, 027	0	469	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 143	1, 760		0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	832	3, 446		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 629	6, 031	0	0	0	73.00
76. 00	03610 SLEEP LAB	193	906	12, 888	1, 314	669	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	140	0.400	0.070		405	00.00
90.00	09000 CLINIC	140		8, 379		435	90.00
91.00	09100 EMERGENCY	4, 713	33, 567	53, 390	14, 325	2, 772	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS			04 500			
95. 00	09500 AMBULANCE SERVICES	1, 414	3, 323	21, 500	0	1, 116	95. 00
440.04	SPECIAL PURPOSE COST CENTERS	00.404	454.047	047.477	E0 4E0	40.005	440.00
118. 00		33, 424	154, 017	816, 476	52, 459	40, 805	118.00
400.00	NONREI MBURSABLE COST CENTERS		1 00	F 000		205	400 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 324	92, 077	0		192. 00
	07950 OTHER NRCC	0	0	0	0	0	194. 00
	1 07951 MARKETI NG	0	1, 469	0	0	0	194. 01
	2 07952 SENI OR CI RCLE	0	17	0	0	0	194. 02
	3 07953 FREE MEALS	0	0	0	0	0	194. 03
200.00	, ,						200. 00
201.00		0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118-201)	33, 424	156, 866	914, 433	52, 459	45, 891	202.00

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151318
 Period: From 01/01/2015
 Worksheet B

 From 01/01/2015
 Part II

 To 12/31/2015
 Date/Time Prepared:
 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				To	12/31/2015	Date/Time Pre 5/31/2016 8:4	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	4 dili
		10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00570 ADMITTING						5. 01
5. 02	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	112, 035	70.000				10.00
11. 00 13. 00	01100 CAFETERIA	0	72, 829 394				11. 00 13. 00
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY		1, 208		111, 409		14. 00
15. 00	01500 PHARMACY		2, 538		2, 456	60, 931	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 791		147	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS				,		
30.00	03000 ADULTS & PEDIATRICS	74, 616	12, 411		6, 493	0	1
31. 00	03100 INTENSIVE CARE UNIT	9, 711	2, 563		718	0	
43. 00	04300 NURSERY	0	961	848	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		4, 221	1, 435	21, 495	0	50.00
51. 00	05100 RECOVERY ROOM		2, 260		895	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	i i	0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	7, 664	2, 512	5, 471	0	54.00
54. 01	05401 ULTRASOUND	0	C	٦ - ١	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	C	0	0	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MRI	0		0	0	0	57. 00 58. 00
60.00	06000 LABORATORY	0	8, 251		22, 586	0	1
65. 00	06500 RESPIRATORY THERAPY		2, 922		2, 067	0	1
66. 00	06600 PHYSI CAL THERAPY	O	30		336	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	C	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C	1	0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	3, 392		261	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	1	12, 107	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0	27, 268 0	0 60, 931	72. 00 73. 00
76. 00	03610 SLEEP LAB	0	667	1	177	00, 731	1
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u></u>	<u> </u>			70.00
90.00	09000 CLI NI C	0	1, 886	0	1, 777	0	90.00
91. 00	09100 EMERGENCY	3, 106	15, 136	9, 976	4, 274	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	0	2 003	ıl ol	2 000	0	95. 00
93.00	SPECIAL PURPOSE COST CENTERS	U U	3, 003	0	2, 808	0	95.00
118.00		87, 433	72, 298	22, 211	111, 336	60, 931	118. 00
	NONREI MBURSABLE COST CENTERS				·]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	20		16		192. 00
	0/07950 OTHER NRCC 07951 MARKETI NG	0	511		0 57		194. 00 194. 01
	207951 MARKETTING 207952 SENI OR CIRCLE		511		0		194. 01
	307953 FREE MEALS	24, 602	C	-	0		194. 02
200.00		2.,552			Ĭ	9	200. 00
201.00	Negative Cost Centers	0	C	o	0		201. 00
202.00	TOTAL (sum lines 118-201)	112, 035	72, 829	22, 211	111, 409	60, 931	202. 00

Health Financial Systems	DUKES MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 151318 F	Period: From 01/01/2015 To 12/31/2015	Worksheet B	epared:
Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	16.00	24. 00	25. 00	26.00		
GENERAL SERVICE COST CENTERS						4
1.00 00100 CAP REL COSTS-BLDG & FIXT 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 10.00 01000 DIETARY 11.00 01400 CAFETERIA 13.00 01400 CAFETERIA 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01600 MEDICAL RECORDS & LIBRARY	97, 681					1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
INPATIENT ROUTINE SERVICE COST CENTERS				<u>'</u>		1
30. 00 03000 ADULTS & PEDIATRICS	4, 873	900, 971	(30.00
31.00 03100 INTENSIVE CARE UNIT	648	107, 815	1			31. 00
43. 00 04300 NURSERY	297	20, 928	(20, 928		43. 00
ANCILLARY SERVICE COST CENTERS	14 007		1	110 001		4
50. 00 05000 OPERATING ROOM	11, 997	410, 801				50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 095	35, 309				51. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	20, 913	309, 100				54.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05401 ULTRASOUND	20, 913	309, 100				54.00
56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN		0				57. 00
58. 00 05800 MRI		0		1		58.00
60. 00 06000 LABORATORY	14, 232	162, 962	1	1 1		60.00
65. 00 06500 RESPIRATORY THERAPY	1, 300	52, 489	1			65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 931	64, 493	1			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	687	21, 157	1			67. 00
68. 00 06800 SPEECH PATHOLOGY	44	928	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 350	39, 897	1	1		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 347	18, 357	(18, 357		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 434	33, 980	(33, 980		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 623	81, 214		81, 214		73. 00
76. 00 03610 SLEEP LAB	564	44, 678	(44, 678		76. 00
OUTPATIENT SERVICE COST CENTERS						4
90. 00 09000 CLI NI C	410	33, 626	1	1		90. 00
91. 00 09100 EMERGENCY	13, 796	273, 480	1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		92. 00
OTHER REIMBURSABLE COST CENTERS	4 140	02.070		02.070		05.00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	4, 140	82, 979	1	82, 979		95. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	97, 681	2, 695, 164		2, 695, 164		118. 00
NONREI MBURSABLE COST CENTERS	77,001	2,073,104		2, 073, 104		1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 868		11, 868		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	o	292, 251				192. 00
194. 00 07950 OTHER NRCC	0	0				194. 00
194. 01 07951 MARKETI NG	o	2, 176		2, 176		194. 01
194. 02 07952 SENI OR CIRCLE	0	17	1	17		194. 02
194.03 07953 FREE MEALS	0	24, 602		24, 602		194. 03
200.00 Cross Foot Adjustments		0	(o o		200. 00
201.00 Negative Cost Centers	0	0		1 1		201. 00
202.00 TOTAL (sum lines 118-201)	97, 681	3, 026, 078	(3, 026, 078		202. 00

COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od: From 01/01/2015	Worksheet B-1	
				To 12/31/2015		
	CAPITAL REL	ATED COSTS			373172010 0.4	4 4111
Cost Center Description	BLDG & FIXT (SQUARE FEE T)	MVBLE EQUIP (SQUARE FEE T)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	ADMI TTI NG (GROSS CHARGES)	Reconciliation	
	1.00	2. 00	SALARI ES) 4. 00	5. 01	5A. 02	
GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	3.01	JA. 02	
1.00 O0100 CAP REL COSTS-BLDG & FIXT	197, 538					1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 394	196, 731 1, 394		6		2. 00 4. 00
5. 01 00570 ADMI TTI NG	2, 121	2, 121	465, 86			5. 01
5. 02 00590 ADMINISTRATIVE AND GENERAL	10, 057	10, 057			-4, 395, 684	5. 02
7. 00 00700 OPERATION OF PLANT	58, 456	58, 456			0	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	2, 295 1, 900	2, 295 1, 900		0	0	8. 00 9. 00
10. 00 01000 DI ETARY	4, 797	4, 797				10.00
11. 00 01100 CAFETERI A	3, 081	3, 081			Ō	11. 00
13. 00 01300 NURSI NG ADMINI STRATI ON	896	896	•		0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	4, 702	4, 702			0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 195 3, 967	2, 195 3, 967			0	15. 00 16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0, 707	3, 707	220,70	., .	<u>, </u>	10.00
30. 00 03000 ADULTS & PEDIATRICS	32, 928	32, 928			1	1
31. 00 03100 INTENSI VE CARE UNI T 43. 00 04300 NURSERY	3, 816 755	3, 816 755			1	31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	/ 55	/55	112,02	3 433, 853	<u> </u>	43.00
50. 00 05000 OPERATI NG ROOM	15, 128	15, 128	460, 91	5 17, 513, 871	0	50.00
51.00 05100 RECOVERY ROOM	1, 089	1, 089	285, 70	1 3, 058, 450		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	10 (40		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 ULTRASOUND	10, 640	10, 640	806, 81	6 30, 535, 234	0	54. 00 54. 01
56. 00 05600 RADI OI SOTOPE	l o	Ö		0 0	ő	56.00
57. 00 05700 CT SCAN	0	0		0	0	57. 00
58. 00 05800 MRI	0	0		0	0	58. 00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	4, 254 1, 826	4, 254 1, 826				60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 506	2, 506				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	820	820		1, 002, 790	1	67. 00
68.00 06800 SPEECH PATHOLOGY	33	33		0 64, 557	1	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 239	1, 239	1			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 4, 885, 926 0 3, 553, 562	1	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0		0 15, 508, 092		73.00
76. 00 03610 SLEEP LAB	1, 769	1, 769	75, 58	6 823, 303	0	76. 00
OUTPATIENT SERVICE COST CENTERS	1 150	1 150	1 240 02	0 500 4/0		00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	1, 150 7, 328	1, 150 7, 328				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7,020	7,020	0, 202, 22	20, 110, 000		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 951	2, 951	199, 27	3 6, 043, 994	. 0	95. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	184, 093	184, 093	11, 510, 02	4 142, 606, 323	-4, 395, 684	118 00
NONREI MBURSABLE COST CENTERS	104, 075	104, 073	11, 310, 02	142,000,323	1 4, 373, 004	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	807	0		0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	12, 638	12, 638		1 0		192. 00
194. 00 07950 OTHER NRCC 194. 01 07951 MARKETI NG	0	0	75, 08	0		194. 00 194. 01
194. 02 07952 SENI OR CI RCLE	0	0	73,00	0 0	1	194. 02
194. 03 07953 FREE MEALS	0	0		0 0		194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	4 004 500	4 (44 570	4 774 (0	4 (00 4(4		201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 381, 500	1, 644, 578	1, 771, 62	2 1, 608, 464		202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 993591	8. 359526	0. 15292	2 0. 011279	,	203. 00
204.00 Cost to be allocated (per Wkst. B,			21, 40		1	204. 00
Part II)			0.0040.			005 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00184	7 0. 000234		205. 00
1 1117	ı l		I	1	1	ı

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151318 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/31/2016 8:44 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY (SQUARE FEE AND GENERAL PLANT LINEN SERVICE (MEALS SERV) (ACCUM. COST) (SQUARE FEE (POUNDS OF T) LAUNDRY) T) 5.02 9. 00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00570 ADMITTING 5.01 00590 ADMINISTRATIVE AND GENERAL 5.02 22, 988, 583 5.02 00700 OPERATION OF PLANT 7.00 2, 421, 322 125, 510 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 73, 782 2, 295 170, 049 8.00 1, 900 9.00 00900 HOUSEKEEPI NG 359, 378 121.315 9.00 01000 DI ETARY 216, 087 4, 797 4, 797 15, 078 10.00 10.00 0 246, 304 3, 081 3, 081 11.00 01100 CAFETERI A 0 11.00 Λ 01300 NURSING ADMINISTRATION 13.00 144,644 896 0 896 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 268, 788 4, 702 0 4,702 0 14.00 01500 PHARMACY 0 15.00 682.675 2, 195 2.195 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 443, 238 3, 967 0 3, 967 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 372, 099 32, 928 67, 506 32, 928 10, 042 30.00 1, 307 03100 INTENSIVE CARE UNIT 476, 424 4, 139 3, 816 31 00 3,816 31 00 43.00 04300 NURSERY 166, 270 755 0 755 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 1, 435, 391 15, 128 28, 218 15, 128 0 50.00 05100 RECOVERY ROOM 419, 030 1, 089 1, 089 51 00 0 0 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 908, 326 10, 640 19, 215 10,640 0 54.00 54 01 05401 ULTRASOUND 54 01 0 C 0 0 0 05600 RADI OI SOTOPE 56.00 0 C 0 0 0 56.00 57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 MRI 0 0 0 58.00 0 06000 LABORATORY 4, 254 4, 254 60 00 1, 741, 959 278 0 60 00 06500 RESPIRATORY THERAPY 65.00 461, 866 1,826 0 1, 826 0 65.00 06600 PHYSI CAL THERAPY 564, 383 2, 506 0 66.00 2.506 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 199, 487 820 0 820 0 67.00 16, 061 06800 SPEECH PATHOLOGY 0 68.00 68.00 33 33 0 69.00 06900 ELECTROCARDI OLOGY 403, 213 1, 239 0 1, 239 0 69.00 257, 964 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 504, 929 C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 883.844 0 0 73.00 03610 SLEEP LAB 132, 814 1,769 4, 258 1, 769 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 363, 900 1. 150 1. 150 90.00 0 09100 EMERGENCY 91.00 4, 920, 020 7, 328 46, 435 7, 328 418 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 486, 975 95.00 2, 951 0 2, 951 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 22, 571, 173 112, 065 170, 049 107, 870 11, 767 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 5.644 807 807 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 194,033 12,638 12, 638 0 194.00 07950 OTHER NRCC C 0 194.00 0 194. 01 07951 MARKETI NG 0 194, 01 215, 233 C 0 0 194. 02 07952 SENI OR CIRCLE 2,500 C 0 0 0 194, 02 194. 03 07953 FREE MEALS 0 0 0 3, 311 194. 03 200.00 Cross Foot Adjustments 200.00 201 00 Negative Cost Centers 201.00

4, 395, 684

0. 191212

0.006824

156, 866

2, 884, 308

22. 980703

914, 433

7. 285738

140, 631

0.827003

0.308493

52, 459

471, 758

3. 888703

0.378280

45, 891

386, 297 202. 00

25. 619910 203. 00 112, 035 204. 00

7. 430362 205. 00

202.00

203.00

204.00

205.00

Part I)

Part II)

111)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

Heal th	Financial Systems	DUKES MEMORIA			In Lieu	i of Form CMS	2552-10
COST A	ILLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre 5/31/2016 8:4	pared:
	Cost Center Description	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON (NURSI NG SALARI ES)	CENTRAL SERVICES & SUPPLY (COSTED REQ U)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	
		11. 00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS		10.00	111.00	10.00	10.00	
1.00 2.00 4.00 5.01 5.02 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	14, 406 78 239 502 552	7, 131, 489 0 0	1, 903, 022 41, 959 2, 514		142, 606, 323	1. 00 2. 00 4. 00 5. 01 5. 02 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2.455	1 140 0/1	110 010	ما	7 114 511	30.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 455 507		110, 910 12, 272		7, 114, 511 945, 524	
43. 00	04300 NURSERY	190		0		433, 853	1
	ANCILLARY SERVICE COST CENTERS				-1	,	1
50.00	05000 OPERATING ROOM	835	460, 915	367, 168	0	17, 513, 871	50. 00
51.00	05100 RECOVERY ROOM	447		15, 292	0	3, 058, 450	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1	0	0	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	1, 516	1	93, 461	0	30, 535, 234	
54. 01 56. 00	05401 ULTRASOUND 05600 RADI OI SOTOPE	0	1	0	0	0	
57. 00	05700 CT SCAN			0	0	0	57.00
58. 00	05800 MRI		ol ol	0	o	0	1
60.00	06000 LABORATORY	1, 632	633, 708	385, 809	0	20, 776, 974	1
65. 00	06500 RESPI RATORY THERAPY	578	0	35, 303	0	1, 897, 283	
66. 00	06600 PHYSI CAL THERAPY	6	1	5, 739	0	2, 819, 249	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY	0	-	0	0	1, 002, 790	1
69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	671	1	4, 455	0	64, 557 4, 889, 997	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0/1	1	206, 810	0	4, 885, 926	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	465, 737		3, 553, 562	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	708, 928	15, 508, 092	73. 00
76. 00	03610 SLEEP LAB	132	0	3, 026	0	823, 303	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	070	ا	20.050	ما	500 4/0	00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	373 2, 994	1	30, 359 73, 005		598, 468 20, 140, 685	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,774	3, 202, 229	73,003	o l	20, 140, 003	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	594	. 0	47, 961	0	6, 043, 994	95. 00
	SPECIAL PURPOSE COST CENTERS						1
118.00		14, 301	7, 131, 489	1, 901, 780	708, 928	142, 606, 323	118. 00
100 00	NONREIMBURSABLE COST CENTERS 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN		ار	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	1 4		267	0		192. 00
	07950 OTHER NRCC	Ö	1	0	o		194. 00
	07951 MARKETI NG	101	O	975	0	0	194. 01
	07952 SENI OR CIRCLE	0	0	0	0		194. 02
	07953 FREE MEALS	0	0	0	0	0	194. 03
200. 00 201. 00	1 1						200. 00
202.00	1 1 3	376, 185	198, 414	452, 764	895, 282	649, 592	
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	26. 113078 72, 829		0. 237918 111, 409		0. 004555 97, 681	203. 00 204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part II)	5. 055463	0. 003114	0. 058543	0. 085948	0. 000685	205. 00
					·		

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151318	Peri od: Worksheet C
		From 01/01/2015 Part I
		T- 10/01/001F D-+-/T! D

				To 12/31/2015	Date/Time Pre 5/31/2016 8:4	pared: 4 am
		Ti tl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 170 101					
30. 00 03000 ADULTS & PEDI ATRI CS	4, 178, 404		4, 178, 40	I	0	
31. 00 03100 INTENSIVE CARE UNIT	736, 355		736, 35	I	0	31.00
43. 00 04300 NURSERY	232, 860		232, 86	0	0	43. 00
ANCILLARY SERVICE COST CENTERS	0.044.404		0.044.40			F0 00
50. 00 05000 OPERATING ROOM	2, 341, 431		2, 341, 43		0	50.00
51. 00 05100 RECOVERY ROOM	565, 606		565, 60		0	51. 00 52. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC	_			9	0	54.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05401 ULTRASOUND	2, 798, 382		2, 798, 38		0	54.00
56. 00 05600 RADI OI SOTOPE	0				0	56.00
57. 00 05700 CT SCAN	0				0	57.00
58. 00 05800 MRI	0				0	58.00
60. 00 06000 LABORATORY	2, 436, 253		2, 436, 25		0	60.00
65. 00 06500 RESPIRATORY THERAPY	631, 378		631, 37		0	65.00
66. 00 06600 PHYSI CAL THERAPY	753, 999		753, 99		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	264, 232	0	264, 23		0	67.00
68. 00 06800 SPEECH PATHOLOGY	20, 312	0	204, 23.		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	554, 459	J	554, 45		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	378, 749		378, 74		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	728, 471		728, 47		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 018, 767		2, 018, 76		0	73. 00
76. 00 03610 SLEEP LAB	217, 180		217, 180		0	76. 00
OUTPATIENT SERVICE COST CENTERS	217,100		217, 10	91 91		70.00
90. 00 09000 CLINIC	484, 071		484, 07	1 0	0	90.00
91. 00 09100 EMERGENCY	6, 383, 178		6, 383, 17		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	780, 413		780, 41	I	0	92. 00
OTHER REIMBURSABLE COST CENTERS				·		
95. 00 09500 AMBULANCE SERVICES	713, 834		713, 83	1 0	0	95. 00
200.00 Subtotal (see instructions)	27, 218, 334	О	27, 218, 33	1 0	0	200. 00
201.00 Less Observation Beds	780, 413		780, 41:	3	0	201. 00
202.00 Total (see instructions)	26, 437, 921	0	26, 437, 92 ⁻	ı o	0	202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151318	
		From 01/01/2015 Part I
		To 12/21/2015 Data/Time Drenared

				Го 12/31/2015	Date/Time Pre 5/31/2016 8:4	pared: 4 am
		Ti tl	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 313, 407		5, 313, 40			30. 00
31.00 03100 INTENSIVE CARE UNIT	945, 524		945, 52			31. 00
43. 00 04300 NURSERY	433, 853		433, 85	3		43. 00
ANCILLARY SERVICE COST CENTERS				1		
50. 00 05000 OPERATI NG ROOM	4, 887, 560	12, 626, 311			0. 000000	50.00
51. 00 05100 RECOVERY ROOM	641, 019	2, 417, 431	3, 058, 450		0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 258, 481	26, 276, 753	30, 535, 23		0. 000000	54.00
54. 01 05401 ULTRASOUND	0	0	(0. 000000	0. 000000	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	(0. 000000	0. 000000	56. 00
57.00 05700 CT SCAN	0	0	(0. 000000	0. 000000	57. 00
58. 00 05800 MRI	0	0	(0. 000000	0. 000000	58. 00
60. 00 06000 LABORATORY	4, 507, 711	16, 269, 263			0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 408, 551	488, 732			0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	509, 510	2, 309, 739			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	428, 097	574, 693			0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	18, 532	46, 025	64, 55		0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 290, 966	3, 599, 031	4, 889, 99		0. 000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 105, 810	2, 780, 116			0.000000	71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	2, 360, 175	1, 193, 387	3, 553, 56		0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 641, 310	7, 866, 782			0.000000	73. 00
76. 00 03610 SLEEP LAB	14, 520	808, 783	823, 30	0. 263791	0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	10, 548	587, 920			0.000000	90. 00
91. 00 09100 EMERGENCY	2, 028, 099	18, 112, 586			0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	388, 691	1, 412, 413	1, 801, 10	0. 433297	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	6, 043, 994	6, 043, 99	0. 118106	0.000000	95. 00
200.00 Subtotal (see instructions)	39, 192, 364	103, 413, 959	142, 606, 32	3		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	39, 192, 364	103, 413, 959	142, 606, 32	3		202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151318		Worksheet C Part I Date/Time Prepared: 5/31/2016 8:44 am

				5/31/2016 8:44 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 O5100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 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
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03610 SLEEP LAB	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS	-			
90. 00 09000 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				
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
	1			1232.00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151318	Period: Worksheet C From 01/01/2015 Part I
		To 12/31/2015 Date/Time Prepared:

			T	o 12/31/2015	Date/Time Pre 5/31/2016 8:4	
		Ti t	le XIX	Hospi tal	PPS	1 Cilli
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
'	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 178, 404		4, 178, 404	. 0	4, 178, 404	30. 00
31.00 03100 INTENSIVE CARE UNIT	736, 355		736, 355	0	736, 355	31.00
43. 00 04300 NURSERY	232, 860		232, 860	0	232, 860	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 341, 431		2, 341, 431	0	2, 341, 431	50. 00
51.00 05100 RECOVERY ROOM	565, 606		565, 606	0	565, 606	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 798, 382		2, 798, 382	. 0	2, 798, 382	54. 00
54. 01 05401 ULTRASOUND	0		C	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0		C	0	0	56. 00
57. 00 05700 CT SCAN	0		C	0	0	57. 00
58. 00 05800 MRI	0		C	0	0	58. 00
60. 00 06000 LABORATORY	2, 436, 253		2, 436, 253	0	2, 436, 253	60.00
65. 00 06500 RESPIRATORY THERAPY	631, 378	0	631, 378	0	631, 378	65. 00
66. 00 06600 PHYSI CAL THERAPY	753, 999	0	753, 999	0	753, 999	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	264, 232	0	264, 232	. 0	264, 232	67. 00
68. 00 06800 SPEECH PATHOLOGY	20, 312	0	20, 312	. 0	20, 312	68. 00
69. 00 06900 ELECTROCARDI OLOGY	554, 459		554, 459	0	554, 459	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	378, 749		378, 749	0	378, 749	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	728, 471		728, 471	0	728, 471	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 018, 767		2, 018, 767	0	2, 018, 767	73.00
76. 00 03610 SLEEP LAB	217, 180		217, 180	0	217, 180	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	484, 071		484, 071	0	484, 071	90.00
91. 00 09100 EMERGENCY	6, 383, 178		6, 383, 178	o	6, 383, 178	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	780, 413		780, 413		780, 413	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	713, 834		713, 834	. 0	713, 834	95. 00
200.00 Subtotal (see instructions)	27, 218, 334	0	27, 218, 334	0	27, 218, 334	200.00
201.00 Less Observation Beds	780, 413		780, 413		780, 413	201. 00
202.00 Total (see instructions)	26, 437, 921	0	26, 437, 921	o	26, 437, 921	202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151318	
		From 01/01/2015 Part To 12/31/2015 Date/Time Prepared:

				Го 12/31/2015	Date/Time Pre 5/31/2016 8:4	pared: 4 am
		Ti t	le XIX	Hospi tal	PPS	
		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 313, 407		5, 313, 40			30. 00
31.00 03100 INTENSIVE CARE UNIT	945, 524		945, 52			31. 00
43. 00 04300 NURSERY	433, 853		433, 853	3		43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	4, 887, 560	12, 626, 311			0. 000000	50.00
51.00 05100 RECOVERY ROOM	641, 019	2, 417, 431	3, 058, 450		0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0. 000000	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 258, 481	26, 276, 753	30, 535, 23		0. 000000	54.00
54. 01 05401 ULTRASOUND	0	0	(0. 000000	0. 000000	54. 01
56. 00 05600 RADI 0I SOTOPE	0	0	(0. 000000	0. 000000	56. 00
57.00 05700 CT SCAN	0	0	(0. 000000	0. 000000	57. 00
58. 00 05800 MRI	0	0	(0. 000000	0. 000000	58. 00
60. 00 06000 LABORATORY	4, 507, 711	16, 269, 263			0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 408, 551	488, 732			0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	509, 510	2, 309, 739			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	428, 097	574, 693			0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	18, 532	46, 025	64, 55		0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 290, 966	3, 599, 031	4, 889, 99		0. 000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 105, 810	2, 780, 116			0.000000	71. 00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	2, 360, 175	1, 193, 387	3, 553, 562		0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 641, 310	7, 866, 782			0.000000	73. 00
76. 00 03610 SLEEP LAB	14, 520	808, 783	823, 303	0. 263791	0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	10, 548	587, 920			0.000000	90. 00
91. 00 09100 EMERGENCY	2, 028, 099	18, 112, 586			0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	388, 691	1, 412, 413	1, 801, 104	0. 433297	0.000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	6, 043, 994	6, 043, 994	0. 118106	0.000000	95. 00
200.00 Subtotal (see instructions)	39, 192, 364	103, 413, 959	142, 606, 323	3		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	39, 192, 364	103, 413, 959	142, 606, 323	3		202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151318	Peri od: Worksheet C From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared:

				5/31/2016 8: 4	14 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 INTENSIVE CARE UNIT					31. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 133690				50.00
51.00 05100 RECOVERY ROOM	0. 184932				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 091644				54.00
54. 01 05401 ULTRASOUND	0. 000000				54. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000				56. 00
57. 00 05700 CT SCAN	0. 000000				57. 00
58. 00 05800 MRI	0. 000000				58. 00
60. 00 06000 LABORATORY	0. 117257				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 332780				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 267447				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 263497				67.00
68.00 06800 SPEECH PATHOLOGY	0. 314637				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 113386				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 077518				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 204997				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 130175				73. 00
76. 00 03610 SLEEP LAB	0. 263791				76. 00
OUTPATIENT SERVICE COST CENTERS	·				1
90. 00 09000 CLI NI C	0. 808850				90.00
91. 00 09100 EMERGENCY	0. 316930				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 433297				92. 00
OTHER REIMBURSABLE COST CENTERS	·				
95. 00 09500 AMBULANCE SERVI CES	0. 118106				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 HO	SPI TAL		In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT	SERVICE COST TO CHARGE RATIOS NET OF	Provider CCN: 151318	Peri od:	Worksheet C

REDUCTIONS FOR MEDICALD ONLY

						5/31/2016 8: 4	<u>4 am</u>
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cos		Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part			Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 341, 431	410, 801	1, 930, 630	0	0	50.00
51.00	05100 RECOVERY ROOM	565, 606	35, 309	530, 29 ⁻	7 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 798, 382	309, 100	2, 489, 28	2 0	0	54.00
54.01	05401 ULTRASOUND	0	0		0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0		0	0	56.00
57.00	05700 CT SCAN	0	0		0	0	57. 00
58.00	05800 MRI	0	0		0	0	58. 00
60.00	06000 LABORATORY	2, 436, 253	162, 962	2, 273, 29 ⁻	1 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	631, 378	52, 489	578, 88	9 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	753, 999	64, 493	689, 50	6 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	264, 232	21, 157	243, 07	5 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	20, 312	928	19, 38	4 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	554, 459	39, 897	514, 56	2 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	378, 749	18, 357	360, 39	2 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	728, 471	33, 980	694, 49	1 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 018, 767	81, 214	1, 937, 55	3 0	0	73. 00
76.00	03610 SLEEP LAB	217, 180	44, 678	172, 50	2 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		•	•		
90.00	09000 CLI NI C	484, 071	33, 626	450, 44	5 0	0	90.00
91.00	09100 EMERGENCY	6, 383, 178	273, 480	6, 109, 69	8 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	780, 413	175, 769	604, 64	4 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>			•		
95.00	09500 AMBULANCE SERVICES	713, 834	82, 979	630, 85	5 0	0	95. 00
200.00	Subtotal (sum of lines 50 thru 199)	22, 070, 715	1, 841, 219	20, 229, 49	6 0	0	200. 00
201.00	,	780, 413					201. 00
202.00	1	21, 290, 302					202. 00
					1		

Health Financial Systems

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF

REDUCTIONS FOR MEDICALD ONLY

Provider CCN: 151318

Period:
From 01/01/2015
To 12/31/2015

Date/Time Prepared:

Title XIX				'	0 12/01/2010	5/31/2016 8: 44 am
Capital and Operating Cost Part 1, col um Ratio (col 6 6 8 7.00 7.00 8.00			Ti t	le XIX	Hospi tal	PPS
ANCILLARY SERVICE COST CENTERS 8	Cost Center Description					
Reduction 8)						
ANCILLARY SERVICE COST CENTERS			Part I, column	Ratio (col. 6		
ANCILLARY SERVICE COST CENTERS 50.00 00000 000000 05100 DEFRATI ING ROOM 5.65, 6.66 3, 058, 450 0. 184932 51.00 05100 RECOVERY ROOM 5.65, 6.66 3, 058, 450 0. 184932 51.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0. 000000 52.00 052.00 05200 DELI VERY ROOM & LABOR ROOM 0 0. 000000 52.00 054.00 05400 RADI LOGY-DI AGNOSTI C 2, 798, 382 30, 535, 234 0. 091644 54.00 05401 ULTRASOUND 0 0 0. 000000 54.01 05401 ULTRASOUND 0 0 0. 000000 55.00 05500 RADI OI SOTOPE 0 0 0. 000000 0. 000000 55.00 05500 RADI OI SOTOPE 0 0 0. 000000 0. 000000 55.00 05800 MRI 0 0 0. 000000 58.00 MRI 0 0 0. 000000 58.00 06.00 RESPI RATIORY 1. 480, 253 20, 776, 974 0. 117257 60.00 0. 00000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 00000000						
50. 00 05000 DEBRATI NG ROOM 2, 341, 431 17, 513, 871 0.133690 50. 00 51. 00 05100 RECOVERY ROOM 565, 606 3, 058, 450 0. 184932 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0.000000 52. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 798, 382 30, 535, 234 0. 091644 54. 00 54. 01 54. 01 05401 ULTRASOUND 0 0 0.000000 55. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0.000000 55. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0.000000 55. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0 0.000000 55. 00 05700 CT SCAN 0 0 0 0.000000 55. 00 05700 CT SCAN 0 0 0 0.000000 57. 00 05700 CT SCAN 0 0 0 0.000000 58. 00 05800 MRI 0 0 0 0.000000 58. 00 06000 LABORATORY 2, 436, 253 20, 776, 974 0. 117257 60. 00 06500 RESPI RATORY THERAPY 631, 378 1, 897, 283 0. 332780 65. 00 06500 RESPI RATORY THERAPY 753, 999 2, 819, 249 0. 267447 66. 00 06600 PHYSI CAL THERAPY 753, 999 2, 819, 249 0. 267447 66. 00 06600 PHYSI CAL THERAPY 264, 232 1, 002, 790 0. 263497 67. 00 06900 ELEGTROCARDI OLOGY 20, 312 64, 557 0. 314637 68. 00 06900 ELEGTROCARDI OLOGY 20, 312 64, 557 0. 314637 68. 00 06900 ELEGTROCARDI OLOGY 554, 459 4, 889, 997 0. 113386 69. 00 06900 ELEGTROCARDI OLOGY 554, 459 4, 889, 997 0. 113386 69. 00 06900 ELEGTROCARDI OLOGY 564, 459 4, 889, 997 0. 130300 73000 73000 ROUGE CHARGED TO PATI ENTS 728, 471 3, 553, 562 0. 204997 72. 00 72. 00 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 10		6. 00	7. 00	8. 00		
51.00 05100 RECOVERY ROOM 565, 606 3, 058, 450 0. 184932 51. 00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0. 0000000 52.00 0. 0000000 52.00 0. 0000000 54. 00 05400 RADI OLGY-DI AGNOSTI C 2, 798, 382 30, 535, 234 0. 091644 54. 00 0. 0000000 54. 01 05401 ULTRASOUND 0 0 0. 0000000 54. 01 05500 RADI OI SOTOPE 0 0 0. 0000000 55. 00 0. 0000000 57. 00 0. 0000000 57. 00 0. 0000000 57. 00 0. 0000000 57. 00 0. 0000000 57. 00 0. 0000000 58. 00 0. 0000000 58. 00 0. 0000000 58. 00 0. 0000000 58. 00 0. 0000000 58. 00 0. 0000000 58. 00 0. 0000000 58. 00 0. 0000000 58. 00 0. 00000000 58. 00 0. 0000000 58. 00 0. 0000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 000000000 58. 00 0. 00000000 58. 00 0. 000000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000 58. 00 0. 00000000000 58. 00 0. 000000000 58. 00 0. 00000000000000000000000000000					_	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0.000000 52. 00 54. 01 05400 RADI OLOGY-DI AGNOSTI C 2, 798, 382 30, 535, 234 0.091644 54. 01 56. 00 05401 JULTRASOUND 0 0 0.000000 54. 01 56. 00 05600 RADI OL SOTOPE 0 0 0.000000 55. 00 57. 00 05700 CT SCAN 0 0 0.000000 58. 00 60. 00 06000 LABORATORY 2, 436, 253 20, 776, 974 0.117257 60. 00 65. 00 06500 RESPI RATORY THERAPY 631, 378 1, 897, 283 0.332780 65. 00 66. 00 06500 RESPI RATORY THERAPY 631, 378 1, 897, 283 0.332780 65. 00 67. 00 06500 PRESPI RATORY THERAPY 264, 232 1, 002, 790 0. 263497 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 264, 232 1, 002, 790 0. 263497 67. 00 68. 00						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 798, 382 30, 535, 234 0. 091644 54. 00 54. 00 54. 01 05401 ULTRASOUND 0 0. 0000000 54. 01 56. 00 05600 RADI OLOGY-DI AGNOSTI C 0 0 0. 0000000 54. 01 57. 00 05700 CT SCAN 0 0 0. 0000000 57. 00 57. 00 58. 00 05800 MRI 0 0 0. 0000000 58. 00 66. 00 60. 00 06500 RESPI RATORY THERAPY 631, 378 1, 897, 283 0. 332780 65. 00 66. 00 66. 00 6600 PHYSI CAL THERAPY 753, 999 2, 819, 249 0. 267447 66. 00 66. 00 66. 00 06600 PHYSI CAL THERAPY 753, 999 2, 819, 249 0. 267447 66. 00 67. 00 06900 PHYSI CAL THERAPY 264, 232 1, 002, 790 0. 263497 67. 00 68. 00 69. 00 06900 SPECCH PATHOLOGY 20, 312 64, 557 0. 314637 68. 00 68. 00 6900 ELECTROCARDI OLOGY 554, 459 4, 889, 997 0. 113386 69. 00 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 728, 471 3, 553, 562 0. 204997 72. 00 72. 00 7300 BRUGS CHARGED TO PATI ENTS 2, 018, 767 15, 508, 092 0. 130175 73. 00 73. 00 7300 DRUGS CHARGED TO PATI ENTS 2, 018, 767 15, 508, 092 0. 130175 73. 00 70. 00 SEEPL LAB 217, 180 823, 303 0. 263791 76. 00 70. 00 SEEPL LAB 20, 140, 685 0. 316930 0. 263791 79. 00 <td< td=""><td></td><td>565, 606</td><td>3, 058, 450</td><td></td><td></td><td></td></td<>		565, 606	3, 058, 450			
54. 01 05401 ULTRASOUND 0 0.000000 54. 01 56. 00 05600 RADI OI 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 2, 436, 253 20, 776, 974 0.117257 60. 00 65. 00 06500 RESPI RATORY THERAPY 631, 378 1, 897, 283 0.332780 65. 00 66. 00 06600 PHYSI CAL THERAPY 753, 999 2, 819, 249 0.267447 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 264, 232 1, 002, 790 0.263497 67. 00 68. 00 06800 SPEECH PATHOLOGY 20, 312 64, 557 0. 314637 68. 00 69. 00 06900 ELECTROCARDI OLOGY 554, 459 4, 889, 997 0. 113386 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 378, 749 4, 885, 926		1 -1	0			
56. 00 05600 RADI OI SOTOPE 0 0 0 0.000000 55. 00	• • • • • • • • • • • • • • • • • • •	2, 798, 382	30, 535, 234			
57. 00 05700 CT SCAN 0 0 0.000000 557. 00 58. 00 05800 MRI 0 0 0 0.000000 58. 00 60. 00 06000 LABORATORY 2, 436, 253 20, 776, 974 0.117257 60. 00 65. 00 06500 RESPI RATORY THERAPY 631, 378 1, 897, 283 0.332780 65. 00 66. 00 06600 PHYSI CAL THERAPY 753, 999 2, 819, 249 0.267447 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 264, 232 1, 002, 790 0.263497 67. 00 68. 00 06800 SPEECH PATHOLOGY 20, 312 64, 557 0.314637 68. 00 69. 00 06900 ELECTROCARDI OLOGY 554, 459 4, 889, 997 0.113386 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 378, 749 4, 885, 926 0.077518 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 728, 471 3, 553, 562 0.204997 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 018, 767 15, 508, 092 0.130175 73. 00 76. 00 03610 SLEEP LAB 217, 180 823, 303 0.263791 76. 00 09200 DESERVATI ON BEDS (NON-DI STINCT PART 780, 413 1, 801, 104 0.433297 92. 00 09200 DRSERVATI ON BEDS (NON-DI STINCT PART 780, 413 1, 801, 104 0.433297 92. 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 95. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 200. 00	54. 01 05401 ULTRASOUND	0	0	0.000000)	54. 01
58. 00 05800 MRI		0	0	0.000000)	
60. 00		0	0			
65. 00	58. 00 05800 MRI	0	0	0.000000)	58. 00
66. 00 06600 PHYSI CAL THERAPY 753, 999 2,819,249 0.267447 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 264,232 1,002,790 0.263497 67. 00 68. 00 06800 SPECH PATHOLOGY 20,312 64,557 0.314637 68. 00 69. 00 06900 ELECTROCARDI OLOGY 554,459 4,889,997 0.113386 69. 00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 378,749 4,885,926 0.077518 71. 00 72.00 IMPL. DEV. CHARGED TO PATI ENT 728,471 3,553,562 0.204997 72. 00 73.00 DRUGS CHARGED TO PATI ENTS 2,018,767 15,508,092 0.130175 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2,018,767 15,508,092 0.130175 73. 00 076.00 09000 CLI NI C 484,071 598,468 0.808850 90. 00 091.00 09100 EMERGENCY 6,383,178 20,140,685 0.316930 91. 00 09200 DRUGS CHARGED TO PATI ENT 780,413 1,801,104 0.433297 92. 00 07000 CHER REI MBURSABLE COST CENTERS 713,834 6,043,994 0.118106 95. 00 09500 AMBULANCE SERVICES 713,834 6,043,994 0.118106 95. 00 0000 Cult of the control o	60. 00 06000 LABORATORY	2, 436, 253	20, 776, 974	0. 117257	'	60.00
67. 00 06700 OCCUPATI ONAL THERAPY 264, 232 1, 002, 790 0. 263497 68. 00 06800 SPEECH PATHOLOGY 20, 312 64, 557 0. 314637 68. 00 69. 00 06900 ELECTROCARDI OLOGY 554, 459 4, 889, 997 0. 113386 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 378, 749 4, 885, 926 0. 077518 71. 00 72. 00 7300 DRUGS CHARGED TO PATI ENTS 2, 018, 767 15, 508, 092 0. 130175 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 018, 767 15, 508, 092 0. 130175 73. 00 03610 SLEEP LAB 217, 180 823, 303 0. 263791 76. 00 09100 EMERGENCY 6, 383, 178 20, 140, 685 0. 316930 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 780, 413 1, 801, 104 0. 433297 92. 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0. 118106 95. 00 201. 00 Less Observation Beds 780, 413 0 201. 00 201. 00 00. 00. 00. 00. 00. 00. 00. 00. 0	65. 00 06500 RESPIRATORY THERAPY	631, 378	1, 897, 283	0. 332780		65. 00
68. 00 06800 SPEECH PATHOLOGY 20, 312 64, 557 0. 314637 68. 00 69. 00 06900 ELECTROCARDI OLOGY 554, 459 4, 889, 997 0. 113386 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 378, 749 4, 885, 926 0. 077518 71. 00 72. 00 72. 00 IMPL. DEV. CHARGED TO PATI ENTS 728, 471 3, 553, 562 0. 204997 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 018, 767 15, 508, 092 0. 130175 73. 00 03610 SLEEP LAB 217, 180 823, 303 0. 263791 76. 00 000 000 CLI NI C 484, 071 598, 468 0. 808850 90. 00 09100 EMERGENCY 6, 383, 178 20, 140, 685 0. 316930 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 780, 413 1, 801, 104 0. 433297 92. 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0. 118106 95. 00 000 000 Cli Ni C 000 000 Cli Ni C 000 000 Cli Ni C 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000	66. 00 06600 PHYSI CAL THERAPY	753, 999	2, 819, 249	0. 267447	7	66. 00
69. 00 06900 ELECTROCARDI OLOGY 554, 459 4, 889, 997 0. 113386 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 378, 749 4, 885, 926 0. 077518 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 728, 471 3, 553, 562 0. 204997 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 018, 767 15, 508, 092 0. 130175 73. 00 03610 SLEEP LAB 217, 180 823, 303 0. 263791 76. 00 000 DUTPATI ENT SERVI CE COST CENTERS 70. 00 09100 EMERGENCY 6, 383, 178 20, 140, 685 0. 316930 91. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 780, 413 1, 801, 104 0. 433297 92. 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0. 118106 95. 00 200. 00 Subtotal (sum of lines 50 thru 199) 22, 070, 715 135, 913, 539 200. 00 201. 00 Less Observation Beds 780, 413 0 201. 00	67. 00 06700 OCCUPATI ONAL THERAPY	264, 232	1, 002, 790	0. 263497	7	67. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 378, 749 4,885,926 0.077518 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 728, 471 3,553,562 0.204997 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2,018,767 15,508,092 0.130175 73. 00 03610 SLEEP LAB 217,180 823,303 0.263791 76. 00 0000 CLI NI C 484,071 598,468 0.808850 90. 00 09100 EMERGENCY 6,383,178 20,140,685 0.316930 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 780,413 1,801,104 0.433297 92. 00 09500 AMBULANCE SERVI CES 713,834 6,043,994 0.118106 95. 00 200. 00 Less Observation Beds 780,413 0 201. 00 201. 00 00. 00 00. 00 00. 00. 00. 00.	68. 00 06800 SPEECH PATHOLOGY	20, 312	64, 557	0. 314637	7	68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 728, 471 3, 553, 562 0. 204997 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 2, 018, 767 15, 508, 092 0. 130175 73. 00 76. 00 03610 SLEEP LAB 217, 180 823, 303 0. 263791 76. 00 0000 CLI NI C 484, 071 598, 468 0. 808850 90. 00 09100 EMERGENCY 6, 383, 178 20, 140, 685 0. 316930 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 780, 413 1, 801, 104 0. 433297 92. 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0. 118106 95. 00 200. 00 Less Observati on Beds 780, 413 0 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 201. 00 20	69. 00 06900 ELECTROCARDI OLOGY	554, 459	4, 889, 997	0. 113386	b l	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 018, 767 15, 508, 092 0. 130175 73. 00 76. 00 03610 SLEEP LAB 217, 180 823, 303 0. 263791 76. 00 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	378, 749	4, 885, 926	0. 077518	3	71.00
76. 00 03610 SLEEP LAB 217, 180 823, 303 0. 263791 76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	728, 471	3, 553, 562	0. 204997	7	72.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 484,071 598,468 0.808850 90.00 91.00 09100 EMERGENCY 6,383,178 20,140,685 0.316930 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 780,413 1,801,104 0.433297 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES 713,834 6,043,994 0.118106 95.00 200.00 Subtotal (sum of lines 50 thru 199) 22,070,715 135,913,539 200.00 201.00 Less Observation Beds 780,413 0 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	2, 018, 767	15, 508, 092	0. 130175	5	73.00
90. 00 09000 CLI NI C 484, 071 598, 468 0.808850 90. 00 91. 00 09100 EMERGENCY 6, 383, 178 20, 140, 685 0.316930 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 780, 413 1, 801, 104 0.433297 92. 00 OTHER REI MBURSABLE COST CENTERS 713, 834 6, 043, 994 0.118106 95. 00 09500 AMBULANCE SERVI CES 713, 834 6, 043, 994 0.118106 95. 00 200. 00 Subtotal (sum of lines 50 thru 199) 22, 070, 715 135, 913, 539 200. 00 201. 00 Less Observation Beds 780, 413 0 201. 00 201. 00	76. 00 03610 SLEEP LAB	217, 180	823, 303	0. 263791		76.00
91. 00 09100 EMERGENCY 6, 383, 178 20, 140, 685 0. 316930 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 780, 413 1, 801, 104 0. 433297 92. 00 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 00						
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 780, 413 1,801,104 0.433297 92. 00 OTHER REI MBURSABLE COST CENTERS 713,834 6,043,994 0.118106 95. 00 200. 00 Subtotal (sum of lines 50 thru 199) 22,070,715 135,913,539 200. 00 201. 00 Less Observation Beds 780,413 0 201. 00	90. 00 09000 CLI NI C	484, 071	598, 468	0. 808850)	90. 00
OTHER REI MBURSABLE COST CENTERS 95. 00	91. 00 09100 EMERGENCY	6, 383, 178	20, 140, 685	0. 316930		91.00
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	780, 413	1, 801, 104	0. 433297	7	92. 00
200. 00 Subtotal (sum of lines 50 thru 199) 22,070,715 135,913,539 201. 00 Less Observation Beds 780,413 0	OTHER REIMBURSABLE COST CENTERS					
201. 00 Less Observation Beds 780, 413 0 201. 00	95. 00 09500 AMBULANCE SERVICES	713, 834	6, 043, 994	0. 118106	b	95. 00
	200.00 Subtotal (sum of lines 50 thru 199)	22, 070, 715	135, 913, 539			200. 00
202. 00 Total (line 200 minus line 201) 21, 290, 302 135, 913, 539 202. 00	201.00 Less Observation Beds	780, 413	0			201. 00
	202.00 Total (line 200 minus line 201)	21, 290, 302	135, 913, 539			202. 00

He	ealth Financial	Systems			DUKES I	MEMORIAL HO	SPI TAL			In Lie	u of Form CMS-2552-10
Al	PPORTI ONMENT OF	I NPATI ENT	ANCILLARY SERVIC	E CAPITAL	COSTS		Provi der	CCN:	151318		Worksheet D
										From 01/01/2015	Part II

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Pr	rovi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Pre 5/31/2016 8:4	
			Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total (Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from W	Vkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I	, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8	3)	2)			
	26)						
	1.00	2.	00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	410, 801		513, 871			32, 082	1
51.00 05100 RECOVERY ROOM	35, 309	3,	058, 450		· ·	2, 171	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0.00000	0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	309, 100	30,	535, 234			15, 962	54. 00
54. 01 05401 ULTRASOUND	0		0	0. 00000		0	54. 01
56. 00 05600 RADI 0I SOTOPE	0		0	0. 00000	0	0	56. 00
57.00 05700 CT SCAN	0		0	0. 00000		0	57. 00
58. 00 05800 MRI	0		0	0. 00000	0	0	58. 00
60. 00 06000 LABORATORY	162, 962		776, 974				60.00
65. 00 06500 RESPI RATORY THERAPY	52, 489	1,	897, 283	0. 02766	5 824, 437	22, 808	65. 00
66. 00 06600 PHYSI CAL THERAPY	64, 493	2,	819, 249	0. 02287	6 248, 023	5, 674	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	21, 157	1,	002, 790	0. 02109	8 246, 570	5, 202	67. 00
68.00 06800 SPEECH PATHOLOGY	928		64, 557	0. 01437	5 14, 453	208	68. 00
69. 00 06900 ELECTROCARDI OLOGY	39, 897	4,	889, 997	0. 00815	9 666, 670	5, 439	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 357	4,	885, 926	0. 00375	7 936, 742	3, 519	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	33, 980	3,	553, 562	0. 00956	2 1, 244, 618	11, 901	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	81, 214	15,	508, 092	0. 00523	7 3, 836, 059	20, 089	73. 00
76. 00 03610 SLEEP LAB	44, 678		823, 303	0. 05426	7 10, 863	590	76. 00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	33, 626		598, 468	0. 05618	7 0	0	90.00
91. 00 09100 EMERGENCY	273, 480	20,	140, 685	0. 01357	8 2, 136	29	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	175, 769	1,	801, 104	0. 09759	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVI CES							95. 00
200.00 Total (lines 50-199)	1, 758, 240	129,	869, 545		12, 911, 766	139, 388	200. 00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	S Provi der		Period: From 01/01/2015 To 12/31/2015		
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54.01	05401 ULTRASOUND	0	0		0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	0		0	0	56. 00
57.00	05700 CT SCAN	0	0		0	0	57.00
58.00	05800 MRI	0	0		0	0	58. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76.00	03610 SLEEP LAB	0	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
00000	00000 CLINIC	0	0			0	00 00

0

0 0 0

0

0

0

90.00

92.00

95. 00 0 200. 00

0

0 91.00

0

0

0

0

0

90.00

91.00

09000 CLI NI C

09100 EMERGENCY

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS |
95. 00 | 09500 | AMBULANCE SERVICES |
200. 00 | Total (lines 50-199)

	ealth Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
	Financial Systems			0011 454040	In Lieu of Form CMS-2552-1			
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider		Peri od: From 01/01/2015	Worksheet D Part IV		
THROUG	H COSTS				To 12/31/2015	Date/Time Pre	pared:	
						5/31/2016 8: 4		
			Ti tl	e XVIII	Hospi tal	Cost		
	Cost Center Description	Total	Total Charges			Inpati ent		
			(from Wkst. C,		Ratio of Cost			
		Cost (sum of		1,		Charges		
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.			
		4)			7)			
		6. 00	7. 00	8. 00	9. 00	10.00		
	ANCILLARY SERVICE COST CENTERS	T				T		
50.00	05000 OPERATI NG ROOM	0	17, 513, 871	•			1	
51. 00	05100 RECOVERY ROOM	0	3, 058, 450	•		188, 028		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0.00000		l	52. 00	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	30, 535, 234			1, 576, 820	1	
54. 01	05401 ULTRASOUND	0	C	0.00000		0		
56.00	05600 RADI OI SOTOPE	0	C	0.00000		0	56. 00	
57. 00	05700 CT SCAN	0	C	0.00000		0	57. 00	
58.00	05800 MRI	0	C	0.00000		0	58. 00	
60.00	06000 LABORATORY	0	20, 776, 974	1		1, 748, 590		
65.00	06500 RESPI RATORY THERAPY	0	1, 897, 283	0.00000	0. 000000	824, 437	65. 00	
66.00	06600 PHYSI CAL THERAPY	0	2, 819, 249			248, 023	1	
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 002, 790					
68.00	06800 SPEECH PATHOLOGY	0	64, 557	0.00000	0. 000000	14, 453	68. 00	
69. 00	06900 ELECTROCARDI OLOGY	0	4, 889, 997	0.00000	0. 000000	666, 670	69. 00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 885, 926	0.00000	0. 000000	936, 742	71. 00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 553, 562	0.00000	0.000000	1, 244, 618	72. 00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	15, 508, 092	0.00000	0.000000	3, 836, 059	73.00	
76.00	03610 SLEEP LAB	0	823, 303	0.00000	0. 000000	10, 863	76. 00	
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	598, 468	0.00000	0. 000000	0	90.00	
91.00	09100 EMERGENCY	0	20, 140, 685	0.00000	0. 000000	2, 136	91.00	
02 00	00200 OBSERVATION BEDS (NON DISTINCT DART	1	1 001 104	0 00000	0 000000	1 0	00 00	

598, 468 20, 140, 685 1, 801, 104

129, 869, 545

0.000000

0.000000

12, 911, 766 200. 00

0 92.00 95.00

Health Financial Systems

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 151318
From 01/01/2015
To 12/31/2015
Date/Time Prepared:

			'	12/31/2013	5/31/2016 8:	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	C				50.00
51.00 05100 RECOVERY ROOM	0	C				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
54. 01 05401 ULTRASOUND	0	C				54. 01
56. 00 05600 RADI OI SOTOPE	0	C				56. 00
57. 00 05700 CT SCAN	0	C				57. 00
58. 00 05800 MRI	0	C				58. 00
60. 00 06000 LABORATORY	0	C				60.00
65. 00 06500 RESPI RATORY THERAPY	0	C				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C) (67. 00
68.00 06800 SPEECH PATHOLOGY	0	C) (68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C) (69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NT O	C) (71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C) (72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C) (73. 00
76. 00 03610 SLEEP LAB	0	C				76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C) (90. 00
91. 00 09100 EMERGENCY	0	C) (91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	RT 0) ()		92. 00
OTHER REIMBURSABLE COST CENTERS				_		
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	0	C) ()		200. 00

					10 12/31/2015	5/31/2016 8: 4	
			Ti tl	e XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	_					
	05000 OPERATING ROOM	0. 133690		3, 304, 24		0	
	05100 RECOVERY ROOM	0. 184932		682, 76	6 0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0. 091644		9, 276, 86	8 0	0	54.00
54. 01	05401 ULTRASOUND	0. 000000	0		0	0	54. 01
56.00	05600 RADI 0I S0T0PE	0. 000000	0		0	0	56. 00
57.00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MRI	0. 000000	0		0	0	58. 00
60.00	06000 LABORATORY	0. 117257	0	6, 272, 05	4 0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 332780	0	245, 50	8 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 267447	0	568, 85	7 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 263497	0	136, 32	5 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 314637	0	5, 57	8 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 113386	0	1, 727, 20	6 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 077518	0	556, 23	8 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 204997	0	410, 22	2 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 130175	l o	3, 150, 87	6 0	0	73. 00
	03610 SLEEP LAB	0. 263791	l o	287, 66	6 0	0	76. 00
Ī	OUTPATIENT SERVICE COST CENTERS	<u>'</u>	•		•		1
90.00	09000 CLI NI C	0. 808850	0	63, 95	0 0	0	90.00
91.00	09100 EMERGENCY	0. 316930	0	5, 374, 48	2 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 433297	l o	755, 39		0	92.00
Ī	OTHER REIMBURSABLE COST CENTERS	•	•				1
95. 00	09500 AMBULANCE SERVICES	0. 118106			0		95. 00
200.00	Subtotal (see instructions)		l o	32, 818, 24	3 0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				o o		201.00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)		0	32, 818, 24	3 0	0	202. 00

Health Financial Systems	DUKES MEMORIAL F	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151318	Peri od: From 01/01/2015	Worksheet D Part V

						From 01/01/2015 To 12/31/2015	Part V Date/Time Pro 5/31/2016 8:	
				Ti tl	e XVIII	Hospi tal	Cost	
		Cos	sts					
	Cost Center Description	Cost		Cost				
		Rei mbursed		mbursed				
		Servi ces		ices Not				
		Subject To		ject To				
		Ded. & Coins.		& Coins.				
		(see inst.)		einst.)				
ANGL	LLADY CEDVICE COCT CENTERS	6. 00		7. 00				
	LLARY SERVICE COST CENTERS	141 745			I			
	O OPERATING ROOM	441, 745		0				50.00
	O RECOVERY ROOM	126, 265		0				51.00
	DELIVERY ROOM & LABOR ROOM	050.4(0		0				52.00
	O RADI OLOGY-DI AGNOSTI C	850, 169		0				54.00
	ULTRASOUND	0		0				54. 01
	O RADI OI SOTOPE	0		0				56. 00
	O CT SCAN	0	1	0				57. 00
	O MRI	705 440		0				58. 00
	O LABORATORY	735, 442		0				60.00
	O RESPIRATORY THERAPY	81, 700	1	0				65. 00
	O PHYSI CAL THERAPY	152, 139		0				66. 00
	O OCCUPATI ONAL THERAPY	35, 921	1	0				67. 00
	O SPEECH PATHOLOGY	1, 755		0				68. 00
	O ELECTROCARDI OLOGY	195, 841		0				69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	43, 118	1	0				71. 00
	O I MPL. DEV. CHARGED TO PATIENTS	84, 094	1	0	1			72. 00
	DO DRUGS CHARGED TO PATIENTS	410, 165		0				73. 00
	O SLEEP LAB ATIENT SERVICE COST CENTERS	75, 884		0				76. 00
	O CLINIC	51, 726	1	0				90. 00
	O EMERGENCY	1, 703, 335		0				91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	327, 312		0	•			92.00
	R REIMBURSABLE COST CENTERS	327, 312			l			72.00
	O AMBULANCE SERVICES	n						95. 00
200. 00	Subtotal (see instructions)	5, 316, 611		0				200.00
201. 00	Less PBP Clinic Lab. Services-Program	3, 310, 011		O				201. 00
201.00	Only Charges							201.00
202. 00	Net Charges (line 200 +/- line 201)	5, 316, 611		0				202. 00
_02.00		3,3.3,011	1	Ü	1			1=02.00

			Componen	L CCN: 152318 1	0 12/31/2015	5/31/2016 8: 4	
			Ti tl	e XVIII S	wing Beds - SNF	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 133690		C	0	0	
	05100 RECOVERY ROOM	0. 184932		0	0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000		C	0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 091644		C	0	0	54.00
54. 01	05401 ULTRASOUND	0. 000000	0	C	0	0	54. 01
56. 00	05600 RADI 0I S0T0PE	0. 000000	0	C	0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0	C	0	0	57. 00
58. 00	05800 MRI	0. 000000	0	C	0	0	58. 00
60.00	06000 LABORATORY	0. 117257	0	C	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 332780	0	C	o	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 267447	0	l c	o	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 263497	0	l c	o	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 314637	0	l c	o	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 113386	0		o	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 077518	l o	l c	o	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 204997	0	l c	o	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 130175	l 0		o	0	73. 00
76. 00	03610 SLEEP LAB	0. 263791		l c	o	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 808850	C	C	0	0	90.00
91.00	09100 EMERGENCY	0. 316930	0		o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 433297			o	0	92.00
	OTHER REIMBURSABLE COST CENTERS		-	-	-1		1
	09500 AMBULANCE SERVICES	0. 118106					95. 00
200.00	Subtotal (see instructions)		0	0	o	0	200.00
201. 00	Less PBP Clinic Lab. Services-Program			1 0	ol		201. 00
	Only Charges]			******
202.00	Net Charges (line 200 +/- line 201)		l c	C	o	0	202. 00
		•	•	•			•

Heal th Financial Systems

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151318

Component CCN: 152318

Title XVIII Swing Beds - SNF Cost

			mponent	CCN: 15Z318	То	12/31/	2015	Date/Time Pre 5/31/2016 8:4	
			Ti tl e	e XVIII	Swi ng	Beds -	- SNF		
	Cos	sts							
Cost Center Description	Cost	Cos	st						
	Rei mbursed	Rei mbu							
	Servi ces	Servi ce							
	Subject To	Subj ec							
		Ded. & (
	(see inst.)	(see i							
ANCILLARY SERVICE COST CENTERS	6. 00	7. C	00						
50. 00 05000 OPERATING ROOM			0						50.00
51. 00 05100 RECOVERY ROOM	0		0						51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		0						52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0						54.00
54. 01 05401 ULTRASOUND			0						54. 01
56. 00 05600 RADI OI SOTOPE	0		0						56.00
57. 00 05700 CT SCAN	0		0						57. 00
58. 00 05800 MRI	Ö		0						58. 00
60. 00 06000 LABORATORY	Ö		0						60.00
65. 00 06500 RESPIRATORY THERAPY	0		0						65. 00
66. 00 06600 PHYSI CAL THERAPY	o		o						66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		o						67.00
68. 00 06800 SPEECH PATHOLOGY	0		o						68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		o						69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		o						71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0						72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0						73. 00
76. 00 03610 SLEEP LAB	0		0						76. 00
OUTPATIENT SERVICE COST CENTERS									
90. 00 09000 CLI NI C	0	l .	0						90. 00
91. 00 09100 EMERGENCY	0	ŀ	0						91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0						92. 00
OTHER REIMBURSABLE COST CENTERS									
95. 00 09500 AMBULANCE SERVI CES	0	ŀ							95.00
200.00 Subtotal (see instructions)	0	1	0						200.00
201.00 Less PBP Clinic Lab. Services-Program	0	1							201. 00
Only Charges (Line 200 - / Line 201)]							202 00
202.00 Net Charges (line 200 +/- line 201)	0	T	0						202. 00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		eu of Form CMS-2	2552-10	
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/31/2016 8:4	
			Ti t	tle XIX	Hospi tal	PPS	T CIII
	Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	·	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
		(from Wkst. B,		Related Cost		Í	
		Part II, col.		(col. 1 - col			
		26)		2)			
		1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDI ATRI CS	900, 971	C	900, 97	1 3, 706	243. 11	30. 00
31.00	INTENSIVE CARE UNIT	107, 815		107, 81	5 453	238.00	31.00
43.00	NURSERY	20, 928		20, 92	8 400	52. 32	43.00
200.00	Total (lines 30-199)	1, 029, 714		1, 029, 71	4 4, 559		200. 00
	Cost Center Description	I npati ent	Inpati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6. 00	7. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDI ATRI CS	109	26, 499	9			30. 00
31.00	INTENSIVE CARE UNIT	0	C				31.00
43.00	NURSERY	0	(43. 00
200.00	Total (lines 30-199)	109	26, 499	9			200. 00

Health Financial Systems		DUKES MEMORIAL HO	SPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPITAL	COSTS	Provi der CCN: 151318	From 01/01/2015	Worksheet D Part II Date/Time Prepared:

APPURT	TOUMENT OF INPATIENT ANGILLARY SERVICE CAPITA	AL CUSTS			From 01/01/2015 To 12/31/2015	Part II Date/Time Pre 5/31/2016 8:4	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26) 1. 00	2.00	2.00	4.00	F 00	
	ANCILLARY CERVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	410, 801	17, 513, 871	0. 02345	6 126, 194	2, 960	50.00
	05100 RECOVERY ROOM			1		2, 960	
51.00	05200 DELIVERY ROOM & LABOR ROOM	35, 309	3, 058, 450	0.01154		193	51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	309, 100	30, 535, 234	•		760	54.00
	05400 RADI OLOGI - DI AGNOSTI C	309, 100	30, 333, 234	0.01012	·	780	54. 00
56. 00	05600 RADI OI SOTOPE	0		0.00000		0	56.00
57. 00	05700 CT SCAN			0.00000		0	57.00
	05800 MRI			0.00000		0	58.00
60. 00	06000 LABORATORY	162, 962	20, 776, 974	1		· ·	60.00
65. 00	06500 RESPIRATORY THERAPY	52, 489		1			65.00
66. 00	06600 PHYSI CAL THERAPY	64, 493		1	·	249	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	21, 157		1		201	67. 00
68. 00	06800 SPEECH PATHOLOGY	928				0	68.00
	06900 ELECTROCARDI OLOGY	39, 897		1		121	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 357		•		127	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	33, 980			·	816	72.00
	07300 DRUGS CHARGED TO PATIENTS	81, 214			·	869	73.00
	03610 SLEEP LAB	44, 678				0.07	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	11,070	020,000	0.00120	,		70.00
90.00	09000 CLI NI C	33, 626	598, 468	0. 05618	7 118	7	90.00
	09100 EMERGENCY	273, 480		•		504	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	175, 770					
00	OTHER REIMBURSABLE COST CENTERS	1,70,770	.,001,101	3.07707	- 0,20,	0.0	1 00
95. 00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	1, 758, 241	129, 869, 545	5	699, 659	8, 572	200. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/31/2016 8:4	
	T; +	le XIX	Hospi tal	PPS	4 аш	
Cost Contar Dosarintian	Nursing School				Total Costs	
Cost Center Description	Nursing school		Medical	Swing-Bed		
		Cost		Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
					minus col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0	0	
31.00 03100 I NTENSI VE CARE UNIT	0	0	1	0	0	31. 00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0)	0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
· ·	Days	5 ÷ col. 6)	Program Days	Program		
		,		Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8.00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 706	0.00	10	9 0		30.00
31.00 03100 INTENSIVE CARE UNIT	453	0.00)	ol o		31.00
43. 00 04300 NURSERY	400		l .	0		43.00
200.00 Total (lines 30-199)	4, 559		10	9 0		200. 00
	1	1	•	1	1	

Hoal th	Financial Systems	DUKES MEMORIA	AI HOSDITAI		In Lie	eu of Form CMS-2	2552 10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS				Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV	pared:
				le XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	n All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	l c		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	l c		0 0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	l c		0 0	0	54. 00
54. 01	05401 ULTRASOUND	0	l		0 0	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	l c		0 0	0	56. 00
57.00	05700 CT SCAN	0	(0 0	0	57. 00
58. 00	05800 MRI	0	(0 0	0	58. 00
60.00	06000 LABORATORY	0	(0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	(0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	(0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	(0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	(0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(0 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l c		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	l c		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	l c		0 0	0	73. 00
76.00	03610 SLEEP LAB	0			0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	•		•	•		1
90 00	09000 CLINIC	0	(0 0	0	1 90 00

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90.00

95. 00 0 200. 00

0 91.00

0 92.00

90.00

91.00

09000 CLI NI C

09100 EMERGENCY

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS |
95. 00 | 09500 | AMBULANCE SERVICES |
200. 00 | Total (lines 50-199)

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS				Period: From 01/01/2015 To 12/31/2015		
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges			I npati ent	
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	17, 513, 871	0.00000	0.000000	126, 194	50.00
51.00	05100 RECOVERY ROOM	0	3, 058, 450				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0.000000	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	30, 535, 234				
54. 01	05401 ULTRASOUND	0	0	0.00000	0. 000000	0	54. 01
56.00	05600 RADI 0I SOTOPE	0	0	0.00000	0. 000000	0	56. 00
57.00	05700 CT SCAN	0	0	0.00000	0. 000000	0	57. 00
58.00	05800 MRI	0	0	0.00000	0.00000	0	58. 00
60.00	06000 LABORATORY	0	20, 776, 974	0.00000	0.00000	95, 950	60.00
65.00	06500 RESPI RATORY THERAPY	0	1, 897, 283	0.00000	0.00000	25, 150	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 819, 249	0.00000	0. 000000	10, 873	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1, 002, 790	0.00000	0. 000000	9, 508	67.00
68.00	06800 SPEECH PATHOLOGY	0	64, 557	0.00000	0. 000000	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	4, 889, 997	0.00000	0.00000	14, 815	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 885, 926	0.00000	0.00000	33, 779	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 553, 562	0.00000	0. 000000	85, 291	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	15, 508, 092	0.00000	0. 000000	165, 868	73. 00
	03610 SLEEP LAB	0		1	0. 000000	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	598, 468	0.00000	0.00000	118	90.00
91.00	09100 EMERGENCY	0		1	0. 000000	37, 093	91.00
	00000 ODCEDVATION DEDC (NON DICTINCT DADT						02.00

598, 468 20, 140, 685 1, 801, 104

129, 869, 545

0.000000

0.000000

92.00 95.00

3, 237

699, 659 200. 00

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 09500 | AMBULANCE SERVICES | Total (lines 50-199)

Health Financial Systems	DUKES MEMORIAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151318	From 01/01/2015	Worksheet D Part IV Date/Time Prepared:

					10	12/31/2015	5/31/2016 8:	
			Ti t	le XIX		Hospi tal	PPS	
Cost Center Description	I npati ent	0utpat	tient	Outpati ent				
	Program	Prog		Program				
	Pass-Through	Char	ges	Pass-Through				
	Costs (col. 8			Costs (col. o	9			
	x col. 10)			x col. 12)				
	11.00	12.	00	13. 00				
ANCI LLARY SERVI CE COST CENTERS								
50. 00 05000 OPERATI NG ROOM	0		0		0			50.00
51.00 05100 RECOVERY ROOM	0		0		0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0		0			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		0		0			54.00
54. 01 05401 ULTRASOUND	0		0		0			54. 01
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	0		0		0			60.00
65. 00 06500 RESPI RATORY THERAPY	0		0		0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0		0		0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0		0			67. 00
68.00 06800 SPEECH PATHOLOGY	0		0		0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0		0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0		0			73. 00
76. 00 03610 SLEEP LAB	0		0		0			76. 00
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLI NI C	0		0		0			90. 00
91. 00 09100 EMERGENCY	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 50-199)	0		0		0			200. 00

Health Financial Systems	In Lie	u of Form CMS-:	2552-10				
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		Provi der		Period: From 01/01/2015 To 12/31/2015		pared: 4 am
			Ti t	le XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Servi i	eimbursed ces (see nst.)		Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00		2.00	3.00	4. 00	5. 00	

	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0. 133690	0	326, 442		0	50.00
	DO RECOVERY ROOM	0. 184932	0	68, 074	0	0	51.00
	DO DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
	DO RADI OLOGY-DI AGNOSTI C	0. 091644	0	764, 046	0	0	54. 00
	D1 ULTRASOUND	0. 000000	l .	0	0	0	54. 01
	00 RADI OI SOTOPE	0. 000000	0	0	0	0	56. 00
	DO CT SCAN	0. 000000	0	0	0	0	57. 00
	DO MRI	0. 000000	0	0	0	0	58. 00
	DO LABORATORY	0. 117257	0	608, 693		0	60.00
	00 RESPI RATORY THERAPY	0. 332780	0	15, 793		0	65.00
	DO PHYSI CAL THERAPY	0. 267447	0	38, 653		0	66. 00
	OO OCCUPATI ONAL THERAPY	0. 263497	0	3, 867		0	67. 00
	DO SPEECH PATHOLOGY	0. 314637	0	5, 369	0	0	68. 00
69. 00 0690	DO ELECTROCARDI OLOGY	0. 113386	0	97, 043	0	0	69. 00
71. 00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0. 077518	0	116, 778	0	0	71. 00
72. 00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	0. 204997	0	18, 709	0	0	72. 00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	0. 130175	0	176, 179	0	0	73. 00
76. 00 036	10 SLEEP LAB	0. 263791	0	34, 377	0	0	76. 00
	PATIENT SERVICE COST CENTERS						
90.00 0900	DO CLI NI C	0. 808850	0	8, 673	0	0	90.00
91.00 0910	DO EMERGENCY	0. 316930	0	796, 868	0	0	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	0. 433297	0	62, 379	0	0	92.00
	ER REIMBURSABLE COST CENTERS						
95. 00 0950	OO AMBULANCE SERVICES	0. 118106	0	189, 073			95. 00
200.00	Subtotal (see instructions)		0	3, 331, 016	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201.00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)		О (3, 331, 016	0	0	202. 00

Health Financial Systems	DUKES MEMORIAL HO	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151318		Worksheet D
			From 01/01/2015	

				To 12/31/2015	Part V Date/Time Pre 5/31/2016 8:4	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost	ts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
		Services Not				
	Subj ect To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	43, 642	0				50. 00
51.00 05100 RECOVERY ROOM	12, 589	0				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	70, 020	0				54. 00
54. 01 05401 ULTRASOUND	0	0				54. 01
56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57. 00
58. 00 05800 MRI	0	0				58. 00
60. 00 06000 LABORATORY	71, 374	0				60.00
65. 00 06500 RESPIRATORY THERAPY	5, 256	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	10, 338	o				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 019	o				67. 00
68.00 06800 SPEECH PATHOLOGY	1, 689	o				68. 00
69. 00 06900 ELECTROCARDI OLOGY	11, 003	o				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NT 9, 052	o				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 835	o				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	22, 934	o				73. 00
76. 00 03610 SLEEP LAB	9, 068	o				76. 00
OUTPATIENT SERVICE COST CENTERS	·					
90. 00 09000 CLI NI C	7, 015	0				90. 00
91. 00 09100 EMERGENCY	252, 551	o				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART 27, 029	o				92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	22, 331					95. 00
200.00 Subtotal (see instructions)	580, 745	o				200. 00
201.00 Less PBP Clinic Lab. Services-Pro	ogram 0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 20	01) 580, 745	o				202. 00
	·					

Health Financial Systems	DUKES MEMORIAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151318	Peri od: From 01/01/2015	Worksheet D-1
				Date/Time Prepared: 5/31/2016 8:44 am
		Title XVIII	Hospi tal	Cost

			10 12/01/2010	5/31/2016 8: 4	4 am
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
	<u> </u>			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days,			3, 871	1.00
2.00	Inpatient days (including private room days, excluding swing-be			3, 706	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	453	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed			2, 530	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	165	5. 00
,	reporting period			ا	,
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	daya) +brayab Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) till odgir becelliber	31 OF THE COST	١	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 2	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember 5	1 of the cost	١	0.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing_hed and	1, 560	9. 00
7. 00	newborn days)	the frogram (exeruating	Swifing bed and	1, 500	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	oom davs)	148	10.00
	through December 31 of the cost reporting period (see instructi				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, ent	er O on this line)	,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
	after December 31 of the cost reporting period (if calendar yea			ا	
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through Docombor 21 o	f the cost		17. 00
17.00	reporting period	till odgir becellber 31 0	i the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00
	reporting period	arts. Becomber 5. c.			10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period	9			
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			4, 178, 404	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	1 of the cost managetin	a ported (line (0	23. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	Tot the cost reportin	g perrou (Trile o	ا	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
24.00	7 x line 19)	or the cost reporti	ing period (inte	١	24.00
25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)	. 3	' '		
26.00	Total swing-bed cost (see instructions)			178, 103	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		4, 000, 301	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	6, 215, 386	
29. 00	Private room charges (excluding swing-bed charges)			945, 524	
30. 00	Semi-private room charges (excluding swing-bed charges)			5, 269, 862	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 643613	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			2, 087. 25	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			2, 082. 95	
34. 00	Average per diem private room charge differential (line 32 minu	, ,	tions)	4. 30	34. 00
35. 00	Average per diem private room cost differential (line 34 x line	31)		2. 77	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			1, 255	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	3, 999, 046	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	THENTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		T	1 070 07	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see i	•		1, 079. 07	38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	-		1, 683, 349 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	•		1, 683, 349	
55	1.1.1g. a.m. gonor at 1.1.patt one Toutino Solvitos Gost (1116-07-1		ı	., 500, 047	

Provider COR. 19/31 Period. / Provider COR. 19/31 Period. 19/	Heal th	Financial Systems DUK	ES MEMORIAL I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description					CCN: 151318	Peri od:		
Cost Denter Description								
Impatient Cost (Inpatient Dosylphon (Col. 1 Col. 3 Col. 4 Col. 5 Col. 4 Col. 5 Col. 4 Col. 5 Col. 4 Col. 6				Ti tl	e XVIII	Hospi tal		4 am
2.00 BMSERP (citie v 8 xiz orly)								
NRSERY (LITUY 9 & XIX only)		Пірас	Tent Costini	atrent bays		-	,	
Intensive Care Type Input ent Hospital Units 736,355 453 1,625.51 298 481.402 43.00 INTERSIVE CARE UNIT 736,355 453 1,625.51 298 481.402 44.00 808 INTERSIVE CARE CARE CARE CARE CARE CARE CARE CAR	42.00							42.00
44.00 CORRMANY CARE UNIT	42.00		<u> </u>		0.0	0	0	42.00
45.00 BURNEL INTENSIVE CARE UNIT			736, 355	453	1, 625. 5	51 298	484, 402	
47.00 OTHER SPECIAL CASE (SPECIFY)								
28								
1.883,623 40.00 Program Inpatient and Illary service cost (Wistr. D-3 coll. 3. Line 200) 1.883,623 40.00 Program Inpatient costs (cum of illnes 4.1 through 48) (see Instructions) 4.051,374 49.00 Program Inpatient costs (cum of illnes 4.1 through 68) (see Instructions) 4.051,374 49.00 Program Inpatient costs (cum of illnes 50 and 51) 5.00 Program inpatient costs (cum of illnes 50 and 51) 5.00 Program inpatient costs (cum of illnes 50 and 51) 5.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00	47.00							47.00
40.00 Pass through costs applicable to Program inpatient routine services (From Wkst. D. sum of Parts I and Department of the North Pass through costs applicable to Program inpatient routine services (From Wkst. D. sum of Parts I and Department of the North Pass through costs applicable to Program inpatient ancillary services (From Wkst. D. sum of Parts II Department of the North Pass through costs applicable to Program inpatient ancillary services (From Wkst. D. sum of Parts II Department of the North Pass II Department of the Nort	40.00	Decare innetient encillant contine cost (What D	2 22 2 1	ina 200)				40.00
PASS_THROUGH_COST_ADUISTNEMTS D. 0.0					ons)			
		PASS THROUGH COST ADJUSTMENTS						F0 00
and IV) 2. 00 Total Program excludable cost (sum of lines 50 and 51) 3. 00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and pedical education costs (line 49 minus line 52) 5. 00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and pedical education costs (line 49 minus line 52) 5. 00 Program discharges 5. 00 Farget amount (line 54 x line 55) 5. 00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6. 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6. 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6. 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6. 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6. 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6. 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6. 50 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 6. 50 Difference of lines 53/54 or 55 from the cost reporti, updated by the market basket 6. 00 Item 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by of 10 do which operating costs (line 53) are less than expected costs (lines 53 target) 6. 00 Relief payment (see instructions) 6. 01 Difference between any size enter zero (see instructions) 6. 02 Difference instructions are lines and size enter zero (see instructions) 6. 03 Difference instructions are lines and size enter zero (see instructions) 6. 04 Difference of lines 53/54 is 168 Difference and size enter zero (see instructions) 6. 05 Difference of lines 50/54 is 168 Difference and size enter zero (see instructions) 7. 00 Difference cost lines and size enter zero (see instructions	50.00		routine ser	rvices (Trom	1 WKST. D, SUN	n of Parts I and	U	50.00
	51. 00		ancillary s	services (fr	om Wkst. D, s	sum of Parts II	0	51.00
medical education costs (line 49 in nus line 52)	52. 00		1 51)				0	52. 00
TARGET ANDUNT AND LIMIT COMPUTATION	53. 00		apital relat	ted, non-phy	sician anesth	netist, and	0	53. 00
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Program routine service cost (line 9 x line 71) 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Program inpatient ancillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 72.00 73.00 74.00 75.00 76.00 77.00 76.00 77.00 77.00 78.00 78.00 79.00 79.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70								
Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 1npatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 87.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 74.00 Total volumna (propram line) 75.00 Total program inpatient operating cost (sum of lines 83 through 85) 76.00 Total program inpatient operating cost (sum of lines 83 through 85) 77.00 Total program inpatient operating cost (sum of lines 87 through 85) 78.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)								
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 1 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 82.00 Program inpatient ancillary services (see instructions) 83.00 Utilization review - physician compensation (see instructions) 84.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 84.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 723 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)								
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 723 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 75.00 Inpatient routine cost per diem (line 27 ÷ line 2)			•			Part II, column		
77.00 78.00 Inpatient routine service cost (line 9 x line 76) 78.00 78.00 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00	76 00							76 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00								
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sue of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		, ,			1->			
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Post Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		33 3 3			*.	nus line 79)		
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 84.00 84.00 85.00 85.00 85.00 86.00 86.00					(81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reservation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reservation bed days (see instructions) 88.00 Reservation bed days (see instructions) 88.00 Reservation bed days (see instructions) 89.00 Reservation bed days (see instructions)								
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		· ·						
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Total observation bed days (see instructions))				
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 723 87.00 1,079.41 88.00		Total Program inpatient operating costs (sum of li	nes 83 throu					
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,079.41 88.00	87 ∩∩		UGH COST				722	87 AA
89.00 Observation bed cost (line 87 x line 88) (see instructions) 780,413 89.00			(line 27 ÷ li	ne 2)				
	89. 00	Observation bed cost (line 87 x line 88) (see inst	ructions)				780, 413	89. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	900, 971	4, 000, 301	0. 22522	6 780, 413	175, 769	90.00
91.00 Nursing School cost	0	4, 000, 301	0.00000	0 780, 413	0	91.00
92.00 Allied health cost	0	4, 000, 301	0. 00000	780, 413	0	92.00
93 00 All other Medical Education	0	4 000 301	0 00000	780 413	0	93 00

Health Financial Systems	DUKES MEMORIAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERA	ATING COST	Provi der CCN: 151318	Peri od: From 01/01/2015	Worksheet D-1
				Date/Time Prepared: 5/31/2016 8:44 am
		Title XIX	Hospi tal	PPS

		Title XIX	Hospi tal	5/31/2016 8: 4 PPS	4 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days do not complete this line.	vate room days,	3, 871 3, 706 0	1. 00 2. 00 3. 00	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room reporting period		31 of the cost	2, 983 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)			109	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi	ons)		0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent	er O on this line)	,	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	3 .	,	0	12.00
13. 00 14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	r, enter O on this line	e)	0	13. 00 14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	(exciduling swring-bed to	lays)	400 0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	J			18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services			0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	0. 00	20. 00
21. 00 22. 00	reporting period Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost report	na period (line	4, 178, 404 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	·		0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	ino 21 minuo lino 24)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		25500	4, 178, 404	27. 00
28. 00 29. 00	Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28. 00 29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	s line 22)(see instruc	tions)	0.00	33.00
34. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		LI OIIS)	0.00	34.00
35. 00 36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	d private room cost di	fferential (line	4, 178, 404	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38. 00	Adjusted general inpatient routine service cost per diem (see i	•		1, 127. 47	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	-		122, 894	39. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	,		0 122, 894	40. 00 41. 00
		,	'	1	

Heal th	n Financial Systems DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST Provider CCN: 151318 Period: From 01/		Worksheet D-1	
		'31/2015	Date/Time Pre	
	Title XIX Hospi	i tal	5/31/2016 8: 44 PPS	4 am
		am Days	Program Cost (col. 3 x col.	
	Inpati ent Cost Inpati ent Days Di em (col. 1 ÷ col. 2)		4)	
42.00	1.00 2.00 3.00 4. NURSERY (title V & XIX only) 232,860 400 582.15	00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	- U	0	42.00
43. 00 44. 00		0	0	43. 00 44. 00
45. 00				45.00
46. 00				46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description			47. 00
10.00			1. 00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		108, 505 231, 399	
	PASS THROUGH COST ADJUSTMENTS			
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Part	s I and	26, 499	50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Pa	rts II	8, 572	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)		35, 071	52. 00
53.00		nd	196, 328	53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION			
	Program di scharges		0	
55. 00 56. 00			0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		0	57. 00
58. 00 59. 00		by the	0 00	58. 00 59. 00
37.00	market basket	by the		
60. 00 61. 00		nt by	0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the tar		O .	01.00
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)		0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)			63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting perio	d (See T	0	64. 00
	instructions)(title XVIII only)	.		
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period instructions) (title XVIII only)	(See	0	65. 00
66. 00		For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting	peri od	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting pe	riod	0	68. 00
	(line 13 x line 20)	1100		
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)			70. 00
71. 00 72. 00				71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)			73. 00
74. 00 75. 00		column		74. 00 75. 00
75.00	26, line 45)	COT UIIII		75.00
76. 00 77. 00				76. 00 77. 00
78. 00	,			78. 00
79. 00 80. 00	, 33 3	70)		79. 00 80. 00
80.00	,	, 7)		80.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)			82.00
83. 00 84. 00				83. 00 84. 00
85. 00	Utilization review - physician compensation (see instructions)			85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST			86. 00
87. 00	Total observation bed days (see instructions)		723	
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)		1, 127. 47 815, 161	
		'	2.2,.01	

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	900, 971	4, 178, 404	0. 21562	6 815, 161	175, 770	90.00
91.00 Nursing School cost	0	4, 178, 404	0.00000	0 815, 161	0	91.00
92.00 Allied health cost	0	4, 178, 404	0.00000	0 815, 161	0	92.00
93.00 All other Medical Education	0	4, 178, 404	0. 00000	815, 161	0	93. 00

Heal th Financial Systems DUKES MEMORIAL F		00N 4E4043		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151318	Peri od: From 01/01/2015	Worksheet D-3	
			To 12/31/2015	Date/Time Pre	pared:
				5/31/2016 8: 4	
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
LAIDATI FAIT DOUTLAIF CEDALI CE COCT CENTEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1	2, 568, 750		30.00
31.00 03100 NTENSI VE CARE UNIT			728, 491		31.00
43.00 04300 NURSERY			720, 491		43.00
ANCI LLARY SERVI CE COST CENTERS					1 43.00
50. 00 05000 OPERATI NG ROOM		0. 1336	90 1, 367, 757	182, 855	50.00
51. 00 05100 RECOVERY ROOM		0. 1849		34, 772	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.0000		0.,,,,2	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0916		144, 506	
54. 01 05401 ULTRASOUND		0.0000		0	
56. 00 05600 RADI 0I SOTOPE		0.0000		0	56.00
57.00 05700 CT SCAN		0.0000	00 0	0	57.00
58. 00 05800 MRI		0.0000	00	0	58.00
60. 00 06000 LABORATORY		0. 1172	57 1, 748, 590	205, 034	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3327	80 824, 437	274, 356	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 2674	47 248, 023	66, 333	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2634	97 246, 570	64, 970	67. 00
68.00 O6800 SPEECH PATHOLOGY		0. 3146		4, 547	
69. 00 06900 ELECTROCARDI OLOGY		0. 1133			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 0775			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2049			
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 1301			
76. 00 03610 SLEEP LAB		0. 2637	91 10, 863	2, 866	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 8088		0	
91. 00 09100 EMERGENCY		0. 3169			
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART		0. 4332	9/ 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		I			05 00
95. 00 09500 AMBULANCE SERVICES		[12 011 7//	1 000 /00	95.00
200.00 Total (sum of lines 50-94 and 96-98) 201.00 Less PBP Clinic Laboratory Services-Program only charges	(Lino 41)		12, 911, 766	1, 883, 623	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges 202.00 Net Charges (line 200 minus line 201)	(Tine 61)		12 011 744		201.00
zoz. ool net charges (Title zoo iiii hus Title zot)		I	12, 911, 766	I	1202.00

Health Financial Systems	DUKES MEMORIAL HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
	Component		From 01/01/2015 To 12/31/2015		
	Ti +1	e XVIII	Swing Beds - SNF	5/31/2016 8: 4 Cost	4 am
Cost Center Description		Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 Charges		(col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			107, 770		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 13369	0 0	0	50.00
51. 00 05100 RECOVERY ROOM		0. 18493	32 0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09164	6, 348	582	54.00
54. 01 05401 ULTRASOUND		0.00000	0 0	0	54. 01
56. 00 05600 RADI 0I SOTOPE		0.00000	0 0	0	56.00
57. 00 05700 CT SCAN		0.00000	0 0	0	57.00
58. 00 05800 MRI		0.00000	0 0	0	58. 00
60. 00 06000 LABORATORY		0. 11725	21, 931	2, 572	60.00
65. 00 06500 RESPIRATORY THERAPY		0. 33278	26, 010	8, 656	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 26744	99, 868	26, 709	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26349	77 101, 228	26, 673	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 31463	37 O	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 11338	615	70	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	IT	0. 07751	8 23, 374	1, 812	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20499	07	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 13017	75 86, 374	11, 244	73. 00
76. 00 03610 SLEEP LAB		0. 26379		0	1
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 80885	0 0	0	90.00
91. 00 09100 EMERGENCY		0. 31693	0	0	91.00
92 OO OO OBSERVATION BEDS (NON-DISTINCT PAR)T	0 43330	٥٦ م	l n	02 00

0. 433297

365, 748

365, 748

0 92.00 95.00

78, 318 200. 00 201. 00 202. 00

200.00

201. 00 202. 00

92. 00 | 09200 | 0BSERVATION | BEDS | (NON-DISTINCT PART | OTHER | REIMBURSABLE | COST | CENTERS | 09500 | AMBULANCE | SERVICES |

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

Health Financial Systems DUKES MEMORIAL HOSPITAL		In Lie	eu of Form CMS-2	DEE2 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provid	der CCN: 151318	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Pre 5/31/2016 8:4	pared:
	Title XIX	Hospi tal	PPS	
Cost Center Description	Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1	
30. 00 03000 ADULTS & PEDI ATRI CS		114, 915		30.00
31. 00 03100 INTENSI VE CARE UNI T		24, 300		31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS		37, 842		43. 00
50, 00 05000 OPERATING ROOM	0. 1336	90 126, 194	16, 871	50.00
51. 00 05100 RECOVERY ROOM	0. 1849			
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 1849			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.0000			54. 00
54. 01 05401 ULTRASOUND	0. 0000		0,077	1
56. 00 05600 RADI OI SOTOPE	0.0000		0	
57. 00 05700 CT SCAN	0.0000		0	57.00
58. 00 05800 MRI	0.0000		0	
60. 00 06000 LABORATORY	0. 1172		11, 251	
65. 00 06500 RESPI RATORY THERAPY	0. 3327			
66. 00 06600 PHYSI CAL THERAPY	0. 2674	47 10, 873	2, 908	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 2634	97 9, 508	2, 505	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 3146	37 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 1133	36 14, 815	1, 680	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 0775	18 33, 779	2, 618	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0. 2049	97 85, 291	17, 484	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 1301	75 165, 868	21, 592	73. 00
76. 00 03610 SLEEP LAB	0. 2637	91 0	0	76. 00
OUTPAȚI ENT SERVI CE COST CENTERS				
90. 00 09000 CLI NI C	0. 8088			
91. 00 09100 EMERGENCY	0. 3169			
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 4332	97 3, 237	1, 403	92.00
OTHER REIMBURSABLE COST CENTERS			ı	
95. 00 09500 AMBULANCE SERVICES			100 5	95. 00
200.00 Total (sum of lines 50-94 and 96-98)		699, 659	108, 505	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61	')	(00.450		201. 00
202.00 Net Charges (line 200 minus line 201)	I	699, 659	I	202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151318	From 01/01/2015	Worksheet E Part B Date/Ti me Prepared: 5/31/2016 8:44 am

			To 12/31/2015	Date/Time Pre 5/31/2016 8:4	
		Title XVIII	Hospi tal	Cost	
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		<u> </u>	1. 00	
1.00	Medical and other services (see instructions)			5, 316, 611	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2. 00
3.00	PPS payments			0	
4.00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	1
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	. col. 13. Line 200		0	
10.00	Organ acqui si ti ons			0	1
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 316, 611	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges				
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	0.40)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	e 69)		0	
14.00	Customary charges			U	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)	iflime 10 evenede li	ma 11) (aaa	0	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds II	ne II) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)		, (
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		5, 369, 777	21. 00
	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			U	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			5, 707	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		5, 365, 359	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	2 and 23] (see	-1, 289	27. 00
	instructions)	50)			
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			-1, 289	29. 00 30. 00
31. 00	Primary payer payments			1, 185	1
32. 00	Subtotal (line 30 minus line 31)			-2, 474	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			1, 277, 632	1
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	etions)		830, 461	1
37. 00	Subtotal (see instructions)	ctrons)		907, 383 827, 987	
	MSP-LCC reconciliation amount from PS&R			027,707	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	ctions)	0	39. 98
39. 99				0	
40.00	Subtotal (see instructions)			827, 987	40.00
40. 01	Sequestration adjustment (see instructions)			16, 560	
41.00	Interim payments Tentative settlement (for contractors use only)			1, 963, 967 0	1
43. 00	,				
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	chapter 1,	1, 132, 340	44. 00
	§115. 2		<u> </u>		
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0 00	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	
	Total (sum of lines 91 and 93)				94.00
55	The state of the s				,

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

				12, 01, 2010	5/31/2016 8: 44	4 am
			e XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 686, 51	9	1, 963, 967	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider	<u> </u>				
3. 01	ADJUSTMENTS TO PROVIDER	08/07/2015	317, 20		0	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER	06/07/2013		0		3. 01
3. 02				0		3. 02
3. 04				0		3. 04
3. 05				o		3. 05
3.03	Provider to Program		'	<u> </u>	0	3.00
3. 50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	7.05551 MENTS TO TROOM W			Ö		3. 51
3. 52				Ö	l ol	3. 52
3. 53				0	ا ا	3. 53
3. 54				o	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		317, 20	O	0	3. 99
	3. 50-3. 98)		·			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 003, 71	9	1, 963, 967	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	1	-	<u> </u>		
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER	T		ol	0	5. 01
5. 02	TENTATIVE TO PROVIDER	}		0		5. 02
5. 02				o		5. 02
5.05	Provider to Program	1	<u> </u>	<u> </u>	0	3.03
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51				Ö		5. 51
5. 52				Ö	l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			Ö	l ol	5. 99
	5. 50-5. 98)				[
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER			0	0	6. 01
6.02	SETTLEMENT TO PROGRAM		458, 09	3	1, 152, 540	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 545, 62		811, 427	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8. 00

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

Provi der CCN: 151318 | Peri od: | From 01/01/2015 | Part | Part | Date/Time Prepared: | 5/31/2016 | 8: 44 am

					5/31/2016 8: 4	4 am
				ving Beds - SNF		
		Inpatier	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		250, 758		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.0
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					[
3.01	ADJUSTMENTS TO PROVIDER	08/07/2015	25, 900		0	3. 0 ⁻
3.02			0		0	3. 02
3.03			0		0	3.03
3.04			0		0	3.0
3.05			0		0	3. 0!
	Provider to Program	<u>'</u>				ĺ
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3.5
3.52			0		0	3. 5
3.53			0		0	3.5
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		25, 900		0	3.9
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		276, 658		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 0°
5.02			0		0	5. 02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 5°
5. 52			0		0	5. 5:
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 9
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		0		0	6.0
6. 02	SETTLEMENT TO PROGRAM		41, 066		0	6. 0
7.00	Total Medicare program liability (see instructions)		235, 592		0	7. 0
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8.00	Name of Contractor	1				8.0

Heal th	Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu o				2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151318 Period: White Pro				
			From 01/01/2015 To 12/31/2015		nared·
			12,01,2010	5/31/2016 8: 4	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S	S-3, Pt. I col. 15 line	14	1, 127	1. 00
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				
3.00	00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-7	12		3, 436	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			142, 606, 323	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	ne 20		30, 521	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168			1	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		0	10. 00
	I NPATIENT HOSPITAL SERVICES UNDER THE I PPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00
31.00	Other Adjustment (specify)			0	31.00
32 00	Ralance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	د)	0	32 00

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

0 30.00 0 31.00 0 32.00

Health Financial Systems	DUKES MEMOR	RLAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	- SWING BEDS	Provi der CCN: 151318	Peri od: From 01/01/2015	Worksheet E-2
		Component CCN: 15Z318		

		component con. 132310	10 12/31/2013	5/31/2016 8: 4	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		161, 299	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,		79, 101	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru				
4.00	Per diem cost for interns and residents not in approved teaching	program (see		0. 00	4. 00
	instructions)			_	
5.00	Program days	>	148	0	
6.00	Interns and residents not in approved teaching program (see insti			0	0.00
7.00	Utilization review - physician compensation - SNF optional method	d only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		240, 400	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		240, 400	0	1
11. 00	Deductibles billed to program patients (exclude amounts applicable and applicable and applicable and applicable and applicable and applicable applicable and	e to physician	0	0	11. 00
12.00	professional services) Subtotal (line 10 minus line 11)		240, 400	0	12.00
	Coinsurance billed to program patients (from provider records)	avel udo, coi neuroneo	240, 400	0	
13.00	for physician professional services)	excrude corrisulance	٩	U	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		240, 400	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		240, 400	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)			0	
	410A RURAL DEMONSTRATION PROJECT		0	ŭ	16. 55
	Allowable bad debts (see instructions)		0	0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruc-	tions)	o	0	
	Total (see instructions)	,	240, 400	0	
	Sequestration adjustment (see instructions)		4, 808	0	1
	Interim payments		276, 658	0	1
	Tentative settlement (for contractor use only)		0	0	1
	Balance due provider/program (line 19 minus lines 19.01, 20, and	21)	-41, 066	0	1
	Protested amounts (nonallowable cost report items) in accordance	,	0	0	1
	chapter 1, §115.2	,			
					•

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151318	From 01/01/2015	Worksheet E-3 Part V Date/Time Pre 5/31/2016 8:4	pared:
	Title XVIII	Hospi tal	Cost	

				5/31/2016 8: 4	4 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE P.	ART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			4, 051, 374	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	s)		0	2. 00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			4, 051, 374	4. 00
5. 00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 091, 888	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 07.1, 000	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			Ö	9. 00
10. 00	Total reasonable charges			0	10. 00
10.00	Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for pa	ymont for sorvices on	a chargo basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			0	
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services of	ii a charge basis	U	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	12 00
14. 00	Total customary charges (see instructions)			0.000000	
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	no 4) (coo	0	
13.00	instructions)	II IIIle 14 exceeds II	ne o) (see	U	13.00
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	a 14) (saa	0	16. 00
10.00	instructions)	II IIIle o exceeds IIII	e 14) (366	U	10.00
17 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	eti olis)		0	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4,	Line 40)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	11116 47)		4, 091, 888	
20. 00	Deductibles (exclude professional component)			513, 948	
21. 00	Excess reasonable cost (from line 16)			0 0	
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 577, 940	
23. 00	Coi nsurance			3, 377, 340	
24. 00	Subtotal (line 22 minus line 23)			3, 760 3, 574, 160	
25. 00	Allowable bad debts (exclude bad debts for professional service	c) (see instructions)		71, 900	
	· ·	s) (see Histructions)			
26. 00	Adjusted reimbursable bad debts (see instructions)	ationa)		46, 735	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	Ctrons)		21, 585	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			3, 620, 895	
29. 00	MSP			-2, 909	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00	Subtotal (see instructions)			3, 617, 986	
30. 01	Sequestration adjustment (see instructions)			72, 360	
31.00				4, 003, 719	
32. 00				0	
33. 00				-458, 093	
34. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	cnapter 1,	528, 559	34. 00
	§115. 2				

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

| Period: | Worksheet G | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/31/2016 8:44 am Provi der CCN: 151318

				1270172010	5/31/2016 8: 4	4 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	AUDDENT AGGETG	1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	(0.420			0	1 00
1.00	Cash on hand in banks	-60, 630			0	1.00
2.00	Temporary investments	0		-		2.00
3.00	Notes recei vabl e Accounts recei vabl e	12 205 402	1	0	0	
4. 00 5. 00		13, 385, 403		0	0	1
6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	-2, 472, 065		0	0	
7. 00	Inventory	957, 640			0	7.00
8. 00	Prepai d expenses	141, 161			0	
9. 00	Other current assets	223, 767			0	9.00
10. 00	Due from other funds	223, 707		1	0	10.00
11. 00	Total current assets (sum of lines 1-10)	12, 175, 276		-		11.00
11.00	FIXED ASSETS	12, 173, 270	'	<u> </u>	0	11.00
12. 00	Land	500, 000		0	0	12. 00
13. 00	Land improvements	218, 645			0	
14. 00	Accumul ated depreciation	-81, 779	1	-		14. 00
15. 00	Bui I di ngs	10, 464, 466	•	-	ő	15. 00
16. 00	Accumulated depreciation	-2, 514, 011	1	-	0	16. 00
17. 00	Leasehold improvements	5, 801, 929	1	0	Ō	17. 00
18. 00	Accumulated depreciation	-1, 599, 518	1	o o	Ō	18. 00
19. 00	Fi xed equipment	1, 656, 618	1	0	0	19. 00
20. 00	Accumul ated depreciation	-580, 963	1	0	0	20.00
21. 00	Automobiles and trucks	540, 643	1	0	0	21. 00
22. 00	Accumul ated depreciation	-370, 198	1	0	0	22. 00
23.00	Major movable equipment	6, 010, 358	3	0	0	23. 00
24.00	Accumulated depreciation	-4, 333, 011	1	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	2, 813, 741		0	0	25. 00
26.00	Accumulated depreciation	-1, 978, 400		o	0	26. 00
27.00	HIT designated Assets	0) (0	0	27. 00
28. 00	Accumulated depreciation	0) (0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0) (0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	16, 548, 520) (0	0	30.00
	OTHER ASSETS]
31.00	Investments	0) (0	0	31. 00
32.00	Deposits on Leases	0)	0	0	32. 00
33.00	Due from owners/officers	0)	0	0	33. 00
34.00	Other assets	296, 844	. (0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	296, 844	. (0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	29, 020, 640)	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	1, 129, 140	1	-		37. 00
38. 00	Salaries, wages, and fees payable	1, 063, 941	1	-	0	38. 00
39. 00	Payroll taxes payable	83, 031		0	0	39. 00
40. 00	Notes and Loans payable (short term)	0)	0	0	40. 00
41. 00	Deferred income	0)	0	0	41. 00
42. 00	Accel erated payments	0)	_	_	42. 00
43.00	Due to other funds	-13, 651, 099	1	0	0	
44. 00	Other current liabilities	482, 767		1	Ĭ	
45. 00	Total current liabilities (sum of lines 37 thru 44)	-10, 892, 220) (0	0	45. 00
14 00	LONG TERM LIABILITIES			2	^	14 00
46. 00	Mortgage payable			1	0	
47. 00	Notes payable	0		-		1
48. 00	Unsecured Loans	0		-	0	48. 00
49. 00	Other long term liabilities	0		-	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49	10 002 220		0 0	_	
51. 00	Total liabilites (sum of lines 45 and 50) CAPITAL ACCOUNTS	-10, 892, 220	' '	<u> </u>	U	51.00
52. 00	General fund balance	39, 912, 860	\			52. 00
53. 00	Specific purpose fund	39, 912, 000	'l (53.00
54. 00	Donor created - endowment fund balance - restricted			΄		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance					56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
50.00	replacement, and expansion					55. 50
59. 00	Total fund balances (sum of lines 52 thru 58)	39, 912, 860		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	29, 020, 640		o o	Ö	60.00
	59)]			

STATEMENT OF CHANGES IN FUND BALANCES

sheet (line 11 minus line 18)

Provi der CCN: 151318 Peri od: Worksheet G-1

From 01/01/2015 12/31/2015 Date/Time Prepared: 5/31/2016 8:44 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 Fund balances at beginning of period 30, 190, 810 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 9, 722, 050 2.00 Total (sum of line 1 and line 2) 39, 912, 860 0 3.00

1.00 2.00 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 39, 912, 860 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 39, 912, 860 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund

7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 19.00 Fund balance at end of period per balance 19.00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			10 12/31/2015	5/31/2016 8:4	
	Cost Center Description	Inpatient	Outpati ent	Total	T GIII
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	5, 273, 85	i9	5, 273, 859	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	5, 273, 85	19	5, 273, 859	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	945, 52	24	945, 524	11. 00
12.00	CORONARY CARE UNIT				12. 00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	945, 52	24	945, 524	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	6, 219, 38		6, 219, 383	17. 00
18. 00	Ancillary services	32, 972, 98		32, 972, 981	18. 00
19. 00	Outpati ent servi ces		0 103, 413, 959	103, 413, 959	19. 00
20.00	RURAL HEALTH CLINIC		0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE OTHER (SPECI FY)			0	26. 00 27. 00
27. 00 28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	39, 192, 36	103, 413, 959	0 142, 606, 323	
26.00	G-3, line 1)	1. 39, 192, 30	103, 413, 939	142, 000, 323	26.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		29, 076, 603		29. 00
30. 00	ADD (SPECIFY)		0		30.00
31. 00			0		31. 00
32. 00			0		32. 00
33. 00			0		33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39.00			0		39. 00
40.00			0		40. 00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	sfer	29, 076, 603		43.00
	to Wkst. G-3, line 4)				

	ealth Financial Systems DUKES MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 151318	Peri od:	Worksheet G-3		
			From 01/01/2015 To 12/31/2015	Date/Time Pre	narodi	
			10 12/31/2013	5/31/2016 8: 4		
				0,01,2010 0. 1		
				1. 00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			142, 606, 323	1. 00	
2.00	Less contractual allowances and discounts on patients' accounts			103, 932, 412	2.00	
3.00	Net patient revenues (line 1 minus line 2)			38, 673, 911	3.00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			29, 076, 603	4. 00	
5.00	Net income from service to patients (line 3 minus line 4)			9, 597, 308	5. 00	
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			0	7. 00	
8.00	Revenues from telephone and other miscellaneous communication services			0	8. 00	
9.00	Revenue from television and radio service			0	9. 00	
10.00	D. 00 Purchase di scounts			0	10.00	
11.00	11.00 Rebates and refunds of expenses			0	11. 00	
12.00	2.00 Parking Lot receipts			0	12. 00	
13.00	.00 Revenue from laundry and linen service			0	13.00	
14.00	00 Revenue from meals sold to employees and guests			0	14.00	
15.00	00 Revenue from rental of living quarters			0	15. 00	
16.00	.00 Revenue from sale of medical and surgical supplies to other than patients			0	16.00	
17.00	00 Revenue from sale of drugs to other than patients			0	17. 00	
18.00	00 Revenue from sale of medical records and abstracts			0	18. 00	
19.00	00 Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
20.00				0	20. 00	
21.00				0	21. 00	
22. 00	00 Rental of hospital space			0	22. 00	
23.00	3.00 Governmental appropriations			0	23. 00	
24.00	OTHER INCOME			124, 742	24. 00	
25.00				124, 742	25. 00	
26.00	Total (line 5 plus line 25)			9, 722, 050	26. 00	
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00	
28. 00				0	28. 00	
29. 00	Net income (or loss) for the period (line 26 minus line 28)			9, 722, 050	29. 00	