This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1318 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/31/2024 10:49 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/31/2024 Time: 10:49 am ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DUKES MEMORIAL HOSPITAL (15-1318) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OF	R ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1		2	SI GNATURE STATEMENT	
1					I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name					2
3	Signatory Title	VICE PRESIDENT,	REVENUE MANAGEMEN			3
4	Date					4

			Title XVIII				
		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	752, 249	-148, 004	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	541, 280	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	1, 293, 529	-148, 004	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

Heal th	Financial Systems	DUKES MEMORIAL	HOSPI TA	L			11	n Lieu	of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provid	der CC	CN: 15		Period: From 01/01/ To 12/31/	′2023 ′2023	Workshe Part I Date/Ti 5/31/20	me Pre	pared:
	1.00	2. 00		3. 00				4. 00	0, 0 1, 20		17 (3.11)
1. 00	<u>Hospital and Hospital Health Care Co</u> Street: 275 WEST 12TH STREET	mplex Address: PO Box:	1								1. 00
2.00	City: PERU	State: IN	Zip Cod	e: 469	970	Count	y: MI AMI				2. 00
		Component Name	CCN	CBS		Provi der			nt Syst		
			Number	Numl	ber	Туре	Certified	V,	0, or		
		1.00	2. 00	3. (	00	4.00	5. 00	6.00	7. 00		-
-	Hospital and Hospital-Based Componen						T				
3. 00 4. 00	Hospi tal Subprovi der - IPF	DUKES MEMORIAL HOSPITAL	151318	999	15	1	07/01/1966	N	0	P	3. 00 4. 00
5. 00	Subprovider - IRF										5. 00
6. 00	Subprovider - (Other)										6. 00
7. 00	Swing Beds - SNF	DUKES MEMORIAL HOSPITAL SB	15Z318	999	15		12/01/2003	N	0	N	7. 00
8. 00	Swing Beds - NF	30									8. 00
9.00	Hospi tal -Based SNF										9. 00
10.00	Hospital Based NF										10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA										12.00
13.00	Separately Certified ASC										13. 00
14.00	Hospi tal -Based Hospi ce										14.00
15. 00 16. 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15. 00 16. 00
	Hospi tal -Based (CMHC) I										17. 00
18.00	Renal Dialysis										18. 00
19. 00	Utner						From:		To		19. 00
							1. 00		2. (		
	Cost Reporting Period (mm/dd/yyyy)						01/01/2	023	12/31	/2023	20.00
21.00	Type of Control (see instructions)						4				21. 00
						1. 00	2. 00		3. (	00	
22.00	Inpatient PPS Information  Does this facility qualify and is it	currently receiving new	monts for		1	N					22. 00
22.00	disproportionate share hospital adju	3 0.3				IN					22.00
	§412.106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo		ndment								
22. 01	Did this hospital receive interim UC		al UCPs,	for		N	N				22. 01
	this cost reporting period? Enter in										
	for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or										
	cost reporting period occurring on o			.0							
22.02	instructions)	requires a final UCD to	ho			N	N				22. 02
22. 02	Is this a newly merged hospital that determined at cost report settlement			umn		IV	IN.				22.02
	1, "Y" for yes or "N" for no, for th	e portion of the cost re	porting								
	period prior to October 1. Enter in for the portion of the cost reportin			no,							
22. 03	Did this hospital receive a geograph	<b>.</b>		)		N	N		N		22. 03
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft										
	Does this hospital contain at least counted in accordance with 42 CFR 41										
	yes or "N" for no.	·									
22. 04	Did this hospital receive a geograph rural as a result of the revised OMB										22. 04
	adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reportin			er							
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft										
	Does this hospital contain at least	,		as							
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" f	for							
23 00	yes or "N" for no. Which method is used to determine Me	dicaid days on lines 24	and/or 25	5			3 N				23. 00
20.00	below? In column 1, enter 1 if date	of admission, 2 if censu	s days, d	or 3							20.00
	if date of discharge. Is the method reporting period different from the			cost							
	reporting period different from the reporting period? In column 2, ente										
		•									

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1318 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 10: 49 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 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. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 62.00 62.00 0.00 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

Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

during in this cost reporting period of HRSA THC program. (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

0.00 62.01

63.00

N

62.01

Heal th	Financial Systems	DUKFS	MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TAL AND HOSPITAL HEALTH CARE COMPI				eri od:	Worksheet S-2	
				F	rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 5/31/2024 10:	pared: 49 am
				Unwei ghted	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovider Settings		•	•	
64. 00	period that begins on or after J Enter in column 1, if line 63 is	yes, or your facilit	ty trained residents	0.00	0.00	0. 000000	64. 00
	in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo	tations occurring in number of unweighted	all nonprovider d non-primary care				
	of (column 1 divided by (column	1 + column 2)). (see	instructions)				
		Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	nospi tai	4))	
		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
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 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	65.00
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting	1.00	2.00	3.00	
	beginning on or after July 1, 20	10					
66. 00	Enter in column 1 the number of			0.00	0.00	0. 000000	66. 00
	FTEs attributable to rotations o Enter in column 2 the number of						
	FTEs that trained in your hospit						
	(column 1 divided by (column 1 +						
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	1103pi tai	477	
		1. 00	2. 00	3. 00	4. 00	5. 00	
67. 00	Enter in column 1, the program			0.00			67. 00
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

97.00

0.00

0 00

applicable column.

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

Health Financial Systems	DUKES MEMOR	RIAL HOSPITAL		In Li	eu of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	CN: 15-1318	Period: From 01/01/202 To 12/31/202		repared:
					1.00	-
147.00 Was there a change in the statist	cal hasis? Enter "Y" for	r ves or "N" for	no		1.00 N	147. 00
148.00 Was there a change in the order of					N N	148. 00
149.00 Was there a change to the simplif				or no.	N	149. 00
		Part A	Part B		Title XIX	
		1.00	2.00	3.00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or						
155. 00 Hospi tal		N	N	N	N	155. 00
156. 00 Subprovi der - IPF		N	N	N	N	156. 00
157. 00 Subprovi der - IRF		N	N	N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	N	N	N	158. 00 159. 00
160.00HOME HEALTH AGENCY		N	N N	N N	N N	160. 00
161. OO CMHC		IV.	N N	N	N N	161. 00
		-			1.00	
Multicampus					1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ferent CBSAs?	N	165. 00			
Effect 1 101 yes of N 101 He.	Name	County	State 2	Zip Code CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00 4.00	5.00	
166.00  f   line 165 is yes, for each 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)					0.	00 166. 00
					1, 00	_
Health Information Technology (HI	T) incentive in the Amer	ican Recovery an	d Reinvestm	ent Act	1.00	
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 10	under §1886(n)? Enter	"Y" for yes or '	'N" for no.		Y	167. 00 168. 00
reasonable cost incurred for the	HIT assets (see instructi	ons)		,		168. 01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "I	N" for no. (see i	nstructions	s) '		
169.00 If this provider is a meaningful transition factor. (see instruction		nd is not a CAH	(line 105 is	s "N"), enter the	0.	00 169. 00
	•			Begi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR	oogi nni ng data and andi n	a data for the re	oporti na	1. 00	2.00	170. 00
period respectively (mm/dd/yyyy)	beginning date and ending		epoi triig			170.00
				1. 00	2.00	
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3, P umn 1. If column 1 is ye	t. I, line 2, col	. 6? Enter	N		0 171. 00

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1318 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 10:49 am Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2.00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2 00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 Ν Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 04/14/2024 04/14/2024 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for 17 00 N N totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-1318	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pro 5/31/2024 10:	epared:	
		Descri	ipti on	Y/N	Y/N		
		(	)	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N	Date	Y/N	Date		
		1. 00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS H	OSPI TALS)				
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases enter	eporting period?	N	24. 00			
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	ting period?	Plf yes, see	N	25. 00	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	instructions. Has the provider's capitalization policy changed during th	e cost reportin	g period? If	yes, submit	N	27. 00	
	Copy. Interest Expense						
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	ntered into dur	ing the cost	reporting	N	28. 00	
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		bt Service F	Reserve Fund)	N	29. 00	
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes	s, see	N	30. 00	
31. 00	Has debt been recalled before scheduled maturity without instructions.	ssuance of new	debt? If yes	s, see	N	31. 00	
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		d through co	ontractual	N	32. 00	
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		g to competi	tive bidding? If	N	33. 00	
	no, see instructions. Provi der-Based Physicians						
34. 00	Were services furnished at the provider facility under an If yes, see instructions.	arrangement wit	h provider-b	based physicians?	Υ	34. 00	
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		its with the	provi der-based	Y	35. 00	
				Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	y Y		36. 00 37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	fice different	from that of	- Y	12/31/2022	38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			s, N		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00	
	i nstructi ons.						
		1.	00	2.	00		
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position	KUZI WA TSI GA				41.00	
42.00	held by the cost report preparer in columns 1, 2, and 3, respectively.	COMMUNITY HEALTH SYSTEMS,					
42. 00	Enter the employer/company name of the cost report preparer.	I NC	II STSIEMS,	W1171 WA T-1	UC NET	42.00	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416		KUZI WA_TSI GA@C	HS. NET	43. 00	

Heal th F	Financial Systems	DUKES MEMORIA	AL HOSPIT	AL			In Lieu	u of Form CMS	-2552-10
HOSPI TA	L AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi	der CCN:		Peri		Worksheet S-	2
							01/01/2023 12/31/2023		
				3.00					
C	Cost Report Preparer Contact Information								
	Enter the first name, last name and the ti		MANAGER,	REVENUE	MANAGEMENT	-			41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,							
1	respecti vel y.		ļ						
42. 00 I	Enter the employer/company name of the co	st report							42. 00
	preparer.								
	Enter the telephone number and email addro								43. 00
1	report preparer in columns 1 and 2, respe	cti vel y.							

 
 Heal th Financial
 Systems
 DUKES

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1318

				Т	o 12/31/2023	Date/Time Prep 5/31/2024 10:4	
						I/P Days / 0/P	+7 alli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	Component C	Li ne No.	01 5000	Avai I abl e	0,41,711,211,110,41,0		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	21	7, 665	45, 568. 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	45, 568. 00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	4	1, 460	3, 824. 00	0	8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY	43. 00				0	13. 00
14. 00	Total (see instructions)		25	9, 125	49, 392. 00	0	14. 00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVIDER - 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
22. 00	HOME HEALTH AGENCY						23. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						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	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	25			O	27. 00
28. 00	Observation Bed Days		23			0	28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	d			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
32. 31	outpatient days (see instructions)						-2.0.
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	l c		0	34. 00

Provider CCN: 15-1318

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/31/2024	10: 49 am

						5/31/2024 10:	49 am
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	833	71	1, 899			1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	559	450				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	755	0	1, 131			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	1			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 588	71	3, 031			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	64	6	159			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		16	237			13.00
14.00	Total (see instructions)	1, 652	93	3, 427	0.00	189. 64	14. 00
15. 00	CAH visits	0	0	0			15. 00
15. 10	REH hours and visits	0	0	0			15. 10
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)			2			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)		_		0.00	189. 64	
28. 00	Observation Bed Days	_	0	597			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			1			30. 00
31.00	Employee discount days - IRF	_	_	0			31.00
32. 00	Labor & delivery days (see instructions)	0	0				32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0	0				33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0	"		34. 00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Provider CCN: 15-1318

				10	) 12/31/2023	5/31/2024 10:	
		Full Time		Di sch	arges	0,01,2021 10.	.,
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	264	26	676	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)			156	111		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	I NTENSI VE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00		0.4	0.4	(7.	13.00
14. 00	Total (see instructions)	0. 00	C	264	26	676	14. 00
15.00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00 17. 00	SUBPROVIDER - I PF						16. 00 17. 00
18. 00	SUBPROVI DER - I RF SUBPROVI DER	+					17. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care			[			34. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-1318	
		From 01/01/2023   Part IV
		To 12/21/2022 Date/Time Propared:

	To 12/31/20	Date/Time Pre 5/31/2024 10:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	241, 299	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2, 162, 175	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	4, 907	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	17, 205	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)	5, 526	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	88, 646	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	802, 646	
18. 00	Medicare Taxes - Employers Portion Only	187, 716	18. 00
19. 00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	30, 501	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (s	see 0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00		0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	3, 540, 621	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Hoal th	Financial Systems DUKES MEMORIAL HOS	SDLTAL		Inlia	u of Form CMS-2	2552_10			
		rovider CCN	l: 15-1318	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre	o pared:			
					5/31/2024 10:	49 am			
					1. 00				
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00				
	Uncompensated and Indigent Care Cost-to-Charge Ratio								
1.00	Cost to charge ratio (see instructions)				0. 217330	1.00			
1.00	Medicaid (see instructions for each line)				0. 217330	1.00			
2.00	Net revenue from Medicaid				6, 243, 535	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?				0,2.0,000	3. 00			
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al pavments	from Medica	i d?		4. 00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments from				0	5. 00			
6.00	Medi cai d charges				46, 660, 373	6. 00			
7.00	Medicaid cost (line 1 times line 6)				10, 140, 699	7. 00			
8.00	Difference between net revenue and costs for Medicaid program (s	see instruc	tions)		3, 897, 164	8. 00			
	Children's Health Insurance Program (CHIP) (see instructions for	each line	)						
9.00	Net revenue from stand-alone CHIP				0	9. 00			
10.00	Stand-alone CHIP charges				0	10.00			
11. 00	,				0	11. 00			
12.00	Difference between net revenue and costs for stand-alone CHIP (s				0	12.00			
	Other state or local government indigent care program (see instr								
13. 00	Net revenue from state or local indigent care program (Not inclu				0	13. 00			
14. 00	Charges for patients covered under state or local indigent care	program (N	ot included	in lines 6 or	0	14. 00			
	10)				_				
15. 00	State or local indigent care program cost (line 1 times line 14)		,		0	15. 00			
16. 00					0	16. 00			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state.	/local indic	ent care program	is (see				
17. 00	instructions for each line) Private grants, donations, or endowment income restricted to fur	nding chari	ty caro		0	17. 00			
18. 00					0	18.00			
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local			(sum of lines	3, 897, 164	19. 00			
17.00	8, 12 and 16)	That gent C	are programs	(Sum of Titles	3, 077, 104	17.00			
	o, 12 and 10)		Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col . 2)				
			1.00	2. 00	3. 00				
	Uncompensated care cost (see instructions for each line)								
20.00	Charity care charges and uninsured discounts (see instructions)		2, 423, 04	7, 667	2, 430, 709	20. 00			
21. 00	Cost of patients approved for charity care and uninsured discour	nts (see	526, 60	7, 667	534, 267	21. 00			
	instructions)								
22. 00	Payments received from patients for amounts previously written of	off as	91	7 0	917	22. 00			
	charity care		-a- //		500 050				
23. 00	Cost of charity care (see instructions)		525, 68	7, 667	533, 350	23. 00			
					1 00				
24 00	Does the amount on line 20 cel. 2 include charges for noticent of	dayla bayland	a Langth of	Cotou limit	1. 00 N	24.00			
24. 00	Does the amount on line 20 col. 2, include charges for patient cimposed on patients covered by Medicaid or other indigent care p		a rength of	Stay IIIII t	IN	24. 00			
25. 00			care program	's Lanath of	0	25. 00			
23.00	stay limit	, margent	care program	i s rengtii ui	U	20.00			
25. 01	Charges for insured patients' liability (see instructions)				0	25. 01			
26. 00					2, 121, 313				
27. 00									
27. 01	Medicare allowable bad debts (see instructions)				445, 181				
28. 00	Non-Medicare bad debt amount (see instructions)				1, 676, 132	28. 00			

520, 087 29. 00 1, 053, 437 30. 00 4, 950, 601 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio    PART II - HOSPITAL DATA	PART II - HOSPITAL DATA   Date/Time Pro   Date/Time Date/Time Date/Time Pro   Date/Time Date/Tim		Financial Systems DUKES MEMORIAL HOSP				eu of Form CMS-	
PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio  Cost to charge ratio (see instructions)  Medicaid (see instructions for each line)  Net revenue from Medicaid  Difference between net revenue and costs for stand-alone CHIP (see instructions)  Net revenue from State or local indigent care program (see instructions)  11 Fline 4 is no, then enter DSH and/or supplemental payments from Medicaid of Medicaid charges  Medicaid cost (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from state or local indigent care program (Not included in lines 6 or 10 lines state or local indigent care program (Not included in lines 6 or 10 lines for patients covered under state or local indigent care program (Not included in lines 6 or 10 lifference between net revenue and costs for state or local indigent care program (see instructions)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for State or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Or Charlty care charges and uninsured discounts (see instructions)  Or Payments received from patients for amounts previously written off as li	PART II - HOSPITAL DATA   Uncompensated and Indigent Care Cost-to-Charge Ratio   Cost to charge ratio (see instructions)   Medicald (see instructions for each line)   Medicald (see instructions)   Medicald charges   Medica	SPI TA	L UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-131		From 01/01/2023	Parts I & II Date/Time Pre	epare
PART II - HOSPITAL DATA Uncompensated and Indigent Care Cost-to-Charge Ratio  Cost to charge ratio (see instructions)  Medicaid (see instructions for each line)  Net revenue from Medicaid  Difference between net revenue and costs for stand-alone CHIP (see instructions)  Net revenue from State or local indigent care program (see instructions)  11 Fline 4 is no, then enter DSH and/or supplemental payments from Medicaid of Medicaid charges  Medicaid cost (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Net revenue from state or local indigent care program (Not included in lines 6 or 10 lines state or local indigent care program (Not included in lines 6 or 10 lines for patients covered under state or local indigent care program (Not included in lines 6 or 10 lifference between net revenue and costs for state or local indigent care program (see instructions)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for State or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Or Charlty care charges and uninsured discounts (see instructions)  Or Payments received from patients for amounts previously written off as li	DART II - HOSPITAL DATA   Uncompensated and Indigent Care Cost-to-Charge Ratio						1 00	-
Uncompensated and Indigent Care Cost-to-Charge Ratio  Cost to charge ratio (see instructions)  Medicald (see instructions for each line)  Net revenue from Medicaid  Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  If line 4 is no, then enter DSH and/or supplemental payments from Medicaid?  Medicaid charges  Medicaid cost (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions)  Children's Health Insurance Program (CHIP) (see instructions)  Other stand-alone CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from Medicaid  Active the state or local indigent care program (Not included in lines 6 or 10)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Overnment grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Or Apyments received from patients for amounts previously written off as charity care	Uncompensated and Indigent Care Cost-to-Charge Ratio  Cost to charge ratio (see instructions)  Medicaid (see instructions for each line)  Net revenue from Medicaid  Did you receive DSH or supplemental payments from Medicaid?  Of If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  Of If line 4 is no, then enter DSH and/or supplemental payments from Medicaid?  Of If line 4 is no, then enter DSH and/or supplemental payments from Medicaid decided and cost (line 1 times line 6)  Of Difference between net revenue and costs for Medicaid program (see instructions)  Children's Heal th Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line)  Other stand-alone CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (see instructions for each line)  Other state or local government indigent care program (see instructions)  Other state or local government indigent care program (see instructions)  Other state or local indigent care program cost (line 1 times line 14)  Other state or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Occupant parties partients patients patients + col. 2)  1.00   2.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00	l c	ATAN IATIDAON INTRODUCTION				1.00	-
Cost to charge ratio (see Instructions)   Medicaid (see Instructions for each line)	Cost to charge ratio (see instructions   Medicaid (see instructions for each line)	_						
Medicald (see instructions for each line)	Medicaid (see instructions for each line)  Net revenue from Medicaid  Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  If line 4 is no, then enter DSH and/or supplemental payments from Medicaid Medicaid charges  Medicaid charges  Medicaid cast (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-alone CHIP cost (line 1 times line 10)  Stand-alone CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Other state or local government indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for stand-alone cHIP (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  OP Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  On Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Octoor of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Octoor of patients approved for charity care and uninsured							T 1
Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid? Dif line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Dif line 4 is no, then enter DSH and/or supplemental payments from Medicaid Dedicaid charges Difference between net revenue and costs for Medicaid program (see instructions) Difference between net revenue and costs for Medicaid program (see instructions) Difference between net revenue and costs for Stand-alone CHIP (see instructions) Difference between net revenue and costs for stand-alone CHIP (see instructions) Difference between net revenue and costs for stand-alone CHIP (see instructions) Difference between net revenue and costs for stand-alone CHIP (see instructions) Difference between net revenue and costs for stand-alone CHIP (see instructions) Difference between net revenue and costs for stand-alone CHIP (see instructions) Difference between net revenue and costs for stand-alone CHIP (see instructions) Difference between net revenue and costs for stand-alone CHIP (see instructions) Difference between net revenue and costs for stand alone CHIP (see instructions) Difference between net revenue and costs for stand alone CHIP (see instructions) Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10) Difference between net revenue and costs for State or local indigent care program (see instructions) Difference between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unrelimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 1) Difference between net revenue and costs for state or local indigent care program (sum of lines 1) Difference between net revenue and costs for State or local indigent care program (see i	Net revenue from Medical d   Did you receive DSH or supplemental payments from Medicaid?   If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid   If line 4 is no, then enter DSH and/or supplemental payments from Medicaid   Medicaid charges   Medicaid charges   Medicaid charges   Medicaid cost (line 1 times line 6)   Difference between net revenue and costs for Medicaid program (see instructions)   Children's Health Insurance Program (CHIP) (see instructions for each line)   Net revenue from stand-alone CHIP   Stand-alone CHIP charges   OS Stand-alone CHIP cost (line 1 times line 10)   OD DIFference between net revenue and costs for stand-alone CHIP (see instructions)   OD DIFference between net revenue and costs for stand-alone CHIP (see instructions for each line)   OD DIFference between net revenue and costs for stand-alone CHIP (see instructions for each line)   OD DIFference between net revenue and costs for stand-alone CHIP (see instructions for each line)   OD DIFference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 10)   OD State or local indigent care program cost (line 1 times line 14)   OD DIFference between net revenue and costs for state or local indigent care program (see instructions)   OD DIFference between net revenue and costs for state or local indigent care program (see instructions)   OD DIFference between net revenue and costs for state or local indigent care program (see instructions)   OD DIFference between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)   OD DIFference between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see instructions)   OD DIFference between net revenue and costs for Medicaid, CHIP and state/local indigent care programs (see instructions)   OD DIFference between net revenue and costs for Medicaid, CHIP and state and local indigent care programs (see instructions)   OD DIFference							
Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  If line 4 is no, then enter DSH and/or supplemental payments from Medicaid Medicaid cost (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-al one CHIP  Stand-al one CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included in lines 6 or 10)  Other state or local indigent care program (see instructions for each line)  Stand-alone CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone CHIP (see instructions for each line)  Net revenue from state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  OPrivate grants, donations, or endowment income restricted to funding charity care  Sovernment grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)	Did you receive DSH or supplemental payments from Medicaid?   If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?   If line 4 is no, then enter DSH and/or supplemental payments from Medicaid   Medicaid charges   Medicaid cost (line 1 times line 6)   Difference between net revenue and costs for Medicaid program (see instructions)   Children's Health Insurance Program (CHIP) (see instructions for each line)   Net revenue from stand-alone CHIP cost (line 1 times line 10)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent ca		,					1 2
If fine 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?  If line 4 is no, then enter DSH and/or supplemental payments from Medicaid Medicaid charges  Medicaid cost (line 1 times line 6)  Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-al one CHIP Stand-al one CHIP Charges  Stand-al one CHIP charges  10 Stand-al one CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-al one CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Operants, donations, or endowment income restricted to funding charity care  Frivate grants, donations, or endowment income restricted to funding charity care  Operants (sum of lines 1 total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (sum of lines 1 total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (sum of lines 2 total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (sum of lines 2 total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 2 total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (sum of lines 3 total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (sum of line	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?   If line 4 is no, then enter DSH and/or supplemental payments from Medicaid   Medicaid charges   Medicaid cost (line 1 times line 6)   Difference between net revenue and costs for Medicaid program (see instructions)   Children's Health Insurance Program (CHIP) (see instructions for each line)   Net revenue from stand-alone CHIP   Stand-alone CHIP cost (line 1 times line 10)   Stand-alone CHIP cost (line 1 times line 10)   Other state or local government indigent care program (see instructions for each line)   Other state or local indigent care program (Not included on lines 2, 5 or 9)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (Not included in lines 6 or 10)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or local indigent care program (See instructions)   Other state or							3
If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid Medicaid charges			payments from Me	di ca	i d?		4
Medicaid cost (line 1 times line 6)   Difference between net revenue and costs for Medicaid program (see instructions)   Children's Health Insurance Program (CHIP) (see instructions for each line)   Net revenue from stand-al one CHIP cost (line 1 times line 10)   Stand-al one CHIP cost (line 1 times line 10)   Difference between net revenue and costs for stand-al one CHIP (see instructions)   Other state or local government indigent care program (see instructions for each line)   Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)   Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)   State or local indigent care program cost (line 1 times line 14)   Difference between net revenue and costs for state or local indigent care program (see instructions)   Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)   Private grants, appropriations or transfers for support of hospital operations   1 ocor   1	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (see instructions) Children's Heal th Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line) Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  OP invate grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Cost of patients approved for charity care and uninsured discounts (see instructions) OP Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	4	3 1	1 2				5
Medicaid cost (line 1 times line 6)   Difference between net revenue and costs for Medicaid program (see instructions)   Children's Health Insurance Program (CHIP) (see instructions for each line)   Net revenue from stand-al one CHIP cost (line 1 times line 10)   Stand-al one CHIP cost (line 1 times line 10)   Difference between net revenue and costs for stand-al one CHIP (see instructions)   Other state or local government indigent care program (see instructions for each line)   Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)   Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)   State or local indigent care program cost (line 1 times line 14)   Difference between net revenue and costs for state or local indigent care program (see instructions)   Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)   Private grants, appropriations or transfers for support of hospital operations   1 ocor   1	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (see instructions) Children's Heal th Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-alone CHIP (see instructions for each line) Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  OP invate grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Cost of patients approved for charity care and uninsured discounts (see instructions) OP Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	00 1	Medicaid charges					1 6
Difference between net revenue and costs for Medicaid program (see instructions)   Children's Health Insurance Program (CHIP) (see instructions for each line)	Difference between net revenue and costs for Medicaid program (see instructions)  Children's Health Insurance Program (CHIP) (see instructions for each line)  Net revenue from stand-al one CHIP charges  Stand-al one CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-al one CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients (col. 1 1,000 2.00 3.00)  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Ocost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)							7
Net revenue from stand-al one CHIP  Stand-al one CHIP charges  Stand-al one CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-al one CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from stand-al one CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from stand or local indigent care program (see instructions)  Other state or local government indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1, 12 and 16)  Uninsured Insured Insured Insured Insured Insured Insured Patients Patient	Net revenue from stand-alone CHIP Stand-al one CHIP charges OS stand-al one CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) ON et revenue from state or local indigent care program (Not included on lines 2, 5 or 9) Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) OS state or local indigent care program cost (line 1 times line 14) OD lifference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unrelmbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) OF private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients patients patients  Uninsured patients patients    Uninsured patients   Insured patients   Fool   1,00   2,00   3,00			e instructions)				8
Stand-al one CHIP charges  Stand-al one CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-al one CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2)  1.00	Stand-al one CHIP charges  Stand-al one CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-al one CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients    Insured patients   Insured patients   Total (col. 1 + col. 2)	C	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
Stand-alone CHIP cost (line 1 times line 10)  Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 1 patients 1 patien	Stand-al one CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-al one CHIP (see instructions) Other state or local government indigent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2) 1.00 2.00 3.00  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	00 [	Net revenue from stand-alone CHIP					7
Difference between net revenue and costs for stand-alone CHIP (see instructions)   Other state or local government indigent care program (see instructions for each line)   Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)   Otherges for patients covered under state or local indigent care program (Not included in lines 6 or 10)   State or local indigent care program cost (line 1 times line 14)   Ifference between net revenue and costs for state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care program (see instructions)   Other state or local indigent care	Difference between net revenue and costs for stand-alone CHIP (see instructions)  Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients   Insured   Insured patients   Insured patients   Insured   Insured	00	Stand-alone CHIP charges					10
Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients  Line of the patients patients patients  Line of the patients patients patients patients (see instructions)  Charity care charges and uninsured discounts (see instructions)  Deagments received from patients for amounts previously written off as charity care	Other state or local government indigent care program (see instructions for each line)  Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Dilfference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured Insured Insured Insured Patients Patients Patients Patients + col. 2)  1.00 2.00 3.00  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)							11
Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2)  Lincompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients  Putients  Uninsured patients  Insured patients  Patients  Patients  Total (col. 1 patients approved for charity care and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)							_ 12
Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured Insured Patients Patients + col. 2)  1.00 2.00 3.00  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  State or local indigent care program cost (line 1 times line 14)  Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Ocovernment grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients patients + col. 2)  1.00 2.00 3.00  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)							
10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients patients rotal (col. 1 patients rotal (col. 1 patients	10) State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  OP Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients   Insured patients   Total (col. 1 patients   patients   + col. 2)   1.00   2.00   3.00   Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)							13
Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2)  1.00 2.00 3.00  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	Difference between net revenue and costs for state or local indigent care program (see instructions) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients patients + col. 2) 1.00 2.00 3.00  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)			rogram (Not inclu	ided	in lines 6 or		14
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  OPrivate grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2)  1.00 2.00 3.00  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients patients + col. 2) 1.00 2.00 3.00  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	00	State or local indigent care program cost (line 1 times line 14)					15
instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2)  1.00 2.00 3.00  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	instructions for each line)  Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients + col. 2)  1.00 2.00 3.00  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)							_ 16
On Private grants, donations, or endowment income restricted to funding charity care  Government grants, appropriations or transfers for support of hospital operations  Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines and local indigent care programs)  Uninsured patients patients patients + col. 2  1.00 2.00 3.00  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	Private grants, donations, or endowment income restricted to funding charity care Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients  1 nou 2 nou 3 nou  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)			and state/local i	ndi g	ent care progra	ms (see	
Occeptations of transfers for support of hospital operations and I ocal unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines)    Uninsured patients   Insured pati	Government grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)  Uninsured patients patients patients  1 nou 2.00 3.00  Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)							١
Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)    Uninsured patients   Insured patients   Total (col. 1 + col. 2)	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines    Uninsured patients   Insured patients   + col. 2			0				
8, 12 and 16)  Uni nsured patients   Insured patients   Total (col. 1 patients   1.00   2.00   3.00    Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	8, 12 and 16)  Uninsured patients patients patients + col. 2)  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)					( 611		
Uncompensated care cost (see instructions for each line)  Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	Uninsured patients patients 1 nsured patients 2 nsured 2			ndigent care prog	rams	(Sum of Tines		19
Description   Patients   Patien	Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)	1,	5, 12 and 10)	Uni nsu	red	Insured	Total (col 1	
Uncompensated care cost (see instructions for each line)  Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	Uncompensated care cost (see instructions for each line)  On Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)						1	
Uncompensated care cost (see instructions for each line)  On Charity care charges and uninsured discounts (see instructions)  Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	Uncompensated care cost (see instructions for each line)  On Charity care charges and uninsured discounts (see instructions)  On Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care  On Cost of charity care (see instructions)							
Ou Cost of patients approved for charity care and uninsured discounts (see instructions)  Payments received from patients for amounts previously written off as charity care	.00 Cost of patients approved for charity care and uninsured discounts (see instructions) .00 Payments received from patients for amounts previously written off as charity care .00 Cost of charity care (see instructions)	l	Uncompensated care cost (see instructions for each line)	<u> </u>			•	
instructions)  Payments received from patients for amounts previously written off as charity care	instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	00	Charity care charges and uninsured discounts (see instructions)					7 20
00 Payments received from patients for amounts previously written off as charity care	Payments received from patients for amounts previously written off as charity care  Cost of charity care (see instructions)			s (see				2
	.00 Cost of charity care (see instructions)	00	Payments received from patients for amounts previously written of	f as				22
20 Just of Granty care (see matractions)		1	<b>,</b>					2
		00 [	Cost of charity care (see instructions)					1

imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

25.00

25.01

26.00

27. 00

27. 01

28.00

29.00

30. 00 31. 00

25.00

25.01

stay limit

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

27.01 | Medicare allowable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

Heal th	Financial Systems	DUKES MEMORIAL	. HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co	CN: 15-1318	Peri od:	Worksheet A	
				<u> </u>	From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/31/2024 10:	
	Cost Center Description	Sal ari es	Other	Total (col 1	Reclassi fi cati	Reclassi fi ed	47 (1111
	cost contor boson per on	04.4.700	0 (110)	+ col . 2)	ons (See A-6)	Trial Balance	
				' ' ' ' ' ' ' '	( ( )	(col. 3 +-	
						col . 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 117, 018	1, 117, 018	1, 252, 244	2, 369, 262	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 401, 489	2, 401, 489	173, 671	2, 575, 160	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	94, 502	98, 176	192, 678	2, 579, 507	2, 772, 185	4.00
5.01	00570 ADMITTING	0	-95	-9!	1, 441, 318	1, 441, 223	5. 01
5.02	00590 ADMINISTRATIVE AND GENERAL	1, 733, 392	11, 592, 914	13, 326, 300	-4, 712, 237	8, 614, 069	5. 02
7.00	00700 OPERATION OF PLANT	386, 822	1, 888, 038	2, 274, 860	407, 012	2, 681, 872	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	132, 234	132, 23	4 0	132, 234	8. 00
9.00	00900 HOUSEKEEPI NG	389, 501	161, 528	551, 029	-1, 401	549, 628	9. 00
10.00	01000 DI ETARY	237, 934	177, 256	415, 190	-86, 781	328, 409	10. 00
11. 00	01100 CAFETERI A	0	0	(	86, 781	86, 781	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	624, 623	94, 705	719, 328	-22, 265	697, 063	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	178, 670	217, 444			278, 164	14. 00
15. 00	01500 PHARMACY	508, 533	1, 040, 414	1, 548, 94	-938, 595	610, 352	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	40, 088	246, 333	286, 42	-309	286, 112	16. 00
17. 00	01700 SOCI AL SERVI CE	194, 304	15, 965	210, 269	9 0	210, 269	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 692, 385	1, 043, 475			3, 435, 131	
31. 00	03100 INTENSIVE CARE UNIT	325, 684	28, 233			353, 917	31.00
43. 00	04300 NURSERY	0	0		316, 137	316, 137	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	497, 949	757, 636			968, 913	
51.00	05100 RECOVERY ROOM	231, 646	39, 341			270, 987	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	()	-	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	300, 647			300, 647	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	729, 339	481, 806			1, 451, 786	54.00
54. 01	05401 ULTRASOUND	106, 796	91, 910			0	54. 01
56.00	05600 RADI OI SOTOPE	99, 541	71, 193			0	56.00
57. 00	05700 CT SCAN	05 004	128, 589			0	57. 00
58. 00	05800 MRI	95, 994	211, 727			1 750 510	58.00
60.00	06000 LABORATORY	987, 381	839, 945			1, 758, 510	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPIRATORY THERAPY	404 207	62, 833			62, 833	1
65. 00 66. 00	06600 PHYSI CAL THERAPY	496, 397	102, 770			574, 435	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	352, 249 235, 953			352, 249 235, 953	
68. 00	06800 SPEECH PATHOLOGY		235, <del>9</del> 53 94, 642			94, 642	68.00
69. 00	06900 ELECTROCARDI OLOGY	130, 762	44, 891			173, 889	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	130, 702	44, 071	175, 05.	85, 866	85, 866	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		106, 730	106, 730	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		822, 255	822, 255	73. 00
76. 00	03610 SLEEP LAB		0		022, 233	022, 233	76.00
76. 01	03560 PULMONARY FUNCTION TESTING	o	0			0	76. 01
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		377, 633	377, 63		377, 633	
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	377,000	0,,,00	51 51	0,7,7000	70.02
90. 00	09000 CLI NI C	107, 120	13, 105	120, 22!	5 0	120, 225	90. 00
91. 00	09100 EMERGENCY	4, 067, 504	1, 679, 255				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	.,,	.,, ====		.,	-,	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	275, 969	365, 914	641, 883	-142, 999	498, 884	95. 00
	SPECIAL PURPOSE COST CENTERS	,					
118.00		15, 232, 836	26, 507, 166	41, 740, 002	2 0	41, 740, 002	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	(	o o		192. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	15, 232, 836	26, 507, 166	41, 740, 002	<u>2</u> 0	41, 740, 002	200. 00
		•			·		

Health Financial Systems	DUKES MEMORIA		In Lieu of Form	
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CCN: 15-13	Peri od: Worksheet From 01/01/2023	t A
			To 12/31/2023 Date/Time	e Prepared:
Cost Center Description	Adjustments	Net Expenses	5/31/2024	4 10: 49 am
cost center bescription		For Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	417, 166	2, 786, 428		1.00
2. 00   00200   CAP REL COSTS-MVBLE EQUI P	65, 454	2, 640, 614		2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 772, 185		4. 00
5. 01 00570 ADMITTING	0	1, 441, 223		5. 01
5. 02 00590 ADMINISTRATIVE AND GENERAL	-450, 271	8, 163, 798		5. 02
7. 00   00700   OPERATION OF PLANT	-12, 613	2, 669, 259		7. 00
8.00   00800   LAUNDRY & LINEN SERVICE 9.00   00900   HOUSEKEEPING	0	132, 234 549, 628		8. 00 9. 00
10. 00   01000 DI ETARY	0	328, 409		10.00
11. 00 01100 CAFETERI A	-68, 304	18, 477		11.00
13. 00 01300 NURSING ADMINISTRATION	36, 818	733, 881		13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	278, 164		14. 00
15. 00   01500   PHARMACY	Ö	610, 352		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-135	285, 977		16. 00
17. 00   01700   SOCI AL   SERVI CE	0	210, 269		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS		, ,		
30. 00 03000 ADULTS & PEDI ATRI CS	-679, 048	2, 756, 083		30.00
31.00 03100 INTENSIVE CARE UNIT	0	353, 917		31.00
43. 00 04300 NURSERY	0	316, 137		43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0	968, 913		50. 00
51.00 O5100 RECOVERY ROOM	0	270, 987		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	O		52.00
53. 00   05300   ANESTHESI OLOGY	-300, 647	1 225 704		53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	-226, 082	1, 225, 704		54.00
54. 01   05401   ULTRASOUND 56. 00   05600   RADI OI SOTOPE	0	0		54. 01 56. 00
57. 00   05700 CT SCAN	0	0		57.00
58. 00   05800   MRI	0	0		58.00
60. 00   06000   LABORATORY	0	1, 758, 510		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	Ö	62, 833		62.00
65. 00 06500 RESPIRATORY THERAPY	Ö	574, 435		65. 00
66. 00   06600   PHYSI CAL THERAPY	o	352, 249		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	235, 953		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	94, 642		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	173, 889		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	85, 866		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	106, 730		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	822, 255		73. 00
76. 00   03610   SLEEP LAB	0	0		76. 00
76.01 03560 PULMONARY FUNCTION TESTING	0	0		76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	377, 633		76. 02
OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLI NI C	0	120, 225		90.00
91. 00   09100   EMERGENCY	-282, 779	5, 462, 818		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	498, 884		95. 00
SPECIAL PURPOSE COST CENTERS	U U	470, 004		95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 500, 441	40, 239, 561		118. 00
NONREI MBURSABLE COST CENTERS	-1, 300, 441	40, 237, 301		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 00
200. 00 TOTAL (SUM OF LINES 118 through 199)	-1, 500, 441	40, 239, 561		200. 00
1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	., 300,			1=00.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/31/2024 10:49 am Provider CCN: 15-1318

					5/31/2024 1	
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2.00 A - EMPLOYEE BENEFITS	3. 00	4. 00	5. 00		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 579, 507		1.00
1.00	TOTALS		— — <del>ŏ</del>	2, 579, 507		1.00
	B - RENT AND LEASES			, , , , , , , , , , , , , , , , , , , ,		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	623, 869		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	159, 962		2. 00
3. 00 4. 00	ADMI TTI NG	5. 01 0. 00	0	75 0		3. 00 4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	O	O		6. 00
7.00		0.00	O	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	o	Ö		12. 00
13.00		0.00	0	0		13. 00
14.00		0. 00	0	0		14. 00
15. 00	TOTALS	0.00		0 		15. 00
	TOTALS  C - OTHER CAPITAL COSTS		U U	763, 900		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	191, 319		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	437, 056		2. 00
3.00	CAP REL COSTS-MVBLE EQUIP		0	1 <u>3, 7</u> 09		3. 00
	TOTALS		0	642, 084		
1. 00	D - REPAIRS AND MAINTENANCE OPERATION OF PLANT	7. 00	0	410, 811		1.00
2. 00	OF EKATTON OF TEAM	0.00	o	410, 011		2. 00
3. 00		0. 00	o	O		3. 00
4.00		0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	0	0		8. 00
9. 00		0.00	o	Ö		9. 00
10.00		0. 00	O	0		10. 00
11. 00		0.00	0	0		11. 00
12. 00		0. 00 0. 00	0	0		12.00
13. 00 14. 00		0.00	0	0		13. 00 14. 00
15. 00		0.00	ő	0		15. 00
	TOTALS			410, 811		
	E - CNO COSTS	40.00	407 407			4.00
1. 00	NURSING ADMINISTRATION		19 <u>7, 4</u> 37 197, 437	- $ 0$		1. 00
	F - MEDICAL SUPPLIES		197, 437	U		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	85, 866		1.00
	PATI ENT					
2.00	I MPL. DEV. CHARGED TO	72. 00	0	106, 730		2. 00
3. 00	PATI ENTS	0.00	0	0		3. 00
4. 00		0.00	o	0		4. 00
	TOTALS	- $  +$		192, 596		
	G - COST OF DRUGS/IV SOLUTION					
1. 00	DRUGS CHARGED TO PATIENTS		0	822, 255		1. 00
	TOTALS H - NURSERY		0	822, 255		
1.00	NURSERY	43. 00	276, 819	39, 318		1.00
	TOTALS		276, 819	39, 318		
	I - QUALITY ASSURANCE					
1.00	ADMI NI STRATI VE AND GENERAL		166, 518	36, 052		1. 00
	TOTALS  J - MISC DEPARTMENTS		166, 518	36, 052		
1. 00	ADMITTING	5. 01	580, 409	860, 834		1.00
1. 50	TOTALS		580, 409	860, 834		1.00
	K - OTHER RADIOLOGY					
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	302, 331	90, 721		1. 00
2.00		0.00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	U	0		3. 00 4. 00
7.00	TOTALS — — — —		302, 331	90, 721		4.00
		1	/ == -	= .		

Н	leal th f	Financial Systems		DUKES MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
F	RECLASS	I FI CATI ONS			Provi der (	CCN: 15-1318	Peri od: From 01/01/2023	Worksheet A-6	5
								Date/Time Pro 5/31/2024 10:	
			Increases						
		Cost Center	Li ne #	Sal ary	0ther				
		2 00	3 00	4 00	5 00				

		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	L - DIETARY COSTS TO CAFETERI	A			
1.00	CAFETERI A	11. 00	49, 301	37, 480	1.00
	TOTALS		49, 301	37, 480	
	M - NON CAPITALIZED EQUIPMENT				
1.00	OPERATION OF PLANT	7. 00	0	956	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3. 00
	TOTALS — — — — —		<u> </u>	956	
	N - SITTER COSTS				
1.00	ADULTS & PEDIATRICS	30.00	15, 850	1, 238	1.00
	TOTALS		15, 850	1, 238	
500.00	Grand Total: Increases		1, 588, 665	6, 497, 758	500.00

Provider CCN: 15-1318

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 10:49 am

Cost Center   Line   S Sal ary   Other   West   A. 7. Neft			Docroscos				5/31/2024 10	: 49 am
Color   Colo		Cost Contor	Decreases	Salary	Othor	Wkst A 7 Dof		
A _ FIRST OVER BRIFFET IS   DO								
ADM IN STRATTLY AND CENTRAL   5.00			7.00	0.00	7. 00	10.00		
CITALS	1.00		5. 02	0	2, 579, 507	0		1.00
DOMESTICATIVE AND CENTRAL   5.00   0   4-9%   10   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00								
2.00   OPERATION OF PLANT		B - RENT AND LEASES						
3.00 MURSING ADMINISTRATION 13.00 0 44 0 3.00  4.00 CENTRAL SERVICES & SUPPLY 15.00 0 114, 429 0 0 4.00  5.00 FHARMACY ELEGIORS & LIBRARY 15.00 0 0 114, 429 0 0 5.00  FHARMACY ELEGIORS & LIBRARY 15.00 0 0 114, 429 0 0 5.00  8.00 MURSING ADMINISTRATION 50.00 0 0 114, 429 0 0 5.00  8.00 FHARMACY ELEGIORS & LIBRARY 15.00 0 0 114, 429 0 0 5.00  8.00 MURSING ADMINISTRATION 54.00 0 0 84, 573 0 0 9.00  9.00 ULTRASQUIM 55.00 0 0 72, 155 0 0 9.00  9.00 ULTRASQUIM 55.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 72, 155 0 0 110.00  10.00 CT SCAN 57.00 0 0 77, 194 0 0 110.00  10.00 CT SCAN 57.00 0 0 0 17, 194 0 0 110.00  10.00 CT SCAN 57.00 0 0 0 17, 194 0 0 110.00  10.00 CT SCAN 57.00 0 0 0 0 0 0 12.00  10.00 CT SCAN 57.00 0 0 0 0 0 0 13.00  10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00		1	•	459			1. 00
4.00   CANTRAL SERVICES & SUPPLY   14.00   0   87.23   0   4.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00   6.00			1	•				2. 00
5.00   PHARMACY   15.00   0   114, 420   0   5.00   6.00   0   7.00   0   6.00   0   7.00   0   6.00   0   7.00   0   6.00   0   7.00   0   6.00   0   7.00   0   6.00   0   7.00   0   6.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0   7.00   0		1						3. 00
6.00 MEDICAL RECORDS & LIBRARY 16.00 0 300 0 6.00 7.00 MEDICAL RECORDS & LIBRARY 16.00 0 0 144.337 0 7.00 MINISTRATING ROWN 50.00 10 144.337 0 8.00 MINISTRATING ROWN 50.00 10 144.337 0 8.00 11.00 MINISTRATING ROWN 50.00 10 127.153 0 11.00 MINISTRATING ROWN 50.00 10 17.194 0 13.00 MINISTRATING ROWN 50.00 10 13 1 2 2.00 10 10 10 10 10 10 13 1 2 2.00 10 10 10 10 10 10 10 10 10 10 10 10 1		1	1					1
7.00 OPERATING ROWN 50.00 IADRIAN ROWN 60.00 IADRIA		1	1					1
8.00   MADIGLOXY-DIAGNOSTIC   54.00   0   84,573   0   8.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.0						i i		•
9.00 ULTRASOUND			1	~		-		•
10. 00   CT SCAN			1	-		- 1		9. 00
11.00 WRI SEADORTORY			1			- 1		10.00
13. 00   RESPINATORY   THERAPY   0,0 0 0 1,744 0 0 14.0	11. 00	MRI	58.00	O		0		11. 00
14. 00   LELCTROCARDIOLOGY	12.00	LABORATORY	60.00	O	35, 604	0		12. 00
15.00   MARGULANCE SERVICES			65.00	0	17, 194	0		13. 00
TOTALS								14. 00
C - OTHER CAPITAL COSTS  2.00  AMNI ISTRATIVE AND GENERAL  5.02  0.00  0.00  0.01  3.00  TOTALS  0.00  0.00  0.00  0.12  3.00  TOTALS  1.00  ADMINISTRATIVE AND GENERAL  1.00  ADMINISTRATIVE AND GENERAL  1.00  D - REPBAIRS AND MAINTENANCE  1.00  ADMINISTRATIVE AND GENERAL  1.00  ADMINISTRATIVE AND GENERAL  1.00  CENTRAL SERVICES & SUPPLY  14.00  0.00  0.00  1.401  0.00  0.1401  0.00  0.1401  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.1920  0.00  0.00  0.1920  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.00  0.	15. 00		95.00					15. 00
1.00				0	783, 906			
2.00	1 00		E 02	٥	442.004	10		1 00
3.00		ADMINISTRATIVE AND GENERAL	1					1
TOTALS			1	-	0			4
D - REPAIRS AND MAINTENANCE   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00	3.00	TOTALS — — — — —			642 084			3.00
1.00   ADMINISTRATI VE AND GENERAL   5.02   0   54,077   0   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.00   0   1.0				<u> </u>	0 12, 00 1			
3. 00 CENTRAL SERVICES & SUPPLY	1.00		5. 02	0	54, 077	0		1.00
4. 00 PHARMACY 5. 00 ADULTS & PEDIATRICS 5. 00 O 1, 173 0 0 5.00 6. 00 PERATING ROOM 5. 00 O 1, 178 24 0 0 6.00 7. 07 RADIO LOCY-DIAGNOSTIC 5. 4. 00 0 0 17, 824 0 0 7.00 8. 00 ULTRASCUIND 5. 4. 01 0 50, 298 0 0 8. 00 9. 00 RADIO INTERSCRIPT 6. 00 O 14, 399 0 0 9. 00 10. 00 CT SCAN 57. 00 0 0 145, 000 0 110. 00 11. 00 MRI 58. 00 0 70, 450 0 0 110. 00 11. 00 MRI 58. 00 0 70, 450 0 0 110. 00 11. 00 MRI 58. 00 0 70, 450 0 0 110. 00 11. 00 RESPIRATORY THERAPY 6. 0. 00 0 7, 266 0 0 13. 00 11. 00 RESPIRATORY THERAPY 6. 0. 00 0 7, 266 0 0 13. 00 11. 00 ADULTANE SERVICES 95. 00 0 140. 811 0 15. 00 ADULTANE SERVICES 95. 00 0 140. 811 0 15. 00 ADULTANE SERVICES 95. 00 0 140. 811 0 15. 00 ADULTANE SERVICES 91. 00 0 197, 437 0 0 10 10. 00 CENTRAL SERVICES & SUPPLY 10. 00 ADULTANE SERVICES & SUPPLY 11. 00 CENTRAL SERVICES & SUPPLY 12. 00 CENTRAL SERVICES & SUPPLY 13. 00 160 0 0 3. 00 10. 00 RESPIRATORY THERAPY 14. 00 0 27, 905 0 0 1.00 10. 00 RESPIRATORY THERAPY 15. 00 0 160 0 0 3. 00 10. 00 RESPIRATORY THERAPY 16. 00 0 192, 566 0 0 1.00 10. 00 PHARMACY 10. 00 192, 566 0 0 1.00 10. 00 PHARMACY 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0 0 1.00 10. 00 192, 566 0		HOUSEKEEPI NG	9. 00	O		0		2. 00
5.00 ADULTS & PEDIATRICS 30.00 0 1, 173 0 0 6.00 OPERATING ROOM 50.00 0 7, 00 RADIOLOGY-DIAGNOSTIC 54, 00 0 67, 838 0 7, 00 RADIOLOGY-DIAGNOSTIC 54, 00 0 67, 838 0 7, 00 RADIOLOGY-DIAGNOSTIC 54, 00 0 67, 838 0 7, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 14, 399 0 0 8, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 14, 399 0 0 9, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 14, 399 0 0 10, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 14, 399 0 0 10, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 14, 399 0 0 10, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 14, 500 0 0 11, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 0 11, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 0 11, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 0 12, 20 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 0 13, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 13, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 13, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 13, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 13, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 13, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 70, 450 0 13, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 14, 00 RADIOLOGY-DIAGNOSTIC 55, 00 0 0 140, 811 RECORDIOLOGY-DIAGNOSTIC 55, 00 0 10, 40, 811 RECORDIOLOGY-DIAGNOSTIC 55, 40, 40, 40, 40, 40, 40, 40, 40, 40, 40	3.00	CENTRAL SERVICES & SUPPLY	14.00	O	2, 814	0		3. 00
6. 00   OPERATI IN ROOM   S0. 00   0   17, 824   0   0   6. 00   0   17, 00   0   0   17, 00   0   0   17, 00   0   0   0   0   0   0   0   0   0	4.00		1		1, 920	0		4. 00
7. 00 RADI OLGOY - PI AGNOSTI C 54. 00 0 67. 838 0 9. 7. 00			1	•		- 1		5. 00
8. 00 ULTRASOUND 54. 01 0 50. 298 0 9. 00 8. 00 00 10. 00 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00		1						•
9.00 RADIO ISOTOPE 56.00 0 143.999 0 10.00 CT SCAN 57.00 0 45.000 0 0 11.00 CT SCAN 57.00 0 45.000 0 0 11.00 CT SCAN 57.00 0 45.000 0 0 11.00 CT SCAN 57.00 0 12.00 11.00 RADIO ISOTOPE 58.00 0 70.450 0 11.00 11.00 REPIRATORY HERAPY 69.00 0 33.212 0 12.00 12.00 REPIRATORY HERAPY 65.00 0 7.266 0 13.00 REPIRATORY HERAPY 91.00 0 805 0 14.00 EMERGENCY 91.00 0 805 0 14.00 EMERGENCY 91.00 0 42.334 0 15.00 REPIRATORY HERAPY 85.00 1 410.811 E C NON COSTS 10.00 REPIRATORY HERAPY 10.00 1 197,437 0 0 1 1.00 REPIRATORY HERAPY 11.00 1 197,437 0 0 1 1.00 REPIRATORY HERAPY 11.00 REPIRATORY HERAPY 11.00 REPIRATORY HERAPY 11.00 REPIRATORY HERAPY 10.00 1 10.00 REPIRATORY HERAPY 10.00 REPIRATORY HERAPY 10.00 1 10.00 REPIRATORY HERAPY 10.00 REPIRATORY HERAPY 10.00 1 10.00 REPIRATORY HERAPY 10.00 REPIR		1	1					1
10.00   CT SCAN			1			- 1		•
11.00   MRI						i i		
12 OO   LABORATORY   60.00   0   33, 212   0   12.00     13.00   RESPIRATORY THERAPY   65.00   0   7,266   0     14.00   EMERGENCY   91.00   0   805   0     15.00   AMBULANCE SERVICES   95.00   0   42,334   0     15.00   AMBULANCE SERVICES   95.00   0   410,811     16.00   AMBULANCE SERVICES   0   410,811     17.00   AMBULANCE SERVICES   197,437   0   0     17.00   TOTALS   197,437   0     18.00   CENTRAL SERVICES & SUPPLY   14.00   0   27,905   0     19.00   OPERATING ROOM   50.00   0   164,174   0     19.00   OPERATING ROOM   50.00   0   164,174   0     19.00   OMERGENCY   91.00   0   257, 0     19.00   AMBULANCE SERVICES & SUPPLY   14.00   0   257, 0     19.00   AMBULANCE SERVICES & SUPPLY   14.00   0   257, 0     19.00   OMERGENCY   10.00   0   160, 0     19.00   OMERGENCY   10.00   0   160, 0     19.00   OMERGENCY   10.00   0   192,596     19.00   OMERGENCY   10.00   0   192,596     19.00   ADULTS & PEDIATRICS   30.00   276,819   39,318   0     19.00   ADULTS & PEDIATRICS   580,409   860,834   0     19.00   ADULTS & PEDIATRICS   580,409		1	1	~		-		1
13. 00   RESPIRATORY THERAPY   65. 00   0   7, 266   0   13. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00			1	-		-		12. 00
14. 00   EMERGENCY   91. 00   0   805   0   14. 00   15. 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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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.			1			- 1		13. 00
TOTALS	14.00	EMERGENCY	91.00	O		0		14. 00
E - CNO COSTS  ADMINISTRATIVE AND GENERAL 5. 02 197, 437 0 0 1  1. 00  ADMINISTRATIVE AND GENERAL 197, 437 0 0 1  F - MEDICAL SUPPLIES 197, 437 0 0 1  1. 00  CENTRAL SERVICES & SUPPLY 14. 00 0 0 27, 905 0 0 1. 00  2. 00 OPERATING ROOM 50. 00 0 164, 174 0 0 2. 00  3. 00 RESPIRATORY THERAPY 65. 00 0 160 0 3. 00  4. 00 EMERGENCY 91.00 0 357 0 0 4. 00  TOTALS 0 191.00 192, 596 0 1. 00  TOTALS 0 0 822, 255 0 1 1. 00  PHARMACY 15. 00 0 822, 255 0 1 1. 00  H - NURSERY 1 - NURSERY 1 - NURSERY 1 - ON STATE 2 - ON STATE 1 - ON STATE 1 - ON STATE 1 - ON STATE 1 - ON STATE 2 - ON STATE 1 - ON ST	15.00	AMBULANCE SERVICES	95.00	o	42, 334	0		15. 00
1.00				0	410, 811			
TOTALS								4
F - MEDICAL SUPPLIES	1. 00				0	0		1. 00
1.00 CENTRAL SERVICES & SUPPLY 14.00 0 27,905 0 2.00 OPERATING ROOM 50.00 0 164,174 0 2.00 (SESPI RATORY THERAPY 65.00 0 164,174 0 3.00 (SESPI RATORY THERAPY 65.00 0 160 0 3.00 (SESPI RATORY THERAPY 91.00 0 357 0 4.00 (SESPI RATORY THERAPY 91.00 0 357 0 4.00 (SESPI RATORY THERAPY 91.00 0 357 0 4.00 (SESPI RATORY THERAPY 91.00 0 192,596 (SESPI RATORY THERAPY 10.00 192,599 (SESPI RATORY				197, 437	0			
2.00   OPERATING ROOM   50.00   0   164, 174   0   3.00   RESPIRATORY THERAPY   65.00   0   160   0   3.00   160   0   4.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   160   0   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00   3.00	1 00		14 00	٥	27 005	0		1 00
3.00 RESPIRATORY THERAPY 65.00 0 160 0 357 0 4.00 EMERGENCY 91.00 0 357 0 4.00 TOTALS 0 192,596 1 1.00 PHARMACY 15.00 0 822,255 0 1.00 TOTALS 1 0 0 822,255 1 0 1.00 ADMINISTRATION 13.00 166,518 36,052 0 1.00 ADMINISTRATIVE AND GENERAL 5.02 580,409 860,834 1 1.00 ADMINISTRATIVE AND GENERAL 55.02 580,409 860,834 1 1.00 ADMINISTRATIVE AND GENERAL 55.00 99,541 56,794 0 2.00 RADIO ISOTOPE 56.00 99,541 56,794 0 3.00 ADMINISTRATI ON 1.00 ADMINISTORE 58.00 95,994 14,124 0 ADMINISTRATY ON 1.00 ADMINISTRATY 1.00 ADMINISTRATY 1.00 ADMINISTRATION 1.00 ADMINISTRATIVE AND GENERAL 5.02 580,409 860,834 ADMINISTRATIVE AND GENERAL 5.02 580,409 860,834 ADMINISTRATIVE AND GENERAL 5.02 580,409 860,834 ADMINISTRATIVE AND GENERAL 5.00 99,541 56,794 0 3.00 ADMINISTRATIVE AND GENERAL 5.00 ADMINISTRAT			1					
4. 00 EMERGENCY 91. 00 0 357 0 0 4. 00 TOTALS 0 0 192, 596 0 1. 00 FARMACY 15. 00 822, 255 0 1 1. 00 FARMACY 15. 00 822, 255 0 1 1. 00 FOR ADMINISTRATION 15. 00 166, 518 166, 518 166, 518 16. 00 17. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATION 15. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 02 580, 409 860, 834 1. 00 FOR ADMINISTRATIVE AND GENERAL 5. 00 FOR ADMINISTRATIVE AN		I	1					1
TOTALS								
1.00   PHARMACY   15.00   0   822, 255   0   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00	00							
TOTALS			NS	- '	,			
H - NURSERY   1.00   ADULTS & PEDI ATRI CS   30.00   276, 819   39, 318   0   1.00	1.00	PHARMACY	15. 00	0	822, 255	0		1. 00
1. 00 ADULTS & PEDI ATRI CS				0	822, 255			
TOTALS								
1. 00	1. 00		30.00					1. 00
1. 00   NURSI NG   ADMI NI STRATI ON   13. 00   166, 518   36, 052   0				276, 819	39, 318			_
TOTALS  J - MI SC DEPARTMENTS  1. 00 ADMI NI STRATI VE AND GENERAL  TOTALS  K - OTHER RADI OLOGY  1. 00 ULTRASOUND  RADI OI SOTOPE  3. 00 CT SCAN  MRI  TOTALS  S8. 00  MRI  TOTALS  S8. 00  95, 994  14, 124  0  MRI  TOTALS  S8. 00  95, 994  14, 124  0  TOTALS  L - DI ETARY COSTS TO CAFETERI A  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00  1. 00	1 00		12.00	1// 510	27 053	٥		1 00
1. 00   ADMI NI STRATI VE AND GENERAL   5. 02   580, 409   860, 834   0   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1. 00   1.	1.00		13.00					1.00
1. 00 ADMI NI STRATI VE AND GENERAL 5. 02 580, 409 860, 834 0 TOTALS 580, 409 860, 834 0 1. 00				100, 310	30, 032			-
TOTALS  K - OTHER RADI OLOGY  1. 00 ULTRASOUND 54. 01 106, 796 8, 369 0 2. 00 RADI OI SOTOPE 56. 00 99, 541 56, 794 0 3. 00 CT SCAN 57. 00 0 11, 434 0 4. 00 MRI 58. 00 95, 994 14, 124 0 TOTALS 302, 331 90, 721  L - DI ETARY COSTS TO CAFETERI A  1. 00 DI ETARY 10. 00 49, 301 37, 480 0	1 00		5 02	580 409	860 834	0		1 00
K - OTHER RADI OLOGY   1. 00   ULTRASOUND   54. 01   106, 796   8, 369   0   1. 00   0   0   0   0   0   0   0   0   0	1.00							1.00
1. 00 ULTRASOUND 54. 01 106, 796 8, 369 0 2. 00 RADI OI SOTOPE 56. 00 99, 541 56, 794 0 3. 00 CT SCAN 57. 00 0 11, 434 0 4. 00 MRI 58. 00 95, 994 14, 124 0 TOTALS 302, 331 90, 721 L - DI ETARY COSTS TO CAFETERI A 1. 00 DI ETARY 10. 00 49, 301 37, 480 0								1
2. 00 RADI OI SOTOPE 56. 00 99, 541 56, 794 0 2. 00 3. 00 CT SCAN 57. 00 0 11, 434 0 3. 00 4. 00 MRI 58. 00 95, 994 14, 124 0 1	1.00		54. 01	106, 796	8, 369	0		1.00
4. 00 MRI 58. 00 95, 994 14, 124 0 4. 00 L - DI ETARY COSTS TO CAFETERIA 10. 00 DI ETARY 10. 00 49, 301 37, 480 0 1. 00 11. 00 12. 00 12. 00 13. 00 13. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 1								2. 00
TOTALS 302, 331 90, 721 L - DI ETARY COSTS TO CAFETERIA 1.00 DI ETARY 10.00 49, 301 37, 480 0 1.00		CT SCAN						3. 00
L - DIETARY COSTS TO CAFETERIA  1. 00 DIETARY	4.00		58. 00					4. 00
1. 00 DI ETARY 10. 00 49, 301 37, 480 0 1. 00				302, 331	90, 721			_
	4 00			10.00	a=	_1		4
101AL3   47, 301  37, 480	1.00							1.00
		IIUIALS	ı I	49, 301	37, 480			I

Heal th Financial Systems

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1318

Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						10	12/31/2023	5/31/2024 10	
		Decreases							
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.				
	6. 00	7. 00	8. 00	9. 00	10. 00				
	M - NON CAPITALIZED EQUIPMENT								
1.00	ADULTS & PEDIATRICS	30.00	0	507	C				1.00
2.00	OPERATING ROOM	50.00	0	337	C				2. 00
3.00	RESPIRATORY THERAPY	65.00	0	112	<u> </u>	)			3. 00
	TOTALS		0	956	)				
	N - SITTER COSTS								
1.00	NURSING ADMINISTRATION	1300	1 <u>5, 8</u> 50		C	)			1. 00
	TOTALS		15, 850	1, 238					
500.00	Grand Total: Decreases		1, 588, 665	6, 497, 758					500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 15-1318

Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared:

5/31/2024 10: 49 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 193, 225 1.00 0 1.00 1,038,384 0 2.00 Land Improvements 0 2.00 29, 476, 515 0 3.00 828, 589 828, 589 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 33, 715, 391 438, 925 438, 925 316, 935 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 0 0 0 6.00 0 7.00 4, 592, 929 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 69, 016, 444 1, 267, 514 1, 267, 514 316, 935 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 69, 016, 444 316, 935 10.00 1, 267, 514 0 1, 267, 514 10.00 Endi ng Bal ance 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 1, 038, 384 0 2.00 3.00 Buildings and Fixtures 30, 305, 104 0 3.00 0 4.00 Building Improvements 33, 837, 381 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 6.00 7.00 HIT designated Assets 4, 592, 929 0 7.00 Subtotal (sum of lines 1-7) 8.00 69, 967, 023 0 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 69, 967, 023 0 10.00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-1318	Peri od: From 01/01/2023	Worksheet A-7	
					To 12/31/2023		pared:
						5/31/2024 10:	49 am
			Sl	JMMARY OF CAP	TTAL		
	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 WORL	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 117, 018	0	)	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 401, 489	0	)	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	3, 518, 507	0	)	0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	ů ,				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 117, 018				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o	2, 401, 489				2. 00
3.00	Total (sum of lines 1-2)	o	3, 518, 507				3. 00
	,	-1		'			

Heal th	n Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2023 To 12/31/2023		pared:
		COMI	PUTATION OF RAT	ΓΙΟS	ALLOCATION OF	OTHER CAPITAL	49 аш
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col 2)	instructions)		
		1.00	2.00	3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI					2.22	
1.00	CAP REL COSTS-BLDG & FLXT	65, 374, 093		65, 374, 09			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 592, 929		4, 592, 92			2. 00
3. 00	Total (sum of lines 1-2)	69, 967, 022		69, 967, 02.			3. 00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	40.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS			1, 498, 878	658, 795	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2, 417, 891	208, 201	2. 00
3.00	Total (sum of lines 1-2)	0	0		3, 916, 769		
0.00	,	3	Sl	JMMARY OF CAPI		000,770	0.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
					Capi tal -Rel ate		
			,	ĺ	d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FIXT	380		·		2, 786, 428	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	813			0	2, 640, 614	
3. 00	Total (sum of lines 1-2)	1, 193	205, 028	437, 05	6 0	5, 427, 042	3. 00

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1318

				To	12/31/2023	Date/Time Prep 5/31/2024 10:4	
				Expense Classification on		3/31/2024 10.2	49 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		O				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	О	5. 00
6.00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service	Α	-12, 613	OPERATION OF PLANT	7. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-2, 483, 432			О	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	-325, 173			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service				0. 00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-68, 304	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-135	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		U		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
22.00	overpayments and borrowings to				0.00		22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
24 00	(chapter 21) Depreciation - CAP REL	^	425	CAP REL COSTS-BLDG & FIXT	1 00	9	24 00
26. 00	COSTS-BLDG & FLXT	A			1. 00		
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-2, 472	CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00	-	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see	Α	-8, 290	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
33. 00	Depreciation and Interest FITNESS REVENUE	В	-135	ADMINISTRATIVE AND GENERAL	5. 02	О	33. 00
		·				<u>'</u>	

12/31/2023 Date/Time Prepared: 5/31/2024 10:49 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 33. 01 MI SCELLANEOUS I NCOME -14, 535 ADMI NI STRATI VE AND GENERAL 5. 02 33. 01 В 36, 818 NURSING ADMINISTRATION EMPLOYEE SELF INS DISCOUNTS 33.02 В 13.00 0 33.02 33.03 PHYSICIAN RECRUITING Α -2, 580 ADMINISTRATIVE AND GENERAL 5.02 33.03 33.04 POB CAPITAL RELATED EXPENSE Α 381, 225 CAP REL COSTS-BLDG & FLXT 1.00 33.04 POB CAPITAL RELATED EXPENSE 19, 824 CAP REL COSTS-MVBLE EQUIP 33 05 2.00 33 05 Α CHARITABLE CONTRIBUTIONS -1, 730 ADMINISTRATIVE AND GENERAL 33.06 Α 5.02 33.06 33. 07 PATIENT TV DEPRECIATION Α -950 CAP REL COSTS-MVBLE EQUIP 2.00 33.07 33.08 INTEREST INCOME ADD BACK В 5, 501 ADMINI STRATI VE AND GENERAL 5. 02 ol 33.08 NON-ALLOWABLE LEGAL FEES -639 ADMINISTRATIVE AND GENERAL 33.09 Α 5.02 33.09 33. 11 MARKETING EXPENSE Α -3, 526 ADMINISTRATIVE AND GENERAL 5.02 33. 11 LOBBYING EXPENSE -4, 364 ADMINI STRATI VE AND GENERAL 34.00 Α 5.02 34.00 EMERGENCY ROOM STAND-BY 984, 434 EMERGENCY 91.00 35.00 35.00 Α **EXPENSE** -1, 500, 441 50.00 TOTAL (sum of lines 1 thru 49) 50.00 (Transfer to Worksheet A, column 6, line 200.)

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-1318

Period: Worksheet A-8-1 From 01/01/2023

				To 12/31/2023	Date/Time Pre 5/31/2024 10:	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	17 Gill
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	380	0	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	813	0	2.00
3.00	5. 02	ADMINISTRATIVE AND GENERAL	PASI OPERATING COSTS	238, 640	177, 543	3.00
3.02	5. 02	ADMINISTRATIVE AND GENERAL	SHARED SERVICE CENTER ALLOCA	985, 127	761, 678	3. 02
3.04	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	34, 926	0	3. 04
4.00	2. 00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	48, 239	0	4.00
4.01	5. 02	ADMINISTRATIVE AND GENERAL	NON-CAPITAL HOME OFFICE COST	1, 308, 642	0	4. 01
4.02	5. 02	ADMINISTRATIVE AND GENERAL	MALPRACTICE COSTS	42, 225	291, 594	4. 02
4.03	5. 02	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	0	878, 889	4.03
4.04	5. 02	ADMINISTRATIVE AND GENERAL	401K FEES	0	5, 151	4.04
4.05	5. 02	ADMINISTRATIVE AND GENERAL	AUDIT FEES	0	28, 023	4.05
4.06	5. 02	ADMINISTRATIVE AND GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	612, 830	4.06
4.07	5. 02	ADMINISTRATIVE AND GENERAL	HIIM ALLOCATION	0	158, 097	4. 07
4.08	5. 02	ADMINISTRATIVE AND GENERAL	CONTRACT MANAGEMENT	0	90, 698	4. 08
4.09	5. 02	ADMINISTRATIVE AND GENERAL	PASI LIEN UNIT COLLECTION FE	0	-20, 338	4.09
5.00	TOTALS (sum of lines 1-4).			2, 658, 992	2, 984, 165	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
* TL-						

\* 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.

1100 110	been posted to worksheet A,	oor annie i arra, or z, trio amour	it dirondbio on	our a bo rriar out ou rri cor aiiir r	or time parti	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2.00	3. 00	4. 00	5. 00	
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	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	0.00	9. 00
10.00		0.00	0.00	10.00
100.00	G. Other (financial or			100.00
	non-financial) specify:			

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

Net
Col
Col. 5)*
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:  1. 00
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:  1. 00
HOME OFFICE COSTS:
1.00     380     11       2.00     813     11       3.00     61,097     0       3.02     223,449     0
2.00     813     11       3.00     61,097     0       3.02     223,449     0
3. 00 61, 097 0 3. 02 223, 449 0 3.
3. 02 223, 449 0 3.
3 04   34 926  10    3
0.07   07,720 10
4. 00   48, 239   10   4.
4. 01   1, 308, 642   0   4.
4. 02   -249, 369   0   4.
4. 03   -878, 889   0   4.
4. 04   -5, 151   0   4.
4. 05   -28, 023   0   4.
4. 06   -612, 830   0   4.
4. 07   -158, 097   0   4.
4. 08   -90, 698   0   4.
4. 09   20, 338   0   4.
5.00 -325,173 5.

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

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

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

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

6. 00	HOSPITAL MANAGEMENT	6.00
7.00	DEBT COLLECTION	7.00
8.00	LAUNDRY SERVICE	8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

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

| Period: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1318

					-	Γο 12/31/2023	B Date/Time Pre 5/31/2024 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00		ADMINISTRATIVE AND GENERAL	18, 732			_		
2.00		ADULTS & PEDIATRICS	670, 758			0		
3.00		ANESTHESI OLOGY	300, 647			0	0	
4.00		RADI OLOGY-DI AGNOSTI C	226, 082			0	0	
5.00		EMERGENCY	2, 706, 956	1, 267, 213	1, 439, 743	0	0	0.00
6.00	0. 00		0	C	0	0	0	0.00
7.00	0. 00		0	C	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	0.00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0		0	0	0	10.00
200.00		0 1 0 1 (5)	3, 923, 175				0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Limit	Memberships &	Component	of Malpractice Insurance	
				LIIIII L	Conti nui ng Educati on	Share of col.	Trisurance	
	1. 00	2.00	8.00	9. 00	12. 00	13.00	14.00	
1. 00		ADMINISTRATIVE AND GENERAL	0.00				14.00	1.00
2. 00		ADULTS & PEDIATRICS	0	-	-	1	-	1
3. 00		ANESTHESI OLOGY	0	1	-	1	1	1
4. 00		RADI OLOGY-DI AGNOSTI C	0	ĺ	-	0	0	1
5. 00		EMERGENCY	0			0	0	
6. 00	0.00		0			0	0	1
7. 00	0.00		0		o o	l o	l o	1
8. 00	0.00		0		0	0	0	8. 00
9. 00	0.00		0	l c	0	0	0	1
10.00	0.00		0		0	0	0	10.00
200.00			0	l c	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADMINISTRATIVE AND GENERAL	0		-		•	1. 00
2.00		ADULTS & PEDIATRICS	0		-	0,0,,00		2. 00
3.00		ANESTHESI OLOGY	0		,	300, 647		3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	C	0	,		4. 00
5.00		EMERGENCY	0	[ C	0	1, 267, 213		5. 00
6.00	0. 00		0	C	0	0		6. 00
7. 00	0.00		0	C	0	0		7. 00
8. 00	0.00		0	C	0	0		8. 00
9. 00	0. 00		0	C	0	0		9. 00
10.00	0. 00		0	C	0	0		10.00
200.00			0	[ C	) 0	2, 483, 432		200.00

Heal th	Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ABLE COST DETERMINATION FOR THERAPY SERVICE E SUPPLIERS	S FURNI SHED BY	Provi der CCN: 15-1318	Peri od: From 01/01/2023 To 12/31/2023		pared:
				Physical Therapy	Cost	
					1. 00	
	PART I - GENERAL INFORMATION					
1.00	1.00 Total number of weeks worked (excluding aides) (see instructions)				0	1.00
2.00	Line 1 multiplied by 15 hours per week				0	2.00
3.00	Number of unduplicated days in which super-	visor or therapist v	was on provider site (se	e instructions)	0	3.00
4. 00	Number of unduplicated days in which thera nor therapist was on provider site (see in		provider site but neith	ner supervisor	0	4. 00
	I am a second and a					

Number of unduplicated offsite visits - supervisors or therapists (see instructions)

Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy

assistant and on which supervisor and/or therapist was not present during the visit(s)) (see

8.00	Optional 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	138. 31	3, 162. 14	1, 887. 53	1, 256. 53	0.00	9. 00
10.00	AHSEA (see instructions)	81. 04	88. 98	50. 50	17. 50	0.00	10.00
11. 00	Standard travel allowance (columns 1 and 2,	44. 49	44. 49	25. 25			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

0.00

0 44.00

0 45.00

		1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION	11.00	
14.00	Supervisors (column 1, line 9 times column 1, line 10)	11, 209	14 00
15. 00	Therapists (column 2, line 9 times column 2, line 10)	281, 367	1
16. 00	Assistants (column 3, line 9 times column 3, line10)	95, 320	
17. 00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all	387, 896	
17.00	others)	307, 090	17.00
18. 00	Aides (column 4, line 9 times column 4, line 10)	21, 989	18. 00
			1
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	409, 885	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech path		
	occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on	line 23	
	the amount from line 20. Otherwise complete lines 21-23.		
21. 00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9	0.00	21. 00
	for respiratory therapy or columns 1 thru 3, line 9 for all others)		
22. 00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22. 00
23. 00	Total salary equivalency (see instructions)	409, 885	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)	0	24. 00
25.00	Assistants (line 4 times column 3, line 11)	0	25. 00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	ol	26. 00
27. 00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all	0	27. 00
	others)	_	
28. 00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and	0	28. 00
	27)	_	
	Optional Travel Allowance and Optional Travel Expense		1
	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29. 00
	Assistants (column 3, line 10 times column 3, line 12)	0	1
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
32.00	columns 1-3, line 13 for all others)	١	32.00
22 00		0	33.00
33.00	Standard travel allowance and standard travel expense (line 28)  Optional travel allowance and standard travel expense (sum of lines 27 and 31)		1
34. 00		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	VIDER SITE	
	Standard Travel Expense		
36. 00		0	
37. 00	Assistants (line 6 times column 3, line 11)	0	37. 00
38. 00		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	
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line		1
	or 46 as appropriate		1

44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)

45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

or 46, as appropriate.

5.00

6.00

7.00

instructions)

Standard travel expense rate

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der Co	1	Period: From 01/01/2023 To 12/31/2023 Physical Therapy	Date/Time Pre 5/31/2024 10:	pared:
						1. 00	
46. 00	Optional travel allowance and optional travel	expense (sum o	of lines 42 an	nd 43 - see ins	structions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	10.00
		1.00	2.00	3.00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION						
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0. 00	0. 0	0.00	0.00	47.00
48. 00	Overtime rate (see instructions)	0. 00	0.00	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	88. 98	50. 50	17. 5	0.00		52. 00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	08. 70	0.50		0 0.00		53.00
54. 00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54. 00
55. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0	,	0		55. 00
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56. 00
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	AD JUSTMENT			1.00	
58. 00 59. 00 60. 00 61. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions)	(from lines 33	34, or 35))	)		409, 885 0 0 0 0 0	58. 00 59. 00 60. 00 61. 00
63. 00	Total allowance (sum of lines 57-62)					409, 885	1
	Total cost of outside supplier services (from	m your records)				349, 285	1
5. 00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	3 - if negative	,			0	65.00
00. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	0	100. 00 100. 01 100. 02
01.00	Line 27 = line 7 times line 3 for respiratory	y therapy or su	m of lines 3 a	ind 4 for all	others	0	101.00
01. 01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31						101. 01 101. 02
02.00	Line 35 CALCULATION	cum of lines of	20 for -	II others		^	102 0
	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. 0

0 102. 02

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

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der CCI	N: 15-1318	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
					Occupati onal Therapy	5/31/2024 10: 4 Cost	<u>49 am</u>
						1.00	
	PART I - GENERAL INFORMATION					1. 00	
1. 00	Total number of weeks worked (excluding aides	) (see instructi	i ons)			0	1.00
2. 00	Line 1 multiplied by 15 hours per week					0	2. 0
3.00	Number of unduplicated days in which supervis					0	3.0
. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see instr		n provider sit	e but neitne	er supervisor	0	4.0
. 00	Number of unduplicated offsite visits - super		pists (see ins	tructions)		o	5.0
. 00	Number of unduplicated offsite visits - thera					0	6. C
	assistant and on which supervisor and/or ther instructions)	apist was not p	resent during	the visit(s)	) (see		
7. 00	Standard travel expense rate					0.00	7.0
3. 00	Optional travel expense rate per mile					0.00	8.0
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
9. 00	Total hours worked	1. 00 1, 934. 36	2.00	3. 00 1, 835. 6	4. 00	5. 00	9. 0
10.00	AHSEA (see instructions)	84. 35	84. 35	50. 5			
11. 00	Standard travel allowance (columns 1 and 2,	42. 18	42. 18	25. 2	25		11. 0
	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	o		0		12. 0
12. 01	Number of travel hours (offsite)	0	O		0		12. C
13.00	Number of miles driven (provider site)	0	0		0		13.0
13. 01	Number of miles driven (offsite)	0	0		0		13. 0
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					163, 163 9, 359	
16. 00	Assistants (column 3, line 9 times column 3,					92, 699	16.0
17. 00	Subtotal allowance amount (sum of lines 14 an		atory therapy	or lines 14-	-16 for all	265, 221	17. C
10.00	others)	10)				0	18. 0
18. 00 19. 00	Aides (column 4, line 9 times column 4, line 10) Trainees (column 5, line 9 times column 5, line 10)						
	Total allowance amount (sum of lines 17-19 fo		herapy or line	s 17 and 18	for all others)	0 265, 221	
	If the sum of columns 1 and 2 for respiratory	therapy or colu	umns 1-3 for p	hysical ther	apy, speech path	nol ogy or	
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		o entries on I	ines 21 and	22 and enter on	line 23	
21. 00	Weighted average rate excluding aides and tra		divided by sum	of columns	1 and 2, line 9	0.00	21.0
	for respiratory therapy or columns 1 thru 3,						
22. 00 23. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	es (line 2 times	s line 21)			0 265, 221	
23. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPU	TATION - PRO	OVI DER SITE	203, 221	25.0
	Standard Travel Allowance						
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	24. 0 25. 0
26. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for al	I others)		0	26. 0
27. 00	Standard travel expense (line 7 times line 3				and 4 for all	0	27. 0
20.00	others)	traval avranca	at the provide	m oi to Coum	of Lines 24 and		20.0
28. 00	Total standard travel allowance and standard 27)	traver expense a	at the provide	i Site (Suiii	or rines 20 and	0	28. 0
	Optional Travel Allowance and Optional Travel	Expense					
29. 00	Therapists (column 2, line 10 times the sum o		2, line 12 )			0	29.0
30. 00 31. 00	Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or		and 30 for al	l others)		0	30. C
	Optional travel expense (line 8 times columns				or sum of	0	32. 0
32.00	columns 1-3, line 13 for all others)	Z1.1	20)				
	Standard travel allowance and standard travel			31)		0	33. 0 34. 0
33. 00	Ontional travel allowance and standard travel					0	
33. 00 34. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel	<u>expense</u> (sum o			LICES OUTSLINE DOG	NUDED SITE	I
33. 00 34. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA			ATION - SERV	TICES OUTSIDE PRO	JVIDER SITE	
33. 00 34. 00 35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense			ATION - SERV	TICES OUTSIDE PRO		36 0
33. 00 34. 00 35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA			ATION - SERV	TICES OUTSIDE PRO	0 0	
32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	NCE AND TRAVEL E	EXPENSE COMPUT	ATION - SERV	TICES OUTSIDE PRO	0 0	37. 0 38. 0
33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	NCE AND TRAVEL E	EXPENSE COMPUT	ATION - SERV	TICES OUTSIDE PRO	0 0	37. C
33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 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	of lines 5 and	EXPENSE COMPUT	ATION - SERV	TICES OUTSIDE PRO	0 0 0	37. 0 38. 0 39. 0
33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	of lines 5 and Expense 1 times column 2	EXPENSE COMPUT	ATION - SERV	TICES OUTSIDE PRO	0 0	37. 0 38. 0 39. 0 40. 0
33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 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 Subtotal (sum of lines 40 and 41)	of lines 5 and Expense 1 times column 2 3, line 10)	6) 2, line 10)	ATION - SERV	TICES OUTSIDE PRO	0 0 0 0	37. 0 38. 0 39. 0 40. 0 41. 0 42. 0
33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 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 lines 5 and Expense 1 times column 2 3, line 10) of columns 1-3,	6) 2, line 10)			0 0 0 0	37. ( 38. ( 39. ( 40. ( 41. ( 42. (

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-8-3 Parts I-VI Date/Time Prepared 5/31/2024 10:49 am	
					Occupati onal Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard travel					0	
46. 00	Optional travel allowance and optional travel		of lines 42 an				46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION		_, _,				
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	O. C	0.00	0.00	47.00
48. 00	Overtime rate (see instructions)	0. 00	0.00				48.00
19. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0.00	0.0	0.00		49. 00
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0. 00	0.0	0.00	0.00	50.00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
2. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	84. 35	50. 50	0.0	0.00		52. OC
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53. 00
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00	
	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)			)		265, 221 0 0 0 0 0 265, 221	62.00
64. 00	Total cost of outside supplier services (from your records)  Excess over limitation (line 64 minus line 63 - if negative, enter zero)  LINE 33 CALCULATION					235, 873	64.00
00. 01	20.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 20.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 20.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION						100. 00 100. 01 100. 02
01. 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
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

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SOUTSIDE SUPPLIERS	SERVICES FURNISHED BY	Provi der 0	CCN: 15-1318	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-VI Date/Time Prep 5/31/2024 10:4	pared:
				Speech Pathology	Cost	
					1 00	
					1. 00	

				Spee	ch Pathology	Cost	47 dili
						1.00	
	PART I - GENERAL INFORMATION					1. 00	
1.00	Total number of weeks worked (excluding aide	s) (see instruc	tions)			0	1.00
2.00	Line 1 multiplied by 15 hours per week	-, (	,			0	2.00
3.00	Number of unduplicated days in which supervi					0	3. 00
4.00	Number of unduplicated days in which therapy		on provider si	te but neither su	pervi sor	0	4. 00
F 00	nor therapist was on provider site (see inst		onioto (ooo in	atrusti ana)			F 00
5. 00 6. 00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - them				orany	0	5. 00 6. 00
0.00	assistant and on which supervisor and/or the					ı	0.00
	instructions)	aprot mas not	prosont darring	(0)		I	
7.00	Standard travel expense rate					0.00	
8. 00	Optional travel expense rate per mile					0.00	8. 00
		Supervi sors	Therapists	Assistants	Ai des	Trai nees	
9. 00	Total hours worked	1.00	2. 00 1, 352. 03	3.00	4. 00 0. 00	5. 00	9. 00
10. 00	AHSEA (see instructions)	0.00	81. 07		0.00		
11. 00	Standard travel allowance (columns 1 and 2,	40. 54	40. 54		0.00	1	11. 00
	one-half of column 2, line 10; column 3,					I	
	one-half of column 3, line 10)					I	
12.00	1	0	0	0		I	12. 00
12. 01	Number of travel hours (offsite)	0	0	-		I	12. 01
13.00	Number of miles driven (provider site)	0	0	0		I	13.00
13. 01	Number of miles driven (offsite)	0	0	0			13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1	, line 10)				0	14. 00
15.00	Therapists (column 2, line 9 times column 2,	line 10)				109, 609	15. 00
16. 00	Assistants (column 3, line 9 times column 3,					0	16. 00 17. 00
17. 00							
10.00	others) 00 Aides (column 4. Line 9 times column 4. Line 10) 0 18.						
18. 00	· · · · · · · · · · · · · · · · · · ·						18. 00 19. 00
19. 00 20. 00							
20.00	If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete						
21. 00	Weighted average rate excluding aides and tr			m of columns 1 an	d 2, line 9	0.00	21. 00
00.00	for respiratory therapy or columns 1 thru 3,						00.00
22. 00 23. 00	Weighted allowance excluding aides and train	ees (line 2 tim	es line 21)			0 109, 609	
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	VANCE AND TRAVE	EXPENSE COMP	IITATION - PROVIDE	R SLTE	109, 609	23.00
	Standard Travel Allowance	WINDE THE THREE	EXI ENGL COM	OTATION TROVIDE	K OITE		
24.00	Therapists (line 3 times column 2, line 11)					0	24. 00
25.00	Assistants (line 4 times column 3, line 11)					0	25. 00
26. 00	Subtotal (line 24 for respiratory therapy or					0	
27. 00	Standard travel expense (line 7 times line 3	for respirator	y therapy or s	um of lines 3 and	4 for all	0	27. 00
20.00	others)	traval avrance	a+ +ba nnavi d	on oite (our of l	inco 24 and		20.00
28.00	Total standard travel allowance and standard 27)	travei expense	at the provid	er site (sum of i	rnes 26 and	0	28. 00
	Optional Travel Allowance and Optional Travel	Expense					
29. 00	Therapists (column 2, line 10 times the sum		d 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 2	9 and 30 for a	II others)		0	31. 00
32. 00	Optional travel expense (line 8 times column	s 1 and 2, line	13 for respir	atory therapy or	sum of	0	32. 00
	columns 1-3, line 13 for all others)		20)				
33.00	Standard travel allowance and standard trave			d 21)		0	
34. 00 35. 00	Optional travel allowance and standard trave					0	
33.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				OUTSLINE PRO		33.00
	Standard Travel Expense	WOL THE THUTTE	EXI ENGL COM C	TATTON SERVICES	OUTUIDE THE	VIDER OF IE	
36. 00	Therapists (line 5 times column 2, line 11)					0	36. 00
37. 00	Assistants (line 6 times column 3, line 11)					0	1
38.00	Subtotal (sum of lines 36 and 37)					0	38. 00
39. 00	Standard travel expense (line 7 times the su	m of lines 5 and	d 6)			0	39. 00
	Optional Travel Allowance and Optional Travel						
40. 00	Therapists (sum of columns 1 and 2, line 12.		2, line 10)			0	
41. 00	Assistants (column 3, line 12.01 times colum	n 3, line 10)				0	ł
42.00	Subtotal (sum of lines 40 and 41)	m of columns 1	3 lino 12 01\			0	
43. 00	.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)  Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45,						43.00
	or 46, as appropriate.	is to service:	omprete on	S ST THE FOLLOWITH	9 111 00 11110	5 11, 45,	
44.00	Standard travel allowance and standard trave	l expense (sum	of lines 38 an	d 39 - see instru	ctions)	0	44. 00
	Optional travel allowance and standard trave						45. 00

Health Financial Systems DUKES MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 15-1318 Peri od: Worksheet A-8-3 From 01/01/2023 Parts I-VI OUTSIDE SUPPLIERS Date/Time Prepared: 12/31/2023 5/31/2024 10:49 am Speech Pathology Cost 1.00 46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions) 0 46.00 Therapi sts Assi stants Ai des Total 2.00 3.00 5.00 PART V - OVERTIME COMPUTATION 47.00 Overtime hours worked during reporting 0.00 0.00 0.00 0.00 0.00 47.00 period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 48.00 Overtime rate (see instructions) 0.00 0.00 0.00 0.00 48.00 49.00 Total overtime (including base and overtime 0.00 0.00 0.00 0.00 49.00 allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 50.00 0 00 0.00 0.00 0 00 0 00 50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year 0.00 0.00 0.00 0.00 0.00 51.00 for one full-time employee times the  $\,$ percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount 81.07 0.00 0.00 0.00 52.00 (see instructions) 53.00 Overtime cost limitation (line 51 times line 0 0 0 53.00 52) 54.00 Maximum overtime cost (enter the lesser of 0 54.00 0 C 0 line 49 or line 53) 55.00 Portion of overtime already included in 0 C 0 55.00 hourly computation at the AHSEA (multiply line 47 times line 52) Overtime allowance (line 54 minus line 55 -0 56.00 0 0 0 56, 00 if negative enter zero) (  ${\sf Enter}$  in  ${\sf column}$  5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) 1.00 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 100 600 57 00

57.00   Salary equivalency amount (from line 23)	[ 109, 609]	57.00
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58. 00
59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00 Overtime allowance (from column 5, line 56)	0	60.00
61.00 Equipment cost (see instructions)	0	61.00
62.00 Supplies (see instructions)	0	62.00
63.00 Total allowance (sum of lines 57-62)	109, 609	63.00
64.00 Total cost of outside supplier services (from your records)	94, 642	64.00
65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
LINE 33 CALCULATION		
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100. 01
100.02 Line 33 = line 28 = sum of lines 26 and 27	0	100. 02
LINE 34 CALCULATION		
101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101. 01
101.02 Line 34 = sum of lines 27 and 31	0	101. 02
LINE 35 CALCULATION		
102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line	0	102. 01
13 for all others		
102.02 Line 35 = sum of lines 31 and 32	0	102. 02

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1318 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 10: 49 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 1 00 00100 CAP REL COSTS-BLDG & FLXT 2, 786, 428 2, 786, 428 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 640, 614 2, 640, 614 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 772, 185 12, 712 12,046 2, 796, 943 4.00 00570 ADMITTING 20, 480 19, 408 107, 236 5 01 1, 441, 223 1, 588, 347 5 01 00590 ADMINISTRATIVE AND GENERAL 5.02 8, 163, 798 158, 665 150, 362 207, 311 0 5.02 7.00 00700 OPERATION OF PLANT 2, 669, 259 755, 433 715, 902 71, 469 0 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 132, 234 32, 918 31, 195 0 8.00 00900 HOUSEKEEPI NG 549, 628 31, 779 71, 964 9 00 30 116 9 00 0 10.00 01000 DI ETARY 328, 409 40, 859 38, 721 34, 852 0 10.00 01100 CAFETERI A 18, 477 36, 694 34, 773 9, 109 11.00 0 11.00 01300 NURSING ADMINISTRATION 733, 881 10, 089 9, 561 118, 189 13.00 13.00 0 01400 CENTRAL SERVICES & SUPPLY 278, 164 51, 250 14.00 48.568 33.011 0 14.00 15.00 01500 PHARMACY 610, 352 29, 603 28, 054 93, 956 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 285, 977 47, 906 45, 399 7, 407 0 16.00 <u>11, 8</u>01 01700 SOCIAL SERVICE <u>12, 452</u> 35, 899 210, 269 0 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 756, 083 395, 098 374, 423 449, 226 82, 096 30.00 31.00 03100 INTENSIVE CARE UNIT 353, 917 49, 694 47, 093 60, 173 6, 582 31.00 04300 NURSERY 10, 795 43.00 316, 137 10, 230 51, 145 1, 363 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 968, 913 177, 323 92, 001 159, 836 50.00 187, 115 50.00 51.00 05100 RECOVERY ROOM 270, 987 14, 729 13, 959 42, 799 33, 478 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 C 0 0 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 225, 704 157, 685 149, 433 190, 610 346, 557 54.00 54.01 05401 ULTRASOUND 0 C 0 0 54.01 0 56.00 05600 RADI OI SOTOPE 0 C 0 0 0 56.00 05700 CT SCAN 0 0 57.00 0 0 57.00 58.00 05800 MRI 0 Ω 58.00 06000 LABORATORY 1.758.510 41.944 221.804 60 00 44, 260 182, 428 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62,833 1, 701 1, 612 3, 555 62.00 06500 RESPIRATORY THERAPY 574, 435 44, 721 33, 195 65.00 42, 381 91.714 65.00 06600 PHYSI CAL THERAPY 352, 249 127, 606 120, 929 28, 905 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 235, 953 17, 165 67.00 3, 473 3, 292 0 67.00 68.00 06800 SPEECH PATHOLOGY 94,642 0 2,712 68.00 69.00 06900 ELECTROCARDI OLOGY 173, 889 58, 586 55, 520 24, 159 54, 543 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 85, 866 71 00 C 0 0 15, 901 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 106, 730 C 0 0 9, 492 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 822, 255 0 0 0 186, 616 73.00 0 76.00 03610 SLEEP LAB 0 0 0 0 76.00 03560 PULMONARY FUNCTION TESTING 76 01 0 0 76 01 0 0 76.02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 377, 633 13,620 12, 907 453 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 120, 225 39, 173 37, 123 19, 791 718 90.00 280, 181 09100 EMERGENCY 751, 506 91.00 5, 462, 818 106, 204 100, 646 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES
SPECIAL PURPOSE COST CENTERS 498, 884 36, 852 34, 924 50, 988 103, 195 95.00 95.00 SUBTOTALS (SUM OF LINES 1 through 117) 40, 239, 561 2, 532, 152 2, 399, 645 2, 796, 943 1, 588, 347 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 10, 735 0 190 00 0 11, 328 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 242, 948 230, 234 0 0 192.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 0 201, 00 TOTAL (sum lines 118 through 201) 2, 786, 428 1, 588, 347 202. 00 40, 239, 561 2, 640, 614 2, 796, 943 202.00

Provider CCN: 15-1318

						5/31/2024 10:	<u>49 am</u>
	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	8, 680, 136	8, 680, 136				5. 02
7.00	00700 OPERATION OF PLANT	4, 212, 063	1, 158, 490	5, 370, 553			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	196, 347	54, 003	110, 950	361, 300		8. 00
9.00	00900 HOUSEKEEPI NG	683, 487	187, 987	107, 113	0	978, 587	9. 00
10.00	01000 DI ETARY	442, 841	121, 799	137, 716	0	26, 802	10.00
11.00	01100 CAFETERI A	99, 053	27, 244	123, 678	0	24, 070	11. 00
13.00	01300 NURSING ADMINISTRATION	871, 720	239, 759	34, 004	0	6, 618	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	410, 993			0	33, 618	1
15.00	01500 PHARMACY	761, 965			0	19, 418	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	386, 689				31, 425	1
17. 00	01700 SOCIAL SERVICE	270, 421	74, 377		0	8, 168	•
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 056, 926	1, 115, 821	1, 331, 696	298, 958	259, 170	30.00
31.00	03100 INTENSIVE CARE UNIT	517, 459				32, 597	31.00
43. 00	04300 NURSERY	389, 670				7, 081	43. 00
.0.00	ANCILLARY SERVICE COST CENTERS	0077070	1077170	00,001	0,701.1	7,001	10.00
50.00	05000 OPERATI NG ROOM	1, 585, 188	435, 992	630, 678	0	122, 741	50.00
51. 00	05100 RECOVERY ROOM	375, 952				9, 662	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0,0,702	0		1	0	•
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 069, 989	-	1		103, 436	1
54. 01	05401 ULTRASOUND	2,007,707	007,002	001, 100	0	0	ł
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57. 00	05700 CT SCAN	0	l o	١	0	0	57. 00
58. 00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	2, 248, 946	618, 552	149, 181	0	29, 033	ł
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	69, 701	19, 171	5, 732		1, 116	•
65. 00	06500 RESPIRATORY THERAPY	786, 446				29, 336	•
66. 00	06600 PHYSI CAL THERAPY	629, 689				83, 705	1
67. 00	06700 OCCUPATI ONAL THERAPY	259, 883				2, 278	1
68. 00	06800 SPEECH PATHOLOGY	97, 354				2, 270	68. 00
69. 00	06900 ELECTROCARDI OLOGY						•
	1 1	366, 697			0	38, 430	1
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	101, 767			0	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	116, 222		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 008, 871	277, 481	0	0	0	
76. 00	03610 SLEEP LAB	0	0		0	0	
76. 01	03560 PULMONARY FUNCTION TESTING	404 (40	0		-	0	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	404, 613	111, 285	36, 433	0	7, 090	76. 02
00.00	OUTPATIENT SERVICE COST CENTERS	047.000	F0 (00	400.000		25 (2)	00.00
90.00	09000 CLINIC	217, 030				25, 696	•
91.00	09100 EMERGENCY	6, 701, 355		357, 966	0	69, 666	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
	OTHER REIMBURSABLE COST CENTERS					_	
95. 00	09500  AMBULANCE SERVI CES	724, 843	199, 362	124, 212	0	0	95.00
	SPECIAL PURPOSE COST CENTERS		T		1		
118.00		39, 744, 316	8, 543, 924	5, 332, 371	361, 300	971, 156	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22, 063			0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	473, 182	130, 144	0	0	0	192. 00
200.00		0					200. 00
201.00		0	0	1	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	40, 239, 561	8, 680, 136	5, 370, 553	361, 300	978, 587	202. 00

Provider CCN: 15-1318

				10	) 12/31/2023	5/31/2024 10:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	·			ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
	OFNEDAL CEDILLOS COCT CENTEDO	10.00	11. 00	13. 00	14. 00	15. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING						5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL						5. 02
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	729, 158					10. 00
11. 00	01100 CAFETERI A	0	274, 045				11. 00
13.00	01300 NURSING ADMINISTRATION	0	12, 876	1, 164, 977			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	7, 683		738, 075		14. 00
15. 00	01500 PHARMACY	0	9, 433		15, 908	1, 116, 074	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 879		291	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	3, 851	0	0	0	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	702 020	F/ 047	E02 1/7	E4 1EE	0	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	702, 038	56, 947 6, 010		54, 155	0	30. 00 31. 00
43. 00	04300 NURSERY	27, 120 0	5, 096	· ·	2, 300 0	0	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	l ol	5, 070	<u> </u>	<u> </u>	0	43.00
50. 00	05000 OPERATI NG ROOM	0	10, 814	82, 950	208, 367	0	50.00
51. 00	05100 RECOVERY ROOM	ol	4, 162		10, 678	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	o	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	26, 413	15, 931	38, 628	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	58. 00
60. 00	06000 LABORATORY	0	33, 745	1	165, 474	0	60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	30, 489	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	0	12, 448	1	19, 769	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		1, 438	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	39 0	0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	0	3, 481		2, 073	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0,401	1	25, 042	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	52, 565	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	ol	0	Ö	0	1, 116, 074	73. 00
76. 00	03610 SLEEP LAB	o	0	0	0	0	76. 00
76. 01	03560 PULMONARY FUNCTION TESTING	o	0	0	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0	0	3, 349	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	2, 139	27, 319	2, 529	0	
91. 00	09100 EMERGENCY	0	27, 327	302, 056	55, 501	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	ام	10 711	1	10 100		
95. 00	09500 AMBULANCE SERVICES	0	48, 741	1, 543	49, 480	0	95. 00
110 00	SPECIAL PURPOSE COST CENTERS	720 150	274 045	1 1/4 077	720 075	1 11/ 07/	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	729, 158	274, 045	1, 164, 977	738, 075	1, 116, 074	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	O	o	Ω	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES		0	1	0		190.00
200.00			0		9	O	200. 00
201.00		ol	0	0	o	0	201. 00
202.00		729, 158	274, 045	1, 164, 977	738, 075	1, 116, 074	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1318 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 10:49 am Cost Center Description MEDI CAL SOCIAL SERVICE Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5.01 5. 01 00590 ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 689, 110 16.00 01700 SOCIAL SERVICE 17.00 398, 788 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 592,635 329, 978 9, 391, 491 9, 391, 491 30.00 03100 INTENSIVE CARE UNIT 27, 564 27, 628 1, 054, 615 0 1, 054, 615 31.00 31.00 43.00 04300 NURSERY 41, 182 623, 899 623, 899 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 129 3, 131, 859 3, 131, 859 50.00 05100 RECOVERY ROOM 0 51.00 616, 146 616, 146 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 C 0 52.00 000000000000000000 0 05300 ANESTHESI OLOGY 53 00 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 355, 212 3, 355, 212 54.00 05401 ULTRASOUND 0 54.01 0 0 54.01 0 05600 RADI OI SOTOPE 56, 00 0 0 56,00 05700 CT SCAN O 57.00 0 57.00 58.00 05800 MRI 0 0 0 0 0 0 0 0 0 58.00 0 06000 LABORATORY 60.00 3, 245, 208 3, 245, 208 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 126, 209 126, 209 62.00 06500 RESPI RATORY THERAPY 65 00 1, 215, 039 1, 215, 039 65 00 06600 PHYSI CAL THERAPY 1, 318, 125 1, 318, 125 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 345, 385 345, 385 67.00 06800 SPEECH PATHOLOGY 124, 130 124, 130 68.00 0 68.00 06900 ELECTROCARDI OLOGY 69.00 Ω 709,004 709, 004 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 154, 799 0 154, 799 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 200, 753 200, 753 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 2, 402, 426 2, 402, 426 73.00 73.00 76.00 03610 SLEEP LAB 0 0 C 0 0 76.00 76. 01 03560 PULMONARY FUNCTION TESTING 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 562, 770 562, 770 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 466, 438 466, 438 90.00 o 91.00 09100 EMERGENCY 13, 782 9, 370, 802 9, 370, 802 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 0 1, 148, 181 0 1, 148, 181 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 689, 110 398, 788 39, 562, 491 0 39, 562, 491 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 73, 744 73, 744 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 603 326 0 603 326 192 00 Ω Cross Foot Adjustments 0 200.00 C 0 200.00

689, 110

398, 788

40, 239, 561

0

ol

0 201.00

40, 239, 561 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1318

				То	12/31/2023	Date/Time Prep 5/31/2024 10:4	
			CAPI TAL REI	LATED COSTS		3/31/2024 10.	47 aiii
	Cost Contor Dosorintian	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Cost Center Description	Assigned New	DLUG & FIXI	MVBLE EQUIP	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZR	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		10 710	12.04/	24.750	24.750	2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING	0	12, 712 20, 480		24, 758 39, 888	24, 758 949	4. 00 5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	0	158, 665		309, 027	1, 835	5. 02
7.00	00700 OPERATION OF PLANT	0	755, 433		1, 471, 335	632	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	32, 918		64, 113	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	31, 779 40, 859		61, 895 79, 580	637 308	9. 00 10. 00
11. 00	01100 CAFETERI A	0	36, 694		71, 467	81	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	10, 089		19, 650	1, 046	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	51, 250		99, 818	292	14. 00
15. 00	01500 PHARMACY	0	29, 603		57, 657	831	15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	47, 906 12, 452		93, 305 24, 253	66 318	16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		12, 102	11,001	21, 200	010	17.00
30.00	03000 ADULTS & PEDIATRICS	0			769, 521	3, 975	30. 00
31. 00	03100   NTENSIVE CARE UNIT	0	49, 694		96, 787	532	31.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	10, 795	10, 230	21, 025	453	43. 00
50.00	05000 OPERATI NG ROOM	0	187, 115	177, 323	364, 438	814	50. 00
51. 00	05100 RECOVERY ROOM	0	14, 729	13, 959	28, 688	379	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 157, 685	I -1	0 307, 118	0 1, 687	53. 00 54. 00
54. 01	05401 ULTRASOUND	0	0	0	0	0	54. 01
56.00	05600 RADI OI SOTOPE	0	0	0	o	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 60. 00	05800   MRI	0	0 44, 260	0 41, 944	0 86, 204	1 414	58. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 701		3, 313	1, 614 0	62. 00
65. 00	06500 RESPIRATORY THERAPY	0	44, 721		87, 102	812	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	127, 606	120, 929	248, 535	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 473	3, 292	6, 765	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0 58, 586	55, 520	0 114, 106	0 214	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 30,380	33, 320	114, 100	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	ō	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76.00	03610 SLEEP LAB	0	0	0	0	0	76. 00
76. 01 76. 02	03560 PULMONARY FUNCTION TESTING 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0 13, 620	-	26, 527	0	76. 01 76. 02
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	10,020	12, 707	20, 027	0	70.02
90.00	09000 CLI NI C	0			76, 296	175	90. 00
91.00	09100 EMERGENCY	0	106, 204	100, 646	206, 850	6, 657	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92. 00
95. 00	09500 AMBULANCE SERVICES	0	36, 852	34, 924	71, 776	451	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		0	2, 532, 152	2, 399, 645	4, 931, 797	24, 758	118. 00
190 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 328	10, 735	22, 063	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES		242, 948		473, 182		192. 00
200.00	Cross Foot Adjustments				o		200. 00
201.00			0 70/ 420		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	2, 786, 428	2, 640, 614	5, 427, 042	24, 758	202.00

Provider CCN: 15-1318

Un Lieu of Form CMS-2552-10
Worksheet B
Part II
B1/2023 Date/Time Prepared:
5/31/2024 10: 49 am Peri od: From 01/01/2023 To 12/31/2023

	Cost Center Description	ADMI TTI NG	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	47 dili
		5. 01	AND GENERAL 5. 02	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	3.01	3.02	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING	40, 837					5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL	0,037					5. 02
7. 00	00700 OPERATION OF PLANT	0					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 934		l		8. 00
9. 00	00900 HOUSEKEEPI NG	0	6, 732			99, 449	9. 00
10. 00	01000 DI ETARY	0	4, 362			2, 724	10.00
11. 00	01100 CAFETERI A	0	976			2, 446	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	8, 586			673	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	4, 048			3, 416	14. 00
15. 00	01500 PHARMACY					1, 973	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					3, 194	16. 00
17. 00	1 1					830	17. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	2,004	11,020	U U	030	17.00
30. 00	03000 ADULTS & PEDIATRICS	2, 108	39, 961	375, 281	80, 523	26, 337	30. 00
31. 00	03100 INTENSIVE CARE UNIT	169				3, 313	31. 00
43. 00		35				720	43. 00
43.00	ANCILLARY SERVICE COST CENTERS	30	3,030	10, 253	10, 047	720	43.00
50. 00	05000 OPERATING ROOM	4, 104	15, 614	177, 729	0	12, 474	50. 00
51. 00	05100 RECOVERY ROOM	859			0	982	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	000		13, 771	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 957	20, 389	149, 775	0	10, 512	54. 00
54. 01	05401 ULTRASOUND	0, 737	20, 307	147,773	0	0, 312	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	5, 694	22, 152	42, 040	0	2, 950	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	91	687			113	62. 00
65. 00	06500 RESPIRATORY THERAPY	852				2, 981	65. 00
66. 00	06600 PHYSI CAL THERAPY	742				8, 507	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	441	2, 560			232	67. 00
68. 00	06800 SPEECH PATHOLOGY	70			0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 400	•		0	3, 905	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	408			0	3, 703	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	244			0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 791	9, 937		0	0	73. 00
76. 00	03610 SLEEP LAB	4,771		0	0	0	76. 00
76. 01	03560 PULMONARY FUNCTION TESTING	Ö	1	0	0	0	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	12		10, 267	0	721	76. 02
70.02	OUTPATIENT SERVICE COST CENTERS	12	3, 703	10, 207	<u> </u>	721	70.02
90. 00		18	2, 138	37, 208	0	2, 611	90. 00
91. 00	09100 EMERGENCY	7, 193			Ö	7, 080	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,170	00,012	100,077	Ŭ	7,000	92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	2, 649	7, 140	35, 004	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS	,	,		-1		
118. 0		40, 837	305, 984	1, 502, 696	97, 314	98, 694	118. 00
	NONREI MBURSABLE COST CENTERS						
190.0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	217	10, 760	0	755	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	4, 661		0		192. 00
200.0	Cross Foot Adjustments						200. 00
201.0	Negative Cost Centers	0	0	0	o	0	201. 00
202.0	TOTAL (sum lines 118 through 201)	40, 837	310, 862	1, 513, 456	97, 314		202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/Time Prepared: | To 12/31/2024 | To 1 Provider CCN: 15-1318

				To	12/31/2023	Date/Time Pre 5/31/2024 10:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	47 (1111
				ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT					i	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					i	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					i	4. 00
5. 01	00570 ADMITTING					i	5. 01
5. 02	00590 ADMINISTRATIVE AND GENERAL					i	5. 02
7.00	00700 OPERATION OF PLANT					i	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					i	8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	125 702				ı	9.00
10. 00 11. 00	01100 CAFETERI A	125, 783	109, 823			i	10. 00 11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	5, 160			i	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	3, 100		159, 332	1	14. 00
15. 00	01500 PHARMACY	0	3, 780	1	3, 434	103, 298	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1, 154	1	63	103, 270	16. 00
17. 00	01700 SOCIAL SERVICE	0	1, 1543	1	0	0	17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	٥	1, 545	ı	<u> </u>		17.00
30. 00	03000 ADULTS & PEDIATRICS	121, 105	22, 823	22, 758	11, 691	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	4, 678	2, 408	1	497	0	31. 00
43.00	04300 NURSERY	0	2, 042	1	0	0	43.00
	ANCILLARY SERVICE COST CENTERS	<u> </u>					
50.00	05000 OPERATING ROOM	0	4, 334	3, 183	44, 982	0	50. 00
51.00	05100 RECOVERY ROOM	0	1, 668	2, 404	2, 305	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	_	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 585	611	8, 339	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	13, 523		35, 722	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	_	6, 582	0	62.00
65. 00	06500 RESPI RATORY THERAPY	0	4, 988		4, 268	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	1	310	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	_	8	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	U	1 205		0	0	68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY	0	1, 395	1	447 5, 406	0	69. 00 71. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		11, 347	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		11, 347	103, 298	73.00
76. 00	03610 SLEEP LAB	0	0		ol	103, 270	76.00
76. 01	03560 PULMONARY FUNCTION TESTING	0	0	1	ol O	Ö	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	- 1	723	0	76. 02
	OUTPATIENT SERVICE COST CENTERS	-,	-		.=.,		
90.00	09000 CLI NI C	0	857	1, 048	546	0	90.00
91.00	09100 EMERGENCY	0	10, 951	11, 589	11, 981	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	19, 533	59	10, 681	0	95. 00
440.00	SPECIAL PURPOSE COST CENTERS	405 700	400.000	14 (00	450 000	100.000	440.00
118.00		125, 783	109, 823	44, 698	159, 332	103, 298	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	o	ol	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		190.00
200.00		٩	0		٩		200. 00
201.00	1	0	0	o l	o		201. 00
202.00		125, 783	109, 823	44, 698	159, 332	103, 298	

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1318 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 10:49 am Cost Center Description MEDI CAL SOCIAL SERVICE Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5.01 5. 01 00590 ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 147,094 16.00 01700 SOCIAL SERVICE 17.00 41, 436 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 126, 500 34, 286 1, 636, 869 1, 636, 869 30.00 31.00 03100 INTENSIVE CARE UNIT 5,884 2, 871 179, 214 0 179, 214 31.00 43.00 04300 NURSERY 4, 279 52, 694 0 52, 694 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 11, 768 0 639, 440 0 639, 440 50.00 54, 979 54, 979 05100 RECOVERY ROOM 0 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 000000000000000000 0 05300 ANESTHESI OLOGY 53 00 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 517, 973 517, 973 54.00 05401 ULTRASOUND 0 0 54.01 0 0 54.01 0 05600 RADI OI SOTOPE 56, 00 0 0 0 56, 00 05700 CT SCAN Ω 0 57.00 0 57.00 58.00 05800 MRI 0 0 0 0 0 0 0 0 0 58.00 0 06000 LABORATORY 209, 910 209, 910 60.00 60 00 12, 401 12, 401 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06500 RESPI RATORY THERAPY 65 00 Ω 151, 227 151, 227 65 00 06600 PHYSI CAL THERAPY 385, 502 385, 502 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 13, 305 13, 305 67.00 06800 SPEECH PATHOLOGY 1,029 1, 029 68.00 C 68.00 06900 ELECTROCARDI OLOGY 0 69.00 180, 726 180, 726 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 6,816 0 0 6,816 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 12, 736 12, 736 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 118,026 118,026 73.00 76.00 03610 SLEEP LAB 0 0 C 0 76.00 76. 01 03560 PULMONARY FUNCTION TESTING 0 0 o 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 42, 235 76.02 76.02 C 42, 235 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 120, 897 120, 897 90.00 o 91.00 09100 EMERGENCY 2,942 432, 132 91.00 432, 132 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 0 147, 293 0 147, 293 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 147,094 41, 436 4, 915, 404 0 4, 915, 404 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 33, 795 33, 795 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 477 843 477 843 192 00 Cross Foot Adjustments 200.00 C 0 200.00 201.00 Negative Cost Centers 0 0 201.00

147,094

41, 436

5, 427, 042

ol

5, 427, 042 202. 00

202.00

TOTAL (sum lines 118 through 201)

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

					Ť	0 12/31/2023	Date/Time Prep 5/31/2024 10:4	
			CAPITAL REI	LATED COSTS			373172024 10.	47 alli
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	ADMITTING	Reconciliation	
		cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	(TIME SPENT)	Reconciliation	
					DEPARTMENT			
					(GROSS SALARI ES)			
			1.00	2.00	4.00	5. 01	5A. 02	
1. 00		AL SERVICE COST CENTERS	102 227	I	ı			1. 00
2.00	1	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	193, 337	193, 337				2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	882					4. 00
5.01		ADMITTING	1, 421	1, 421		182, 038, 506		5. 01
5. 02 7. 00		ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	11, 009 52, 416	1		0	-8, 680, 136 0	5. 02 7. 00
8.00		LAUNDRY & LINEN SERVICE	2, 284			Ö	Ö	8. 00
9.00		HOUSEKEEPI NG	2, 205	1		0	0	9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	2, 835 2, 546	1		0	0	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	700			0	0	13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY	3, 556	l .		0	0	14. 00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	2,054	l ·		0	0	15. 00 16. 00
17. 00		SOCIAL SERVICE	3, 324 864			0		
	I NPAT	ENT ROUTINE SERVICE COST CENTERS			T			
30.00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	27, 414					30. 00 31. 00
31. 00 43. 00		NURSERY	3, 448 749			754, 363 156, 188		43.00
	ANCI L	LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM RECOVERY ROOM	12, 983				0	
51. 00 52. 00		DELIVERY ROOM & LABOR ROOM	1, 022	1, 022		3, 837, 051	0	51. 00 52. 00
53. 00		ANESTHESI OLOGY	0	0		0	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	10, 941	10, 941	1, 031, 670	39, 713, 142		54.00
54. 01 56. 00	1	ULTRASOUND RADI OI SOTOPE	0	0	0	0	0	54. 01 56. 00
57. 00	1	CT SCAN	0	Ö	ő	o	Ö	57. 00
58. 00	05800		0	0	0	0	0	58. 00
60. 00 62. 00		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	3, 071 118	3, 071 118		25, 421, 618 407, 431	0	60. 00 62. 00
65. 00		RESPIRATORY THERAPY	3, 103	l .		3, 804, 553		65. 00
66.00		PHYSI CAL THERAPY	8, 854	1		3, 312, 908	0	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	241	241	1	1, 967, 320		67. 00 68. 00
69.00		ELECTROCARDI OLOGY	4, 065	_	1	310, 840 6, 251, 373		69.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		1, 822, 508		71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1, 087, 894		72.00
73. 00 76. 00		DRUGS CHARGED TO PATIENTS SLEEP LAB	0	0	0	21, 388, 601 0	0	73. 00 76. 00
76. 01	03560	PULMONARY FUNCTION TESTING	0	Ō		0	0	76. 01
76. 02		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	945	945	0	51, 877	0	76. 02
90. 00		TIENT SERVICE COST CENTERS CLINIC	2, 718	2, 718	107, 120	82, 300	0	90. 00
91. 00		EMERGENCY	7, 369			32, 112, 444		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00		REIMBURSABLE COST CENTERS  AMBULANCE SERVICES	2, 557	2, 557	275, 969	11, 827, 515	0	95. 00
75.00		AL PURPOSE COST CENTERS	2, 557	2, 557	275, 707	11, 627, 515	0	75.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	175, 694	175, 694	15, 138, 334	182, 038, 506	-8, 680, 136	118. 00
100.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	704	786	1 0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	786 16, 857	l .		0		190.00
200.00	1	Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers	0.70/ 400	0 (40 (44	0.70/.040	4 500 047		201. 00
202.00	)	Cost to be allocated (per Wkst. B, Part I)	2, 786, 428	2, 640, 614	2, 796, 943	1, 588, 347		202. 00
203.00	)	Unit cost multiplier (Wkst. B, Part I)	14. 412285	13. 658089	0. 184759	0. 008725		203. 00
204.00	)	Cost to be allocated (per Wkst. B,			24, 758	40, 837		204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part			0. 001635	0. 000224		205. 00
		[11]			0.001033	5. 500224		
206.00	O	NAHE adjustment amount to be allocated						206. 00
207. 00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
250		Parts III and IV)						" " " " " " " " " " " " " " " " " " "

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

					To	0 12/31/2023	Date/Time Prep 5/31/2024 10:4	
		Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	47 aiii
		·	AND GENERAL	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DA	
			(ACCUMULATE D COST)	(SQUARE FEET)	(TOTAL PATI ENT DAYS)		YS)	
			5. 02	7. 00	8. 00	9. 00	10. 00	
	GENER	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	1	EMPLOYEE BENEFITS DEPARTMENT ADMITTING						4. 00 5. 01
5. 01		ADMINISTRATIVE AND GENERAL	31, 559, 425					5. 01
7. 00		OPERATION OF PLANT	4, 212, 063	110, 557				7. 00
8.00		LAUNDRY & LINEN SERVICE	196, 347	2, 284	2, 295			8. 00
9.00		HOUSEKEEPI NG	683, 487	2, 205		103, 511		9. 00
10.00		DIETARY	442, 841	2, 835		2, 835	2, 124	
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	99, 053 871, 720	2, 546 700		2, 546 700	0	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	410, 993	3, 556		3, 556	0	14. 00
15.00		PHARMACY	761, 965			2, 054	0	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	386, 689			3, 324	0	16. 00
17. 00		SOCIAL SERVICE	270, 421	864	0	864	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	4, 056, 926	27, 414	1, 899	27, 414	2, 045	30. 00
31. 00	1	INTENSIVE CARE UNIT	517, 459				79	31. 00
43.00		NURSERY	389, 670			749	0	43.00
		LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM	1, 585, 188			12, 983	0	50.00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	375, 952	1, 022 0	0	1, 022 0	0	51. 00 52. 00
53. 00	1	ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	2, 069, 989	10, 941	Ö	10, 941	0	54. 00
54. 01	05401	ULTRASOUND	0	0	0	0	0	54. 01
56. 00	1	RADI OI SOTOPE	0	0		0	0	56. 00
57. 00	1	CT SCAN	0	0	_	0	0	57. 00
58. 00 60. 00	05800	MRI LABORATORY	2, 248, 946	0 3, 071	0	3, 071	0	58. 00 60. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	69, 701	118	0	118	0	62.00
65.00		RESPI RATORY THERAPY	786, 446	3, 103		3, 103	0	65. 00
66. 00		PHYSI CAL THERAPY	629, 689	8, 854	0	8, 854	0	66. 00
67. 00		OCCUPATIONAL THERAPY	259, 883	241		241	0	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	97, 354 366, 697	0 4, 065		0 4, 065	0	68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	101, 767	4,003	1	4, 003	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	116, 222	Ö		Ö	0	72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	1, 008, 871	0	0	0	0	73. 00
76.00		SLEEP LAB	0	0	0	0	0	76. 00
76. 01 76. 02	1	PULMONARY FUNCTION TESTING PSYCHIATRIC/PSYCHOLOGICAL SERVICES	404, 613	0 750		0 750	0	76. 01
70.02		TIENT SERVICE COST CENTERS	404, 613	/50	U	750	U	76. 02
90.00	09000	CLI NI C	217, 030	2, 718	0	2, 718	0	90. 00
91.00	09100	EMERGENCY	6, 701, 355	7, 369	0	7, 369	0	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00		REI MBURSABLE COST CENTERS  AMBULANCE SERVI CES	724, 843	2, 557	0	0	0	95. 00
93.00		AL PURPOSE COST CENTERS	124, 043	2, 557	U	U <sub>I</sub>	U	95.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31, 064, 180	109, 771	2, 295	102, 725	2, 124	118. 00
		MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	22, 063			786		190. 00
192. 00 200. 00	1	PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments	473, 182	0	0	0	0	192. 00 200. 00
200.00		Negative Cost Centers						200.00
202.00		Cost to be allocated (per Wkst. B,	8, 680, 136	5, 370, 553	361, 300	978, 587	729, 158	
		Part I)			·			
203.00		Unit cost multiplier (Wkst. B, Part I)	0. 275041	48. 577232		9. 453942	343. 294727	
204.00	)	Cost to be allocated (per Wkst. B,	310, 862	1, 513, 456	97, 314	99, 449	125, 783	204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part	0. 009850	13. 689373	42. 402614	0. 960758	59. 219868	205. 00
_00.00		II)	3. 30 7030	15. 507575	12. 702014	3. 700730	57. 217000	_55.56
206.00	)	NAHE adjustment amount to be allocated						206. 00
207.00		(per Wkst. B-2)						207.00
207. 00	'	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	I .	1. 2. 23 · · · · · · · · · · · · · · · · · ·	ا ا	1	1	ı	l	

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

					To	12/31/2023	Date/Time Pre 5/31/2024 10:	
		Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	, , <u>G</u> ,,,,
			(FTES)	ADMI NI STRATI ON		(COSTED REQ)	RECORDS &	
				(NURSING SA	SUPPLY (COSTED REQ)		LIBRARY (TIME SPENT)	
				LARIES)	(OOOTED REQ)		(TIME SIENT)	
			11. 00	13.00	14. 00	15. 00	16. 00	
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT		I		T		1. 00
2.00	1	CAP REL COSTS-BEDG & TTXT						2.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		ADMITTI NG						5. 01
5. 02	1	ADMINISTRATIVE AND GENERAL						5. 02
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9.00
10.00	1	DI ETARY						10.00
11. 00	1	CAFETERI A	14, 090	•				11. 00
13.00	1	NURSI NG ADMI NI STRATI ON	662					13.00
14. 00 15. 00	1	CENTRAL SERVI CES & SUPPLY PHARMACY	395 485			822, 255		14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	148			022, 233	100	•
17. 00	1	SOCIAL SERVICE	198	0	0	0	0	17. 00
		ENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	2, 928			0	86	1
43. 00		NURSERY	309 262			0	4	31. 00 43. 00
43.00		LARY SERVICE COST CENTERS	202			<u> </u>		1 43.00
50.00		OPERATING ROOM	556	298, 393	429, 421	0	8	50. 00
51.00	1	RECOVERY ROOM	214	225, 346		0	0	
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	1, 358	57, 309	79, 606	0	0	53. 00 54. 00
54. 01		ULTRASOUND	0	0	0	0	0	54. 01
56.00	05600	RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	1	CT SCAN	0	0	1	0	0	57. 00
58.00	05800	· ·	1 725	0	·	0	0	58.00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	1, 735	997 0		0	0	60. 00 62. 00
65. 00	1	RESPIRATORY THERAPY	640	0		0	0	65.00
66.00	1	PHYSI CAL THERAPY	0	0	2, 964	0	0	66. 00
67. 00		OCCUPATI ONAL THERAPY	0	0	80	0	0	67. 00
68.00	1	SPEECH PATHOLOGY	170	0	0	0	0	68. 00
69. 00 71. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	179 0	0	4, 272 51, 609	0	0	69. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	822, 255	0	73. 00
76. 00		SLEEP LAB	0	0	0	0	0	76. 00
76. 01 76. 02	1	PULMONARY FUNCTION TESTING	0	0		0	0	76. 01
70.02		PSYCHIATRIC/PSYCHOLOGICAL SERVICES TIENT SERVICE COST CENTERS	0		6, 901	<u> </u>	0	76. 02
90.00		CLI NI C	110	98, 273	5, 211	0	0	90.00
91. 00	1	EMERGENCY	1, 405			0	2	ł
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	2, 506	5, 550	101, 971	0	0	95. 00
70.00		AL PURPOSE COST CENTERS	2,000	0,000	1017771	٩.		70.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14, 090	4, 190, 723	1, 521, 071	822, 255	100	118. 00
400.00		MBURSABLE COST CENTERS		Ι .		ام	-	1.00.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	0	1	0		190. 00 192. 00
200.00		Cross Foot Adjustments	Ü	0		o <sub>l</sub>	O	200. 00
201.00	1	Negative Cost Centers						201. 00
202.00		Cost to be allocated (per Wkst. B,	274, 045	1, 164, 977	738, 075	1, 116, 074	689, 110	202. 00
202.00		Part I)	10 440/10	0 277000	0.405334	1 257222	/ 001 100000	202.00
203. 00 204. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	19. 449610 109, 823			1. 357333 103, 298	6, 891. 100000 147, 094	
204.00	1	Part II)	107, 023	44, 070	137, 332	103, 270	147,074	204.00
205.00	)	Unit cost multiplier (Wkst. B, Part	7. 794393	0. 010666	0. 104750	0. 125628	1, 470. 940000	205. 00
20/ 22		II)						204 60
206.00	ľ	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00		NAHE unit cost multiplier (Wkst. D,						207. 00
		Parts III and IV)						

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1318 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 10:49 am Cost Center Description SOCIAL SERVICE (TOTAL PATI ENT DAYS) 17.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00570 ADMITTING 5.01 00590 ADMINISTRATIVE AND GENERAL 5.02 5.02 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 16.00 17.00 01700 SOCIAL SERVICE 2, 295 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 1 899 30.00 31.00 03100 INTENSIVE CARE UNIT 159 31.00 43.00 04300 NURSERY 237 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 0 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 000000000000000000 52.00 53 00 05300 ANESTHESI OLOGY 53 00 |05400| RADI OLOGY-DI AGNOSTI C 54.00 54.00 54.01 05401 ULTRASOUND 54.01 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57 00 57 00 58.00 05800 MRI 58.00 06000 LABORATORY 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 65.00 06500 RESPIRATORY THERAPY 65 00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 03610 SLEEP LAB 76.00 76.00 76.01 03560 PULMONARY FUNCTION TESTING 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 76.02 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 2, 295 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190.00 192.00 0 200.00 Cross Foot Adjustments l200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 398, 788 202.00 Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 173. 763834 203.00 204.00 Cost to be allocated (per Wkst. B, 41, 436 204.00 Part II) Unit cost multiplier (Wkst. B, Part 18. 054902 205.00 205.00 H) 206 00 NAHE adjustment amount to be allocated 206 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207. 00 Parts III and IV)

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1318	Peri od: Worksheet C From 01/01/2023 Part I

12/31/2023 Date/Time Prepared: To 5/31/2024 10:49 am Title XVIII Hospi tal Cost Costs Total Cost Therapy Limit Cost Center Description Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 5. 00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 9, 391, 491 30 00 9, 391, 491 0 Ω 31.00 03100 INTENSIVE CARE UNIT 1,054,615 1, 054, 615 0 0 31.00 04300 NURSERY 623, 899 o 43.00 43.00 623, 899 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 3, 131, 859 3, 131, 859 0 51.00 05100 RECOVERY ROOM 616, 146 616, 146 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 53.00 Λ 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 355, 212 3, 355, 212 0 54.00 54.01 05401 ULTRASOUND 54.01 56.00 05600 RADI OI SOTOPE 0 0 56.00 0 05700 CT SCAN 0 0 57.00 57.00 0 58.00 05800 MRI 0 0 58.00 06000 LABORATORY 3, 245, 208 60.00 3, 245, 208 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 126 209 126, 209 0 62 00 65.00 06500 RESPIRATORY THERAPY 1, 215, 039 1, 215, 039 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 318, 125 1, 318, 125 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 345, 385 345, 385 0 67.00 06800 SPEECH PATHOLOGY 68 00 124, 130 124, 130 68 00 0 69.00 06900 ELECTROCARDI OLOGY 709,004 709,004 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 154, 799 154, 799 71.00 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 200.753 200.753 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 402, 426 2, 402, 426 0 73.00 76.00 03610 SLEEP LAB 0 76.00 03560 PULMONARY FUNCTION TESTING 0 76. 01 0 0 0 76.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 562, 770 562, 770 0 0 76.02 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 466, 438 466, 438 0 0 90.00 91.00 09100 EMERGENCY 9, 370, 802 9, 370, 802 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 1, 545, 830 1, 545, 830 n OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 148, 181 1, 148, 181 0 95.00 0 200.00 Subtotal (see instructions) 41, 108, 321 41, 108, 321 0 200. 00 0 201. 00 201.00 Less Observation Beds 1, 545, 830 1, 545, 830 202.00 Total (see instructions) 39, 562, 491 39, 562, 491 0 202. 00

DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
Provi der CCN: 15-1318	Peri od:	Worksheet C
_	Provi der CCN: 15-1318	

				rom 01/01/2023 To 12/31/2023	Part I Date/Time Prep 5/31/2024 10:4	
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
LUDATI ENT. DOUTLING OFFINA OF COOT OFFITEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	7 440 470		7 440 47	\		00.00
30. 00   03000   ADULTS & PEDI ATRI CS	7, 419, 173		7, 419, 173			30.00
31.00 03100 INTENSIVE CARE UNIT	754, 363		754, 363			31. 00
43. 00 04300 NURSERY	156, 188		156, 188	3		43. 00
ANCILLARY SERVICE COST CENTERS	0 (00 007	45 747 040	40.040.05	0.4700(0	0.00000	F0 00
50. 00   05000   OPERATI NG   ROOM	2, 603, 237	15, 716, 019			0.000000	50.00
51. 00 05100 RECOVERY ROOM	422, 322	3, 414, 729			0.000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(		0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	04 540 700	00 710 14	0.000000	0.000000	53. 00 54. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   ULTRASOUND	5, 170, 409	34, 542, 733	39, 713, 142	0. 084486 0. 000000	0. 000000 0. 000000	54.00
	0	0				
56. 00   05600   RADI 01 SOTOPE 57. 00   05700   CT   SCAN	0	0	(	0.000000	0. 000000 0. 000000	56. 00 57. 00
	0	0		0. 000000 0. 000000		57.00
58. 00   05800   MRI 60. 00   06000   LABORATORY	4 044 (4)	0 57/ 070	05 401 (10		0.000000	60.00
	4, 844, 646	20, 576, 972	25, 421, 618 407, 43		0. 000000 0. 000000	62.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL 65.00   06500   RESPIRATORY THERAPY	212, 479 3, 010, 976	194, 952 793, 577	3, 804, 553		0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 198, 304	2, 114, 604			0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 196, 304	701, 510	1, 967, 320		0.000000	67. 00
68. 00   06800   SPEECH PATHOLOGY	110, 781	200, 059			0. 000000	68.00
69. 00   06900   SPEECH PATHOLOGY	1, 343, 107	4, 908, 266			0.000000	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 155, 476	667, 032			0.000000	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	237, 669	850, 225	1, 087, 894		0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	9, 553, 841	11, 834, 760			0.000000	73.00
76. 00   03610 SLEEP LAB	9, 333, 641	11,034,700	21, 300, 00		0.000000	76.00
76. 01 03560 PULMONARY FUNCTION TESTING	0	0			0.000000	76. 00
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		51, 877	51, 87		0.000000	76. 02
OUTPATIENT SERVICE COST CENTERS	<u> </u>	31, 077	31, 07	10. 040100	0.000000	70.02
90. 00 09000 CLINIC	22, 130	60, 170	82, 300	5. 667533	0.000000	90.00
91. 00   09100   EMERGENCY	2, 985, 468	29, 126, 976			0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	670, 698	1, 319, 453				92. 00
OTHER REIMBURSABLE COST CENTERS	373,070	1, 017, 400	1, 7,0, 10	3.773740	3. 333000	72.00
95. 00 09500 AMBULANCE SERVI CES	12, 088	11, 815, 427	11, 827, 515	0. 097077	0.000000	95. 00
200.00 Subtotal (see instructions)	43, 149, 165	138, 889, 341	182, 038, 506			200. 00
201.00 Less Observation Beds		,, 0				201. 00
202.00 Total (see instructions)	43, 149, 165	138, 889, 341	182, 038, 506			202. 00
1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				!	ļ	

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1318	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared:

			10 12/31/2023	5/31/2024 10: 49 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   05100   RECOVERY ROOM	0. 000000			51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
54. 01   05401   ULTRASOUND	0. 000000			54. 01
56. 00   05600   RADI 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. 000000			60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62. 00
65. 00  06500   RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00   03610   SLEEP LAB	0. 000000			76. 00
76.01 03560 PULMONARY FUNCTION TESTING	0. 000000			76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			76. 02
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   SERVI CES	0. 000000			95. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1318	
		From 01/01/2023   Part I

				0 12/31/2023	Date/Time Prep 5/31/2024 10:4	pared: 49 am
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	9, 391, 491		9, 391, 491	0	9, 391, 491	30. 00
31. 00   03100   I NTENSI VE CARE UNI T	1, 054, 615		1, 054, 615	0	1, 054, 615	31.00
43. 00   04300 NURSERY	623, 899		623, 899	0	623, 899	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	3, 131, 859		3, 131, 859	0	3, 131, 859	50. 00
51.00   05100   RECOVERY ROOM	616, 146		616, 146	0	616, 146	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	O	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0		0	O	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 355, 212		3, 355, 212	0	3, 355, 212	54. 00
54. 01 05401 ULTRASOUND	0		0	0	0	54. 01
56. 00 05600 RADI 0I SOTOPE	0		l o	o	ol	56. 00
57. 00 05700 CT SCAN	0		l o	o	ol	57. 00
58. 00 05800 MRI	0		l o	o	ol	58. 00
60. 00   06000   LABORATORY	3, 245, 208		3, 245, 208	0	3, 245, 208	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	126, 209	l .	126, 209		126, 209	62. 00
65. 00 06500 RESPIRATORY THERAPY	1, 215, 039	l .			1, 215, 039	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 318, 125		1, 318, 125		1, 318, 125	
67. 00 06700 OCCUPATI ONAL THERAPY	345, 385		345, 385		345, 385	
68.00 06800 SPEECH PATHOLOGY	124, 130	l .	124, 130		124, 130	68. 00
69. 00   06900   ELECTROCARDI OLOGY	709, 004		709, 004		709, 004	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	154, 799		154, 799		154, 799	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	200, 753	l .	200, 753		200, 753	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 402, 426	l e	2, 402, 426		2, 402, 426	73. 00
76. 00 03610 SLEEP LAB	2, 102, 120		2, 102, 120	0	2, 102, 120	76. 00
76. 01 03560 PULMONARY FUNCTION TESTING	0			0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	562, 770		562, 770		562, 770	76. 02
OUTPATIENT SERVICE COST CENTERS	302,770		302,770	<u> </u>	302,770	70.02
90. 00 09000 CLINIC	466, 438		466, 438	0	466, 438	90.00
91. 00   09100   EMERGENCY	9, 370, 802		9, 370, 802		9, 370, 802	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 545, 830	1	1, 545, 830		1, 545, 830	
OTHER REIMBURSABLE COST CENTERS	1, 343, 030		1, 343, 030		1, 343, 030	72.00
95. 00 09500 AMBULANCE SERVICES	1, 148, 181		1, 148, 181	0	1, 148, 181	95. 00
200.00 Subtotal (see instructions)	41, 108, 321	0	41, 108, 321		41, 108, 321	
201. 00 Less Observation Beds	1, 545, 830	ı	1, 545, 830		1, 545, 830	
202.00 Total (see instructions)	39, 562, 491					
202.00   TOTAL (SEE THSTI UCTIONS)	J7, 30∠, 491	ı	J 37, 302, 491	ı Y	37, 302, 491	1202. UU

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1318	Peri od: Worksheet C
		From 01/01/2023   Part I
		To 12/21/2022   Dota/Time December

					To 12/31/2023	Date/Time Pre 5/31/2024 10:	pared: 49 am
			Ti tl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
		4.00	7. 00	8. 00	9. 00	Rati o 10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
30. 00	03000 ADULTS & PEDIATRICS	7, 419, 173		7, 419, 173			30.00
31. 00	03100 I NTENSI VE CARE UNI T	754, 363		754, 363			31.00
43. 00	04300 NURSERY	156, 188		156, 188			43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	130, 100		130, 100	7		43.00
50. 00	05000 OPERATING ROOM	2, 603, 237	15, 716, 019	18, 319, 256	0. 170960	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	422, 322	3, 414, 729			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0,, , 2,	1		0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 170, 409	34, 542, 733	39, 713, 142		0.000000	
54. 01	05401 ULTRASOUND	0	0	(	0. 000000	0. 000000	54. 01
56.00	05600 RADI OI SOTOPE	0	0		0. 000000	0.000000	
57.00	05700 CT SCAN	O	0		0.000000	0.000000	57. 00
58.00	05800 MRI	0	0	(	0. 000000	0.000000	58. 00
60.00	06000 LABORATORY	4, 844, 646	20, 576, 972	25, 421, 618	0. 127655	0. 000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	212, 479	194, 952	407, 431	0. 309768	0. 000000	62.00
65.00	06500 RESPIRATORY THERAPY	3, 010, 976	793, 577	3, 804, 553	0. 319364	0. 000000	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 198, 304	2, 114, 604	3, 312, 908	0. 397876	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 265, 810	701, 510	1, 967, 320		0. 000000	
68. 00	06800 SPEECH PATHOLOGY	110, 781	200, 059			0.000000	
69. 00	06900 ELECTROCARDI OLOGY	1, 343, 107	4, 908, 266			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 155, 476	667, 032			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	237, 669	850, 225			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	9, 553, 841	11, 834, 760	21, 388, 601		0. 000000	
76. 00	03610 SLEEP LAB	0	0	(	0.000000	0. 000000	
76. 01	03560 PULMONARY FUNCTION TESTING	0	0	(	0.000000	0. 000000	
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	51, 877	51, 877	10. 848160	0. 000000	76. 02
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	22, 130	60, 170			0. 000000	
91.00	09100 EMERGENCY	2, 985, 468	29, 126, 976			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	670, 698	1, 319, 453	1, 990, 151	0. 776740	0. 000000	92.00
95. 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	12 000	11 015 407	11 007 515	0. 097077	0. 000000	95. 00
200.00		12, 088 43, 149, 165	11, 815, 427 138, 889, 341			0.000000	200.00
200.00		43, 149, 105	138, 889, 341	182, 038, 506			200.00
201.00	· ·	12 140 145	138, 889, 341	182, 038, 506			201.00
202.00	p protai (See Histiactions)	43, 149, 165	130, 007, 341	102,030,500	김		1202.00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARG	ES Provi der CCN: 15-1318	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

				10 12/31/2023	5/31/2024 10: 4	9 am
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT					31. 00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 170960				50.00
	05100 RECOVERY ROOM	0. 160578				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 084486				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. 127655				60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 309768				62.00
65. 00	06500 RESPIRATORY THERAPY	0. 319364				65.00
66. 00	06600 PHYSI CAL THERAPY	0. 397876				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 175561				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 399337				68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 113416				69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 084937				71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 184534				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 112323				73.00
76. 00	03610 SLEEP LAB	0. 000000				76.00
76. 01	03560 PULMONARY FUNCTION TESTING	0. 000000				76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	10. 848160				76. 02
	OUTPATIENT SERVICE COST CENTERS					
90. 00	09000 CLI NI C	5. 667533				90.00
91. 00	09100 EMERGENCY	0. 291812				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 776740				92.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVI CES	0. 097077				95.00
200. 00	,					200. 00
201.00	Less Observation Beds					201. 00
202. 00	Total (see instructions)				2	202. 00

Cost Center Description						0 12/31/2023	5/31/2024 10:	
West. B, Part   West. B, Part Research				Ti tl	e XIX	Hospi tal		
Amount		Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
NCI LLARY SERVI CE COST CENTERS   1.00		·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
NOTE   LARY SERVICE COST CENTERS			I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
ANCI LLARY SERVICE COST CENTERS								
50.00			1.00	2.00	3.00	4. 00	5. 00	
51.00								
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   0   52. 00   53. 00   05300   ANESTHESI OLOGY   0   0   0   0   0   0   0   54. 00   05400   RADI OLOGY-DI AGNOSTI C   3, 355, 212   517, 973   2, 837, 239   0   0   54. 00   54. 01   05401   ULTRASOUND   0   0   0   0   0   0   55. 00   05500   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   57. 00   05700   CT SCAN   0   0   0   0   0   0   58. 00   05700   CT SCAN   0   0   0   0   0   0   58. 00   05800   MRI   0   0   0   0   0   0   60. 00   06000   LABORATORY   3, 245, 208   209, 910   3, 035, 298   0   0   60. 00   60. 00   06000   LABORATORY   12, 215, 039   151, 227   1, 063, 812   0   0   65. 00   65. 00   06500   RESPI RATORY THERAPY   1, 215, 039   151, 227   1, 063, 812   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   1, 318, 125   385, 502   932, 623   0   0   66. 00   66. 00   06600   SPECH PATHOLOGY   124, 130   1, 029   123, 101   0   0   68. 00   68. 00   06800   SPECH PATHOLOGY   709, 004   180, 726   528, 278   0   0   69. 00   69. 00   06900   ELECTROCARDI OLOGY   709, 004   180, 726   528, 278   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   2, 402, 426   118, 026   2, 284, 400   0   73. 00   76. 01   03560   PLUMONARY FUNCTION TESTI NG   0   0   0   0   0   76. 01   03560   PLUMONARY FUNCTION TESTI NG   0   0   0   0   76. 02   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   562, 770   42, 235   520, 535   0   0   76. 02   792. 00   09000   CLIVIT C   0   466, 438   120, 897   345, 541   0   0   92. 00   792. 00   09000   DISSERVATI ON BEDS (NON-DISTINCT PART   1, 545, 830   269, 427   1, 276, 403   0   92. 00   790. 00   09000   EMERGENCY   9, 370, 802   432, 132   8, 938, 670   0   92. 00   790. 00   09000   EMERGENCY   9, 370, 802   432, 132   8, 938, 670   0   92. 00   790. 00   09000   CLIVIT C   0   0   0   0   0   0   700. 00   09500   AMBULANCE SERVI CES   1, 148, 181   147, 293   1, 000, 888   0   0   95. 00   700. 00   0000   0000   0000   0000   0000   0000   0000   0000   0000			3, 131, 859	639, 440	2, 492, 419	0	0	
53.00   05300   AMESTHESI OLOGY   0   0   0   0   0   0   53.00			616, 146	54, 979	561, 167	0	0	51.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   3, 355, 212   517, 973   2, 837, 239   0   0   54. 00   54. 01   05401   ULTRASOUND   0   0   0   0   0   55. 00   05600   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   57. 00   05700   CT SCAN   0   0   0   0   0   0   58. 00   05800   MRI   0   0   0   0   0   0   60. 00   06000   LABGRATORY   3, 245, 208   209, 910   3, 035, 298   0   0   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   126, 209   12, 401   113, 808   0   0   62. 00   65. 00   06500   RESPI RATORY THERAPY   1, 215, 039   151, 227   1, 063, 812   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   1, 318, 125   385, 502   932, 623   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   345, 385   13, 305   332, 080   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   124, 130   1, 029   123, 101   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   779, 004   180, 726   528, 278   0   0   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   154, 799   6, 816   147, 983   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   20, 402, 426   118, 026   2, 284, 400   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   2, 402, 426   118, 026   2, 284, 400   0   0   76. 01   76. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   562, 770   42, 235   520, 535   0   0   76. 01   79. 00   09000   OBSERVATI ON BEDS (NON-DI STI NCT PART   1, 545, 830   269, 427   1, 276, 403   0   0   0   70   00   00   00   00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
54. 01   05401   ULTRASOUND   0   0   0   0   0   0   0   0   0	53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
56. 00   05600   RADI OI SOTOPE   0   0   0   0   0   0   0   0   0	54.00	05400  RADI OLOGY-DI AGNOSTI C	3, 355, 212	517, 973	2, 837, 239	0	0	54.00
57. 00   05700   CT SCAN   0   0   0   0   0   0   0   0   0	54. 01	05401 ULTRASOUND	0	0	C	0	0	54. 01
58.00   05800   MRI	56.00	05600  RADI OI SOTOPE	0	0	C	0	0	56. 00
60. 00 06000 LABORATORY	57.00	05700 CT SCAN	0	0	C	0	0	57. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 126, 209 12, 401 113, 808 0 0 65. 00 65. 00 RESPI RATORY THERAPY 1, 215, 039 151, 227 1, 063, 812 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 318, 125 385, 502 932, 623 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 345, 385 13, 305 332, 080 0 0 67. 00 68. 00 6800 SPEECH PATHOLOGY 124, 130 1, 029 123, 101 0 0 68. 00 69. 00 69. 00 ELECTROCARDI OLOGY 709, 004 180, 726 528, 278 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 200, 753 12, 736 188, 017 0 0 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 200, 753 12, 736 188, 017 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 402, 426 118, 026 2, 284, 400 0 0 75. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58.00	05800  MRI	0	0	C	0	0	58. 00
65. 00	60.00	06000 LABORATORY	3, 245, 208	209, 910	3, 035, 298	0	0	60.00
66. 00	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	126, 209	12, 401	113, 808	0	0	62.00
67. 00	65.00	06500 RESPI RATORY THERAPY	1, 215, 039	151, 227	1, 063, 812	0	0	65. 00
68. 00	66.00	06600 PHYSI CAL THERAPY	1, 318, 125	385, 502	932, 623	0	0	66. 00
69. 00   06900   ELECTROCARDI OLOGY   709, 004   180, 726   528, 278   0   0   69. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 0	67.00	06700 OCCUPATI ONAL THERAPY	345, 385	13, 305	332, 080	0	0	67. 00
71. 00	68.00	06800 SPEECH PATHOLOGY	124, 130	1, 029	123, 101	0	0	68. 00
72. 00	69.00	06900 ELECTROCARDI OLOGY	709, 004	180, 726	528, 278	0	0	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	154, 799	6, 816	147, 983	0	0	71. 00
76. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	200, 753	12, 736	188, 017	0	0	72. 00
76. 01 03560 PULMONARY FUNCTION TESTING 0 0 0 0 0 0 76. 01 76. 02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 562, 770 42, 235 520, 535 0 0 76. 02  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 466, 438 120, 897 345, 541 0 0 0 90. 00 91. 00 09100 EMERGNCY 9, 370, 802 432, 132 8, 938, 670 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 545, 830 269, 427 1, 276, 403 0 0 92. 00  OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES 1, 148, 181 147, 293 1, 000, 888 0 0 95. 00 200. 00 Subtotal (sum of lines 50 thru 199) 30, 038, 316 3, 316, 054 26, 722, 262 0 0 200. 00 201. 00 Less Observation Beds 1, 545, 830 269, 427 1, 276, 403 0 0 0 201. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	2, 402, 426	118, 026	2, 284, 400	0	0	73. 00
76. 02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES 562, 770 42, 235 520, 535 0 0 76. 02 OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 466, 438 120, 897 345, 541 0 0 90. 00 91. 00 91. 00 91. 00 91. 00 92. 00 09200 0BERGENCY 9, 370, 802 432, 132 8, 938, 670 0 0 91. 00 92. 00 09200 0BERGENATION BEDS (NON-DISTINCT PART 1, 545, 830 269, 427 1, 276, 403 0 0 92. 00 09200 0BERGENCY 10 09200 0BE	76.00	03610 SLEEP LAB	0	0	C	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS   90.00   O9000   CLINIC   466, 438   120, 897   345, 541   0   0   90.00     91.00   O9100   EMERGENCY   9, 370, 802   432, 132   8, 938, 670   0   0   91.00     92.00   O9200   OBSERVATION BEDS (NON-DISTINCT PART   1, 545, 830   269, 427   1, 276, 403   0   0   92.00     95.00   O9500   AMBULANCE SERVICES   1, 148, 181   147, 293   1, 000, 888   0   0   95.00     95.00   O9500   AMBULANCE SERVICES   1, 148, 181   147, 293   1, 000, 888   0   0   95.00     90.00   Subtotal (sum of lines 50 thru 199)   30, 038, 316   3, 316, 054   26, 722, 262   0   0   200.00     90.00   Less Observation Beds   1, 545, 830   269, 427   1, 276, 403   0   0   201.00   0	76. 01	03560 PULMONARY FUNCTION TESTING	0	0	C	0	0	76. 01
90. 00	76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	562, 770	42, 235	520, 535	0	0	76. 02
91. 00   09100   EMERGENCY   9, 370, 802   432, 132   8, 938, 670   0   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   1,545, 830   269, 427   1,276, 403   0   92. 00   07HER REIMBURSABLE COST CENTERS   1,148, 181   147, 293   1,000, 888   0   0   95. 00   95. 00   09500   AMBULANCE SERVICES   1,148, 181   147, 293   1,000, 888   0   0   0   95. 00   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500   09500		OUTPATIENT SERVICE COST CENTERS						
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   1,545,830   269,427   1,276,403   0   0   92. 00   0THER REI MBURSABLE COST CENTERS   1,148,181   147,293   1,000,888   0   0   95. 00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00   0.00	90.00	09000 CLI NI C	466, 438	120, 897	345, 541	0	0	90. 00
OTHER REIMBURSABLE COST CENTERS           95. 00         09500 AMBULANCE SERVICES         1, 148, 181         147, 293         1, 000, 888         0         0         95. 00           200. 00         Subtotal (sum of lines 50 thru 199)         30, 038, 316         3, 316, 054         26, 722, 262         0         0 200. 00           201. 00         Less Observation Beds         1, 545, 830         269, 427         1, 276, 403         0         0 201. 00	91.00	09100 EMERGENCY	9, 370, 802	432, 132	8, 938, 670	0	0	91. 00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 545, 830	269, 427	1, 276, 403	0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199) 30,038,316 3,316,054 26,722,262 0 0 200.00 201.00 Less Observation Beds 1,545,830 269,427 1,276,403 0 0 201.00		OTHER REIMBURSABLE COST CENTERS						
201.00 Less Observation Beds 1,545,830 269,427 1,276,403 0 0 201.00	95.00	09500 AMBULANCE SERVICES	1, 148, 181	147, 293	1, 000, 888	0	0	95. 00
	200.00	Subtotal (sum of lines 50 thru 199)	30, 038, 316	3, 316, 054	26, 722, 262	0	0	200. 00
202. 00   Total (line 200 minus line 201)   28, 492, 486  3, 046, 627  25, 445, 859  0  0 202. 00	201.00	Less Observation Beds	1, 545, 830	269, 427	1, 276, 403	0	0	201. 00
	202. 00	Total (line 200 minus line 201)	28, 492, 486	3, 046, 627	25, 445, 859	0	0	202. 00

Health Financial Systems

DUKES MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

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

Provider CCN: 15-1318

Period: Worksheet C From 01/01/2023 TO 12/31/2023 Date/Time Prepared: Date/Time Prepared:

						5/31/2024 10:	49 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6. 00	7. 00	8. 00			
AN	CILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	3, 131, 859	18, 319, 256	0. 170960			50.00
	5100 RECOVERY ROOM	616, 146	3, 837, 051	0. 160578			51.00
52. 00 05	5200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000			52. 00
53. 00 05	300 ANESTHESI OLOGY	0	0	0.000000			53. 00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	3, 355, 212	39, 713, 142	0. 084486			54.00
54. 01 05	401 ULTRASOUND	0	0	0.000000			54. 01
56. 00 05	6600 RADI 0I SOTOPE	0	0	0.000000			56. 00
57. 00 05	5700 CT SCAN	0	0	0.000000			57. 00
58. 00 05	5800 MRI	0	0	0.000000			58. 00
60.00 06	0000 LABORATORY	3, 245, 208	25, 421, 618	0. 127655			60.00
62. 00 06	200 WHOLE BLOOD & PACKED RED BLOOD CELL	126, 209	407, 431	0. 309768			62. 00
65. 00 06	500 RESPI RATORY THERAPY	1, 215, 039	3, 804, 553	0. 319364			65. 00
66. 00 06	600 PHYSI CAL THERAPY	1, 318, 125	3, 312, 908	0. 397876			66. 00
67. 00 06	700 OCCUPATIONAL THERAPY	345, 385	1, 967, 320	0. 175561			67. 00
68. 00 06	800 SPEECH PATHOLOGY	124, 130	310, 840	0. 399337			68. 00
69. 00 06	900 ELECTROCARDI OLOGY	709, 004	6, 251, 373	0. 113416			69. 00
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT	154, 799	1, 822, 508	0. 084937			71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS	200, 753	1, 087, 894	0. 184534			72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS	2, 402, 426	21, 388, 601	0. 112323			73. 00
	3610 SLEEP LAB	0	0	0. 000000			76. 00
76. 01 03	8560 PULMONARY FUNCTION TESTING	O	0	0.000000			76. 01
76. 02 03	8550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	562, 770	51, 877	10. 848160			76. 02
	ITPATIENT SERVICE COST CENTERS	<u> </u>	·		<u>'</u>		
90. 00 09	POOO CLI NI C	466, 438	82, 300	5. 667533			90.00
91. 00 09	2100 EMERGENCY	9, 370, 802	32, 112, 444	0. 291812			91. 00
92. 00 09	200 OBSERVATION BEDS (NON-DISTINCT PART	1, 545, 830	1, 990, 151	0. 776740			92. 00
	HER REIMBURSABLE COST CENTERS						
95. 00 09	2500 AMBULANCE SERVICES	1, 148, 181	11, 827, 515	0. 097077			95. 00
200.00	Subtotal (sum of lines 50 thru 199)	30, 038, 316	173, 708, 782				200. 00
201.00	Less Observation Beds	1, 545, 830	0				201. 00
202.00	Total (line 200 minus line 201)	28, 492, 486	173, 708, 782				202. 00
'	,			•			•

Health Financial Systems	DUKES MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Peri od: From 01/01/2023	Worksheet D Part II	
				To 12/31/2023	Date/Time Pre 5/31/2024 10:	pared: 49 am_
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOULL ARV CERVI OF COCT OFNITERS	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS  50. 00 05000 OPERATING ROOM	(20, 440	10 210 254	0. 03490	NE 240	0.010	50.00
51. 00   05100   OPERATING ROOM	639, 440 54, 979		•		8, 910 676	
52. 00   05200   DELI VERY ROOM & LABOR ROOM	54, 979	3, 837, 051	0.01432		0/6	52.00
53. 00   05300   ANESTHESI OLOGY		0	0.00000		0	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	517, 973	39, 713, 142				54.00
54. 01   05400   RADI 0E0G1-DI AGNOSTI C	317, 973	39,713,142	0.00000		21,021	54.00
56. 00   05600   RADI OI SOTOPE			0.00000		0	56.00
57. 00   05700   CT   SCAN			0.00000		0	57.00
58. 00   05800   MRI			0.00000		0	58.00
60. 00   06000   LABORATORY	209, 910	25, 421, 618			_	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12, 401				2, 492	
65. 00 06500 RESPIRATORY THERAPY	151, 227					
66. 00   06600   PHYSI CAL THERAPY	385, 502					
67. 00 06700 OCCUPATI ONAL THERAPY	13, 305					1
68. 00 06800 SPEECH PATHOLOGY	1, 029					
69. 00 06900 ELECTROCARDI OLOGY	180, 726					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 816					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 736			79, 347	929	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	118, 026			8 2, 917, 803	16, 100	73. 00
76. 00 03610 SLEEP LAB	0	0	0.00000	0	0	76. 00
76. 01 03560 PULMONARY FUNCTION TESTING	0	0	0. 00000	0 0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	42, 235	51, 877	0. 81413	0 0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
00 00 00000 CLINIC	120 907	92 200	1 46907	0.		1 00 00

120, 897

432, 132

269, 427

3, 168, 761

82, 300 32, 112, 444 1, 990, 151

161, 881, 267

1. 468979

0.013457

0. 135380

0

1, 185

8, 923, 296

90.00 0

92.00

95.00

0 91.00

150, 800 200. 00

160

90.00

91.00

200.00

09000 CLI NI C

09100 EMERGENCY

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 95. 00 | 09500 | AMBULANCE SERVICES |

Total (lines 50 through 199)

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1318	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

THROUG	H COSTS			7	From 01/01/2023 Fo 12/31/2023	Part IV Date/Time Pre 5/31/2024 10:	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZN	2.00	J. JA	3.00	
	05000 OPERATING ROOM	0	0	(	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	O		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	(	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
54. 01	05401 ULTRASOUND	0	0	(	0	0	54. 01
	05600 RADI 0I SOTOPE	0	0	(	0	0	56. 00
	05700 CT SCAN	0	0	(	0	0	57. 00
	05800 MRI	0	0	(	0	0	58. 00
	06000 LABORATORY	0	0	(	0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(	0	0	62. 00
	06500 RESPI RATORY THERAPY	0	0	(	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	9	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	03610 SLEEP LAB	0	0		0	0	76. 00
	03560 PULMONARY FUNCTION TESTING	0	0		0	0	76. 01
76. 02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES OUTPATIENT SERVICE COST CENTERS	0	0		<u>)                                    </u>	0	76. 02
90.00	09000 CLINIC	0	0		0	0	90.00
	09100 EMERGENCY	0	1			0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	Ö	·			0	1
	OTHER REIMBURSABLE COST CENTERS	·					1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL			eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period: From 01/01/2023	Worksheet D Part IV	
THROUG	H COSTS				To 12/31/2023	Date/Time Pre	pared:
				\n,u,ı,		5/31/2024 10:	49 am_
	0 1 0 1 0 1 1	111 011		XVIII	Hospi tal	Cost	
	Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
		Education Cost	1, 2, 3, and 4)	col s. 2, 3,	8)	7)	
			4)	and 4)	0)	(see	
				allu 4)		instructions)	
		4.00	5. 00	6, 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 18, 319, 256	0.000000	50.00
51. 00	05100 RECOVERY ROOM	0	l o		0 3, 837, 051	0. 000000	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	O		0 0	0. 000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		o o	0. 000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 39, 713, 142	0.000000	54.00
54. 01	05401 ULTRASOUND	0	0		0 0	0.000000	54. 01
56.00	05600 RADI 0I SOTOPE	0	0		0 0	0.000000	56. 00
57.00	05700 CT SCAN	0	0		o o	0.000000	57. 00
58.00	05800 MRI	0	0		0 0	0.000000	58. 00
60.00	06000 LABORATORY	0	0		0 25, 421, 618	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 407, 431	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 3, 804, 553	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 3, 312, 908	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 1, 967, 320	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 310, 840	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 6, 251, 373	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 1, 822, 508	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 087, 894	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 21, 388, 601	0. 000000	73. 00
	03610 SLEEP LAB	0	0		0 0	0. 000000	76. 00
76. 01	03560 PULMONARY FUNCTION TESTING	0	0		0 0	0. 000000	76. 01
76. 02	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 51, 877	0. 000000	76. 02
	OUTPATIENT SERVICE COST CENTERS						
00 00	09000 CLENI C	0	l n		n 82 300	0 000000	90 00

0 0 0 0 0 0 82, 300 32, 112, 444 1, 990, 151

161, 881, 267

0 0 0 0. 000000 0. 000000

0.000000

90.00

91.00

92.00

95.00

200. 00

90.00

92.00

200.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

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

Total (lines 50 through 199)

91. 00 09100 EMERGENCY

Health Financial Systems	DUKES MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ERVICE OTHER PASS	Provi der Co		Peri od: From 01/01/2023	Worksheet D	
THROUGH COSTS				To 12/31/2023	Part IV Date/Time Pre	nared·
				10 12/01/2020	5/31/2024 10:	49 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS		055 040				
50. 00   05000   OPERATI NG ROOM	0. 000000	255, 268		0	0	50.00
51. 00   05100   RECOVERY ROOM	0. 000000	47, 175		0	0	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 000000	1, 672, 988		0	0	54.00
54. 01   05401   ULTRASOUND	0. 000000	0		0	0	54. 01
56. 00   05600   RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57. 00   05700   CT   SCAN	0. 000000	0		0	0	57. 00
58. 00   05800   MRI	0. 000000	0		0	0	58. 00
60. 00   06000   LABORATORY	0. 000000	1, 455, 413		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	81, 871		0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	915, 771		0	0	65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 000000	277, 513		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	279, 874		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	38, 815		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	540, 866		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	359, 407		0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	79, 347		0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 917, 803		0	0	73. 00
76. 00   03610   SLEEP LAB	0. 000000	0		0	0	76. 00
76. 01 03560 PULMONARY FUNCTION TESTING	0. 000000	0		0	0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
au uu luauuulu lulu	0.000000	0	1	0	Λ .	90 00

0. 000000 0. 000000

0. 000000

1, 185

8, 923, 296

0 0 0

0 0 0 0 90.00

91.00

0 200. 00

0

0 92.00 95.00

90.00

91.00

200.00

09000 CLI NI C

09100 EMERGENCY

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 95. 00 | 09500 | AMBULANCE SERVICES |

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1318 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/31/2024 10:49 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 170960 2, 909, 843 0 50.00 51.00 05100 RECOVERY ROOM 0.160578 702, 295 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52 00 0 O 52 00 0 05300 ANESTHESI OLOGY 53.00 0.000000 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.084486 7, 438, 547 0 54.00 54. 01 05401 ULTRASOUND 0.000000 0 0 0 0 0 0 0 0 0 0 0 54.01 0 05600 RADI OI SOTOPE 56.00 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 57.00 05800 MRI 0.000000 58.00 0 0 58.00 06000 LABORATORY 4, 093, 113 0 127655 60 00 60 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.309768 65,056 0 62.00 06500 RESPIRATORY THERAPY 0. 319364 211, 382 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0.397876 372, 122 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 63, 485 0.175561 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.399337 11, 557 0 68.00 06900 ELECTROCARDI OLOGY 0. 113416 1, 422, 555 0 69.00 69.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.084937 82, 032 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72 00 0.184534 136, 385 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 112323 4, 225, 952 1, 674 0 73.00 03610 SLEEP LAB 0 76.00 76.00 0.000000 0 0 0 03560 PULMONARY FUNCTION TESTING 76.01 0.000000 0 0 0 76.01 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76.02 76.02 10.848160 38, 675 0 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 5. 667533 10, 335 292 0 90.00 91.00 09100 EMERGENCY 0. 291812 0 0 91.00 4, 963, 365 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.776740 0 460, 837 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 097077 95.00 200.00 Subtotal (see instructions) Λ 27, 207, 536 1, 966 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

27, 207, 536

1, 966

0 202. 00

202.00

Net Charges (line 200 - line 201)

				To 12/31/2023	Date/Time Prepared:   5/31/2024 10:49 am
			Title XVIII	Hospi tal	Cost
		Cos			
	Cost Center Description	Cost	Cost		
		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
			Ded. & Coins.		
		(see inst.)	(see inst.)		
	T	6. 00	7. 00		
	ANCILLARY SERVICE COST CENTERS		-1		
50.00	05000 OPERATING ROOM	497, 467	0		50. 00
51. 00	05100 RECOVERY ROOM	112, 773	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	O		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	628, 453	0		54. 00
54. 01	05401 ULTRASOUND	0	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	0	0		58. 00
60.00	06000 LABORATORY	522, 506	0		60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	20, 152	0		62. 00
65. 00	06500 RESPI RATORY THERAPY	67, 508	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	148, 058	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	11, 145	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 615	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	161, 340	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 968	0		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	25, 168	O		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	474, 672	188		73.00
76.00	03610 SLEEP LAB	0	O		76. 00
76. 01	03560 PULMONARY FUNCTION TESTING	0	O		76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	419, 553	O		76. 02
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	58, 574	1, 655		90.00
91.00	09100 EMERGENCY	1, 448, 369	O		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	357, 951	O		92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVI CES	0			95. 00
200.00	Subtotal (see instructions)	4, 965, 272	1, 843		200. 00
201.00	Less PBP Clinic Lab. Services-Program	0			201. 00
	Only Charges				
202.00	Net Charges (line 200 - line 201)	4, 965, 272	1, 843		202. 00

Heal th Financi	ial Systems	DUKES MEMORI.	AL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTI ONMENT	OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
					rom 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/31/2024 10:	
			Ti tl	e XIX	Hospi tal	PPS	47 (1111
C	Cost Center Description	Capi tal	Swing Bed	Reduced	<del></del>	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	
I NPATI E	ENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS	& PEDI ATRI CS	1, 636, 869	510, 422	1, 126, 447	2, 496	451. 30	30.00
31. 00   I NTENSI	IVE CARE UNIT	179, 214		179, 214	1 159	1, 127. 13	31.00
43. 00 NURSER	Υ	52, 694		52, 694	237	222. 34	43.00
200. 00 Total	(lines 30 through 199)	1, 868, 777		1, 358, 355	2, 892		200. 00
C	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)				
		6.00	7.00				
I NPATI E	ENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS	& PEDI ATRI CS	71	32, 042	2			30.00
31. 00   I NTENSI	IVE CARE UNIT	6	6, 763	3			31.00
43. 00 NURSER	Υ	16	3, 557	'			43. 00
200. 00 Total	(lines 30 through 199)	93	42, 362	2			200. 00

Heal th	Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-1318	Period: From 01/01/2023 To 12/31/2023		
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
			(from Wkst. C,			(column 3 x	
		(from Wkst. B,	·		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			,			
	05000 OPERATI NG ROOM	639, 440		1		8, 776	
	05100 RECOVERY ROOM	54, 979	3, 837, 051			554	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000		0	52. 00
	05300 ANESTHESI OLOGY	0	0	0. 00000		0	53. 00
	05400  RADI OLOGY-DI AGNOSTI C	517, 973	39, 713, 142	1		2, 331	54. 00
	05401 ULTRASOUND	0	0	0. 00000		0	54. 01
	05600  RADI OI SOTOPE	0	0	0. 00000		0	56. 00
	05700  CT SCAN	0	0	0. 00000		0	57. 00
58. 00	05800  MRI	0	0	0.00000	00	0	58. 00
60. 00	06000 LABORATORY	209, 910	25, 421, 618	0.00825	166, 838	1, 378	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12, 401	407, 431	0. 03043	17, 394	529	62. 00
	06500 RESPI RATORY THERAPY	151, 227	3, 804, 553	0. 03974	50, 789	2, 019	65. 00
66.00	06600 PHYSI CAL THERAPY	385, 502	3, 312, 908	0. 11636	5, 050	588	66.00

13, 305

180, 726

1,029

6,816

0

12, 736

42, 235

120, 897

432, 132

269, 427

3, 168, 761

118, 026

1, 967, 320

6, 251, 373

1, 822, 508

1, 087, 894

51,877

21, 388, 601

82, 300 32, 112, 444

1, 990, 151

161, 881, 267

310, 840

0.006763

0.003310

0.028910

0.003740

0.011707

0.005518

0.000000

0.000000

0.814137

1. 468979

0.013457

0.135380

7,880

3, 724

23, 004

31, 716

282, 649

3, 284

1, 864

98, 893

14, 094

1, 176, 031

0

53

12

665

119

1, 560

2, 738

1, 331

1, 908

38

0

0 76.01

0

24, 599 200. 00

67.00

68 00

69.00

71.00

72.00

73.00

76.00

76. 02

90.00

91.00

92.00

95.00

67.00

68.00

69.00

72.00

73.00

76.00

76. 01

76.02

90.00

91.00

92.00

200.00

06700 OCCUPATIONAL THERAPY

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

03560 PULMONARY FUNCTION TESTING

OTHER REIMBURSABLE COST CENTERS

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

03610 SLEEP LAB

09000 CLI NI C

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	S Provider C		Period: From 01/01/2023 To 12/31/2023		pared: 49 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
'	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	3	Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	o	0		0	0	31.00
43. 00 04300 NURSERY	l ol	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,		,		
		minus col. 4)				
	4.00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	2, 49	6 0.00	71	30.00
31. 00 03100 INTENSIVE CARE UNIT		0	15		6	31.00
43. 00   04300   NURSERY		0	23			
200.00 Total (lines 30 through 199)		0	•		•	200.00
Cost Center Description	Inpatient		2,07		, , , ,	200.00
000 00 00 00 00 0 0 0 0 0 0 0 0 0 0 0	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00   03100   NTENSI VE CARE UNI T						31.00
43. 00   04300   NURSERY						43.00
200.00 Total (lines 30 through 199)	0					200.00
200.00    10tai (1111e3 30 till ough 177)	١					1200.00

Health Financial Systems	DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1318	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

					To 12/31/2023	Date/Time Pre 5/31/2024 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3. 00	
ANG	CILLARY SERVICE COST CENTERS	1.00	ZA	2.00	3A	3.00	
	OOO OPERATING ROOM	0	1	1	0 0	0	50.00
	100 RECOVERY ROOM	0			0 0	o n	51.00
	200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	, O	52.00
	300 ANESTHESI OLOGY	0	Ö	,	0 0	Ō	53. 00
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 054	401 ULTRASOUND	0	0		0 0	0	54. 01
56. 00 056	600 RADI OI SOTOPE	0	0		0 0	0	56. 00
57. 00 05	700 CT SCAN	0	0		0 0	0	57. 00
58. 00   058	800 MRI	0	0	)	0 0	0	58. 00
60.00 060	000 LABORATORY	0	0		0	0	60.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62. 00
	500 RESPI RATORY THERAPY	0	0	)	0	0	65. 00
	600 PHYSI CAL THERAPY	0	0	)	0	0	66. 00
	700 OCCUPATI ONAL THERAPY	0	0	)	0	0	67. 00
	800 SPEECH PATHOLOGY	0	0	1	0	0	68. 00
	900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71. 00
	200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72. 00
	300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73. 00
	610 SLEEP LAB	0	0		0	0	76. 00
	560 PULMONARY FUNCTION TESTING	0	0		0	0	76. 01
	550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES TPATIENT SERVICE COST CENTERS	0	0	1	0 0	0	76. 02
	000 CLINIC	0	0	I	0 0	0	90.00
	100 EMERGENCY	0	0		0 0	, o	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	o o	
	HER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	1			1
	500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	)	0	0	200. 00

	Financial Systems	DUKES MEMORIA				eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider Co		Peri od: From 01/01/2023	Worksheet D Part IV	
THROUG	H COSTS				To 12/31/2023		nared:
					12/01/2020	5/31/2024 10:	49 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	T		1	1	I	
	05000 OPERATING ROOM	0	0		0 18, 319, 256		50.00
	05100 RECOVERY ROOM	0	0	1	0 3, 837, 051	0.000000	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 0	0.000000	52.00
	05300 ANESTHESI OLOGY	0	0	1	0	0.000000	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 39, 713, 142		54.00
	05401 ULTRASOUND	0	0	)	0	0.000000	54. 01
	05600 RADI 0I S0T0PE	0	0	)	0	0.000000	56.00
	05700 CT SCAN	0	0	)	0	0.000000	
	05800 MRI	0	0	)	0	0.000000	
60.00	06000 LABORATORY	0	0	1	0 25, 421, 618	0.000000	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0 407, 431	0.000000	62.00
	06500 RESPI RATORY THERAPY	0	0	1	0 3, 804, 553	0.000000	65.00
	06600 PHYSI CAL THERAPY	0	0	1	0 3, 312, 908		
67.00	06700 OCCUPATI ONAL THERAPY	0	0	)	0 1, 967, 320	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	)	0 310, 840	0.000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	)	0 6, 251, 373	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	)	0 1, 822, 508	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0 1, 087, 894	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 21, 388, 601	0.000000	73.00
76.00	03610 SLEEP LAB	0	0		0 0	0.000000	76.00
76. 01	03560 PULMONARY FUNCTION TESTING	0	0	)	0 0	0.000000	76. 01
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 51, 877	0.000000	76.02
	OUTPATIENT SERVICE COST CENTERS						
00 00	UDUUU CLINIC	0	0		0 83 300	0.000000	00 00

0 0 0

0 0 0

82, 300 32, 112, 444 1, 990, 151

161, 881, 267

0 0 0

90.00

91.00

92.00

95.00

200. 00

0. 000000 0. 000000

0.000000

90.00

92. 00

200.00

09000 CLI NI C

95. 00 09500 AMBULANCE SERVICES

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

Total (lines 50 through 199)

91. 00 09100 EMERGENCY

		DUMES MEMORIAL				6.5. 040	0550 40	
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	DUKES MEMORIAL	Provider C	CN: 15 1210	In Lieu of Form CMS-2552-10 Period: Worksheet D			
	THROUGH COSTS		Flovide		From 01/01/2023			
11111000	00010				To 12/31/2023	Date/Time Pre	pared:	
						5/31/2024 10:	49 am	
				e XIX	Hospi tal	PPS		
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent		
		Ratio of Cost	Program	Program	Program	Program		
		to Charges	Charges	Pass-Through		Pass-Through		
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9		
		7)	40.00	x col. 10)	10.00	x col . 12)		
	ANCILL ADV. CEDVI CE COCT. CENTEDO	9. 00	10. 00	11.00	12.00	13. 00		
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.000000	251 427				- 00	
50. 00 51. 00	05000 OPERATI NG ROOM	0. 000000	251, 437	1	0	0		
	05100 RECOVERY ROOM	0.000000	38, 694		0	1		
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0. 000000 0. 000000	0	1	0	0		
53.00			170 701	1	0	0		
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C	0.000000	178, 721		0	0		
	05401   ULTRASOUND   05600   RADI OI SOTOPE	0. 000000 0. 000000	0		0	0		
56.00	05700 CT SCAN		0		0	0	00.00	
57. 00		0.000000	0		0			
58.00	05800 MRI	0.000000	1// 020		0	0		
60.00	06000 LABORATORY	0.000000	166, 838		0	0		
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	17, 394		0	0		
65. 00	06500 RESPI RATORY THERAPY	0.000000	50, 789		0	1		
66.00	06600 PHYSI CAL THERAPY	0. 000000	5, 050		0	0		
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	7, 880		0	0		
68. 00	06800 SPEECH PATHOLOGY	0. 000000	3, 724		0	0		
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	23, 004	1	0	0		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	31, 716		0	0		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 284	1	0	0		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	282, 649		0	0		
76. 00	03610 SLEEP LAB	0. 000000	0	1	0	0		
76. 01	03560 PULMONARY FUNCTION TESTING	0.000000	0	1	0	0		
76. 02	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0	1	0	0	76. 02	

0. 000000 0. 000000

0. 000000

1, 864 98, 893

14, 094

1, 176, 031

0

0

0

90.00 0

91.00

92.00 0

95.00

0 200. 00

0

03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 95. 00 | 09500 | AMBULANCE SERVICES |

Total (lines 50 through 199)

90.00

91.00

200.00

09000 CLI NI C

09100 EMERGENCY

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre	pared:
		T: ±1	- VIV	11! +-1	5/31/2024 10:	49 am_
		Title XIX		Hospi tal	PPS	
0 1 0 1 0 1 1	0 1 1 01	DDC D : 1	Charges	0 1	Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Services	Services Not		
	Part I, col. 9		Subject To Ded. & Coins.	Subject To Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 170960		329, 55	5 0	0	50.00
51. 00   05100   RECOVERY   ROOM	0. 160578	l .	52, 37		0	
			32, 37	0	0	
52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	0. 000000 0. 000000			0	0	
			F74 27	0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 084486	l .	574, 37	/	_	
54. 01   05401   ULTRASOUND	0. 000000		1	0	0	
56. 00   05600   RADI 01 SOTOPE	0. 000000			0	0	
57. 00   05700   CT   SCAN	0. 000000			0	0	
58. 00   05800   MRI	0. 000000		١	0	0	
60. 00   06000   LABORATORY	0. 127655		357, 41	6 0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 309768	l .	1	이	0	
65. 00 06500 RESPI RATORY THERAPY	0. 319364		7, 11		0	
66. 00 06600 PHYSI CAL THERAPY	0. 397876	0	102, 60		0	
67.00 06700 OCCUPATIONAL THERAPY	0. 175561	0	95, 10		0	
68.00 06800 SPEECH PATHOLOGY	0. 399337	0	10, 60		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 113416	l .	59, 33		0	
71.00  07100   MEDICAL SUPPLIES CHARGED TO PATIENT	0. 084937	0	17, 39	7 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 184534	0	93, 12		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 112323	l .	162, 87	3 0	0	
76. 00   03610   SLEEP LAB	0. 000000		1	0 0	0	76. 00
76.01 03560 PULMONARY FUNCTION TESTING	0. 000000	0	1	0 0	0	
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	10. 848160	0		0 0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	5. 667533	0	1, 09	4 0	0	90.00
91. 00 09100 EMERGENCY	0. 291812	0	766, 62	8 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 776740	0	46, 61	4 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0. 097077	0	318, 05	1		95. 00
200.00 Subtotal (see instructions)		0	2, 994, 26	1 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				ol ol		201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)		0	2, 994, 26	1 0	0	202. 00

ALTONITORING OF MEDICAL, OTHER REALTH SERVICES AND	VACCINE COST		. 13 1310	From 01/01/2023 To 12/31/2023	Part V Date/Time Prep 5/31/2024 10:4	pared: 49 am
			e XIX	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	56, 341	0				50. 00
51.00   05100   RECOVERY ROOM	8, 409	0				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	48, 527	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	45, 626	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
65. 00 06500 RESPIRATORY THERAPY	2, 271	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	40, 824	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	16, 696	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	4, 235	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 730	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 478	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 185	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 294	0				73. 00
76. 00   03610   SLEEP LAB	0	0				76. 00
76. 01 03560 PULMONARY FUNCTION TESTING	0	0				76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0				76. 02
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	6, 200	0				90.00
91. 00   09100   EMERGENCY	223, 711	0	1			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	36, 207	0	1			92. 00
OTHER REIMBURSABLE COST CENTERS	22,20,					
95. 00 09500 AMBULANCE SERVICES	30, 875					95. 00
200.00 Subtotal (see instructions)	563, 609	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	000,007					201. 00
Only Charges						
202.00   Net Charges (line 200 - line 201)	563, 609	0				202. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-13	Peri od: From 01/01/2023	Worksheet D-1
			Date/Time Prepared: 5/31/2024 10:49 am
	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	5/31/2024 10: Cost	49 am_
	Cost Center Description	II the Aviii	1103pi tai	COST	
	DADT I ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		3, 628	1. 00
2.00	Inpatient days (including private room days, excluding swing-	ped and newborn days)		2, 496	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ad days)		1, 899	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	1, 131	5. 00
	reporting period			,	
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	1	7. 00
7.00	reporting period	ii days) tiii dagii beceiibei	of the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			000	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	833	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	755	10. 00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period	(			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	diii (exci dariig swriig-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT				47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing ported (line	9, 391, 491 0	
22.00	5 x line 17)	er 31 of the cost report	ing period (inte	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24.00	X line 18)	s 21 of the cost managet:	ng poriod (line	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	31 of the cost reporti	ng period (iine	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
04 00	x line 20)			0 000 500	04 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 928, 532 6, 462, 959	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Title 21 milles Title 20)		0, 402, 737	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 34	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 6, 462, 959	36. 00 37. 00
37.00	27 minus line 36)	and private room cost ur	Transmittal (Title	0, 402, 303	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			0.500.55	00.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		2, 589. 33 2, 156, 912	
40. 00	Medically necessary private room cost applicable to the Progra	•		2, 150, 912	
	Total Program general inpatient routine service cost (line 39	•		2, 156, 912	

	ATION OF INPATIENT OPERATING COST		Provi der C	JN: 15-1318	Peri od:	Worksheet D-1	
					From 01/01/2023 To 12/31/2023		
			Title	XVIII	Hospi tal	Cost	47 am
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
12.00	NUDCEDY (+; +l c V & VIV only)	1.00	2. 00	3.00	4. 00 00 0	5. 00	42. 0
12.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	j Uj	0	0.	00  0	0	42.0
	INTENSIVE CARE UNIT	1, 054, 615	159	6, 632.	80 64	424, 499	1
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 0 45. 0
	SURGICAL INTENSIVE CARE UNIT						46. 0
7. 00	OTHER SPECIAL CARE (SPECIFY)	1					47. 0
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					1, 306, 395	
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)	0 3, 887, 806	48. 0 49. 0
7. 00	PASS THROUGH COST ADJUSTMENTS	41 till odgir 40. 0	r) (see Tristi uc	ti ons)		3, 667, 600	47.0
0. 00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, su	m of Parts I and	0	50. 0
51. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51.0
	and IV)	•		,			
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist. and	0	
55	medical education costs (line 49 minus line						] 55.5
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						]   54. 0
	Target amount per discharge						55.0
	Permanent adjustment amount per discharge					1	55.0
	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55	<b>J</b> ,				0.00	55.0
7. 00	Difference between adjusted inpatient operat		get amount (I	ine 56 minus	line 53)	0	1
	Bonus payment (see instructions)	on line EE from	the east rand	mting nomind	anding 1004	0	58. 0 59. 0
59. 00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						59.0
0. 00	0 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60. C
1. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of th	ne amount by w	hich operati	ng costs (line	0	61. C
	enter zero. (see instructions)	00), 0 % 0.	the target an		o), othor in oo		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		·				
4. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decer	mber 31 of the	cost report	ing period (See	1, 954, 944	64.0
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reportin	g period (See	0	65.0
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line d	54 nlus line 6	5)(title XVI	II only): for	1, 954, 944	66.0
0.00	CAH, see instructions	110 00313 (11110 )	or prus rine e	0)(11110 XVI	11 0111 377, 101	1,751,711	00.0
7. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 c	f the cost r	eporting period	0	67.0
8. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 0
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	ine 67 ± lino	(68)		0	69.0
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				)		70. C
	Program routine service cost (line 9 x line		ne 70 ÷ Time	2)			72.0
	Medically necessary private room cost applic	5	•	,			73.0
	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74. C
	26, line 45)						
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. C
	Inpatient routine service cost (line 74 minu						78.0
	Aggregate charges to beneficiaries for exces			*.	nuc line 70\		79.0
	Total Program routine service costs for comp Inpatient routine service cost per diem limi		טיינו ווחו tation	(iine /8 mi	nus iine 79)		80.0
32. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82.0
	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		s)				83. C
	Utilization review - physician compensation		ns)				85.0
	Total Program inpatient operating costs (sum	of lines 83 th					86. 0
,	PART IV - COMPUTATION OF OBSERVATION BED PAS						1
37. 00	Total observation bed days (see instructions	)				597	87.0

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 636, 869	9, 391, 491	0. 17429	1, 545, 830	269, 427	90.00
91.00 Nursing Program cost	0	9, 391, 491	0.00000	1, 545, 830	0	91.00
92.00 Allied health cost	0	9, 391, 491	0.00000	1, 545, 830	0	92.00
93.00 All other Medical Education	0	9, 391, 491	0. 000000	1, 545, 830	0	93. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1318	Peri od: From 01/01/2023	Worksheet D-1
			Date/Time Prepared: 5/31/2024 10:49 am
	Title XLX	Hospi tal	PPS

Description  PART I ALL PROVIDER CONCENSIONS  ALL PROVIDER CONCENSIONS	-		Title XIX	Hospi tal	5/31/2024 10: 4 PPS	49 am_
NACT 1 - ALL PROVIDER COMPONENTS   1.00		Cost Center Description	II tie xix	поѕрі таі	PFS	
INPATEENT DAYS   1.00   Impatient days (including private room days, and sating-bed days, excluding newborn)   3.678   1.00   1.00   Impatient days (including private room days, accluding sating-bed and observation bed days)   1.7 you have only private room days   3.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   1					1. 00	
Impatient days (including private room days and saing-bed days, excluding nexporm)	-					
Impatient days (including private room days, excluding swing-bed and neberon days)   2,496   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00   2,00	4 00				2 (22	
Private room days (excluding swing-bed and observation bed days). If you have only private room days.  do not complete this liculuding saing-bed and observation bed days).  2.00 Sail-pri vate room days (excluding saing-bed and observation bed days).  2.00 Sail-pri vate room days (excluding saing-bed and observation bed days).  2.00 Total saing-bed SNI type inpatient days (including private room days) through December 31 of the cost reporting period.  2.00 Total saing-bed KF type inpatient days (including private room days) through December 31 of the cost reporting period (ir calendar year, enter 0 on this line).  2.00 Total saing-bed KF type inpatient days (including private room days) through December 31 of the cost reporting period (ir calendar year, enter 0 on this line).  3.01 Total saing-bed KF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line).  3.01 Total saing-bed KF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line).  3.01 Total saing-bed KF type inpatient days applicable to it the XFIII only (including private room days).  3.01 Total saing-bed SNI type inpatient days applicable to it the XFIII only (including private room days).  3.02 Saing-bed SNI type inpatient days applicable to title XVIII only (including private room days).  3.03 Total saing-bed SNI type inpatient days applicable to title XVIII only (including private room days).  3.04 Total saing-bed SNI type inpatient days applicable to title XVIII only (including private room days).  3.05 Saing-bed NF type inpatient days applicable to title XVIII only (including private room days).  3.06 Total saing-bed SNI type inpatient days applicable to title XVIII only (including private room days).  3.07 Total saing-bed SNI type inpatient days applicable to title XVIII only (including private room days).  3.08 Total saing-bed SNI type inpatient days applicable to title XVIII only (in						
do not complete this line. 4 00 Selle-pit vater room days (excluding swing-bed and observation bed days) 5 00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7 00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8 00 Total sing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and new days) (see instructions) 10 00 Swing-bed SW type inpatient days applicable to the Program (excluding private room days) 11 0 00 Swing-bed SW type inpatient days applicable to the SW III only (including private room days) 12 0 00 Swing-bed SW type inpatient days applicable to thitle SW III only (including private room days) 13 0 0 Swing-bed SW type inpatient days applicable to thitle SW III only (including private room days) 14 0 0 Swing-bed SW type inpatient days applicable to thitle SW III only (including private room days) 15 0 0 Swing-bed SW type inpatient days applicable to thitle SW III only (including private room days) 16 0 0 Swing-bed SW type inpatient days applicable to thitle SW III only (including private room days) 17 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				vato room days	, , , , ,	
5.8ml - private room days. (excluding sating-bed ART type inpatient days. (Including private room days.) through December 31 of the cost reporting period reporting period of type inpatient days. (Including private room days.) after December 31 of the cost sampled SRT type inpatient days. (Including private room days.) after December 31 of the cost reporting period of the color of the cost of the cost away in through December 31 of the cost reporting period of the color of the cost reporting period (line of the cost reporting pe	3.00		ys). If you have only pri	vate room days,	ا	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total input ind days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total input ind days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Total input ind days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNF type inpatient days (applicable to title XVIII only (including private room days))  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNF type inpatient days applicable to titles X or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  Swing-bed SNF type inpatient days applicable to titles X or XIX only (including private room days)  Swing-bed SNF type inpatient days applicable to titles X or XIX only (including private room days)  Total nursery days (title V or XIX only)  Modically members by two two two proof (if calendar year, enter 0 on this line)  Modically members by two two two proof (if calendar year, enter 0 on this line)  Modically members by two two two proof (if calendar year, enter 0 on this line)  Modical rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  Modical private room shall pri	4.00		ed days)		1, 899	4.00
1-00   1-01   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02   1-02				r 31 of the cost		5. 00
reporting period (if calendar year, either 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period to the line of the cost of						
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (17 color reporting reporting reporting period (17 color reporting reporting reporting reporting period (18 color reporting reporting period (18 color reporting re	6.00		om days) after December :	31 of the cost	0	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 0 12. 00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 0 13. 00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 Total nursery days (if the V or XIX only) 1 15. 00 To	7.00			21 -6		7 00
10   10   10   10   10   10   10   10	7.00		ii days) through becember	31 Of the Cost	'	7.00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) after on through becember 31 of the cost reporting period (see instructions) 12.00 Swing-bed SRF type inpatient days applicable to title XVIII only report on this line) 13.00 Swing-bed SRF type Inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Narrsery days (title V or XIX only) 17.00 Narrsery days (title V or XIX only) 18.00 Narrsery days (title V or XIX only) 18.00 Medically necessary private room days applicable to services through December 31 of the cost reporting period 18.00 Medically applicable of the SWF services applicable to services after December 31 of the cost reporting period 19.00 Medical care rate for swing-bed SWF services applicable to services after December 31 of the cost reporting period (line Swing-bed SWF services applicable to services after December 31 of the cost reporting period (line Swing-bed SWF services applicable to services after December 31 of the cost reporting period (line Swing-bed SWF services applicable to services after December 31 of the cost reporting period (line Swing-bed sort applicable to SWF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SWF type services after December 31 of the cost reporting	8 00		m days) after December 3	1 of the cost	0	8 00
10.00   Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and provides)   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.	0.00		daye, arter becomes: e	. 0 0001		0.00
10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.	9.00		the Program (excluding	swing-bed and	71	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.01 Os himp-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.02 Os himp-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.03 Os himp-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.04 Os after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.05 Os Total Jurisory days (title V or XIX only)  1.06 Os Total Jurisory days (title V or XIX only)  1.07 Os Win No Bed ADJUSMENT  1.08 Os Win No Bed ADJUSMENT  1.09 Os Win No Bed ADJUSMENT  1.09 Os Win No Bed ADJUSMENT  1.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (in exporting period wind)  1.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (in exporting period wind)  1.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line oxide)  1.00 Os Wing-bed cost applicable to SWF type services through December 31 of the cost reporting period (line oxide)  1.00 Os Wing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line oxide)  1.00 Os Wing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line oxide)  1.00 Os Wing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line oxide)  1.00 Os Wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line oxide)  1.00 Os Wing-bed cost applicable to NF type services aft						
11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Wedically necessary private room days applicable to titles V or XIX only (including private room days)  15. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  16. 00 Nursery days (title V or XIX only)  17. 00 Nursery days (title V or XIX only)  18. 00 Nursery days (title V or XIX only)  19. 00 Wedicare rate for swing-bed SNF services applicable to services through December 31 of the cost  19. 00 Wedicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Wedicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Wedicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Wedicald rate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Wedicald rate for swing-bed NF services applicable to services after December 31 of the cost  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 19)  25. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 19)  26. 00 Wedical Archive SWING	10. 00			oom days)	0	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00   12.00	11 00			nom dovo) often		11 00
12.00   Swing-bed MF type inpatient days applicable to titles \( V or XIX only \( (including private room days) \)	11.00			Dom days) arter	ا	11.00
through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Novery days (title V or XIX only)  17. 00 Medicaler rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 Total swing-bed cost (see instructions)  29. 00 Total swing-bed cost (see instructions)  29. 00 Total swing-bed cost (see instructions)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Average period lenger of the cost reporting period (line 29 290 0000000000000000000000000000000	12.00			e room days)	0	12.00
3. 00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   13. 00   13. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   1		through December 31 of the cost reporting period	y ( manning process		-	
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   Nursery days (title V or XIX only)   16   16.00   16.00   Nursery days (title V or XIX only)   16   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00	13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
15.00   Total nursery days (title V or XIX only)   16.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   17.00   17.00   17.00   17.00   17.00   17.00   17.00   1						
16. 00   Nursery days (title V or XIX only)   16   16. 00   17. 00   18. 00   18. 00   Modi care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 00   19. 0			am (excluding swing-bed o	days)		
SWING BED ADJUSTMENT  17. 00  18. 00  18. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00  10. 00						
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 perporting period (20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 perporting period (20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 perporting period (10.00 Total general inpatient routine service cost (see instructions) 9, 391, 491 period (10.00 Total general inpatient routine service cost (see instructions) 9, 391, 491 period (10.00 Total general inpatient routine services after December 31 of the cost reporting period (10.00 Total general inpatient routine services after December 31 of the cost reporting period (10.00 Total general inpatient routine services after December 31 of the cost reporting period (10.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (10.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (10.00 Total swing-bed cost (see instructions) 2, 928, 532 period swing-bed cost (see instructions) 2, 900 period swing-bed cost (see instructions) 3, 000 period swing-bed cost (see instructions) 4, 6462, 959 period swing-bed cost (see instructions) 4, 6462, 959 period swing-bed cost (see instructions) 5, 000 period swing-bed cost (see instructions) 5, 000 period swing-bed cost (see instructions) 6, 6462, 959 period swing-bed cost (see instructions) 6, 6462, 959 period swing-bed cost (see instructions) 6, 6462, 959 period swing-bed cost (see instructions) 7, 000 period swing-bed cost and private room	16.00				10	16.00
reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19.	17 00		es through December 31 o	f the cost		17 00
18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19. 00   Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   19. 00   20. 00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   0. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20. 00   20.	17.00	1	ss through becomber of o	the cost		17.00
19.00   Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20.00   20	18.00		es after December 31 of	the cost		18.00
reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 Private room charges (excluding swing-bed charges)  29. 00 Private room charges (excluding swing-bed charges)  29. 00 Private room charges (excluding swing-bed charges)  29. 00 Average private room per diem charge (line 29 + line 3)  20. 01 Average per diem private room per diem charge (line 30 + line 4)  20. 02 Average per diem private room per diem charge (line 30 + line 4)  20. 03. 03  20. 04 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  20. 04 Average per diem private room cost differential (line 34 x line 31)  20. 05 Average per diem private room cost differential (line 34 x line 31)  20. 04 Average per diem private room cost differential (line 34 x line 35)  20. 05 Average per diem private room cost differential (line 35 x line 35)  20. 00 Average per diem private room cost differential (line 35 x line 35)  20. 00 Average per diem private room cost differential (line 35 x line 35)  20. 00 Average per diem private room cost differential (line 35 x line 36)  20. 00 Avera						
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  20.00 Overage per diem private room per diem charge (line 29 * line 3)  30.00 Semi-private room per diem charge (line 29 * line 3)  30.00 Average per diem private room charge differential (line 27 * line 28)  30.00 Average per diem private room charge differential (line 3 x line 31)  30.00 Semi-private room cost differential (line 3 x line 31)  30.00 Average per diem private room charge differential (line 3 x line 31)  30.00 General inpatient routine service cost per diem (see instructions)  30.00 Semi-private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Foreignem general inpatient routine service cost per diem (see instructions)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x l	19. 00		s through December 31 of	the cost	0.00	19. 00
reporting period Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROWD DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  28.00 Semi-private room charges (excluding swing-bed charges) OPTIVATE room charges (excluding swing-bed charges) OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  29.00 Semi-private room charges (excluding swing-bed charges) OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  31.00 OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  32.00 Average private room charges (excluding swing-bed charges) OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  33.00 OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  34.00 OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  35.00 OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  36.00 OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  37.00 OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  38.00 OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT  38.00 OPTIVATE ROWD DIFFERENTIAL ADJUSTMENT ROUGH COST ADJUSTMENTS  38.00 OPTIVATE ROWD DIFFERENT OPTIVATE ROWD COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 OPTIVATE ROWD DIFFERENT OPTIVATE ROWD COST ADJUSTMENTS  38.00 OPTIVATE ROWD DIFFERENT OPTIVATE ROWD COST ADJUSTMENTS  38.00 OPTIVATE ROWD DIFFERENT OPTIVATE ROWD COST ADJUSTMENTS  38.00 OPTIVATE ROWD DIFFERENT OPTIVA	20.00		after December 21 of the	no cost	0.00	20.00
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost nat of swing-bed cost and private room cost differential (line 27 minus line 36) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20.00		s arter becember 31 or tr	ie cost	0.00	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average per diem private room cost differential (line 32 x line 31) 34.00 Average per diem private room cost differential (line 32 x line 31) 35.00 Average per diem private room cost differential (line 32 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	21. 00	' " "	s)		9, 391, 491	21. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge (line 29 + line 3)  30.00 Average per diem private room charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36)  27.00 Private room cost differential djustment (line 3 x line 35)  38.00 Average per diem private room sost differential (line 3 x line 35)  38.00 Agiusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Medically necessary private room cost differential (line 38)  40.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				ng period (line		
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 2, 928, 532 26.00 Total swing-bed cost (see instructions) 2, 928, 532 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 6, 462, 959 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room per diem charge (line 27 + line 28) 0 20.00 Semi-private room per diem charge (line 30 + line 3) 0 20.00 Semi-private room cost differential (line 32 minus line 33) (see instructions) 0 20.00 Semi-private room cost differential (line 34 x line 31) 0 20.00 Semi-private room cost differential (line 34 x line 31) 0 20.00 Semi-private room cost differential (line 34 x line 35) 0 37.00 Semi-private room cost differential dipustment (line 34 x line 35) 0 37.00 Semi-private room cost differential (line 54 x line 35) 0 37.00 Semi-private room cost differential (line 55 x line 36) 0 37.00 Semi-private room cost differential (line 57 x line 38) 0 39.00 Program general inpatient routine service cost per diem (see instructions) 183,842 39.00 40.00 Medically necess		· · · · · · · · · · · · · · · · · · ·				
24.00  24.00  25.00  25.00  25.00  25.00  26.00  26.00  27.10  28.00  29.00  29.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20.00  20	23. 00		31 of the cost reporting	g period (line 6	0	23. 00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32.00 Average private room per diem charge (line 29 ± line 3)  33.00 Average semi-private room per diem charge (line 30 ± line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  38.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 6, 462, 959)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24 00	/	r 21 of the cost reporti	ag poriod (line	ا	24.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average per diem private room cost differential (line 32 * line 4)  34.00 Average per diem private room cost differential (line 32 * line 31)  35.00 Average per diem private room cost differential (line 34 * line 31)  36.00 Private room cost differential adjustment (line 3 * line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  37.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost line 9 * line 38)  38.00 Program general inpatient routine service cost line 9 * line 38)  38.00 Medically necessary private room cost applicable to the Program (line 14 * line 35)  0 40.00  40.00	24.00		31 of the cost reportin	ig perrou (Trile	ا	24.00
x line 20)  26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 * line 28)  32. 00 Average private room per diem charge (line 29 * line 3)  33. 00 Average semi-private room per diem charge (line 30 * line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  PRIVATE ROOM DIFFERENTIAL ADD SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  2, 589. 33  38. 00  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  Pri vate room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32. 00 Average private room per diem charge (line 29 ± line 3)  Average per diem private room charge differential (line 30 ± line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34. 00 Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 36)  Private room cost differential adjustment (line 3 x line 35)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Average per diem private room cost applicable to the Program (line 14 x line 35)  Average per diem private room cost differential (line 3 x line 36)  Bas, 842  Average per diem private room cost differential (line 3 x line 36)  Bas, 842  Av			, ,			
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  38. 00 Ajusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  38. 00 Ajusted general inpatient routine service cost (line 9 x line 38)  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  29. 00  29. 00  20. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 00  30. 0						
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 6, 462, 9	27. 00		(line 21 minus line 26)		6, 462, 959	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 0 30.00 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .0000000 0 .00000000	20.00		d and abaseriation had also	2555		20.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			a and observation bed cha	ar ges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi -private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.0000000000000000000000000000000000					1	
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			+ line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00  34.00  35.00  36.00  37.00  2.589.33  38.00  40.00		,	,		1	
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 462, 959)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 .00 35.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.				tions)	1	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  40.00		, , , , , , , , , , , , , , , , , , , ,	ne 31)		1	
27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,589.33 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,	and private many cost di	Efonontial (line		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,589.33 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  183,842 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00	,	and private room cost di	rrerentral (Tine	0, 402, 939	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,589.33 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,589.33 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			JSTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 183,842 39.00 40.00	38. 00				2, 589. 33	38. 00
	39. 00	Program general inpatient routine service cost (line 9 x line	38)		183, 842	39. 00
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   183,842   41.00						
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)		183, 842	41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	DUKES MEMORIA						2552-10
	ATTON OF INPATTENT OPERATING COST		Provi der	CCN:	15-1318	Peri od:	Worksheet D-1	
						From 01/01/2023 To 12/31/2023		pared:
			Ti	tle X	′I V	Hospi tal	5/31/2024 10: PPS	49 am
	Cost Center Description	Total	Total		verage Per			
		npatient Cost	npatient Day		em (col. 1		(col. 3 x col.	
		1.00	2.00	+	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	623, 899		37	2, 632.			42. 00
42.00	Intensive Care Type Inpatient Hospital Units	1 054 /15	11	rol -	( (22 )	00	1 20 707	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 054, 615	1:	59	6, 632.	80	39, 797	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT							45. 00
	SURGICAL INTENSIVE CARE UNIT							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description							47. 00
	<u> </u>						1. 00	
48.00	Program inpatient ancillary service cost (Wkst						200, 109	1
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines 41					, column 1)	0 465, 868	
17.00	PASS THROUGH COST ADJUSTMENTS	trii oagir 10. 0	1) (300 111311	uctre	113)		100,000	17.00
50. 00	Pass through costs applicable to Program inpat	ient routine s	services (fr	om Wk	st. D, sur	m of Parts I and	42, 362	50.00
51. 00	<pre>III) Pass through costs applicable to Program inpat</pre>	ient ancillar	y services (	from	Wkst. D, s	sum of Parts II	24, 599	51.00
F0 5-	and IV)	-	•				,	F
52. 00 53. 00	Total Program excludable cost (sum of lines 50 Total Program inpatient operating cost excludi		lated non-n	hvei c	ian anosti	hetist and	66, 961 398, 907	
33.00	medical education costs (line 49 minus line 52	9 1	rated, non-p	niyai c	i an anesti	netrat, and	370, 707	33.00
<b></b>	TARGET AMOUNT AND LIMIT COMPUTATION							4
54. 00 55. 00	Program discharges Target amount per discharge						0 00	54. 00 55. 00
55. 01	Permanent adjustment amount per discharge						0.00	1
55. 02	Adjustment amount per discharge (contractor us							55. 02
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55.0 Difference between adjusted inpatient operation		ract amount	(Line	. 56 minus	lino 52)	0 0	
58. 00	Bonus payment (see instructions)	g cost and tai	rget allourt	(11116	; 50 III Hus	111le 55)	0	1
59. 00	Trended costs (lesser of line 53 ÷ line 54, or	line 55 from	the cost re	porti	ng period	endi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, o	r line 55 from	m nrior vear	cost	renort i	undated by the	0.00	60.00
00.00	market basket)	i iiile 55 iioi	ii pi i oi yeai	COST	терогі, і	updated by the	0.00	00.00
61. 00	Continuous improvement bonus payment (if line						0	61. 00
	55.01, or line 59, or line 60, enter the lesse 53) are less than expected costs (lines 54 x 6							
	enter zero. (see instructions)	0), 01 1 % 01	the target	amour	11 (11110 0	o), otherwise		
62.00	Relief payment (see instructions)	<b>.</b> / ! <b>.</b>	-+:>					62.00
63. 00	Allowable Inpatient cost plus incentive paymen PROGRAM INPATIENT ROUTINE SWING BED COST	t (see instru	ctions)				0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs	through Decer	mber 31 of t	he co	st reporti	ing period (See	0	64. 00
65. 00	instructions) (title XVIII only)	after December	or 21 of the	cost	roportin	a pariod (Saa		65. 00
65.00	Medicare swing-bed SNF inpatient routine costs instructions)(title XVIII only)	arter beceilibe	er 31 Or the	COST	i eboi ti ii	g perrou (see		65.00
66. 00	Total Medicare swing-bed SNF inpatient routine	costs (line	64 plus line	65)(	title XVI	<pre>II only); for</pre>	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine	costs through	December 31	of t	he cost re	enorting period	0	67. 00
07.00	(line 12 x line 19)	G						07.00
68. 00	Title V or XIX swing-bed NF inpatient routine	costs after De	ecember 31 o	f the	cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient ro	utine costs (I	line 67 + li	ne 68	3)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NUR	SING FACILITY,	AND ICF/III	D ONL	Y			
70. 00 71. 00	Skilled nursing facility/other nursing facilit Adjusted general inpatient routine service cos				(line 37)	)		70.00
72.00	Program routine service cost (line 9 x line 71		ille 70 ÷ illi	le 2)				72.00
73. 00	Medically necessary private room cost applicab	le to Program			35)			73. 00
74. 00 75. 00	Total Program general inpatient routine servic				choot D. I	Dort II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient ro 26, line 45)	utine service	COSTS (110III	WOIK	SHEEL D, I	Part II, Corumn		75.00
76. 00	Per diem capital-related costs (line 75 ÷ line							76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line 7 Inpatient routine service cost (line 74 minus							77. 00 78. 00
	Aggregate charges to beneficiaries for excess		rovi der reco	rds)				79.00
80.00	Total Program routine service costs for compar	ison to the co		-	ine 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limita Inpatient routine service cost limitation (lin		)					81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (se							83. 00
84.00	Program inpatient ancillary services (see inst	ructions)						84. 00
	Utilization review - physician compensation (s Total Program inpatient operating costs (sum o							85. 00 86. 00
JU. UU	PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 00)				1	. 55. 60
07 00	Total observation bed days (see instructions)						l .	87. 00
87. 00 88. 00	Adjusted general inpatient routine cost per di							88. 00

Health Financial Systems	DUKES MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 636, 869	9, 391, 491	0. 17429	3 1, 545, 830	269, 427	90.00
91.00 Nursing Program cost	0	9, 391, 491	0.00000	0 1, 545, 830	0	91.00
92.00 Allied health cost	0	9, 391, 491	0.00000	0 1, 545, 830	0	92.00
93.00 All other Medical Education	0	9, 391, 491	0. 00000	0 1, 545, 830	0	93. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL		In lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Ci	CN: 15-1318	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3	pared:
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			2, 332, 689		30.00
31.00 03100 INTENSIVE CARE UNIT			260, 546		31.00
43. 00   04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 17096	0 255, 268	43, 641	50.00
51.00   05100   RECOVERY ROOM		0. 16057	8 47, 175	7, 575	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000	0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 00000	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08448	1, 672, 988	141, 344	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. 12765	5 1, 455, 413	185, 791	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 30976	81, 871	25, 361	62.00
65. 00 06500 RESPIRATORY THERAPY		0. 31936	915, 771	292, 464	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 39787	6 277, 513	110, 416	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 17556	1 279, 874	49, 135	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 39933	7 38, 815	15, 500	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 11341	6 540, 866	61, 343	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 08493	7 359, 407	30, 527	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18453	· ·		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 11232	2, 917, 803	327, 736	73. 00
76. 00   03610   SLEEP LAB		0. 00000		0	76. 00
76.01 03560 PULMONARY FUNCTION TESTING		0.00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		10. 84816		0	76. 02
OUTPATIENT SERVICE COST CENTERS					1
			.		1

5. 667533

0. 291812

0. 776740

1, 185

8, 923, 296

8, 923, 296

0 90.00

0 91.00

92.00

95.00

201. 00 202. 00

920

1, 306, 395 200. 00

90. 00 09000 CLI NI C

91.00

92.00

95.00

200.00

201.00

202.00

09100 EMERGENCY

09500 AMBULANCE SERVICES

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

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

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1318	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z318	From 01/01/2023 To 12/31/2023		pared 49 an
	Ti tl e	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS					30.
. 00   03100   INTENSIVE CARE UNIT . 00   04300   NURSERY					31. 43.
. 00   04300  NURSERY   ANCI LLARY SERVI CE COST CENTERS					43.
. 00 05000 OPERATING ROOM		0. 1709	50 1, 770	303	50.
. 00   05100   RECOVERY ROOM		0. 1605			
. 00   05200   DELI VERY ROOM & LABOR ROOM		0.00000			
. 00   05300   ANESTHESI OLOGY		0. 00000		o o	
. 00   05400 RADI OLOGY-DI AGNOSTI C		0. 08448		4, 671	54.
. 01   05401   ULTRASOUND		0.0000		1	54.
. 00   05600   RADI 0I SOTOPE		0.0000	00	0	56.
. 00   05700   CT   SCAN		0.0000	00	0	57.
. 00   05800   MRI		0.00000	00	0	58.
. 00   06000   LABORATORY		0. 1276!	55 319, 506	40, 787	60.
.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 3097	68 8, 757	2, 713	
. 00   06500   RESPI RATORY THERAPY		0. 3193	· ·		
. 00 06600 PHYSI CAL THERAPY		0. 3978			
. 00   06700   OCCUPATI ONAL THERAPY		0. 1755	· ·		
. 00 06800 SPEECH PATHOLOGY		0. 3993			
. 00 06900 ELECTROCARDI OLOGY		0. 1134	· ·		
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 08493			
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1845			
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1123			
. 00 03610 SLEEP LAB		0.0000			
. 01   03560   PULMONARY FUNCTION TESTING		0.00000			
. 02   03550  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES OUTPATI ENT SERVI CE COST CENTERS		10. 8481	60 0	0	76.
. 00 O9000 CLINIC		5. 6675	33 0	0	90.
.00   09100   EMERGENCY		0. 2918			1
. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART		0. 77674			

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

201. 00 202. 00

640, 464 200. 00

3, 102, 162

3, 102, 162

200.00

201. 00 202. 00

Health Financial Systems DUKE	S MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/31/2024 10:	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			470 (00		00.00
30. 00   03000   ADULTS & PEDI ATRI CS			172, 629		30.00
31. 00   03100   I NTENSI VE CARE UNI T			44, 569		31.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS			16, 499		43. 00
50. 00 05000 OPERATING ROOM		0. 17096	251, 437	42, 986	50.00
51. 00   05100   RECOVERY ROOM		0. 17070		6, 213	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0, 213	52.00
53. 00   05300   ANESTHESI OLOGY		0.00000	1	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08448		15, 099	54.00
54. 01   05401   ULTRASOUND		0.00000		0	54. 01
56. 00   05600   RADI 01 SOTOPE		0.00000		0	56.00
57. 00 05700 CT SCAN		0.00000	ol ol	0	57.00
58. 00   05800   MRI		0.00000	o	0	58. 00
60. 00   06000   LABORATORY		0. 12765	166, 838	21, 298	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 30976	17, 394	5, 388	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 31936		16, 220	
66. 00 06600 PHYSI CAL THERAPY		0. 39787		2, 009	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 17556		1, 383	
68. 00   06800   SPEECH PATHOLOGY		0. 39933		1, 487	
69. 00   06900   ELECTROCARDI OLOGY		0. 11341	23, 004	2, 609	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 08493		2, 694	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18453		606	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 11232		31, 748	73. 00
76. 00   03610   SLEEP LAB		0.00000		0	76. 00
76.01 03560 PULMONARY FUNCTION TESTING		0.00000		0	76. 01
76. 02 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		10. 84816	0	0	76. 02

5. 667533 0. 291812

0. 776740

1, 864

98, 893

14, 094

1, 176, 031

1, 176, 031

90.00

91.00

92.00

95.00

201. 00 202. 00

10, 564

28, 858

10, 947

200, 109 200. 00

OUTPATIENT SERVICE COST CENTERS

09500 AMBULANCE SERVICES

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

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

09000 CLI NI C

09100 EMERGENCY

90.00

91.00

92.00

95.00

200.00

201.00

202.00

		Ti +l o VVIII	Hoopi tal	5/31/2024 10: Cost	49 am_
		Title XVIII	Hospi tal	COST	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			4, 967, 115 0	1. 00 2. 00
3.00	OPPS or REH payments			5, 441, 892	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000 0	5. 00 6. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs including REH direct gradu	uate medical educa	ation costs from	0	9. 00
40.00	Wkst. D, Pt. IV, col. 13, line 200				40.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 4, 967, 115	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			4, 707, 115	11.00
	Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14. 00
15. 00	Aggregate amount actually collected from patients liable for payment	for services on a	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for paymen		9	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	17. 00
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if li	ina 18 avcaads lii	na 11) (saa	0	18. 00 19. 00
17.00	instructions)	ne to exceeds thi	(366	O	17.00
20.00	Excess of reasonable cost over customary charges (complete only if li	ine 11 exceeds lir	ne 18) (see	0	20. 00
	instructions)			5 04 / 70 /	
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			5, 016, 786 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions	s)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			5, 441, 892	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	CALL :		36, 111	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the			4, 548, 859 431, 816	26. 00 27. 00
27.00	instructions)	, sum of fiftes 22	ana 25] (300	431, 010	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
28. 50	REH facility payment amount (see instructions)				28. 50
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 431, 816	29. 00 30. 00
31. 00	Primary payer payments			189	31. 00
32. 00	Subtotal (line 30 minus line 31)			431, 627	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			420, 024	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			420, 824 273, 536	
	Allowable bad debts for dual eligible beneficiaries (see instructions	s)		416, 272	
37. 00	Subtotal (see instructions)	•		705, 163	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)			0	39. 50 39. 75
39. 97	Demonstration payment adjustment amount (see instructions)			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devi	ces (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions)			705, 163	40.00
40. 01	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			14, 103 0	40. 01 40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			o l	40. 03
41.00	Interim payments			839, 064	41.00
41. 01	Interim payments-PARHM			_	41. 01
42. 00 42. 01	Tentative settlement (for contractors use only)			0	42. 00 42. 01
42. 01	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-148, 004	42.01
43. 00	Balance due provider/program-PARHM (see instructions)			170, 004	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance with	n CMS Pub. 15-2, (	chapter 1,	0	44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)		Т	0	90. 00
90.00	Outlier reconciliation adjustment amount (see instructions)			0	90.00
92. 00	The rate used to calculate the Time Value of Money			0. 00	92. 00
93. 00	Time Value of Money (see instructions)			0	93. 00

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1318	Peri od:	Worksheet E	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	
			5/31/2024 10:	49 am
	Title XVIII	Hospi tal	Cost	
			1. 00	
94.00 Total (sum of lines 91 and 93)			0	94.00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

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

			XVIII	Hospi tal	Cost	
		Innation				
		прапен	t 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	-		2, 587, 03	7	839, 064	1. 00
2.00 Interim payments payable on individual	bills, either		(		0	2. 00
submitted or to be submitted to the cor	ntractor for					
services rendered in the cost reporting	period. If none,					
write "NONE" or enter a zero						
3.00 List separately each retroactive lump s						3. 00
amount based on subsequent revision of						
for the cost reporting period. Also sho						
payment. If none, write "NONE" or enter	a zero. (1)					
Program to Provider 3.01 ADJUSTMENTS TO PROVIDER		00 (04 (2022	220, 200	<u></u>	0	2 01
		08/04/2023	228, 200		0	3. 01
3. 02			(		0	3. 02 3. 03
3. 04 3. 05			(			3. 04 3. 05
Provider to Program				ال	0	3. 05
3. 50 ADJUSTMENTS TO PROGRAM			(	1	0	3. 50
3.51			(		0	3. 50
3.52			(		l ol	3. 52
3.53					0	3. 53
3.54					Ö	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus	sum of lines		228, 200		Ö	3. 99
3. 50-3. 98)	Sam of Tries		220, 200	1	Ĭ	0. 77
4.00 Total interim payments (sum of lines 1,	2. and 3.99)		2, 815, 23	7	839. 064	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 settleme						5. 00
desk review. Also show date of each pay	ment. If none,					
write "NONE" or enter a zero. (1)						
Program to Provider				-T	_	
5. 01 TENTATI VE TO PROVI DER			(		0	5. 01
5. 02			(		0 0	5. 02
5. 03			(	)	0	5. 03
Provider to Program 5.50 TENTATIVE TO PROGRAM			(	1	0	5. 50
5. 51			(		0	5. 50
5. 52						5. 52
5. 99   Subtotal (sum of lines 5. 01-5. 49 minus	sum of lines				0	5. 99
5. 50-5. 98)	Jam Of FFFIGS		`	1		J. 77
6.00 Determined net settlement amount (balar	nce due) based on					6. 00
the cost report. (1)	les das, basea on					0. 00
6. 01 SETTLEMENT TO PROVIDER			752, 249		0	6. 01
6. 02 SETTLEMENT TO PROGRAM			,02,2.		148, 004	6. 02
7.00 Total Medicare program liability (see i	nstructions)		3, 567, 486		691, 060	7. 00
, , , , , , , , , , , , , ,			.,,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8.00 Name of Contractor						8. 00

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

		'			5/31/2024 10:	49 am
		Title	XVIII S	wing Beds - SNF	Cost	
		Inpatien	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		1, 805, 581		0	1.00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/04/2023	213, 700		0	3. 01
3.02			(		0	3. 02
3.03			(		0	3. 03
3.04			(		0	3. 04
3.05			(	)	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3. 51			(		0	3. 51
3.52			(		0	3. 52
3. 53			(		0	3. 53
3. 54			(		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		213, 700	)	0	3. 99
4 00	3. 50-3. 98)		0.040.00			4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 019, 281		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					ł
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02	TERMINE TO THORISEN				0	5. 02
5. 03					0	5. 03
	Provider to Program			1		
5.50	TENTATI VE TO PROGRAM		(	)	0	5.50
5. 51					0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		541, 280		0	6. 01
6.02	SETTLEMENT TO PROGRAM		(		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 560, 561		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	In	(	)	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems DUKES MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1318	Peri od: From 01/01/2023 To 12/31/2023		epared:
		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-3, Pt. I col. 15 line	2 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	-			
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	Other Adjustment (specify)				31.00
22 00	Polones due provider (line 0 (en line 10) minus line 20 and l	ing 21) (and instruction	)		22.00

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

30. 00 31. 00 32. 00

		Component CCN: 15-Z318	To 12/31/2023	Date/Time Pre 5/31/2024 10:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COCT OF COVERED CERVICES		1. 00	2. 00	
1.00	COMPUTATION OF NET COST OF COVERED SERVICES  Inpatient routine services - swing bed-SNF (see instructions)		1, 974, 493	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		1, 774, 475	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D,	646, 869	0	1
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin	ig-bed pass-through, see			
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)	/		0.00	3. 01
4.00	Per diem cost for interns and residents not in approved teachi instructions)	ng program (see		0. 00	4. 00
5. 00	Program days		755	0	5. 00
6.00	Interns and residents not in approved teaching program (see in	structi ons)		0	6.00
7.00	Utilization review - physician compensation - SNF optional met	hod only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2, 621, 362	0	
9. 00 10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		2, 621, 362	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	able to physician	2, 021, 302	0	1
	professional services)	azi e te pilyel el all			
12.00	Subtotal (line 10 minus line 11)		2, 621, 362	0	12. 00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	8, 545	0	13. 00
14 00	for physician professional services)			0	14.00
14. 00 15. 00	80% of Part B costs (line 12 x 80%) Subtotal (see instructions)		2, 612, 817	0	1
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		2, 012, 017	0	1
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ation) payment	0		16. 55
14 00	adjustment (see instructions)		0	0	1, 00
16. 99 17. 00	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	
17. 00	Adjusted reimbursable bad debts (see instructions)		o o	0	1
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
	Total (see instructions)		2, 612, 817	0	
19. 01	Sequestration adjustment (see instructions)		52, 256	0	
19. 02 19. 03	Demonstration payment adjustment amount after sequestration)		0	0	19. 02 19. 03
19. 03	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)		0	0	1
	Interim payments		2, 019, 281	0	1
	Interim payments-PARHM				20. 01
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)	40.05.00 1.04)	E44 000		21. 01
22. 00 22. 01	Balance due provider/program (line 19 minus lines 19.01, 19.02 Balance due provider/program-PARHM (see instructions)	r, 19.25, 20, and 21)	541, 280	0	22. 00 22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub 15-2	0	0	1
20.00	chapter 1, §115.2				20.00
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200. 00	Is this the first year of the current 5-year demonstration per	iod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement				1
201. 00	Medicare swing-bed SNF inpatient routine service costs (from W	/kst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital)				
202. 00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lin	e		202. 00
202 00	200 (title XVIII swing-bed SNF)) Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	ration	1
	peri od)				
	Medicare swing-bed SNF target amount	mag Line 204)			205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				206. 00
207. 00	Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	-	1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 00
210.00	Reserved for future use Comparision of PPS versus Cost Reimbursement				210. 00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
2.0.00	instructions)	p. 40 210) (300			

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1318	From 01/01/2023	Worksheet E-3 Part V Date/Time Prepared: 5/31/2024 10:49 am
	T: 11 \0.0111		0 1

PART V - CALCULATION OF REIMBURSEMENT STITLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		Title XVIII Hospital	5/31/2024 10: 4 Cost	49 am_
PART Y - CALCHATION OF REINBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REINBURSEMENT			1.00	
Impatient services   3,887,806   1.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.00   2.		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT	1.00	
Nursing and Allied Health Managed Care payment (see instructions)	1.00		3, 887, 806	1. 00
Cell Lafar Therapy acquisition cost (see instructions)   3, 301	2.00			2. 00
Subtotal (sum of lines I through 3.01)	3.00	Organ acqui si ti on	0	3. 00
Primary payer payments	3.01	Cellular therapy acquisition cost (see instructions)	0	3. 01
Total cost (line 4 less line 5). For CAH (see instructions)   3,926,684   6,00	4.00	Subtotal (sum of lines 1 through 3.01)	3, 887, 806	
COMPUTATION OF LESSER OF COST OR CHARGES			-	
Reasonable charges	6.00		3, 926, 684	6. 00
Routine service charges				
Ancil lary service charges   0	7 00	J .		7 00
0,00				
10. 00   Total reasonable charges				
Customary charges				
11.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   11.00	10.00			10.00
had such payment been made in accordance with 42 CFR 413.13(e)   0.0000000   13.00   14.00   10.0000000   13.00   14.00   10.00   10.0000000   13.00   14.00   10.00   10.00   13.00   14.00   10.00   10.00   13.00   14.00   10.00   10.00   10.00   13.00   14.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00   10.00	11.00		0	11. 00
13. 00   Ratio of line 11 to line 12 (not to exceed 1.000000)   13. 00   14. 00   14. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00   15. 00	12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	12.00
14.00   Total customary charges (see instructions)   0   14.00   15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   Excess of reasonable cost of covered services (sum of lines 6, 17 and 18)   18.00   Excess reasonable cost (from line 16)   3.926, 684   19.00   20.00   Excess reasonable cost (from line 16)   2.100   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23.00   23				
15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   17.00   17.00   17.00   18.00   18.00   18.00   18.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.00   19.0				
Instructions   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   16.00   16.00   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   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   17.00   17.00   17.00   17.00   17.00   17.				
16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   17.00   Cost of physicians' services in a teaching hospital (see instructions)   0   17.00   COMPUTATION OF RELIMBURSEMENT SETTLEMENT	15. 00		0	15. 00
Instructions   Cost of physicians' services in a teaching hospital (see instructions)   To 0   To	16 00			16 00
17.00	10.00			10.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT	17. 00		0	17. 00
19.00   Cost of covered services (sum of lines 6, 17 and 18)   3,926,684   19.00   20.00   Deductibles (sexclude professional component)   302,224   20.00   21.00   Excess reasonable cost (from line 16)   0   21.00   22.00   Subtotal (line 19 minus line 20 and 21)   3,624,460   22.00   0   23.00   23.00   23.00   23.00   24.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   24,357   25.00   Allowable bad debts (exclude bad debts (see instructions)   15,832   26.00   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   22,228   27.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29.00   29				
20. 00   Deductibles (exclude professional component)   302, 224   20. 00	18.00		0	18. 00
21.00   Excess reasonable cost (from line 16)	19.00	Cost of covered services (sum of lines 6, 17 and 18)	3, 926, 684	19.00
22.00   Subtotal (line 19 minus line 20 and 21)   3,624,460   22.00   23.00   Coinsurance   3,624,460   24.00   23.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   24,357   25.00   24,000   27.00   Allowable bad debts (see instructions)   24,357   25.00   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   22,228   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00   27.00				
23.00   Coinsurance			1	
24.00       Subtotal (line 22 minus line 23)       3,624,460       24.00         25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       24,357       25.00         26.00       Allowable bad debts (see instructions)       15,832       26.00         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       22,228       27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       3,640,292       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29.50         29.99       Recovery of accelerated depreciation.       0       29.98         29.99       Demonstration payment adjustment amount before sequestration       0       29.98         30.01       Sequestration adjustment (see instructions)       3,640,292       30.00         30.02       Sequestration adjustment amount after sequestration       0       29.98         10.10       Interim payments       2,815,237       31.00         31.01       Interim payments       2,815,237       31.00         32.01       Tentative settlement (for contractor use only)       32.01         33.01				
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment (see instructions) 30. 01 Interim payments 30. 03 Interim payments 31. 01 Interim payments 32. 01 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 38. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 38. 02 Sequestration adjustment (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 39. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01)				
26. 00   Adj usted reimbursable bad debts (see instructions)   15,832   26. 00   27. 00   All lowable bad debts for dual eligible beneficiaries (see instructions)   22,228   27. 00   28. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00   29. 00				
27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       22, 228       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       3, 640, 292       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29. 00         29. 50       Pi oneer ACO demonstration payment adjustment (see instructions)       0 29. 50         29. 98       Recovery of accelerated depreciation.       0 29. 98         29. 99       Demonstration payment adjustment amount before sequestration       0 29. 98         30. 00       Subtotal (see instructions)       3, 640, 292       30. 00         30. 01       Sequestration adjustment (see instructions)       72, 806       30. 01         30. 02       Sequestration adjustment amount after sequestration       0 30. 02         30. 03       Sequestration adjustment-PARHM       0 30. 02         31. 00       Interim payments       2, 815, 237       31. 00         31. 01       Interim payments-PARHM       31. 00         32. 01       Tentative settlement (for contractor use only)       32. 00         33. 00       Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)       31. 01, and 32. 01         33. 01       Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01 <td></td> <td></td> <td></td> <td></td>				
28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Sequestration adjustment (see instructions) 31. 00 Interim payments 31. 01 Interim payments 32. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33. 05 Subtotal (sum of lines 2 instructions) 34. 00 Other ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 00 29. 00 29. 90 29. 90 30. 01 29. 90 30. 02 30. 01 30. 02 30. 01 30. 02 30. 03 30. 01 30. 02 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03		, ,		
29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29. 00         29. 50       Pi oneer ACO demonstration payment adjustment (see instructions)       0       29. 50         29. 98       Recovery of accelerated depreciation.       0       29. 98         29. 99       Demonstration payment adjustment amount before sequestration       0       29. 99         30. 01       Sequestration adjustment (see instructions)       3, 640, 292       30. 00         30. 02       Demonstration payment adjustment amount after sequestration       72, 806       30. 01         30. 03       Sequestration adjustment-PARHM       30. 02         31. 01       Interim payments       2, 815, 237       31. 00         31. 01       Interim payments-PARHM       31. 01         32. 01       Tentative settlement (for contractor use only)       32. 01         32. 01       Tentative settlement-PARHM (for contractor use only)       32. 01         33. 01       Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)       752, 249       33. 00         33. 01       Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)       33. 01				
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  31. 00 Interim payments  31. 01 Interim payments-PARHM  32. 00 Tentative settlement (for contractor use only)  32. 01 Tentative settlement-PARHM (for contractor use only)  33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)				
29. 99       Demonstration payment adjustment amount before sequestration       0       29. 99         30. 00       Subtotal (see instructions)       3, 640, 292       30. 00         30. 01       Sequestration adjustment (see instructions)       72, 806       30. 01         30. 02       Sequestration adjustment amount after sequestration       0       30. 02         30. 03       Sequestration adjustment-PARHM       30. 03         31. 01       Interim payments       2, 815, 237       31. 00         31. 01       Interim payments-PARHM       31. 01         32. 00       Tentative settlement (for contractor use only)       31. 01         32. 01       Tentative settlement-PARHM (for contractor use only)       32. 01         33. 00       Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)       752, 249       33. 00         33. 01       Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)       33. 01	29. 50		0	29. 50
30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33. 00 Subtotal (see instructions) 34. 640, 292 30. 00 30. 01 30. 02 30. 03 30. 03 30. 03 31. 00 31. 01 31. 01 31. 01 32. 01 33. 00 33. 01	29. 98	Recovery of accelerated depreciation.	0	29. 98
30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 37.01 Sequestration adjustment (see instructions) 30.01 30.02 30.02 30.03 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00	29. 99	Demonstration payment adjustment amount before sequestration	0	29. 99
30. 02 Demonstration payment adjustment amount after sequestration 0 30. 02 30. 03 Sequestration adjustment-PARHM 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 2, 815, 237 31. 00 31. 01 Interim payments-PARHM 31. 01 Tentative settlement (for contractor use only) 31. 01 Tentative settlement-PARHM (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 32. 01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 752, 249 33. 00 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31. 01, and 32. 01) 33. 01				
30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 Interim payments 2, 815, 237 31. 00 31. 01 Interim payments-PARHM 2, 815, 237 31. 00 31. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 32. 01 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 752, 249 33. 00 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31. 01, and 32. 01) 33. 01				
31. 00 Interim payments 31. 01 Interim payments		1	0	
31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33. 01		1 '	2 015 227	
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 32.00 32.00 32.01 32.01 32.01		1 9	2, 815, 237	
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33.01		1 9		
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  752,249 33.00 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  33.01		, , , , , , , , , , , , , , , , , , , ,		
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33.01			752, 249	
§115. 2		§115. 2		

Health Financial Systems	DUKES MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1318	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 10:49 am

			10 12/31/2023	5/31/2024 10:	
		Title XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			563, 609	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	563, 609	
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	563, 609	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges		000 (0)		0.00
8.00	Routi ne servi ce charges		233, 696	0.004.074	8. 00
9.00	Ancillary service charges		1, 176, 031	2, 994, 261	9.00
10. 00 11. 00	Organ acquisition charges, net of revenue		0		10.00
12.00	Incentive from target amount computation		1, 409, 727	2, 994, 261	11. 00 12. 00
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		1, 409, 727	2, 994, 201	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
10.00	basis	ser vices on a charge			10.00
14. 00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	,	0. 000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		1, 409, 727	2, 994, 261	16. 00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	1, 409, 727	2, 430, 652	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)			_	
19. 00	Interns and Residents (see instructions)		0	0	
20. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		0	563, 609	21.00
22 00	Other than outlier payments	compreted for FF3 provide	0	0	22. 00
23. 00	Outlier payments		0	0	
24. 00	Program capital payments		0	· ·	24. 00
25. 00	, , ,		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	1
27. 00	Subtotal (sum of lines 22 through 26)		0	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	563, 609	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	0	563, 609	
32.00	Deducti bl es		0	0	
33.00	Coi nsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0		35. 00
36. 00		1 33)	0	563, 609	
	REMOVE SETTLEMENT		0	-563, 609	
38. 00	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	_	39.00
40.00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		0	0	
41. 00 42. 00	Interim payments  Release due provides (program (Line 40 minus Line 41)		0	0	
42.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordar	ace with CMS Dub 15 2	0	0	
43.00	chapter 1, §115.2	ICE WITH CIND PUD 10-2,			43.00
	Ondpto: 17 3110.2		1		1

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

Provider CCN: 15-1318

Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 1.00 Cash on hand in banks -439, 030 0 0 0 0 0 2.00 Temporary investments 0 2.00 0 3.00 Notes receivable 0 0 3.00 0 4 00 10, 127, 050 4 00 Accounts receivable 0 0 5.00 Other receivable 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable -1, 806, 380 6.00 0 7.00 Inventory 931, 193 0 0 7.00 0 8.00 Prepaid expenses 499, 197 0 8.00 0 9.00 Other current assets 32, 325 0 9.00 10 00 Due from other funds 0 0 0 10 00 Total current assets (sum of lines 1-10) 9, 344, 355 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 500,000 0 0 0 12.00 Land improvements 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 246, 545 οl Accumulated depreciation 14.00 -167, 935 0 14.00 15.00 Bui I di ngs 10, 619, 283 0 0 15.00 0 16.00 Accumulated depreciation -5, 148, 855 16.00 11, 476, 985 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation -6, 794, 231 0 18 00 Fi xed equipment 3, 112, 251 19.00 19.00 0 0 20.00 Accumulated depreciation -2, 239, 778 0 20.00 0 21.00 Automobiles and trucks 609, 143 0 21.00 22.00 Accumulated depreciation -583, 590 0 22.00 23.00 Major movable equipment 8, 657, 506 0 0 23.00 Accumulated depreciation -5, 787, 935 0 24.00 0 24.00 4, 385, 337 0 25.00 Mi nor equi pment depreci able Λ 25, 00 26.00 Accumulated depreciation -3, 554, 461 0 0 26.00 27.00 HIT designated Assets 0 0 0 27.00 0 28.00 Accumulated depreciation C 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 15, 330, 265 0 30.00 OTHER ASSETS 31 00 Investments O 0 0 31 00 0 0 32.00 Deposits on Leases C 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 3, 610, 606 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 3, 610, 606 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 28, 285, 226 0 0 0 36.00 CURRENT LIABILITIES 37 00 991 218 O 0 n 37 00 Accounts payable 1, 490, 126 0 0 38.00 Salaries, wages, and fees payable 0 38.00 0 Payroll taxes payable 128, 296 0 0 39.00 39.00 0 40.00 Notes and Loans payable (short term) 250, 516 0 40.00 0 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments 42.00 43.00 Due to other funds -37, 313, 697 0 0 0 43.00 Other current liabilities 420, 790 0 0 44.00 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 -34, 032, 751 0 45.00 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 47.00 Notes payable 0 47.00 0 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 356, 891 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 356, 891 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 -33, 675, 860 0 0 0 51.00 CAPITAL ACCOUNTS 61, 961, 086 52.00 General fund balance 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 61, 961, 086 0 59.00 0 60.00 Total liabilities and fund balances (sum of lines 51 and 28, 285, 226 0 0 0 60.00

Provider CCN: 15-1318

					10 12/31/2023	5/31/2024 10:	
		General	Fund	Special F	Purpose Fund	Endowment Fund	17 (1111
		1.00	2. 00	3.00	4.00	5. 00	
1.00	Fund balances at beginning of period	1.00	63, 678, 449		4.00	3.00	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		-1, 717, 366				2. 00
3.00	Total (sum of line 1 and line 2)		61, 961, 083		0		3. 00
4.00	WORKSHEET G AND G-1 ADJUSTMENTS	3	, ,		0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		3		0		10.00
11. 00	Subtotal (line 3 plus line 10)		61, 961, 086		0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14. 00		0			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00		0	_		0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19. 00	Fund balance at end of period per balance		61, 961, 086		0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Eridomilorre i dirid		1 4.14			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	WORKSHEET G AND G-1 ADJUSTMENTS		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9. 00 10. 00	T-+-1 -		U				9. 00 10. 00
11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)				0		10.00
12. 00	Deductions (debit adjustments) (specify)	١	0		٩		12.00
13. 00	beductions (debit adjustillents) (specify)		0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	l ol			0		19. 00
	sheet (line 11 minus line 18)	1					
				•	•	'	

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

			To 12/31/2023	Date/Time Pre 5/31/2024 10:	pared: 49 am
	Cost Center Description	I npati ent	Outpati ent	Total	.,
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	7, 575, 36	1	7, 575, 361	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)	7, 575, 36	51	7, 575, 361	
	Intensive Care Type Inpatient Hospital Services	, , , , ,		, , , , , , , , , , , , , , , , , , , ,	
11. 00	INTENSIVE CARE UNIT	754, 36	3	754, 363	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	754, 36	3	754, 363	16. 00
	11-15)			,	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 329, 72	24	8, 329, 724	17. 00
18. 00	Ancillary services	31, 129, 05		127, 696, 371	18. 00
19. 00	Outpati ent services	3, 678, 29		34, 184, 895	
20. 00	RURAL HEALTH CLINIC		0 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	12, 08	11, 815, 427	11, 827, 515	23. 00
24. 00	CMHC	,	11,010,10	,,	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	I P CONTRACTED HOSPI CE	42, 67	4 0	42, 674	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks			182, 081, 179	28. 00
	G-3, line 1)		133,331,31	,,	
	PART II - OPERATING EXPENSES	· · · · · · · · · · · · · · · · · · ·			
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41, 740, 002		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)		O		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	41, 740, 002		43.00
	to Wkst. G-3, line 4)				

	Financial Systems DUKES MEMORI ENT OF REVENUES AND EXPENSES	RIAL HOSPITAL  Provider CCN: 15-1318	Peri od:	u of Form CMS-2 Worksheet G-3	
DIAILW	LENT OF REVENUES AND EXPENSES	FIOVIDE CCN. 15-1318	From 01/01/2023	WOLKSHEET G-3	
			To 12/31/2023		
				5/31/2024 10:	49 am
		11 00		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			182, 081, 179	1.00
2.00	Less contractual allowances and discounts on patients' ac	ccounts		142, 150, 463	2.00
3.00	Net patient revenues (line 1 minus line 2)			39, 930, 716	3.00
1.00	Less total operating expenses (from Wkst. G-2, Part II, I			41, 740, 002	4.00
5. 00	Net income from service to patients (line 3 minus line 4)			-1, 809, 286	5. 00
	OTHER I NCOME			0	, 0,
5. 00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
3. 00	Revenues from telephone and other miscellaneous communication	ation services		0	8. 00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from laundry and linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15. 0
	Revenue from sale of medical and surgical supplies to oth	ner than patients		0	16. 0
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 0
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 0
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 0
21. 00	Rental of vending machines			0	21. 00
	Rental of hospital space			0	22. 0
	Governmental appropriations			0	23. 0
24. 00	OTHER I NCOME			91, 920	
	COVI D-19 PHE Fundi ng			0	24. 50
	Total other income (sum of lines 6-24)			91, 920	
	Total (line 5 plus line 25)			-1, 717, 366	
	OTHER EXPENSES (SPECIFY)			0	27. 0
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 2	28)		-1, 717, 366	29.00