llaal +b Fi nanai d	al Cuatama	DEKALB MEMORIAL HO	CDLTAL	1.5.11	eu of Form CMS-2552-10
Health Financia	<i>J</i>				· · · · · · · · · · · · · · · · · · ·
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	re to report can r	esult in all interir	n FORM APPROVED
payments made	since the beginning of the co	st reporting period being d	eemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provider CCN: 1500	045 Peri od:	Worksheet S
AND SETTLEMENT	SHMMARY			From 10/01/2014	1 Parts I-III
700 SETTELMENT	SOMMUNICI			To 09/30/2015	Date/Time Prepared:
					2/23/2016 3:12 pm
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 2/23/2	016 Time: 3:12 pm
use only	2. [] Manually submitted co	ost report			
	3. [0] If this is an amended	I report enter the number of	times the provide	er resubmitted this	cost report
	4. [F] Medicare Utilization.	Enter "F" for full or "L"	for low.		·
Contractor	5. [1]Cost Report Status	6. Date Received:		10. NPR Date:	
use only	(1) As Submitted			11. Contractor's Vend	dor Code: 4
use only	(2) Settled without Audit	8. [N] Initial Report for	this Provider CCN	12. [0] If line 5. d	column 1 is 4: Enter
	(3) Settled with Audit	9. N Final Report for th	nis Provider CCN		mes reopened = 0-9.
				ridiliber of tr	mes reopened - 0 7.
	(4) Reopened				

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEKALB MEMORIAL HOSPITAL (150045) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-81, 859	84, 215	63, 705	-96, 285	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	-81, 859	84, 215	63, 705	-96, 285	200. 00

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

пеагти	Financial Systems	DEKALB	MEMORIAL H	OSPI TAL				In Lie	u of Fo	rm CMS-2	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	TA	Provi de	r CCN: 1		Period: From 10/01 To 09/30	1/2014 0/2015	Part I Date/T	eet S-2	pared:
	1.00	2.	00	3.	00			4. 00	2/23/2	016 3:0	8 pm
	Hospital and Hospital Health Care Co										
1.00	Street: 1316 EAST 7TH STREET	PO Box:					BEWALB				1.00
2. 00	Ci ty: AUBURN	State: I Component Na		p Code: 4		Count Provi der	y: DEKALB Date	Daym.	ent Syst	tom (D	2. 00
		Component Na			umber	Type	Certi fi ed		$\overline{}$, 0, or		
						. 7 -		V	XVIII		
		1.00	2	2. 00	3. 00	4.00	5. 00	6. 00	7.00	8.00	
	Hospital and Hospital-Based Componer						I				
3.00	Hospi tal	DEKALB MEMORIAL HOSPITAL	15	50045	99915	1	07/01/196	6 N	P	0	3. 00
4.00	Subprovi der - IPF	HUSPI IAL									4. 00
5. 00	Subprovider - IRF										5. 00
6.00	Subprovider - (Other)										6. 00
7.00	Swing Beds - SNF										7. 00
8.00	Swing Beds - NF										8. 00
9.00	Hospi tal -Based SNF										9.00
10. 00 11. 00	Hospi tal -Based NF Hospi tal -Based OLTC				-						10. 00 11. 00
12. 00	Hospi tal -Based HHA	DEKALB HOME HEAL	TH 15	57157	99915		07/09/198	5 N	P	l N	12.00
12.00	nospi tai Basea iiii.	AGENCY		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,		077 077 170] "	'	"	12.00
13.00	Separately Certified ASC										13.00
	Hospi tal -Based Hospi ce	DEKALB HOSPICE	15	51559	99915		11/06/199	6			14. 00
	Hospital -Based Health Clinic - RHC										15.00
16.00	Hospital Based Health Clinic - FOHC										16. 00 17. 00
17. 00 17. 10	Hospi tal -Based (CMHC) Hospi tal -Based (CORF)										17. 00
18. 00	Renal Dialysis										18. 00
19. 00											19.00
							Fron		To		
00.00	0 1 5 1: 5 1 ((11/						1.0			00	00.00
20. 00 21. 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						10/01/	2014 2	09/30	/2015	20. 00 21. 00
21.00	Inpatient PPS Information										21.00
22. 00	Does this facility qualify and is it	currently receiv	ing paymen	ts for di	spropor	ti onate	Y		1	V	22. 00
	share hospital adjustment, in accord	lance with 42 CFR	§412. 106?	In colum	nn 1, er	nter "Y"		l			
	for yes or "N" for no. Is this facil				06(c)(2)	(Pi ckl e					
22 01	amendment hospital?) In column 2, er					+!	N	J		NI .	22. 01
22. 01	Did this hospital receive interim ur period? Enter in column 1, "Y" for y						IN			•	22.01
	reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)							J			
22. 02	Is this a newly merged hospital that						N		ľ	1	22. 02
	determined at cost report settlement or "N" for no, for the portion of th						5				
	in column 2, "Y" for yes or "N" for						,				
	or after October 1.	no, ror the porti	on or the	0031 1000	or cring p	JC1 1 GG G1		J			
22. 03	Did this hospital receive a geograph	nic reclassificati	on from ur	ban to ru	ural as	a result	t N		ı	1	22. 03
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for	no for the portion	on of the c	ost repor	rting pe	eriod	_				
	prior to October 1. Enter in column cost reporting period occurring on c						9	J			
	hospital contain at least 100 but no						n	J			
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N	l" for no.								
23.00	Which method is used to determine Me	edicaid days on li	nes 24 and					3	ı	V	23. 00
			·3 if date								
	1, enter 1 if date of admission, 2 i				rom the	e method		J			
	1, enter 1 if date of admission, 2 i method of identifying the days in the	nis cost reporting	period di			for no					
	1, enter 1 if date of admission, 2 i	nis cost reporting	period di !, enter "Y	" for yes	or "N'			Medi ca	id (ther	
	1, enter 1 if date of admission, 2 i method of identifying the days in the	nis cost reporting	period di		e Ou	for no. t-of ate	Out-of State	Medica HMO da		Other di cai d	
	1, enter 1 if date of admission, 2 i method of identifying the days in the	nis cost reporting	period di !, enter "Y In-State	" for yes In-Stat Medicai eligibl	e Ou d St e Medi	t-of ate caid N	Out-of State Medicaid		ys Me		
	1, enter 1 if date of admission, 2 i method of identifying the days in the	nis cost reporting	period di 2, enter "Y In-State Medicaid	for yes In-Stat Medicai eligibl unpaid	e Ou d St e Medi	t-of ate caid N	Out-of State Medicaid eligible		ys Me	di cai d	
	1, enter 1 if date of admission, 2 i method of identifying the days in the	nis cost reporting	period di 2, enter "Y In-State Medicaid paid days	" for yes In-Stat Medicai eligibl unpaid days	e Ou d St e Medi paid	t-of ate caid M days	Out-of State Medicaid eligible unpaid	HMO da	iys Me	di cai d days	
	1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	nis cost reporting riod? In column 2	period di 2, enter "Y In-State Medicaid paid days	" for yes In-Stat Medicai eligibl unpaid days	s or "N' e Ou d St e Medi pai d	t-of ate caid M days 6	Out-of State Medicaid eligible unpaid 4.00	HMO da	ys Me	di cai d days 6. 00	24 00
	1, enter 1 if date of admission, 2 i method of identifying the days in thused in the prior cost reporting per	nis cost reporting riod? In column 2	period di 2, enter "Y In-State Medicaid paid days	" for yes In-Stat Medicai eligibl unpaid days	e Ou d St e Medi paid	t-of ate caid M days	Out-of State Medicaid eligible unpaid	HMO da	iys Me	di cai d days 6. 00	24. 00
	1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	nis cost reporting iod? In column 2	period di 2, enter "Y In-State Medicaid paid days	" for yes In-Stat Medicai eligibl unpaid days	s or "N' e Ou d St e Medi pai d	t-of ate caid M days 6	Out-of State Medicaid eligible unpaid 4.00	HMO da	ys Me	di cai d days 6. 00	24. 00
	1, enter 1 if date of admission, 2 i method of identifying the days in thused in the prior cost reporting per lifthis provider is an IPPS hospital in-state Medicaid paid days in colout-of-state Medicaid paid days in colour-of-state Medicaid paid days in colour	nis cost reporting riod? In column 2 , enter the nn 1, in-state umn 2, column 3,	period di 2, enter "Y In-State Medicaid paid days	" for yes In-Stat Medicai eligibl unpaid days	s or "N' e Ou d St e Medi pai d	t-of ate caid M days 6	Out-of State Medicaid eligible unpaid 4.00	HMO da	ys Me	di cai d days 6. 00	24. 00
	1, enter 1 if date of admission, 2 i method of identifying the days in thused in the prior cost reporting per lifthis provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in cout-of-state Medicaid eligible unpaid cout-of-state Medicaid eligible unpaid days in cout-of-state Medicaid eligible unpaid	nis cost reporting riod? In column 2 , enter the nn 1, in-state umn 2, column 3, d days in column	period di 2, enter "Y In-State Medicaid paid days	" for yes In-Stat Medicai eligibl unpaid days	s or "N' e Ou d St e Medi pai d	t-of ate caid M days 6	Out-of State Medicaid eligible unpaid 4.00	HMO da	ys Me	di cai d days 6. 00	24. 00
	1, enter 1 if date of admission, 2 i method of identifying the days in thused in the prior cost reporting per lifthis provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in colout-of-state Medicaid paid days in colout-of-state Medicaid eligible unpaid, Medicaid HMO paid and eligible bu	nis cost reporting iod? In column 2 , enter the nn 1, in-state umn 2, column 3, d days in column at unpaid days in	period di 2, enter "Y In-State Medicaid paid days	" for yes In-Stat Medicai eligibl unpaid days	s or "N' e Ou d St e Medi pai d	t-of ate caid M days 6	Out-of State Medicaid eligible unpaid 4.00	HMO da	ys Me	di cai d days 6. 00	24. 00
24. 00	1, enter 1 if date of admission, 2 i method of identifying the days in thused in the prior cost reporting per lift this provider is an IPPS hospital in-state Medicaid paid days in colout-of-state Medicaid paid days in colout-of-state Medicaid eligible unpaid of the cout-of-state Medicaid eligible unpaid, Medicaid HMO paid and eligible bucolumn 5, and other Medicaid days in	nis cost reporting riod? In column 2 , enter the nn 1, in-state umn 2, column 3, d days in column it unpaid days in column 6.	period di nenter "Y In-State Medicaid paid days 1.00	" for yes In-Stat Medicai eligibl unpaid days 2.00	s or "N" e Ou'd Stee Medipaid 3.446	t-of ate caid days 00	Out-of State Medicaid eligible unpaid 4.00 28	HMO da	Mer	di cai d days 6. 00	
24. 00	1, enter 1 if date of admission, 2 i method of identifying the days in thused in the prior cost reporting per lifthis provider is an IPPS hospital in-state Medicaid paid days in colout-of-state Medicaid paid days in colout-of-state Medicaid eligible unpaid, Medicaid HMO paid and eligible bucolumn 5, and other Medicaid days in If this provider is an IRF, enter the	nis cost reporting iod? In column 2 , enter the nn 1, in-state umn 2, column 3, d days in column it unpaid days in column in column 6. ne in-state	period di 2, enter "Y In-State Medicaid paid days	" for yes In-Stat Medicai eligibl unpaid days 2.00	s or "N' e Ou d St e Medi pai d	t-of ate caid M days 6	Out-of State Medicaid eligible unpaid 4.00	HMO da	ys Me	di cai d days 6. 00	
24. 00	1, enter 1 if date of admission, 2 i method of identifying the days in thused in the prior cost reporting per lift this provider is an IPPS hospital in-state Medicaid paid days in colout-of-state Medicaid paid days in colout-of-state Medicaid eligible unpaid of the cout-of-state Medicaid eligible unpaid, Medicaid HMO paid and eligible bucolumn 5, and other Medicaid days in	nis cost reporting iod? In column 2 , enter the nn 1, in-state umn 2, column 3, d days in column at unpaid days in column 6. ne in-state in-state	period di nenter "Y In-State Medicaid paid days 1.00	" for yes In-Stat Medicai eligibl unpaid days 2.00	s or "N" e Ou'd Stee Medipaid 3.446	t-of ate caid days 00	Out-of State Medicaid eligible unpaid 4.00 28	HMO da	Mer	di cai d days 6. 00	
24. 00	If this provider is an IPPS hospital in-state Medicaid paid days in column 5, and other Medicaid days in column 6, and other Medicaid days in column 6, and other Medicaid days in column 7, the Medicaid paid days in column 6, and other Medicaid days in column 6, and other Medicaid days in column 6, and other Medicaid days in column 6, and days in column 1, the Medicaid eligible unpaid days in column 1.	nis cost reporting iod? In column 2 , enter the mn 1, in-state umn 2, column 3, d days in column at unpaid days in column 6. to in-state in-state umn 2, m 3, out-of-state	period di nenter "Y In-State Medicaid paid days 1.00	" for yes In-Stat Medicai eligibl unpaid days 2.00	s or "N" e Ou'd Stee Medipaid 3.446	t-of ate caid days 00	Out-of State Medicaid eligible unpaid 4.00 28	HMO da	Mer	di cai d days 6. 00	
24. 00	1, enter 1 if date of admission, 2 i method of identifying the days in thused in the prior cost reporting per lifthis provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in colut-of-state Medicaid paid days in colut-of-state Medicaid eligible unpaid, Medicaid HMO paid and eligible bucolumn 5, and other Medicaid days in If this provider is an IRF, enter the Medicaid paid days in column 1, the Medicaid eligible unpaid days in column 1.	nis cost reporting iod? In column 2 , enter the in 1, in-state umn 2, column 3, d days in column it unpaid days in column 6. The in-state in-state in-state umn 2, in 3, out-of-state umn 4, Medicaid	period di nenter "Y In-State Medicaid paid days 1.00	" for yes In-Stat Medicai eligibl unpaid days 2.00	s or "N" e Ou'd Stee Medipaid 3.446	t-of ate caid days 00	Out-of State Medicaid eligible unpaid 4.00 28	HMO da	Mer	di cai d days 6. 00	24. 00

care or general surgery. (see instructions)

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150045 Peri od: Worksheet S-2 From 10/01/2014 Part I Date/Time Prepared: 09/30/2015 2/23/2016 3:08 pm Program Name Program Code Unweighted IME Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE

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

	CATION DATA	L HOSPITAL Provi der C	CN: 150045	Peri od:		u of Form CMS- Worksheet S-:	
				From 10	0/01/2014 9/30/2015	Part I Date/Time Pro 2/23/2016 3:	epared 08 pm
					1. 00	2.00	-
All Providers					1.00	2.00	
40.00 Are there any related organization or home of chapter 10? Enter "Y" for yes or "N" for no i are claimed, enter in column 2 the home office	in column 1. If y	yes, and home of	office cost	:s	N		140. (
1.00	2. 00				3. 00		
If this facility is part of a chain organization home office and enter the home office contraction.	· ·		9	name and	address	of the	
	actor's Name:	TET GOTOT TIGINGO		tor's Nu	mber:		141.
12.00 Street: PO Box							142.
3. 00 Ci ty: State:			Zi p Coo	le:			143.
						1.00	+
4.00 Are provider based physicians' costs included	d in Worksheet A?	?				Y	144.
					1. 00	2.00	1.15
5.00 f costs for renal services are claimed on Whinpatient services only? Enter "Y" for yes or no, does the dialysis facility include Medica period? Enter "Y" for yes or "N" for no in a	r "N" for no in c are utilization f	column 1. If co	olumn 1 is		N		145.
46.00 Has the cost allocation methodology changed 1 Enter "Y" for yes or "N" for no in column 1. yes, enter the approval date (mm/dd/yyyy) in	(See CMS Pub. 15			f	N		146.
						1.00	-
17.00 Was there a change in the statistical basis?	Enter "Y" for ye	es or "N" for m	no.			N N	147.
48.00Was there a change in the order of allocation						N	148.
19.00Was there a change to the simplified cost fir	nding method? Ent					N	149.
	_	Part A 1.00	Part B 2.00		itle V 3.00	Title XIX 4.00	-
Does this facility contain a provider that qu	ualifies for an e						
or charges? Enter "Y" for yes or "N" for no	for each componer			(See 42			
55.00 Hospi tal		N N	N N		N	N	155. 156.
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N N	N N		N N	N N	157.
58. OO SUBPROVI DER			14		14		158.
59. 00 SNF		N	N		N	N	159.
60.00 HOME HEALTH AGENCY		N	N		N	N	160.
61. 00 CMHC			N		N	N	161.
61. 10 CORF			N		N	N	161.
Maria: annua						1.00	
Multicampus 65.00 s this hospital part of a Multicampus hospit	tal that has one	or more campus	ses in difi	erent CB	SAs?	N	165.
Enter "Y" for yes or "N" for no.		· ·				FTF (0	
Nan 0		County 1. 00	2. 00	3.00	4. 00	FTE/Campus 5.00	+
66.00 f ine 165 is yes, for each		1.00	2.00	3.00	4.00		0 166.
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
Live and the second sec						1.00	
				ent Act		V	1/7
Health Information Technology (HIT) incentive	36(n)? Enter "Y"	for yes or "I	N TOP NO. 167 is "Y'), enter	the	Y	167. 0168.
57.00 s this provider a meaningful user under §188 58.00 f this provider is a CAH (line 105 is "Y") a			107 13 1				
67.00 s this provider a meaningful user under §188 68.00 f this provider is a CAH (line 105 is "Y") a reasonable cost incurred for the HIT assets ((see instructions	s)			shi p		168.
67.00 Is this provider a meaningful user under §188 68.00 If this provider is a CAH (line 105 is "Y") a reasonable cost incurred for the HIT assets (68.01 If this provider is a CAH and is not a meaning exception under §413.70(a)(6)(ii)? Enter "Y"	(see instructions ngful user, does for yes or "N" f	s) this provider For no. (see in	qualify fo	or a hard s)	•	0.2	
67.00 s this provider a meaningful user under §188 68.00 f this provider is a CAH (line 105 is "Y") a reasonable cost incurred for the HIT assets (68.01 f this provider is a CAH and is not a meanin	(see instructions ngful user, does for yes or "N" f	s) this provider For no. (see in	qualify fo	or a hard s) s "N"), e	nter the		168. 5169.
67.00 s this provider a meaningful user under §18868.00 If this provider is a CAH (line 105 is "Y") a reasonable cost incurred for the HIT assets (68.01 If this provider is a CAH and is not a meanin exception under §413.70(a)(6)(ii)? Enter "Y" 69.00 If this provider is a meaningful user (line 1	(see instructions ngful user, does for yes or "N" f	s) this provider For no. (see in	qualify fo	or a hard S) S "N"), e	•	0. 2 Endi ng 2. 00	

Health Financial Systems	u of Form CMS-	2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN:	150045	From 10/01/2014		
					Date/Time Pre 2/23/2016 3:0	
					272072010 0.0	J
					1.00	1
171.00 If line 167 is "Y", does this provide	N	171. 00				
Medicare cost plans reported on Wkst	nd "N" for no.					
(see instructions)						

the other adjustments:

				Pa	rt A	Part B	
		Descr	ription	Y/N	Date	Y/N	
			0	1. 00	2. 00	3. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see			N		N	21. 00
	i nstructi ons.						
	T	/=				1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			4
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purpose					N	22. 00
23. 00	Have changes occurred in the Medicare depreci	ation expense	e due to apprais	als made durir	ng the cost	N	23. 00
	reporting period? If yes, see instructions.						
24. 00	Were new leases and/or amendments to existing	g Leases enter	ed into during	this cost repo	orting period?	N	24. 00
	If yes, see instructions						
25. 00	Have there been new capitalized leases entere	ed into during	, the cost repor	ting period? I	f yes, see	N	25. 00
	instructions.						
26. 00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during t	he cost reporti	ng period? If	yes, see	N	26. 00
	i nstructi ons.						1
27. 00	Has the provider's capitalization policy char	nged during th	ne cost reportin	g period? If y	yes, submit	N	27. 00
	copy.						
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or Letter	rs of credit e	entered into dur	ing the cost r	reporting	Υ	28. 00
	period? If yes, see instructions.						
29. 00	Did the provider have a funded depreciation a			bt Service Res	serve Fund)	N	29. 00
	treated as a funded depreciation account? If	yes, see inst	ructions				
30.00	Has existing debt been replaced prior to its	scheduled mat	curity with new	debt? If yes,	see	N	30. 00
	i nstructi ons.						
31.00	Has debt been recalled before scheduled matur	ity without i	ssuance of new	debt? If yes,	see	N	31.00
	i nstructi ons.						
	Purchased Servi ces						
32.00	Have changes or new agreements occurred in pa	atient care se	ervices furnishe	d through conf	tractual	N	32. 00
	arrangements with suppliers of services? If y	es, see instr	ructions.				
33.00	If line 32 is yes, were the requirements of 9	Sec. 2135.2 ap	plied pertainin	g to competiti	ve bidding? If		33. 00
	no, see instructions.						
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	ty under an a	rrangement with	provi der-base	ed physi ci ans?	Υ	34.00
	If yes, see instructions.						
35.00	If line 34 is yes, were there new agreements	or amended ex	disting agreemen	ts with the pr	rovi der-based	N	35. 00
	physicians during the cost reporting period?	If yes, see i	nstructions.				
					Y/N	Date	
					1. 00	2. 00	
	Home Office Costs				<u>'</u>		
36.00	Were home office costs claimed on the cost re	eport?			N		36. 00
37.00	If line 36 is yes, has a home office cost sta		repared by the	home office?			37. 00
	If yes, see instructions.						
38. 00	If line 36 is yes, was the fiscal year end of	of the home of	fice different	from that of			38. 00
	the provider? If yes, enter in column 2 the 1						
39.00	If line 36 is yes, did the provider render se						39. 00
	see instructions.			<i>y</i> ,			
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	If ves. see			40.00
	instructions.			,			
			1	00	2	00	1
	Cost Report Preparer Contact Information				2.		
41. 00		/nosition	MI CHAEL		ALESSANDRI NI		41. 00
41.00	held by the cost report preparer in columns		INIT CHALL		ALLOSANDININI		41.00
	respectively.	i, Z, allu J,					
42. 00	Enter the employer/company name of the cost i	renort	BLUE AND CO.,	II C			42. 00
42.00	preparer.	cpoi t	DEUL AND CO.,	LLU			J 42.00
43. 00	Enter the telephone number and email address	of the cost	317-713-7959		MALESSANDRI NI @	RITIEANDOO COM	43. 00
45.00	report preparer in columns 1 and 2, respective		517-713-7757		WALLOCANDRINI®	DEULANDOU. CUM	J 45.00
	Troport proparer in corumns rand 2, respectiv	, c., y.	I		1		II

From 10/01/2014 To 09/30/2015 Part II Date/Time Prepared: 2/23/2016 3:08 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 12/08/2015 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position SENIOR MANAGER 41.00 held by the cost report preparer in columns 1, 2, and 3,

42.00

43.00

respecti vel y.

preparer.

42.00

43.00

Enter the employer/company name of the cost report

report preparer in columns 1 and 2, respectively.

Enter the telephone number and email address of the cost

Heal th FinancialSystemsDEKALBHOSPITALANDHOSPITALHEALTH CARE COMPLEXSTATISTICALDATA Provi der CCN: 150045

					1	o 09/30/2015		
							2/23/2016 3:00 I/P Days / 0/P	o piii
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	IVO.	or beds	Avai I abl e	CAIT HOURS	II LIE V	
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		29			0.00	1. 00
00	8 exclude Swing Bed, Observation Bed and	00.00		- 7	.0,000	0.00		
	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			29	10, 585	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		8	2, 920	0.00	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)			37	13, 505	0.00	l e	14.00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	116. 00		0	C)		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
25. 10	CMHC - CORF	99. 10					0	
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER			0.7				26. 25
27. 00	Total (sum of lines 14-26)			37				27. 00
28. 00	Observation Bed Days						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	C	Y .		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33. 00
55.00	Lion non covered days				I	1	I	J J J J J J J J J J J J J J J J J J J

Provider CCN: 150045

				'	0 097 307 2013	2/23/2016 3:0	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	•			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 715	316	4, 959			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	1 557	1 255				2 00
2.00	HMO and other (see instructions) HMO IPF Subprovider	1, 557	1, 255 0				2. 00 3. 00
3. 00 4. 00	HMO IRF Subprovider		0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	o o	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 715	316	١			7. 00
7.00	beds) (see instructions)	1,713	310	4, 757			7.00
8.00	INTENSIVE CARE UNIT	557	0	1, 461			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	950			13.00
14.00	Total (see instructions)	2, 272	316	7, 370	0.00	456. 56	14. 00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	2 002	0	, ,1,1	0.00	14.04	21. 00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	2, 982	U	6, 614	0.00	14. 86	22. 00 23. 00
24. 00	HOSPICE	3, 677	0	3, 708	0.00	1. 71	
24. 10	HOSPICE (non-distinct part)	3,077	0		0.00	1.71	24. 10
25. 00	CMHC - CMHC	Ĭ	Ü				25. 00
25. 10	CMHC - CORF	o	0	0	0.00	0.00	1
26. 00	RURAL HEALTH CLINIC	_	_	Ī			26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	473. 13	27. 00
28. 00	Observation Bed Days		46	926			28. 00
29. 00	Ambul ance Tri ps	1, 340					29. 00
30.00	Employee discount days (see instruction)			94			30. 00
31.00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	72				32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)	_					
33. 00	LTCH non-covered days	0					33. 00

 Heal th Financial
 Systems
 DEKALB

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 150045

				To	09/30/2015	Date/Time Prep 2/23/2016 3:08	
		Full Time		Di sch	arges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	TI LIE V	TITLE XVIII	II ti e xi x	Patients	
		11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		C		79	2, 379	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)			447	340		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	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00			70	0.070	13.00
14.00	Total (see instructions)	0. 00	C	693	79	2, 379	14.00
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18. 00 19. 00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPICE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days	3.00					28. 00
29. 00	Ambulance Trips					ļ	29. 00
30. 00	Employee discount days (see instruction)					ļ	30. 00
31. 00	Employee discount days - IRF					İ	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						33. 00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 10/01/2014 Part II
To 09/30/2015 Date/Time Prepared: 2/23/2016 3:08 pm Provi der CCN: 150045

						09/30/2015	2/23/2016 3:0	
		Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
		Line Number	Reported	on of Salaries (from	Salaries (col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				Worksheet A-6)	3)	col. 4	COI . 5)	
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							1
1. 00	SALARIES Total salaries (see	200. 00	26, 860, 597	1	26, 860, 597	993, 600. 00	27. 03	1.00
1.00	instructions)	200.00	20, 000, 377		20, 000, 377	773, 000. 00	27.03	1.00
2.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
2 00	A		0			0.00	0.00	2 00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4.00	Physician-Part A -		292, 451	0	292, 451	1, 902. 00	153. 76	4. 00
	Admi ni strati ve							
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0	_	0	0. 00 0. 00		
6.00	Non-physician-Part B		0	0	0	0.00		
7. 00	Interns & residents (in an	21. 00	0	Ö	Ö	0.00	l	
	approved program)							
7. 01	Contracted interns and		0	0	0	0.00	0. 00	7. 01
	residents (in an approved programs)							
8.00	Home office personnel		0	0	0	0.00	0.00	8. 00
9.00	SNF	44. 00	0	0	0	0.00	l .	
10. 00	Excluded area salaries (see instructions)		9, 044, 650	-5, 975	9, 038, 675	282, 574. 00	31. 99	10.00
	OTHER WAGES & RELATED COSTS							1
11. 00	Contract Labor: Direct Patient		977, 091	0	977, 091	16, 972. 00	57. 57	11. 00
40.00	Care					0.00		10.00
12. 00	Contract labor: Top level management and other		0	0	0	0. 00	0.00	12. 00
	management and administrative							
	services							
13. 00	Contract Labor: Physician-Part A - Administrative		118, 875	0	118, 875	1, 096. 00	108. 46	13. 00
14. 00	Home office salaries &		0	0	0	0.00	0.00	14. 00
	wage-related costs							
15. 00	Home office: Physician Part A		0	0	0	0. 00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16. 00
10.00	Physicians Part A - Teaching		O		o o	0.00	0.00	10.00
	WAGE-RELATED COSTS			1			1	
17. 00	Wage-related costs (core) (see instructions)		5, 409, 368	0	5, 409, 368			17. 00
18. 00	Wage-related costs (other)		0	0	О			18. 00
	(see instructions)							
19.00	Excluded areas		2, 228, 272	0	2, 228, 272			19.00
20. 00	Non-physician anesthetist Part		Ü	0	U			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
	В			_				
22. 00	Physician Part A - Administrative		23, 198	0	23, 198			22. 00
22. 01	Physician Part A - Teaching		0	О	0			22. 01
23. 00	Physician Part B		0	_	0			23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	l .				24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
	OVERHEAD COSTS - DIRECT SALARIE	S						1
26. 00	Employee Benefits Department	4. 00	179, 355		·	5, 328. 00		
27. 00	Administrative & General Administrative & General under	5. 00	3, 538, 246			137, 456. 00		
28. 00	contract (see inst.)		398, 597	0	398, 597	1, 665. 00	239. 40	28. 00
29. 00	Maintenance & Repairs	6. 00	0	0	О	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	642, 510	l .		23, 448. 00	l .	1
31.00	Laundry & Linen Service	8. 00	28, 366	l .		2, 124. 00	l e	1
32. 00 33. 00	Housekeeping under contract	9. 00	602, 315	-418 0	601, 897	48, 430. 00 0. 00	i e	1
33.00	(see instructions)		O		Ĭ	0.00	0.00	33.00
34.00	Di etary	10. 00	564, 711	-335, 032	229, 679	12, 405. 00		
35. 00	Di etary under contract (see		1, 073	0	1, 073	20. 00	53. 65	35. 00
36. 00	instructions) Cafeteria	11. 00	0	334, 640	334, 640	22, 754. 00	14. 71	36. 00
37. 00	Maintenance of Personnel	12. 00	0		0	0.00		
38. 00	Nursing Administration	13. 00	726, 989			20, 051. 00		
39.00	Central Services and Supply	14. 00 15. 00	90, 825			6, 800. 00	l	
40. 00	Pharmacy	15. 00	442, 114	-307	441, 807	11, 137. 00	J 39. 67	40. 00

Health Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 10/01/2014		
					To 09/30/2015		
						2/23/2016 3:0	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	495, 842	-344	495, 49	8 28, 040. 00	17. 67	41.00
Records Library							
42.00 Social Service	17. 00	66, 630	-46	66, 58	4 1, 908. 00	34. 90	42.00
43.00 Other General Service	18. 00	0) 0		0.00	0.00	43. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150045

							2/23/2010 3.0) PIII
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		27, 260, 267	0	27, 260, 267	995, 285. 00	27. 39	1.00
	instructions)							
2.00	Excluded area salaries (see		9, 044, 650	-5, 975	9, 038, 675	282, 574. 00	31. 99	2.00
	instructions)							
3.00	Subtotal salaries (line 1		18, 215, 617	5, 975	18, 221, 592	712, 711. 00	25. 57	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 095, 966	0	1, 095, 966	18, 068. 00	60. 66	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		5, 432, 566	0	5, 432, 566	0.00	29. 81	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		24, 744, 149	5, 975	24, 750, 124	730, 779. 00	33. 87	6. 00
7.00	Total overhead cost (see		7, 777, 573	13, 215	7, 790, 788	321, 566. 00	24. 23	7.00
	instructions)							

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150045	Peri od: Worksheet S-3
		From 10/01/2014 Part IV

	To 09/30/2015	Date/Time Prep 2/23/2016 3:08	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	528, 613	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		l
5.00	401K/TSA Plan Administration fees	4, 387	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)	4, 837, 012	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	47, 865	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)	57, 496	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	287, 103	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		1
	TAXES		
	FICA-Employers Portion Only	1, 824, 597	
	Medicare Taxes - Employers Portion Only	0	
	Unemployment Insurance	22, 403	1
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))	_	
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	51, 362	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	7, 660, 838	24. 00
05.00	Part B - Other than Core Related Cost	40.700	05.00
25.00	UNI FORMS	13, 708	₁ 25.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150045	From 10/01/2014	Worksheet S-3 Part V Date/Time Prep 2/23/2016 3:08	pared:
Cost Center Description		Contract Labor 1.00		
DART V Contract Labor and Ronofit Cost				

			2/23/2016 3:0	3 pm
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF			8.00
9.00	Hospi tal -Based NF			9.00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
17. 00	Renal Dialysis			17.00
18. 00	Other	0	0	18.00

Heal th	Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	HEALTH AGENCY STATISTICAL DATA			CCN: 150045	Period: From 10/01/2014		
			Componen	t CCN: 157157	To 09/30/2015	2/23/2016 3:0	
					Home Health Agency I	PPS	
					1.	00	-
0. 00	County						0. 00
		Title V	Title XVIII	Title XIX	0ther	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3.00	4. 00	5. 00	
1.00	Home Heal th Ai de Hours	0	C		0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0. 00	168.00				2. 00
				Number of Em	ployees (Full Ti	me Equivarent)	
		Enter the numb	on of bound in	Staff	Contract	Total	
			ler of hours in I work week	Starr	Contract	Total	
		, , , , , , , , , , , , , , , , , , , ,					
		(0	1.00	2. 00	3. 00	
2 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		40.00	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	20 00	0.00	2 00
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. (•	1
5. 00	Other Administrative Personnel			5. (0.00	5. 01	1
6.00	Direct Nursing Service			3. 3			1
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.0			1
9. 00	Physical Therapy Supervisor			0. (1	1
10.00	Occupational Therapy Service			0.0		1	1
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. (•	1
13. 00	Speech Pathology Supervisor			0. (
14.00	Medical Social Service			0. !			1
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.0			1
17. 00	Home Health Aide Supervisor			0. (1	
18. 00	Other (specify)			0.0	0.00	0.00	18. 00
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2	I	19. 00
17.00	you provided services during the cost						17.00
20.00	reporting period.			00015			20.00
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			99915			20. 00
	contains the first code).						
20. 01		Full E	oi sodes	50031			20. 01
			With Outliers	LUPA Epi sode	s PEP Only	Total (cols.	
		Outliers	2.00	2.00	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	1, 503		1	47 52	1	
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	281, 175 612		. 1	02 9, 717 5 16	1	1
24. 00	Physical Therapy Visits Physical Therapy Visit Charges	113, 345		1	28 2, 968		1
25. 00	Occupational Therapy Visits	17	1		0 0	18	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges	3, 171	188	1	0 0		1
28. 00	Speech Pathology Visits Speech Pathology Visit Charges	3, 610		1	0 0	1	1
29. 00	Medical Social Service Visits	47	2		0 3	52	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	13, 379 439		1	0 855 2 34	1	1
32.00	Home Health Aide Visit Charges	48, 698			23 3, 783	1	1
33. 00	Total visits (sum of lines 21, 23, 25, 27,	2, 637			54 105	•	1
24 00	29, and 31)	0	,				24 00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	463, 378	30, 480	1	0		1
	30, 32, and 34)						
36. 00	Total Number of Episodes (standard/non outlier)	186		:	22 7	215	36. 00
37. 00	Total Number of Outlier Episodes		5	5	C		
38. 00	Total Non-Routine Medical Supply Charges	15, 059	2, 178	3	30 91	17, 358	38. 00

Health Financial Systems		DEKALB MEMORI	AL HOS	PITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL IDENTIFICATION DATA			F	Provi der	CCN: 150045	Peri od:	Worksheet S-9	
						From 10/01/2014	Parts I & II	
			C	Component	CCN: 151559	To 09/30/2015	Date/Time Pre	pared:
				•			2/23/2016 3:0	8 pm
						Hospi ce I		
	Unduplicated							
	Days							
	Title XVIII	Title XIX	Titl∈	e XVIII	Title XIX	All Other	Total (sum of	
			Ski	LLed	Nursi na		cols 1 2 &	

		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility	j		·	
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	3, 629	0	856	0	0	3, 629	2.00
3.00	Inpatient Respite Care	10	0	0	0	0	10	3.00
4.00	General Inpatient Care	37	0	0	0	0	37	4.00
5.00	Total Hospice Days	3, 676	0	856	0	0	3, 676	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	0	0	0	0	0	0	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0.00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	0.00	0.00	0.00	0. 00	0.00	0. 00	8.00
	5/line 6)							
9.00	Unduplicated Census Count	85	0	0	0	0	85	9. 00

HOSPIT	Financial Systems DEKALB MEMORIAL HOSI			u of Form CMS-2	
1100111	TAL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 150045	Peri od:	Worksheet S-10	0
			From 10/01/2014 To 09/30/2015	Date/Time Pre 2/23/2016 3:0	
				1. 00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ed by line 202 colum	n 8)	0. 307008	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2, 892, 209	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3. 00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		d?		4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from M	edi cai d		0	
6.00	Medi cai d charges			11, 642, 179	
7.00	Medicaid cost (line 1 times line 6)			3, 574, 242	1
8. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ne 7 minus sum of li	nes 2 and 5; if	682, 033	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for each line)			
9.00	Net revenue from stand-alone SCHIP			0	9. 00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11. 00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 minus line 9;	if < zero then	0	12.00
	enter zero)				
	Other state or local government indigent care program (see instru		<u>, </u>		
13. 00	Net revenue from state or local indigent care program (Not includ	· · · · · · · · · · · · · · · · · · ·	,	0	
14. 00	Charges for patients covered under state or local indigent care p	rogram (Not included	lin lines 6 or	0	14. 00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15. 00
16.00	Difference between net revenue and costs for state or local indig	ent care program (Li	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)				
	Uncompensated care (see instructions for each line)				
17. 00		3		0	
	Government grants, appropriations or transfers for support of hos			0	
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and local 8, 12 and 16)	indigent care progra	ams (sum of lines	682, 033	19. 00
	, -,	Uni nsured		Total (col. 1	
		patients	pati ents	+ col . 2)	
00.00		1.00	2. 00	3.00	00.00
20. 00	Total initial obligation of patients approved for charity care (a		563 0	1, 149, 563	20. 00
	charges excluding non-reimbursable cost centers) for the entire f Cost of initial obligation of patients approved for charity care		925 0	352, 925	
21 00	cost of fill trai obiligation of patients approved for charity care	(11116 1 352,	923		1 21 00
21. 00	times line 20)				21. 00
	times line 20) Partial nayment by patients approved for charity care				
22. 00	Partial payment by patients approved for charity care	352	0 0	0	22. 00
	Partial payment by patients approved for charity care	352, 9	-	0 352, 925	22. 00
22. 00 23. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)		925 0	0 352, 925 1. 00	22. 00 23. 00
22. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d	ays beyond a Length	925 0	0 352, 925	22. 00
22. 00 23. 00 24. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr	ays beyond a length ogram?	of stay limit	0 352, 925 1. 00	22. 00 23. 00 24. 00
22. 00 23. 00 24. 00 25. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent	ays beyond a length ogram? care program's leng	of stay limit	0 352, 925 1. 00 N	22. 00 23. 00 24. 00 25. 00
22. 00 23. 00 24. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instr	ays beyond a length ogram? care program's leng uctions)	of stay limit	0 352, 925 1. 00 N 0 5, 403, 094	22. 00 23. 00 24. 00 25. 00 26. 00
22. 00 23. 00 24. 00 25. 00 26. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instructi	ays beyond a length ogram? care program's lenq uctions) ons)	of stay limit	0 352, 925 1. 00 N	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instr	ays beyond a length ogram? care program's lenguctions) ons) 26 minus line 27)	of stay limit of stay limit	0 352, 925 1. 00 N 0 5, 403, 094 132, 914	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22) Does the amount in line 20 column 2 include charges for patient d imposed on patients covered by Medicaid or other indigent care pr If line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instructi Medicare bad debts for the entire hospital complex (see instructi Non-Medicare and non-reimbursable Medicare bad debt expense (line	ays beyond a length ogram? care program's lenguctions) ons) 26 minus line 27)	of stay limit of stay limit	0 352, 925 1. 00 N 0 5, 403, 094 132, 914 5, 270, 180	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00

Heal th	Financial Systems	DEKALB MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 10/01/2014 To 09/30/2015	Data/Timo Dro	narod:
					To 09/30/2015	Date/Time Pre 2/23/2016 3:0	
	Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati	Reclassi fi ed	, p
	'			+ col . 2)	ons (See A-6)	Trial Balance	
				ĺ	` ′	(col. 3 +-	
						col . 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		4, 805, 256	1		4, 805, 256	
1. 01	00101 MAC WEST - NEW		24, 478				
1. 02	00102 NORTH ANNEX - NEW		4, 274	1		4, 274	
1. 03	00103 GARRETT CLINIC - NEW		16, 587				
1.04	00104 BUTLER - NEW		11, 914			11, 914	
1.05	00105 MAC EAST - NEW		151, 548				
1.06	00106 GARRETT LAB - NEW		54.003	1	0	0	
1.07	00107 MEDI CAL ARTS - NEW		54, 937	54, 93	0	54, 937	1. 07
1.08	00108 DAY SPRING - NEW		0		0	0	1. 08
2.00	OO2OO CAP REL COSTS-MVBLE EQUIP OO3OO OTHER CAP REL COSTS		0		0	0	2. 00 3. 00
3. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	179, 355	1, 574, 481	1, 753, 83	6 -124	1, 753, 712	1
5. 00	00500 ADMINISTRATIVE & GENERAL	3, 538, 246	5, 856, 302	l .			1
7. 00	00700 OPERATION OF PLANT	642, 510	1, 421, 283		-		
8. 00	00800 LAUNDRY & LINEN SERVICE	28, 366	50, 526				1
9. 00	00900 HOUSEKEEPING	602, 315	392, 930			994, 827	
10. 00	01000 DI ETARY	537, 459	533, 520			397, 317	1
10. 00	01001 SNACK BAR	27, 252	36, 921				
	01100 CAFETERI A	27, 232	30, 721	1	0 673, 289	'	1
13. 00	01300 NURSING ADMINISTRATION	726, 989	223, 246	1			1
14. 00	01400 CENTRAL SERVICES & SUPPLY	90, 825	164, 206	1			
15. 00	01500 PHARMACY	442, 114	104, 200				
16. 00	01600 MEDICAL RECORDS & LIBRARY	495, 842	160, 351				1
	01700 SOCI AL SERVI CE	66, 630	11, 452	1			1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	00,030	11, 432	. 70,00	2 40	70,030	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 547, 625	877, 732	3, 425, 35	7 -879, 377	2, 545, 980	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	930, 845	444, 376				
43. 00	04300 NURSERY	0	1, 251	1			
	ANCILLARY SERVICE COST CENTERS	<u>'</u>	·			<u> </u>	1
50.00	05000 OPERATING ROOM	1, 657, 949	1, 739, 968	3, 397, 91	7 -1, 150	3, 396, 767	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 561, 100	561, 100	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 590, 966	1, 430, 706			2, 988, 648	54. 00
60.00	06000 LABORATORY	1, 325, 035	1, 888, 105	3, 213, 14	0 -919	3, 212, 221	60.00
60. 01	06001 BLOOD LABORATORY	0	0)	0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	463, 594	150, 011	1		613, 283	1
66. 00	06600 PHYSI CAL THERAPY	342, 558	837, 212	1			1
66. 01	06601 CARDI AC REHAB	97, 295	22, 421	1			1
69. 00	06900 ELECTROCARDI OLOGY	70, 852	5, 687				
70.00	07000 ELECTROENCEPHALOGRAPHY	46, 109	26, 846	1		'	
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PAT	0	1, 706, 314			1, 706, 314	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	999, 275				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	l U	2, 270, 191	2, 270, 19	1 0	2, 270, 191	/3.00
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	62, 314	9, 347	71, 66	1 -43	71, 618	90.00
	09100 EMERGENCY	1, 302, 902	473, 836				
	09200 OBSERVATION BEDS (NON-DISTINCT	1, 302, 702	473,030	1, 770, 73	- 704	1, 773, 034	92.00
72.00	OTHER REI MBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVI CES	1, 122, 923	310, 175	1, 433, 09	8 -779	1, 432, 319	95. 00
	09910 CORF	0	0.0, ., 0	1	0 0		99. 10
101.00	10100 HOME HEALTH AGENCY	723, 434	372, 925			1, 106, 066	
	SPECIAL PURPOSE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,	,	,	
113.00	11300 I NTEREST EXPENSE		0		0 0	0	113. 00
116.00	11600 HOSPI CE	134, 331	223, 864	358, 19	5 1, 012	359, 207	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	19, 796, 635	29, 284, 454	49, 081, 08	9 4, 601	49, 085, 690	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0)	0		190. 00
	19100 RESEARCH	0	0	1	0		191. 00
	19200 PHYSICIANS PRIVATE OFFICES	37, 711	41, 631				192. 00
	19201 DEKALB MEDI CAL SERVI CES	6, 621, 681	2, 902, 096				
	19202 PHARMACARE	404, 570	3, 576, 349	1		3, 980, 919	
	19300 NONPAI D WORKERS	0	0	1	0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0	2	0		194. 00
	07951 ADULT DAY CARE	0	0	'l	0		194. 01
	07952 FOUNDATION	0 00 50	396	1			194. 02
200.00	TOTAL (SUM OF LINES 118-199)	26, 860, 597	35, 804, 926	62, 665, 52	3 0	62, 665, 523	1200.00

Provider CCN: 150045

| Period: | Worksheet A | From 10/01/2014 | To 09/30/2015 | Date/Time Prepared: 2/23/2016 3:08 pm

				2/23/2016 3: 08	B pm
	Cost Center Description	Adjustments	Net Expenses		
	· ·	(See A-8)	For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	-339, 481	4, 465, 775	1	1. 00
1. 01	00101 MAC WEST - NEW	0	24, 478		1. 01
1.02	00102 NORTH ANNEX - NEW	0	4, 274	1	1. 02
1.03	00103 GARRETT CLINIC - NEW	0	16, 587	7	1. 03
1.04	00104 BUTLER - NEW	0	11, 914	1	1. 04
1.05	00105 MAC EAST - NEW	0	151, 548	3	1. 05
1.06	00106 GARRETT LAB - NEW	0	0		1. 06
1.07	00107 MEDICAL ARTS - NEW	0	54, 937	7	1. 07
1.08	00108 DAY SPRING - NEW	0	0		1. 08
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-674, 261	1, 079, 451		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 712, 668	7, 686, 445	5	5.00
7.00	00700 OPERATION OF PLANT	-9, 725	2, 053, 622		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-1, 736	77, 136		8.00
9.00	00900 HOUSEKEEPI NG	-2, 131	992, 696		9.00
10.00	01000 DI ETARY	-7, 102	390, 215		10.00
10. 01	01001 SNACK BAR	-58, 426	5, 728	3	10. 01
11. 00	1	-244, 362	428, 927		11.00
13.00	1	0	949, 731		13.00
14. 00		0	254, 968		14.00
15. 00	1	0	441, 807		15. 00
16. 00	1	-1, 275	654, 574		16. 00
17. 00		0	78, 036	1	17. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		70,000		17.00
30. 00		-155, 650	2, 390, 330		30. 00
31. 00		-61, 400		1	31. 00
43. 00		01,100			43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		017,701		10.00
50. 00		-788, 825	2, 607, 942		50. 00
52. 00		0		1	52. 00
54. 00		-38, 220			54. 00
60. 00		-1, 800		1	60. 00
60. 01		0	0,210,121		60. 01
65. 00		0	613, 283		65. 00
66. 00		-12, 038	1, 119, 019		66. 00
66. 01		-15, 662	152, 462		66. 01
69. 00		-4, 380	104, 031		69. 00
70. 00		-4, 380	72, 923		70. 00
71.00		0	1, 706, 314	l e e e e e e e e e e e e e e e e e e e	71.00
71.00		0	999, 275	l l	71.00
	07300 DRUGS CHARGED TO PATIENTS	-3, 191	2, 267, 000	l l	73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	-3, 191	2, 267, 000)	73.00
90. 00		0	71, 618		90. 00
91.00	1	-140, 151	1, 635, 683		91.00
92. 00	1	-140, 131	1,035,065		92.00
92.00	OTHER REIMBURSABLE COST CENTERS				92.00
05 00	09500 AMBULANCE SERVICES	-51, 515	1, 380, 804	1	95. 00
	09910 CORF	-51,515	1, 360, 604	† 	99. 10
	0 10100 HOME HEALTH AGENCY	-48, 395	1, 057, 671		101. 00
101.0	SPECIAL PURPOSE COST CENTERS	-40, 393	1,037,671		101.00
112 0	0 11300 I NTEREST EXPENSE	1 0			112 00
		214	350,001		113.00
118.0	O 11600 HOSPICE O SUBTOTALS (SUM OF LINES 1-117)	-216			116.00
118.0		-4, 372, 610	44, 713, 080)	118. 00
100 0	NONREI MBURSABLE COST CENTERS	1 0			100 00
	0 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
	0 19100 RESEARCH	0	70 01/		191. 00
	0 19200 PHYSI CI ANS PRI VATE OFFI CES	0	79, 316		192.00
	1 19201 DEKALB MEDI CAL SERVI CES	0	9, 519, 202		192. 01
	2 19202 PHARMACARE	-3, 210	3, 977, 709		192. 02
	0 19300 NONPALD WORKERS	0	0		193. 00
	0 07950 OTHER NONREIMBURSABLE COST CENT	0	0	1	194. 00
	1 07951 ADULT DAY CARE	0	0	1	194. 01
	2 07952 FOUNDATION	0	396		194. 02
200.0	O TOTAL (SUM OF LINES 118-199)	-4, 375, 820	58, 289, 703]	200. 00

| Peri od: | Worksheet A-6 | From 10/01/2014 | To 09/30/2015 | Date/Time Prepared:

					10 09/30/2015 Date	e/IIme Prepared: 3/2016 3:08 pm
		Increases			2,2	57 20 10 01 00 piii
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3.00	4.00	5. 00		
	A - CAFETERIA RECLASS					
1.00	CAFETERI A	11. 00	334, 640	338, 649		1. 00
	0		334, 640	338, 649		
	C - LABOR DELIVERY NURSERY					
1.00	NURSERY	43.00	209, 778	106, 732		1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	37 <u>1, 8</u> 88	18 <u>9, 2</u> 12		2. 00
	0		581, 666	295, 944		
	D - NORTH ANNEX RECLASS					
1.00	HOME HEALTH AGENCY	101.00	0	10, 209		1. 00
2.00	HOSPICE	116.00		<u>1, 1</u> 05		2. 00
	0		0	11, 314		
	E - REHABILITATION OFFICE REC					
1.00	CARDI AC REHAB	66.01	44, 625	3,850		1. 00
	0		44, 625	3, 850		
4 00	F - RADI OLOGY ADMI N RECLASS	(0.00	40.000	40.500		4.00
1. 00	ELECTROCARDI OLOGY	69.00	13, 332	1 <u>8, 5</u> 89		1. 00
	O DONIES ACCOUNT DECLASS		13, 332	18, 589		
1. 00	G - BONUS ACCRUAL RECLASS ADMINISTRATIVE & GENERAL	5.00	15, 879	0		1.00
2.00	ADMINISTRATIVE & GENERAL	0.00	15, 679	0		1. 00 2. 00
3.00		0.00	0	0		3.00
4. 00		0.00	0	0		4.00
5. 00		0.00	o	0		5. 00
6.00		0.00	o	0		6. 00
7. 00		0.00	ő	0		7. 00
8. 00		0.00	ő	0		8. 00
9. 00		0.00	o	0		9.00
10. 00		0.00	o	0		10.00
11. 00		0.00	o	0		11. 00
12. 00		0.00	Ö	Ö		12.00
13. 00		0.00	O	0		13. 00
14.00		0.00	o	О		14. 00
15. 00		0.00	o	О		15. 00
16.00		0.00	O	0		16. 00
17.00		0.00	o	О		17. 00
18.00		0.00	0	О		18. 00
19. 00		0.00	0	О		19. 00
20.00		0.00	0	О		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00	<u> </u>	0.00		0		28. 00
E00.00	U		15, 879	0		500.00
500.00	Grand Total: Increases	ı l	990, 142	668, 346		500.00

| Peri od: | Worksheet A-6 | From 10/01/2014 | To 09/30/2015 | Date/Time Prepared: Provider CCN: 150045

COST Center						10		e Prepared: 6 3:08 pm
1.00 A - CAFETRIA R RECLASS 1.00 0.0			Decreases		'		12, 20, 20.	<u> </u>
A - CAFETERIA RECLASS 10.00 334,640 338,649 0 1.00		Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
1.00		6. 00	7. 00	8. 00	9. 00	10. 00		
1.00 C LABOR DELIVERY NURSERY		A - CAFETERIA RECLASS						
C - LABOR DELIVERY NURSERY	1.00	DI ETARY	10. 00	334, 640	33 <u>8, 6</u> 49	0		1. 00
1.00		0		334, 640	338, 649			
2.00		C - LABOR DELIVERY NURSERY						
D		ADULTS & PEDIATRICS		581, 666	295, 944	0		
1.00	2.00		000	0	0			2. 00
1.00		0		581, 666	295, 944			
2.00								
The color of the		ADMINISTRATIVE & GENERAL	•			1		
1. 00 PHYSICAL THERAPY	2. 00		0.00		:			2. 00
1.00		0		0	11, 314			
The color						1		
1.00 RADI OLOGY ADMIN RECLASS 13, 332 18, 589 0 0 0 0 0 0 0 0 0	1.00	PHYSICAL THERAPY	66.00					1.00
1.00		0		44, 625	3, 850			
13,332			5 4 aal	40.000	10 500			
G - BONUS ACCRUAL RECLASS EMPLOYEE BENEFITS DEPARTIMENT	1.00	RADI OLOGY - DI AGNOSTI C	54.00					1.00
1. 00		O BONIUS ASSERLATE DESILACE		13, 332	18, 589			
2. 00 OPERATION OF PLANT 7. 00 446 0 0 0 3. 00 3. 00 LAUNDRY & LI NEN SERVI CE 8. 00 20 0 0 0 4. 00 HOUSEKEEPING 9. 00 418 0 0 0 5. 00 DI ETARY 10. 00 373 0 0 0 6. 00 SNACK BAR 10. 01 19 0 0 0 7. 00 NURSI NG ADMINISTRATI ON 13. 00 504 0 0 0 8. 00 CENTRAL SERVI CES & SUPPLY 14. 00 63 0 0 0 9. 00 PHARMACY 15. 00 307 0 0 10. 00 MEDI CAL RECORDS & LI BRARY 16. 00 344 0 0 0 11. 00 SOCI AL SERVI CE 17. 00 46 0 0 12. 00 ADULTS & PEDI ATRI CS 30. 00 1, 767 0 13. 00 INTENSI VE CARE UNIT 31. 00 646 0 0 14. 00 OPERATING ROOM 50. 00 1, 150 0 15. 00 RADIO LOGY-JO LAGNOSTI C 54. 00 1, 103 0 15. 00 RADIO LOGY-JO LAGNOSTI C 54. 00 1, 103 0 16. 00 LABORATORY 66. 00 322 0 0 17. 00 RESPIRATORY THERAPY 66. 00 238 0 0 19. 00 CARDI AC REHAB 66. 01 67 0 0 22. 00 CLEUTROCARDIOLOGY 69. 00 49 0 23. 00 ELECTROCARDIOLOGY 69. 00 49 0 24. 00 ABBULANCE SERVI CES 95. 00 779 0 0 25. 00 CLEUTROCARDIOLOGY 91. 00 90. 40 0 25. 00 DEKALRADORY 16. 00 97. 90 0 26. 00 OPERATI NA ABBULANCE SERVI CES 95. 00 779 0 0 26. 00 DEKALRADORY 16. 00 97. 90 0 27. 00 PHYSI CI AL THERAPY 16. 00 90. 40 0 28. 00 DEKALRADORY 16. 00 97. 90 0 29. 00 CLEOTROCARDIOLOGY 91. 00 90. 40 0 20. 00 CLEO	4 00		4 00	404				4.00
3. 00 LAUNDRY & LI NEN SERVI CE						1		
4. 00 HOUSEKEEPING 9, 00 418 0 0 0 4.00 5. 00 DI ETARY 10.00 373 0 0 5.00 6. 00 SNACK BAR 10.01 19 0 0 6.00 7. 00 NURSING ADMINISTRATION 13. 00 504 0 0 7. 00 8. 00 CENTRAL SERVICES & SUPPLY 14. 00 63 0 0 9.00 10. 00 MEDI CAL RECORDS & LI BRARY 16. 00 307 0 0 9.00 11. 00 MEDI CAL RECORDS & LI BRARY 16. 00 344 0 0 0 10. 00 11. 00 SOCI AL SERVICE 17. 00 46 0 0 11. 00 11. 00 SOCI AL SERVICE 30. 00 1, 767 0 0 12. 00 13. 00 INTENSIVE CARE UNIT 31. 00 646 0 0 13. 00 15. 00 RADIOLOGY-DI AGNOSTI C 54. 00 1, 150 0 0 15. 00 RADIOLOGY-DI AGNOSTI C 54. 00 1, 103 0 0 15. 00 16. 00 LABORATORY 60. 00 919 0 0 16. 00 17. 00 RESPIRATORY THERAPY 66. 00 928 0 0 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 232 0 0 17. 00 19. 00 CARDIA C REHAB 66. 01 67 0 0 18. 00 19. 00 CARDIA C REHAB 66. 01 67 0 0 20. 00 21. 00 ELECTROCARDIOLOGY 69. 00 49 0 0 20. 00 21. 00 ELECTROCARDIOLOGY 69. 00 49 0 0 22. 00 21. 00 ELECTROCARDIOLOGY 91. 00 99. 00 22. 00 22. 00 CLI NI C 90. 00 43 0 0 22. 00 23. 00 EMERGENCY 91. 00 99. 00 0 23. 00 24. 00 AMBULANCE SERVICES 95. 00 779 0 0 22. 00 25. 00 HOME HEALTH AGENCY 101. 00 93 0 0 0 22. 00 27. 00 PHYSI CAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDICAL SERVICES 192. 00 26 0 0 0 27. 00						1		
5.00 DIETARY 10.00 373 0 0 0 5.00					ŭ	٦		
6. 00 SNACK BAR					ŭ	١		
7. 00 NURSI NG ADMINISTRATI ON 13. 00 504 0 0 0 8. 00 8. 00 CENTRAL SERVI CES & SUPPLY 14. 00 63 0 0 0 9. 00 10. 00 MEDI CAL RECORDS & LI BRARY 16. 00 307 0 0 10. 00 11. 00 SOCI AL SERVI CE 17. 00 46 0 0 11. 00 12. 00 ADULTS & PEDI ATRICS 30. 00 1, 767 0 0 12. 00 13. 00 INTENSI VE CARE UNI T 31. 00 646 0 0 133. 00 14. 00 OPERATI NG ROOM 50. 00 1, 150 0 0 14. 00 15. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 103 0 0 15. 00 17. 00 RESPI RATORY THERAPY 66. 00 919 0 0 15. 00 18. 00 PHYSI CAL THERAPY 66. 00 238 0 0 0 17. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 19. 00 20. 00 ELECTROENCEPHALOGRAPHY 70. 00 32 0 0 21. 00 21. 00 ELECTROENCEPHALOGRAPHY 70. 00 32 0 0 22. 00 0 23. 00 23. 00 EMERGENCY 91. 00 99. 00 43 0 0 0 22. 00 24. 00 AMBULANCE SERVI CES 95. 00 779 0 0 22. 00 25. 00 PHYSI CAL THEATH AGENCY 101. 00 93 0 0 22. 00 26. 00 PHYSI CAL SERVI CES 192. 00 26 0 0 27. 00 27. 00 PHYSI CAL SERVI CES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 0 27. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					ŭ	٦		
8. 00 CENTRAL SERVICES & SUPPLY 14. 00 63 0 0 0 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 10. 00 McDI CAL RECORDS & LI BRARY 16. 00 344 0 0 0 10. 00 11. 00 SOCI AL SERVICE 17. 00 46 0 0 11. 00					0			
9. 00 PHARMACY 15. 00 307 0 0 0 9. 00 10. 00 MEDI CAL RECORDS & LI BRARY 16. 00 344 0 0 0 11. 00 11. 00 SOCI AL SERVI CE 17. 00 46 0 0 11. 00 12. 00 ADULTS & PEDI ATRI CS 30. 00 1, 767 0 0 0 12. 00 13. 00 INTENSI VE CARE UNIT 31. 00 646 0 0 0 13. 00 14. 00 OPERATI NG ROOM 50. 00 1, 150 0 0 0 14. 00 15. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 103 0 0 0 15. 00 16. 00 LABORATORY 60. 00 919 0 0 16. 00 17. 00 RESPI RATORY THERAPY 65. 00 322 0 0 0 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 238 0 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 0 18. 00 20. 00 ELECTROCARDI OLOGY 69. 00 49 0 0 20. 00 21. 00 ELECTROCARDI OLOGY 90. 00 43 0 0 22. 00 22. 00 CLI NI C 90. 00 43 0 0 22. 00 23. 00 EMERGENCY 91. 00 904 0 0 23. 00 24. 00 AMBULANCE SERVI CES 95. 00 779 0 0 24. 00 26. 00 HOSPI CE 116. 00 93 0 0 0 22. 00 26. 00 HOSPI CE 116. 00 93 0 0 0 22. 00 27. 00 PHYSI CAL SERVI CES 192. 01 4, 575 0 0 0 28. 00 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 28. 00 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0				· · · · · · · · · · · · · · · · · · ·	0			4
10. 00 MEDI CAL RECORDS & LI BRARY 16. 00 344 0 0 0 11. 00 11. 00 11. 00 SOCI AL SERVI CE 17. 00 46 0 0 11. 00 11. 00 11. 00 12. 00 ADULTS & PEDI ATRI CS 30. 00 1, 767 0 0 0 12. 00 13. 00 INTENSI VE CARE UNI T 31. 00 646 0 0 13. 00 11. 00 14. 00 OPERATI NG ROOM 50. 00 1, 150 0 0 0 14. 00 OPERATI NG ROOM 50. 00 1, 150 0 0 0 14. 00 15. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 103 0 0 0 15. 00 16. 00 LABORATORY 60. 00 919 0 0 0 16. 00 17. 00 RESPI RATORY THERAPY 65. 00 322 0 0 0 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 238 0 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 19. 00 20. 00 21. 00 ELECTROCARDI OLOGY 69. 00 49 0 0 20. 00 21. 00 ELECTROCARDI OLOGY 69. 00 43 0 0 0 22. 00 22. 00 CLI NI C 90. 00 43 0 0 0 22. 00 23. 00 EMERGENCY 91. 00 90. 00 43 0 0 0 22. 00 22. 00 23. 00 EMERGENCY 91. 00 950 0 779 0 0 0 22. 00 25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 0 25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 0 25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 0 25. 00 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 DEKALB MEDI CAL SERVI CES 192. 01 15, 879 0					0			
11. 00 SOCI AL SERVI CE		1			0			
12. 00 ADULTS & PEDIATRICS 30. 00 1, 767 0 0 0 12. 00 13. 00 INTENSIVE CARE UNIT 31. 00 646 0 0 0 13. 00 14. 00 OPERATING ROOM 50. 00 1, 150 0 0 14. 00 15. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 103 0 0 0 15. 00 16. 00 LABORATORY 60. 00 919 0 0 0 16. 00 17. 00 RESPI RATORY THERAPY 65. 00 322 0 0 0 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 238 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 19. 00 20. 00 ELECTROCARDI OLOGY 69. 00 49 0 0 20. 00 21. 00 ELECTROCARDI OLOGY 69. 00 49 0 0 22. 00 22. 00 CLI NI C 90. 00 43 0 0 22. 00 23. 00 EMERGENCY 91. 00 90. 00 43 0 0 22. 00 24. 00 AMBULANCE SERVI CES 95. 00 779 0 0 24. 00 25. 00 HOSPI CE 116. 00 93 0 0 26. 00 27. 00 PHYSI CI ALS PRI VATE OFFI CES 192. 00 26. 00 28. 00 DEKALB MEDI CAL SERVI CES 192. 00 26. 00 DEKALB MEDI CAL SERVI CES 192. 00 27. 00 DEKALB MEDI CAL SERVI CES 192. 00 27. 00 DEKALB MEDI CAL SERVI CES 192. 00 26. 00 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 DEKALB MEDI CAL SERVI CES 192. 01 55. 879				•	-	-		4
13. 00 INTENSI VE CARE UNIT 31. 00 646 0 0 0 14. 00 14. 00 14. 00 OPERATI NG ROOM 50. 00 1, 150 0 0 14. 00 15. 00 RADI OLOGY - DI AGNOSTI C 54. 00 1, 103 0 0 0 15. 00 16. 00 LABORATORY 60. 00 919 0 0 16. 00 17. 00 RESPI RATORY THERAPY 65. 00 322 0 0 0 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 238 0 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 0 19. 00				•	ŭ	١		
14. 00 OPERATING ROOM 50. 00 1, 150 0 0 14. 00 15. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 103 0 0 0 15. 00 16. 00 LABORATORY 60. 00 919 0 0 16. 00 17. 00 16. 00 17. 00 16. 00 17. 00 17. 00 18. 00 0 0 17. 00 18. 00 0 0 17. 00 18. 00 0 0 18. 00 18. 00 18. 00 19. 00 19. 00 0 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 19. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 21. 00 22. 00 21. 00 22. 00 22. 00 22. 00 22. 00 22. 00 23. 00 22. 00 23. 00 22. 00 23. 00 22. 00 23. 00 24. 00 23. 00 24. 00 23. 00 24. 00 24. 00 24. 00 24. 00 25. 00 25. 00 26. 00 27. 00 26. 00 27. 00 26. 00 <					-	- 1		4
15. 00 RADI OLOGY-DI AGNOSTI C 54. 00 1, 103 0 0 16. 00 16. 00 16. 00 16. 00 919 0 0 0 16. 00 17. 00 RESPI RATORY THERAPY 65. 00 322 0 0 0 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 238 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 19. 00 19.					ŭ	١		
16. 00 LABORATORY					-	-		
17. 00 RESPIRATORY THERAPY 65. 00 322 0 0 0 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 238 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 19. 00 20. 00 ELECTROCARDI OLOGY 69. 00 49 0 0 20. 00 21. 00 ELECTROENCEPHALOGRAPHY 70. 00 32 0 0 21. 00 22. 00 CLI NI C 90. 00 43 0 0 0 22. 00 23. 00 EMERGENCY 91. 00 90.4 0 0 23. 00 24. 00 AMBULANCE SERVI CES 95. 00 779 0 0 24. 00 25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 25. 00 26. 00 HOSPI CE 116. 00 93 0 0 27. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 26 0 0 28. 00 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 28. 00 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 28. 00					0			4
18. 00 PHYSI CAL THERAPY 66. 00 238 0 0 0 18. 00 19. 00 CARDI AC REHAB 66. 01 67 0 0 0 19. 00 20. 00 ELECTROCARDI OLOGY 69. 00 49 0 0 20. 00 21. 00 ELECTROENCEPHALOGRAPHY 70. 00 32 0 0 21. 00 22. 00 CLI NI C 90. 00 43 0 0 22. 00 23. 00 EMERGENCY 91. 00 904 0 0 23. 00 24. 00 AMBULANCE SERVI CES 95. 00 779 0 0 24. 00 25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 25. 00 26. 00 HOSPI CE 116. 00 93 0 0 0 27. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 26. 00 0 0 28. 00 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 0 28. 00					0	o o		4
19. 00 CARDI AC REHAB 66. 01 67 0 0 0 19. 00 20. 00 ELECTROCARDI OLOGY 69. 00 49 0 0 0 21. 00 ELECTROENCEPHALOGRAPHY 70. 00 32 0 0 22. 00 CLI NI C 90. 00 43 0 0 0 23. 00 EMERGENCY 91. 00 90.4 0 0 22. 00 24. 00 AMBULANCE SERVI CES 95. 00 779 0 0 24. 00 25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 26. 00 HOSPI CE 116. 00 93 0 0 27. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 28. 00 0 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 0 28. 00 0 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 0 28. 00					0	o		4
20. 00 ELECTROCARDI OLOGY 69. 00 49 0 0 0 20. 00 21. 00 ELECTROENCEPHALOGRAPHY 70. 00 32 0 0 0 22. 00 CLI NI C 90. 00 43 0 0 0 23. 00 EMERGENCY 91. 00 904 0 0 0 24. 00 AMBULANCE SERVI CES 95. 00 779 0 0 25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 26. 00 HOSPI CE 116. 00 93 0 0 27. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 26 0 0 28. 00 DEKALB MEDI CAL SERVI CES 192. 01 4, 575 0 0 0 0 0 28. 00 0 0 0 0 0 0 0 0 0 0				•	0	ol ol		4
21. 00 ELECTROENCEPHALOGRAPHY 70. 00 32 0 0 0 0 21. 00 22. 00 22. 00 23. 00 EMERGENCY 91. 00 90.4 0 0 23. 00 24. 00 24. 00 24. 00 24. 00 25. 00 40. 00 25. 00 40. 00 25. 00 40. 00 25. 00 40. 00 25. 00 40. 00 25. 00 40. 00 25. 00 40. 00 25. 00 40. 00 25. 00 40. 00 25. 00 2					0	ol ol		
22. 00 CLINIC 90.00 43 0 0 23. 00 EMERGENCY 91.00 904 0 0 24. 00 AMBULANCE SERVICES 95.00 779 0 0 24.00 25. 00 HOME HEALTH AGENCY 101.00 502 0 0 25.00 26. 00 HOSPICE 116.00 93 0 0 26.00 27. 00 PHYSICIANS PRIVATE OFFICES 192.00 26 0 0 27.00 28. 00 DEKALB MEDICAL SERVICES 192.01 4,575 0 0 0 15,879 0 0 28.00				32	0	o		
24. 00 AMBULANCE SERVICES 95. 00 779 0 0 25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 26. 00 HOSPICE 116. 00 93 0 0 27. 00 PHYSICIANS PRIVATE OFFICES 192. 00 26 0 0 28. 00 DEKALB MEDICAL SERVICES 192. 01 4, 575 0 0 0 15, 879 0 0	22. 00		90.00		0	o		22. 00
25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 0 26. 00 26. 00 27. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00	EMERGENCY	91.00	904	0	o		23. 00
25. 00 HOME HEALTH AGENCY 101. 00 502 0 0 0 26. 00 26. 00 27. 00 PHYSI CI ANS PRI VATE OFFI CES 192. 00 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00	AMBULANCE SERVICES	95.00	779	0	o		
27. 00 PHYSICIANS PRIVATE OFFICES 192. 00 26 0 0 0 27. 00 28. 00 0 0 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	HOME HEALTH AGENCY	I .	502	0	o		25. 00
27. 00 PHYSICIANS PRIVATE OFFICES 192. 00 26 0 0 0 27. 00 28. 00 0 0 28. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26. 00	HOSPI CE	116.00	93	0	o		26. 00
0 15,879 0	27.00	PHYSICIANS PRIVATE OFFICES	I		0	o		27. 00
	28.00	DEKALB MEDICAL SERVICES	192. 01	4, 575	0	o		28. 00
500.00 Grand Total: Decreases 990, 142 668, 346 500.00				15, 879				
	500.00	Grand Total: Decreases		990, 142	668, 346			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150045

				Ī	o 09/30/2015	Date/Time Prep 2/23/2016 3:08	
			·	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	393, 118	0	(0	0	1. 00
2.00	Land Improvements	1, 692, 300	89, 670		89, 670	0	2. 00
3.00	Buildings and Fixtures	52, 729, 557	7, 481, 117	(7, 481, 117	0	3. 00
4.00	Building Improvements	0	0	(0	0	4. 00
5.00	Fi xed Equipment	0	0	(0	0	5. 00
6.00	Movable Equipment	23, 763, 167	8, 384, 412	(8, 384, 412	7, 871, 199	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	78, 578, 142	15, 955, 199	C	15, 955, 199	7, 871, 199	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	78, 578, 142	15, 955, 199	C	15, 955, 199	7, 871, 199	10.00
		Endi ng Bal ance	Ful l y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	393, 118	0				1. 00
2.00	Land Improvements	1, 781, 970	0				2. 00
3.00	Buildings and Fixtures	60, 210, 674	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	24, 276, 380	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	86, 662, 142	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	86, 662, 142	0				10. 00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 150045

Period: Worksheet A-7 From 10/01/2014 Part II To 09/30/2015 Date/Time Prepared:

09/30/2015 To 2/23/2016 3:08 pm SUMMARY OF CAPITAL Cost Center Description Depreciation Lease Interest Insurance (see Taxes (see instructions) instructions) 10.00 11.00 13.00 9.00 12.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FLXT 4, 421, 775 383, 481 1.00 1.00 1.01 MAC WEST - NEW 24, 478 0 0 0 0 0 0 0 1.01 0 NORTH ANNEX - NEW 0 1.02 4, 274 0 0 1 02 1.03 GARRETT CLINIC - NEW 16, 587 0 1.03 BUTLER - NEW 11, 914 0 0 1.04 0 1.04 MAC EAST - NEW 0 1.05 151, 548 0 0 1.05 GARRETT LAB - NEW 1.06 0 1.06 1.07 MEDICAL ARTS - NEW 54, 937 0 0 0 1.07 1.08 DAY SPRING - NEW 0 0 1.08 0 2.00 CAP REL COSTS-MVBLE EQUIP n 0 2.00 0 3.00 Total (sum of lines 1-2) 4, 685, 513 383, 481 0 3.00 SUMMARY OF CAPITAL Other Total (1) (sum Cost Center Description Capi tal -Relate of cols. d Costs (see through 14) instructions) 14.00 15.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 4, 805, 256 1.00 1.01 MAC WEST - NEW 0 24, 478 1.01 NORTH ANNEX - NEW 4, 274 1.02 0 0 0 0 0 0 0 1.02 16, 587 1 03 GARRETT CLINIC - NEW 1.03 1.04 BUTLER - NEW 11, 914 1.04 1.05 MAC EAST - NEW 151, 548 1.05 GARRETT LAB - NEW 1.06 1.06 MEDICAL ARTS - NEW 54, 937 1.07 1.07 1.08 DAY SPRING - NEW 0 1.08 2.00 CAP REL COSTS-MVBLE EQUIP 0 2.00 Total (sum of lines 1-2) 5, 068, 994 3.00 3.00

		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4, 421, 775	0	1.00
1. 01	MAC WEST - NEW	0	0	0	24, 478	0	1. 01
1.02	NORTH ANNEX - NEW	0	0	0	4, 274		1. 02
1.03	GARRETT CLINIC - NEW	0	0	0	16, 587	0	1. 03
1.04	BUTLER - NEW	0	0	0	11, 914	0	1. 04
1.05	MAC EAST - NEW	0	0	0	151, 548	0	1. 05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	54, 937	0	1. 07
1.08	DAY SPRING - NEW	0	0	0	0	0	1. 08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4, 685, 513	0	3.00
	SUMMARY OF CAPITAL						
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)			
					d Costs (see	through 14)	
		44.00	10.00	40.00	instructions)	45.00	
	DART LLL DECONOLLLATION OF CARLTAL COOTS OF	11.00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE				_		
1.00	CAP REL COSTS-BLDG & FIXT	44, 000	0	0	0	4, 465, 775	1.00
1.01	MAC WEST - NEW	0	0	0	0	24, 478	1. 01
1.02	NORTH ANNEX - NEW	0	0	0	0	4, 274	1. 02
1.03	GARRETT CLINIC - NEW	0	0	0	0	16, 587	1. 03
1.04	BUTLER - NEW	0	0	0	0	11, 914	1. 04
1. 05	MAC EAST - NEW	0	0	0	0	151, 548	1. 05
1. 06	GARRETT LAB - NEW	0	0	0	0	0	1. 06
1. 07	MEDICAL ARTS - NEW	0	0	0	0	54, 937	1. 07
1. 08	DAY SPRING - NEW	0	0	0	0	0	1. 08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2. 00
3.00	Total (sum of lines 1-2)	44, 000] 0] 0) 0	4, 729, 513	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 DEKALB MEMORIAL HOSPITAL Provi der CCN: 150045 Peri od: Worksheet A-8 From 10/01/2014 To 09/30/2015 Date/Time Prepared:

					To 09/30/2015	Date/Time Prep 2/23/2016 3:08	
				Expense Classification or			э рш
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Rasis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	odst center bescriptron	1.00	2.00	3. 00	4. 00	5. 00	
1.00	Investment income - CAP REL	В	-339, 481	CAP REL COSTS-BLDG & FIXT	1. 00	11	1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - MAC WEST -		0	MAC WEST - NEW	1. 01	0	1. 01
	NEW (chapter 2)						
1. 02	Investment income - NORTH ANNEX - NEW (chapter 2)		0	NORTH ANNEX - NEW	1. 02	0	1. 02
1. 03	Investment income - GARRETT		0	GARRETT CLINIC - NEW	1. 03	0	1. 03
	CLINIC - NEW (chapter 2)			DUT ED NEW			
1. 04	Investment income - BUTLER - NEW (chapter 2)		0	BUTLER - NEW	1.04	0	1. 04
1.05	Investment income - MAC EAST -		0	MAC EAST - NEW	1. 05	0	1. 05
1. 06	NEW (chapter 2) Investment income - GARRETT		0	GARRETT LAB - NEW	1. 06	0	1. 06
1.00	LAB - NEW (chapter 2)		0	GARRETT LAB - NEW	1.00		1.00
1. 07	Investment income - MEDICAL		0	MEDICAL ARTS - NEW	1. 07	O	1. 07
1. 08	ARTS - NEW (chapter 2) Investment income - DAY SPRING		0	DAY SPRING - NEW	1. 08	0	1. 08
1.00	- NEW (chapter 2)		0	DAT SERVING NEW	1.00	Ĭ	1.00
2.00	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)		_				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5.00	Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)		_			_	
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7.00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 1, 191, 075-		0.00	0	9. 00 10. 00
10.00	adjustment	A-0-2	-1, 191, 075				10.00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
.2.00	transactions (chapter 10)		· ·				
13.00	Laundry and linen service	B B	·	LAUNDRY & LINEN SERVICE CAFETERIA	8.00		
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-244, 362 0	CAFETERIA	11. 00 0. 00		14. 00 15. 00
	and others						
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
	patients						
17. 00	Sale of drugs to other than	В	-752	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-1. 275	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts		•				
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00	Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00	o	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	n	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
∠4. UU	therapy costs in excess of	A-0-3	U	I III STOAL IIILKAPT	00.00		24. UU
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
	COSTS-BLDG & FLXT	1		<u> </u>	İ	l	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150045 Peri od: Worksheet A-8 From 10/01/2014 | worksneet A-8 | To 09/30/2015 | Date/Time Prepared:

				To	09/30/2015	Date/Time Pre 2/23/2016 3:0	
				Expense Classification on	Worksheet A	2/23/2010 3.0	o piii
				To/From Which the Amount is 1			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost conten bescriptron	1.00	2.00	3.00	4. 00	5. 00	
26. 01	Depreciation - MAC WEST - NEW		0	MAC WEST - NEW	1. 01	0	26. 01
26. 02	Depreciation - NORTH ANNEX -		0	NORTH ANNEX - NEW	1. 02	0	26. 02
	NEW		_			_	
26. 03	Depreciation - GARRETT CLINIC		0	GARRETT CLINIC - NEW	1. 03	0	26. 03
26. 04	- NEW Depreciation - BUTLER - NEW		0	BUTLER - NEW	1. 04	0	26. 04
26. 05	Depreciation - MAC EAST - NEW			MAC EAST - NEW	1. 05	0	26. 05
26. 06	Depreciation - GARRETT LAB -			GARRETT LAB - NEW	1. 06	Ö	1
	NEW						
26. 07	Depreciation - MEDICAL ARTS -		0	MEDICAL ARTS - NEW	1. 07	0	26. 07
	NEW		_			_	
26. 08	Depreciation - DAY SPRING - NEW		0	DAY SPRING - NEW	1. 08	0	26. 08
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
27.00	COSTS-MVBLE EQUIP		0	ON REE GOOTS MVDEE EGOTT	2.00	Ĭ	27.00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0. 00	0	29. 00
30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	therapy costs in excess of						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
30. 77	instructions)		Ü	ADDETS & FEDIATRICS	30.00		30. 77
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	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 MISCELLANEOUS INCOME	В	2 421	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
33. 00	MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 02	INVESTMENT MANAGEMENT FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 05	WASTE DI SPOSAL REVENUE	В		OPERATION OF PLANT	7. 00	0	
33. 06	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7. 00	0	1
33. 07	HOUSEKEEPING INCOME	В	-2, 131	HOUSEKEEPI NG	9. 00	0	33. 07
33. 08	RADIOLOGY NON-PATIENT REVENUE	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	
33. 09	NON-PATIENT LAB REVENUE	В		LABORATORY	60.00	0	
33. 10	MI SCELLANEOUS I NCOME	В		CARDI AC REHAB	66. 01	0	
33. 11 33. 12	MI SCELLANEOUS I NCOME AMBULANCE SERVI CE REVENUE	B B		DRUGS CHARGED TO PATIENTS AMBULANCE SERVICES	73. 00 95. 00	0	33. 11 33. 12
33. 12	DIABETES SERVICE MISC INCOME	В		DI ETARY	10. 00	0	ı
33. 16	HOME HEALTH MI SCELLANEOUS	B	·	HOME HEALTH AGENCY	101.00	0	ı
	INCOME						
33. 18	LOBBYING PORTION OF IHA & AHA	A	-4, 796	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
	DUES		407	Lucopi of	444.00		
33. 19	LOBBYING PORTION OF LAHHC DUES - HOS	5 A	-107	HOSPI CE	116. 00	0	33. 19
33. 20	LOBBYING PORTION OF LAHHC DUES	s A	-234	HOME HEALTH AGENCY	101. 00	0	33. 20
33. 20	- HHA		254	HOWE HEALTH AGENCY	101.00	9	33. 20
33. 23	NON-ALLOWABLE MARKETING	A	-993	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 23
33. 24	NON-ALLOWABLE MARKETING	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 25	NON-ALLOWABLE MARKETING	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	
33. 26	NON-ALLOWABLE MARKETING	A		PHYSI CAL THERAPY	66.00	0	
33. 27 33. 28	NON-ALLOWABLE MARKETING NON-ALLOWABLE MARKETING	A A		CARDIAC REHAB HOME HEALTH AGENCY	66. 01 101. 00	0	
33. 31	NON-ALLOWABLE MARKETING	A		HOSPI CE	116. 00	9	•
33. 32	NON-ALLOWABLE MARKETING	A		PHARMACARE	192. 02	ó	
33. 33	SNACK BAR	A		SNACK BAR	10. 01	0	1
33. 37	FLOWER/GI FTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 39	SELF-INSURANCE EXPENSES	Α	·	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
33. 40	CHRI STMAS PARTY & OPEN HOUSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
33. 41	PHYSICIAN RECRUITMENT	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 42 33. 43	THERAPY MISCELLANEOUS REVENUE HAF FEE	B A		PHYSICAL THERAPY ADMINISTRATIVE & GENERAL	66. 00 5. 00	0	
50. 00	TOTAL (sum of lines 1 thru 49)		-1, 186, 561 -4, 375, 820		5.00		50.00
55. 60	(Transfer to Worksheet A,		1, 3, 3, 320				55.50
	column 6, line 200.)						
(1) De	scription - all chapter referer	nces in this col	umn pertain to	CMS Pub 15-1			_

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

 ⁽²⁾ Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10	
ADJUSTMENTS TO EXPENSES			Provi der		Peri od:	Worksheet A-8	
					From 10/01/2014 To 09/30/2015	Date/Time Pre 2/23/2016 3:0	pared: 8 pm
				ssification or			
			To/From Which	the Amount is	to be Adjusted		
0 1 0 1 0 1 1	D : (0 (0)	Δ 1	0 1 /	0 1	1 . "	W . A 7 D C	
Cost Center Description	Basis/Code (2)	Amount	Cost	Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2.00	3.	00	4. 00	5. 00	

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						10 09/30/2013	2/23/2016 3:0	
	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	54.00	RADI OLOGY-DI AGNOSTI C	37, 399	37, 39	9 0	177, 200	0	1. 00
2.00	50.00	OPERATING ROOM	788, 175	788, 17	5 0	177, 200	0	2. 00
3.00	91.00	EMERGENCY	140, 151	140, 15	1 0	177, 200	0	3. 00
4.00	5. 00	ADMINISTRATIVE & GENERAL	16, 475		0 16, 475			4.00
5.00		ELECTROCARDI OLOGY	3, 080			177, 200		5. 00
6.00		INTENSIVE CARE UNIT	50, 400	•		1		1
7. 00	30, 00	ADULTS & PEDIATRICS	148, 800	148, 80	0 0	177, 200		7. 00
8. 00		ELECTROCARDI OLOGY	1, 300	•		177, 200		8. 00
9.00		ADULTS & PEDIATRICS	6, 850			177, 200		9. 00
10. 00		INTENSIVE CARE UNIT	11, 000	•			1	
11. 00		OPERATING ROOM	650	•		177, 200		
200.00			1, 204, 280	•			155	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
		I denti fi er	Limit		E Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12. 00	13.00	14.00	
1.00	54. 00	RADI OLOGY-DI AGNOSTI C	0		0 0	0	0	1. 00
2.00	50.00	OPERATING ROOM	0		0	0	0	2. 00
3.00	91. 00	EMERGENCY	0		0	0	0	3. 00
4.00	5. 00	ADMINISTRATIVE & GENERAL	13, 205	66	0	0	0	4. 00
5.00	69. 00	ELECTROCARDI OLOGY	0		0	0	0	5. 00
6.00	31. 00	INTENSIVE CARE UNIT	0		0	0	0	6. 00
7.00	30. 00	ADULTS & PEDIATRICS	0		0	0	0	7. 00
8.00	69. 00	ELECTROCARDI OLOGY	0		0	0	0	8. 00
9.00	30.00	ADULTS & PEDIATRICS	0		0	0	0	9. 00
10.00	31. 00	INTENSIVE CARE UNIT	0		0	0	0	10.00
11.00	50. 00	OPERATING ROOM	0		0	0	0	11. 00
200.00			13, 205	66		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		RADI OLOGY-DI AGNOSTI C	0	1	0			1. 00
2.00		OPERATING ROOM	0	1	0	788, 175		2. 00
3.00		EMERGENCY	0		0	140, 151		3. 00
4.00		ADMINISTRATIVE & GENERAL	0		· ·			4. 00
5.00		ELECTROCARDI OLOGY	0		0	3, 080		5. 00
6.00		INTENSIVE CARE UNIT	0	1	0	,		6. 00
7. 00		ADULTS & PEDIATRICS	0	1	0	148, 800		7. 00
8. 00		ELECTROCARDI OLOGY	0		0	1, 300		8. 00
9. 00		ADULTS & PEDIATRICS	0		0	6, 850		9. 00
10.00		INTENSIVE CARE UNIT	0		0	11, 000	1	10. 00
11. 00	50. 00	OPERATING ROOM	0	1	0	650	1	11. 00
200.00			0	13, 20	5 3, 270	1, 191, 075		200. 00

Provi der CCN: 150045

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2014 | Part I | To 09/30/2015 | Date/Time Prepared: 2/23/2016 3:08 pm

CAPITAL RELATED COSTS	ADDETT CLINIC	
A LO L B LLL	ADDETT CLINIC	
Cost Center Description Net Expenses BLDG & FLXT MAC WEST - NEW NORTH ANNEX - GA		
for Cost NEW	- NEW	
Allocation (from Wkst A		
col. 7)		
0 1.00 1.01 1.02	1. 03	
GENERAL SERVICE COST CENTERS		
1. 00 00100 CAP REL COSTS-BLDG & FIXT 4, 465, 775 4, 465, 775 4, 465, 775 4, 478	l l	1.00
1. 01 00101 MAC WEST - NEW 24, 478 0 24, 478 1. 02 00102 NORTH ANNEX - NEW 4, 274 0 0 4, 274		1. 01 1. 02
1. 03 00103 GARRETT CLI NI C - NEW 16, 587 0 0 0		1. 02
1. 04 00104 BUTLER - NEW 11, 914 0 0 0		1. 04
1.05 00105 MAC EAST - NEW 151,548 0 0 0		1. 05
1. 06 00106 GARRETT LAB - NEW 0 0 0 0 0 0		1.06
1. 07 00107 MEDI CAL ARTS - NEW 54, 937 0 0 0 1. 08 00108 DAY SPRI NG - NEW 0 0 0 0		1. 07 1. 08
2. 00 00200 CAP REL COSTS-MVBLE EQUI P		2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 079, 451 0 0	l l	4. 00
5. 00 00500 ADMINI STRATI VE & GENERAL 7, 686, 445 560, 582 0 0		5. 00
7. 00 00700 OPERATION OF PLANT 2, 053, 622 1, 746, 246 4, 392 0		7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 77, 136 26, 001 0 0 9. 00 00900 HOUSEKEEPI NG 992, 696 41, 571 0 0	l l	3.00
9. 00 00900 HOUSEKEEPI NG 992, 696 41, 571 0 0 10. 00 01000 DI ETARY 390, 215 21, 820 0 0		9. 00 0. 00
10. 01 01000 SNACK BAR 5,728 0 0	l l	0. 01
11. 00 01100 CAFETERI A 428, 927 51, 326 0 0	0 11	1. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 949, 731 23, 083 0 0	ı	3. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 254, 968 27, 416 0 0		4. 00
15. 00 01500 PHARMACY	l l	5. 00 5. 00
17. 00 01700 SOCI AL SERVI CE 78, 036 3, 571 0		7. 00
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDIATRICS 2, 390, 330 255, 346 0 0	l l	0. 00
31. 00 03100 I NTENSI VE CARE UNI T	l l	1. 00 3. 00
43. 00 04300 NURSERY 317, 761 19, 424 0 0 0	0 43	3. 00
50. 00 05000 0PERATI NG ROOM 2, 607, 942 386, 330 0 0	0 50	0. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 561, 100 300, 423 0 0		2. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 2, 950, 428 202, 844 0 0 0		4. 00
60. 00 06000 LABORATORY 3, 210, 421 91, 220 995 0 60. 01 06001 BLOOD LABORATORY 0 0 0		0. 00 0. 01
65. 00 06500 RESPI RATORY THERAPY 613, 283 23, 779 0 0		5. 00
66. 00 06600 PHYSI CAL THERAPY 1, 119, 019 113, 584 0 0	l l	5. 00
66. 01 06601 CARDI AC REHAB 152, 462 59, 775 0 0	l l	5. 01
69. 00 06900 ELECTROCARDI OLOGY 104, 031 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 72, 923 0 0 0 0 0 0 0 0 0	ı	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00 1. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 999, 275 0 0		2. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 267, 000 0 0	0 73	3. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 71.618 0 0 0		
90. 00 09000 CLI NI C 71, 618 0 0 0 0 0 0 0 0 0		0. 00 1. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT		2. 00
OTHER REIMBURSABLE COST CENTERS		
95. 00 09500 AMBULANCE SERVI CES 1, 380, 804 38, 261 0 0		5. 00
99. 10 09910 CORF	0 99 0 101	9. 10
SPECIAL PURPOSE COST CENTERS	0 101	1.00
113. 00 11300 I NTEREST EXPENSE	113	3. 00
116. 00 11600 HOSPI CE 358, 991 0 0 262	0 116	
118. 00 SUBTOTALS (SUM OF LINES 1-117) 44, 713, 080 4, 354, 695 5, 387 2, 682	3, 468 118	3. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CAN 0 0 0	0 190	2 00
191. 00 19100 RESEARCH 0 0 0 0	0 191	
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 79, 316 0 5, 357 0	0 192	2. 00
192. 01 19201 DEKALB MEDI CAL SERVI CES 9, 519, 202 111, 080 13, 734 1, 592	13, 119 192	
192. 02 19202 PHARMACARE 3, 977, 709 0 0	0 192	
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 194. 00 0 7950 OTHER NONREI MBURSABLE COST CENT 0 0 0 0	0 193 0 194	
194. 00 07950 OTHER NONKET MBURSABLE COST CENT 0 0 0 0 0 0 0	0 194	
194. 02 07952 FOUNDATION 396 0 0	0 194	
200.00 Cross Foot Adjustments		0. 00
201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0	0 201	
202.00 TOTAL (sum lines 118-201) 58, 289, 703 4, 465, 775 24, 478 4, 274	16, 587 202	∠. ∪∪

Provider CCN: 150045

Period: Worksheet B
From 10/01/2014 Part I
To 09/30/2015 Date/Time Prepared: 2/23/2016 3:08 pm

						2/23/2016 3:0	.8 pm
			CAF	TAL RELATED C	0STS		
Cost Cen	nter Description	BUTLER - NEW	MAC EAST - NEW	GARRETT LAB -	MEDICAL ARTS -	DAY SPRING -	
				NEW	NEW	NEW	
		1. 04	1. 05	1.06	1. 07	1. 08	
GENERAL SERVIC	CE COST CENTERS						
	COSTS-BLDG & FLXT						1.00
1.01 00101 MAC WEST							1. 01
1.02 00102 NORTH AN	INEX - NEW						1. 02
1. 03 00103 GARRETT	CLINIC - NEW						1. 03
1. 04 00104 BUTLER -		11, 914					1. 04
1. 05 00105 MAC EAST		0	l	,			1. 05
			131, 340				1
1.06 00106 GARRETT		0)))		1. 06
1. 07 00107 MEDI CAL	ARTS - NEW	0)) (54, 937		1. 07
1.08 00108 DAY SPRI	NG - NEW	0) () (0	0	1. 08
2.00 00200 CAP REL	COSTS-MVBLE EQUIP						2.00
	BENEFITS DEPARTMENT	0			n n	0	1
			20.20			l .	1
	RATIVE & GENERAL	0	20, 293			0	
7. 00 00700 OPERATI C		0	45, 043		4, 357	0	1
8. 00 00800 LAUNDRY	& LINEN SERVICE	0) C) (0	0	8. 00
9. 00 00900 HOUSEKEE	EPI NG	0	307	'l c	0	0	9. 00
10. 00 01000 DI ETARY		0	825	:	0	0	10.00
10. 01 01001 SNACK BA	ND.	0			i o	0	1
11. 00 01100 CAFETERI		0	1	y ·)	0	
13. 00 01300 NURSI NG	ADMI NI STRATI ON	0) C) (0	0	13. 00
14. 00 01400 CENTRAL	SERVICES & SUPPLY	0) () (0	0	14. 00
15. 00 01500 PHARMACY	<i>(</i>	0	ol c	ol c	0	0	15. 00
	RECORDS & LI BRARY		1, 148			Ö	1
		0		1		l	1
17. 00 01700 SOCIAL S		0)) (0	0	17. 00
	TINE SERVICE COST CENTERS						1
30.00 03000 ADULTS &	PEDI ATRI CS	0) () (0	0	30.00
31.00 03100 INTENSIV	/E CARE UNIT	0	ol c		0	0	31.00
43. 00 04300 NURSERY		0	1	•		0	43.00
<u> </u>	/ICE COST CENTERS			`	·		1 .0.00
		0) (0	_	FO 00
				1	_		
	ROOM & LABOR ROOM	0)	0		1
54. 00 05400 RADI 0L00	GY-DI AGNOSTI C	0) C) (0	0	54.00
60. 00 06000 LABORATO)RY	843	c c		0	0	60.00
60. 01 06001 BLOOD LA		0	ol c) .	0	0	1
65. 00 06500 RESPIRAT						Ö	
		0				l .	1
66. 00 06600 PHYSI CAL		0)))	0	
66. 01 06601 CARDI AC	REHAB	0) C) () 0	0	66. 01
69. 00 06900 ELECTROC	CARDI OLOGY	0) C) (0	0	69. 00
70. 00 07000 ELECTROE	ENCEPHALOGRAPHY	0	ol c	ol c	0	l 0	70.00
	SUPPLIES CHARGED TO PAT	0		ا ا	0	0	1
	EV. CHARGED TO PATIENTS					ĺ	
		0		,			
	ARGED TO PATIENTS	0	1 () () 0	0	73. 00
	RVICE COST CENTERS						1
90. 00 09000 CLI NI C		0) C) (0	0	90.00
91. 00 09100 EMERGENO	CY	0) (0	0	91.00
, ,	TION BEDS (NON-DISTINCT]	92.00
				I			1 .2. 50
	SABLE COST CENTERS	_				_	05 00
95. 00 09500 AMBULANO	LE SEKVILES		1	<u>'</u>	<u>'</u>	0	1
99. 10 09910 CORF		0) C) (0		
101.00 10100 HOME HEA	ALTH AGENCY	0)) (0	0	101.00
SPECIAL PURPOS	SE COST CENTERS						1
113. 00 11300 I NTEREST							113. 00
116. 00 11600 HOSPI CE	EM EMOE	0				_	116.00
	C (CUM OF LINEC 4 447)						
118. 00 SUBTOTAL	S (SUM OF LINES 1-117)	843	67, 616		4, 357	0	118. 00
	_E COST CENTERS						1
190. 00 19000 GLFT FL	LOWER COFFEE SHOP & CAN	0) () (0		190. 00
191. 00 19100 RESEARCH	1	0) C) (0	0	191. 00
192. 00 19200 PHYSI CI A		1	م ا		م ا		192. 00
192. 01 19201 DEKALB N		11, 071	83, 932	_	50, 580		192. 01
		11,0/1	03, 932		30, 380		
192. 02 19202 PHARMACA		0	1		0		192. 02
193. 00 19300 NONPAI D		0	oj C	ol c	0		193. 00
194.00 07950 OTHER NC	ONREIMBURSABLE COST CENT	0) () (0	0	194. 00
194. 01 07951 ADULT DA		0) () (n	n	194. 01
194. 02 07952 FOUNDATI					م ا		194. 02
			1	1	ή	l	
	oot Adjustments						200.00
	e Cost Centers	0	y C	ן כ	0		201. 00
202.00 TOTAL (s	sum lines 118-201)	11, 914	151, 548	3 (54, 937] 0	202. 00

| Peri od: | Worksheet B | From 10/01/2014 | Part I | To 09/30/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150045

					09/30/2015	Date/Time Pre 2/23/2016 3:0	
	Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL		y piii
		2.00	DEPARTMENT 4.00	4A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS	2.00	1. 00		0. 00	7.00	
1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 2. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 14. 00 15. 00 16. 00 17. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 MAC WEST - NEW 00102 NORTH ANNEX - NEW 00103 GARRETT CLINIC - NEW 00104 BUTLER - NEW 00105 MAC EAST - NEW 00106 GARRETT LAB - NEW 00107 MEDICAL ARTS - NEW 00108 DAY SPRING - NEW 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01001 SNACK BAR 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 0 0 0 0 0 0 0 0	1, 079, 451 143, 789 25, 976 1, 147 24, 351 8, 190 1, 102 13, 539 29, 391 3, 672 17, 874 20, 046 2, 694	8, 411, 109 3, 879, 636 104, 284 1, 058, 925 421, 050 6, 830 493, 792 1, 002, 205 286, 056 484, 898 736, 632 84, 301	654, 231 17, 586 178, 569 71, 003 1, 152 83, 269 169, 004 48, 238 81, 769 124, 220	4, 533, 867 34, 839 57, 919 35, 189 0 68, 773 30, 929 36, 735 33, 788 89, 839 4, 785	1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 2. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	0 0 0	79, 465 37, 633 8, 487	2, 725, 141 1, 459, 231 345, 672	246, 073	342, 142 145, 278 26, 027	30. 00 31. 00 43. 00
50. 00 52. 00 54. 00 60. 00 65. 00 66. 01 69. 00 70. 00 71. 00 72. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06601 CARDIAC REHAB 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0 0 0 0 0 0 0 0	67, 029 15, 045 63, 782 53, 570 0 18, 743 12, 044 5, 739 3, 404 1, 864	107, 435 74, 787 1, 706, 314 999, 275	542, 498 566, 691 0 110, 590 209, 887 36, 758 18, 117 12, 611 287, 739 168, 510	517, 649 402, 541 271, 794 174, 748 0 31, 862 152, 193 80, 094 0 0	50. 00 52. 00 54. 00 60. 01 65. 00 66. 01 69. 00 70. 00 71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	2, 267, 000	382, 289	0	73. 00
	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0	2, 519 52, 675			0 224, 555	90. 00 91. 00 92. 00
99. 10	09500 AMBULANCE SERVICES 09910 CORF 10100 HOME HEALTH AGENCY	0 0 0	45, 399 0 29, 248	0	0	51, 266 0 80, 882	95. 00 99. 10 101. 00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	5, 431 793, 848				113. 00 116. 00 118. 00
191. 00 192. 00 192. 00 192. 00 193. 00 194. 00	19000 GIFT FLOWER COFFEE SHOP & CAN 19100 RESEARCH 19200 PHYSICIANS PRIVATE OFFICES 19201 DEKALB MEDICAL SERVICES 19202 PHARMACARE 19300 NONPAID WORKERS 007950 OTHER NONREIMBURSABLE COST CENT 07951 ADULT DAY CARE 107952 FOUNDATION Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0 0	0 0 1, 525 267, 710 16, 368 0 0 0 0	10, 072, 020 3, 994, 077 0 0 0 396 0 0	1, 698, 447 673, 529 0 0 0 67	0 104, 312 1, 526, 975 0 0 0 0	192. 01 192. 02 193. 00 194. 00 194. 01 194. 02 200. 00 201. 00

| Period: | Worksheet B | From 10/01/2014 | Part | To 09/30/2015 | Date/Time Prepared: | 2/23/2016 3:08 pm Provider CCN: 150045

						2/23/2016 3:0	8 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	
		LINEN SERVICE		10.00	10.01	44.00	
	CENEDAL CEDALCE COCT CENTEDO	8. 00	9. 00	10.00	10. 01	11. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT	T		I	T		1.00
1.00	00100 CAP REL COSTS-BEDG & FIXT						1.00
1.01	OO102 NORTH ANNEX - NEW						1.01
1.02	00102 NORTH ANNEX - NEW						1. 02
1.03	00103 GARRETT CETNIC - NEW						1.03
1.04	00104 BOTLER - NEW						1.04
1.05	00105 WAC EAST - NEW						1.06
1.00	00100 GARRETT EAB - NEW						1. 07
1. 07	00108 DAY SPRING - NEW						1. 08
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	156, 709					8.00
9. 00	00900 HOUSEKEEPI NG	11, 528	ł				9. 00
10. 00	01000 DI ETARY	0	1				10.00
10. 01	01001 SNACK BAR	0	10, 555	0	7, 982		10. 01
11. 00	01100 CAFETERI A	0	20, 239	١	7, 982	674, 055	1
13. 00	1 1	0	9, 102	1	7, 702	19, 659	1
14. 00		0	10, 811	0	ol	6, 824	1
15. 00		0	9, 943	١	ol	11, 165	1
16. 00			l	1	ő	28, 341	1
17. 00	1 1	0		1	ő	2, 066	1
17.00	I NPATIENT ROUTINE SERVICE COST CENTERS		1, 100	<u> </u>	٥,	2,000	17.00
30. 00		49, 335	100, 686	420, 128	o	85, 650	30.00
31. 00		13, 873			o		1
43. 00	+ I	0	7, 659		ol		1
10.00	ANCILLARY SERVICE COST CENTERS		,,,,,,	<u> </u>	٥,	0,700	10.00
50.00	05000 OPERATING ROOM	23, 784	152, 335	0	O	56, 328	50.00
52. 00		0	118, 461	0	ol	12, 313	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 741	79, 984		ol	52, 843	1
60. 00	06000 LABORATORY	0	51, 425		ol	54, 032	1
60. 01	06001 BLOOD LABORATORY	0	0		ol	0	1
65. 00	06500 RESPIRATORY THERAPY	377	9, 377	- 1	ol	17, 552	1
66. 00	1	0	44, 788		ol	12, 981	1
66. 01	06601 CARDI AC REHAB	0	23, 570		o	6, 386	1
69. 00	1 1	0	0	0	ol	4, 299	1
70. 00		537	0	0	ol	1, 795	1
71. 00	1 1	0	0	0	o	0	1
72. 00	1 1	0	0	0	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			•		1
90.00	09000 CLI NI C	855	0	0	0	2, 296	90.00
91.00	09100 EMERGENCY	31, 032	66, 082	0	o	44, 474	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	4, 080	15, 087	0	0	55, 034	95. 00
	09910 CORF	0	0	0	0	0	99. 10
101.00	0 10100 HOME HEALTH AGENCY	0	23, 802	0	0	31, 013	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	D 11300 I NTEREST EXPENSE						113. 00
116.00	0 11600 H0SPI CE	94	2, 576	0	0	3, 569	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	155, 236	826, 881	537, 597	7, 982	549, 630	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
	D 19100 RESEARCH	0		0	0	0	191. 00
192.00	0 19200 PHYSICIANS PRIVATE OFFICES	0	30, 697	0	0	7, 743	192. 00
	1 19201 DEKALB MEDICAL SERVICES	1, 473	449, 363	0	0	116, 682	
192. 02	2 19202 PHARMACARE	0	0	0	0	0	192. 02
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194. 00
	1 07951 ADULT DAY CARE	0	0	0	0		194. 01
	2 07952 FOUNDATI ON	0	0	0	0	0	194. 02
200.00	1 1						200. 00
201.00		0	1	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	156, 709	1, 306, 941	537, 597	7, 982	674, 055	202. 00

Provider CCN: 150045

			10	09/30/2015	2/23/2016 3:0	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	RECORDS &	SOCIAL SERVICE	у ріп
	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	17. 00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	17.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1.01 00101 MAC WEST - NEW						1. 01
1.02 00102 NORTH ANNEX - NEW						1. 02
1.03 00103 GARRETT CLINIC - NEW						1. 03
1.04 00104 BUTLER - NEW						1. 04
1.05 00105 MAC EAST - NEW						1. 05
1.06 00106 GARRETT LAB - NEW						1. 06
1.07 00107 MEDI CAL ARTS - NEW						1. 07
1. 08 00108 DAY SPRING - NEW						1. 08
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
10. 01 01001 SNACK BAR						10. 01
11. 00 01100 CAFETERI A						11. 00
13.00 01300 NURSING ADMINISTRATION	1, 230, 899					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	28, 906	417, 570				14.00
15. 00 01500 PHARMACY	0	0	621, 563			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	1, 005, 470		16. 00
17. 00 01700 SOCIAL SERVICE	8, 740	0	0	0	115, 516	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		_1	_1			
30. 00 03000 ADULTS & PEDI ATRI CS	362, 842	0	0	97, 403	115, 516	30.00
31. 00 03100 NTENSI VE CARE UNIT	144, 254	0	0	47, 100	0	31.00
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS	29, 446	0	0	8, 346	0	43. 00
50. 00 05000 OPERATING ROOM	238, 611	ol	0	199, 972	0	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	52, 201	o	0	14, 795	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	Ö	Ö	191, 405	0	54. 00
60. 00 06000 LABORATORY	21, 229	Ö	0	142, 683	0	60. 00
60. 01 06001 BLOOD LABORATORY	0	Ö	Ō	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0	0	40, 970	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	31, 567	0	66.00
66. 01 06601 CARDI AC REHAB	0	0	0	3, 884	0	66. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	10, 595	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	7, 748	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	417, 570	0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	621, 563	174	0	73. 00
90. 00 09000 CLINIC	9, 709	o	0	2, 843	0	90. 00
91. 00 09100 EMERGENCY	188, 446	0	0	102, 654	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	100, 440	ĭ	Ö	102, 054	O	92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	131, 433	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	15, 082	0	0	5, 687		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	1, 230, 899	417, 570	621, 563	907, 826	115, 516	118. 00
NONREI MBURSABLE COST CENTERS	ما	ما		ما		100.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 191.00 19100 RESEARCH	0	0	0	0		190. 00 191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		191.00
192. 00 19200 PHISICIANS PRIVATE OFFICES 192. 01 19201 DEKALB MEDICAL SERVICES	0	0	0	97, 644		192. 00
192. 02 19202 PHARMACARE	0	0	0	97, 044		192. 01
193. 00 19300 NONPALD WORKERS	0	o O	0	n		193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENT	n	n	0	n		194. 00
194. 01 07951 ADULT DAY CARE	ő	ol	0	o		194. 01
194. 02 07952 FOUNDATI ON	ő	ol	o	ől		194. 02
200.00 Cross Foot Adjustments	1	Ĭ		ا	· ·	200. 00
201.00 Negative Cost Centers	О	o	0	o		201. 00
202.00 TOTAL (sum lines 118-201)	1, 230, 899	417, 570	621, 563	1, 005, 470	115, 516	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150045

				To 09/30/2015 Date/Time 2/23/2016	
Cost Center Description	Subtotal	Intern &	Total	2, 29, 2010	J. 50 p
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FLXT	T				1.00
1. 01 00100 CAF KEE COSTS-BEDG & TTXT					1. 00
1. 02 00102 NORTH ANNEX - NEW					1. 02
1.03 O0103 GARRETT CLINIC - NEW					1. 03
1. 04 00104 BUTLER - NEW					1. 04
1. 05 00105 MAC EAST - NEW 1. 06 00106 GARRETT LAB - NEW					1. 05 1. 06
1. 07 00107 MEDI CAL ARTS - NEW					1. 07
1. 08 00108 DAY SPRING - NEW					1. 08
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10. 00
10. 01 01001 SNACK BAR					10. 01
11. 00 01100 CAFETERIA					11.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY					13. 00 14. 00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCIAL SERVICE					17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	4 750 000		4 750 0	20	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	4, 758, 389 2, 250, 091		4, 758, 38 2, 250, 09		30. 00 31. 00
43. 00 04300 NURSERY	482, 391	1	482, 39		43. 00
ANCILLARY SERVICE COST CENTERS			.52,		
50.00 05000 OPERATING ROOM	4, 766, 213	1	4, 766, 2		50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 624, 696	1	1, 624, 69		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	4, 375, 319 4, 371, 325	1	4, 375, 3° 4, 371, 32		54. 00 60. 00
60. 01 06001 BLOOD LABORATORY	4, 371, 323		4, 371, 32	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	866, 533	0	866, 53	33	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 696, 063	1	1, 696, 00		66. 00
66. 01 06601 CARDI AC REHAB 69. 00 06900 ELECTROCARDI OLOGY	368, 668		368, 60		66. 01
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	140, 446 97, 478	1	140, 44 97, 47		69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	2, 411, 623	1	2, 411, 62		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 167, 785		1, 167, 78		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 271, 026	0	3, 271, 02	26	73. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	102 242	2 0	102.2	12	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	102, 342 2, 826, 162		102, 34 2, 826, 16		90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	2,020,102	o o	2,020,10		92. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	1, 836, 886	1	1, 836, 88		95. 00
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY	1 540 144	1	1 540 14	0	99. 10 101. 00
SPECIAL PURPOSE COST CENTERS	1, 540, 166	<u>oj</u> <u>Oj</u>	1, 540, 10	50	101.00
113. 00 11300 I NTEREST EXPENSE					113. 00
116. 00 11600 H0SPI CE	461, 942		461, 94		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	39, 415, 544	0	39, 415, 54	14	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN					190. 00
191. 00 19100 RESEARCH		1		o o	190.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	243, 486	1	243, 48		192. 00
192.01 19201 DEKALB MEDICAL SERVICES	13, 962, 604		13, 962, 60		192. 01
192. 02 19202 PHARMACARE	4, 667, 606	<u> </u>	4, 667, 60	06	192. 02
193. 00 19300 NONPALD WORKERS 194. 00 07950 OTHER NONRELMBURSABLE COST CENT					193. 00 194. 00
194.00 07950 0THER NONRETMBURSABLE COST CENT 194.01 07951 ADULT DAY CARE		1		ol	194. 00
194. 02 07952 FOUNDATI ON	463	1	46	53	194. 02
200.00 Cross Foot Adjustments	C			0	200. 00
201.00 Negative Cost Centers	0	0		0	201. 00
202.00 TOTAL (sum lines 118-201)	58, 289, 703	8 0	58, 289, 70	J3	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150045

						2/23/2016 3:0	8 pm
				CAPITAL RE	LATED COSTS		
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	
		Related Costs 0	1.00	1. 01	1. 02	1. 03	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 MAC WEST - NEW						1. 01
1. 02 1. 03	00102 NORTH ANNEX - NEW 00103 GARRETT CLINIC - NEW						1. 02 1. 03
1. 04	00104 BUTLER - NEW						1. 04
1. 05	00105 MAC EAST - NEW						1. 05
1.06	00106 GARRETT LAB - NEW						1. 06
1.07	00107 MEDI CAL ARTS - NEW						1. 07
1. 08 2. 00	00108 DAY SPRING - NEW 00200 CAP REL COSTS-MVBLE EQUIP						1. 08 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0		o	o	0	1
5.00	00500 ADMINISTRATIVE & GENERAL	0	560, 582	0	Ō	0	
7.00	00700 OPERATION OF PLANT	0	1, 746, 246	1	0	0	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	26, 001	1	0	0	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	41, 571 21, 820	1	0	0	
10. 00	01001 SNACK BAR	0	21,020	1	0	0	
11. 00	01100 CAFETERI A	0	51, 326	0	0	0	
13. 00	01300 NURSING ADMINISTRATION	0	23, 083	1	0	0	
14.00		0	27, 416	1	0	0	
15. 00 16. 00	· · · ·	0	25, 217 60, 864	1	0	0	1
17. 00	l l	0		1	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		5, 5.		-1		1
30. 00	03000 ADULTS & PEDIATRICS	0	1			0	1
31.00	03100 NTENSI VE CARE UNI T	0			0	0	
43. 00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	19, 424	1 0	0	0	43.00
50. 00		0	386, 330	0	0	0	50.00
52. 00		0	300, 423		0	0	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	202, 844		0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	91, 220		0	3, 468 0	1
65. 00	06500 RESPIRATORY THERAPY	0	23, 779	1	0	0	
66.00	06600 PHYSI CAL THERAPY	0	113, 584	1	0	0	1
66. 01	06601 CARDI AC REHAB	0	59, 775	0	0	0	
69. 00		0	C	0	0	0	
70. 00 71. 00		0			0	0	1
72. 00	· · · ·	0		o o	o	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1 0			ما		00.00
90.00	09000 CLI NI C 09100 EMERGENCY	0	l e			0	
	09200 OBSERVATION BEDS (NON-DISTINCT		107, 30	,	Ŭ,	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	1,	1	0	0	
	09910 CORF D 10100 HOME HEALTH AGENCY	0	l		0 2, 420	0	99. 10 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	0		<u>)</u>	2, 420	0	1101.00
	11300 I NTEREST EXPENSE						113. 00
	D 11600 HOSPI CE	0		0	262		116. 00
118. 00		0	4, 354, 695	5, 387	2, 682	3, 468	118. 00
100 0	NONREIMBURSABLE COST CENTERS D 19000 GIFT FLOWER COFFEE SHOP & CAN	0) 0	٥	0	190. 00
	019100 RESEARCH	0			0		191.00
	19200 PHYSICIANS PRIVATE OFFICES	0		5, 357	Ō		192. 00
	1 19201 DEKALB MEDICAL SERVICES	0	111, 080	13, 734	1, 592		192. 01
	2 19202 PHARMACARE	0	C	0	0		192. 02
	0 19300 NONPALD WORKERS 0 07950 OTHER NONREIMBURSABLE COST CENT	0			0		193. 00 194. 00
	1 07951 ADULT DAY CARE	0		o o	0		194. 00
	2 O7952 FOUNDATI ON	0		o	o		194. 02
200.00							200. 00
201. 00 202. 00	1 1 3	0	4, 465, 775	0 5 24, 478	0 4, 274		201. 00 202. 00
202.00		1	1 4,400,775	24, 4/8	4, 2/4	10, 387	1202.00

Provi der CCN: 150045

				CAP	ITAL RELATED C	0STS	2/23/2016 3:0	o pili
		Cost Center Description	BUTLER - NEW	MAC EAST - NEW	GARRETT LAB -	MEDICAL ARTS -	DAY SPRING -	
					NEW	NEW	NEW	
	GENER	AL SERVICE COST CENTERS	1. 04	1. 05	1. 06	1. 07	1. 08	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1. 01
1.02		NORTH ANNEX - NEW						1. 02
1.03		GARRETT CLINIC - NEW						1.03
1. 04 1. 05		BUTLER - NEW MAC EAST - NEW						1. 04 1. 05
1.05		GARRETT LAB - NEW						1.05
1. 07	1	MEDICAL ARTS - NEW						1. 07
1. 08		DAY SPRING - NEW						1. 08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	C	0	0	
5.00		ADMINISTRATIVE & GENERAL	0	20, 293		0	0	1
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	45, 043		4, 357	0	
9. 00		HOUSEKEEPING		307				1
10. 00	1	DI ETARY		825		ol o	Ö	
10. 01	1	SNACK BAR	0	0	C	0	0	1
11. 00	01100	CAFETERI A	0	0	C	0	0	11. 00
13.00	1	NURSING ADMINISTRATION	0	0	C	0	0	
14.00		CENTRAL SERVICES & SUPPLY	0	0		0	0	
15. 00	1	PHARMACY	0	1 140		0	0	1
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE		1, 148 0			0	
17.00		I ENT ROUTI NE SERVI CE COST CENTERS				,	<u> </u>	17.00
30.00		ADULTS & PEDIATRICS	0	0	C	0	0	30.00
31. 00	4	INTENSIVE CARE UNIT	0	l .			l e	1
43.00		NURSERY	0	0	C	0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	0) 0	0	50.00
52. 00	4	DELIVERY ROOM & LABOR ROOM						
54. 00		RADI OLOGY-DI AGNOSTI C				ól ő	ĺ	
60.00		LABORATORY	843	Ō	d	Ö	Ō	
60. 01	06001	BLOOD LABORATORY	0	0	C	0	0	60. 01
65. 00	4	RESPI RATORY THERAPY	0	0	C	0	0	
66. 00	- 1	PHYSI CAL THERAPY	0	0		0	0	1
66. 01 69. 00	- 1	CARDI AC REHAB ELECTROCARDI OLOGY	0	0			0	
70. 00		ELECTROENCEPHALOGRAPHY		0			ĺ	
71. 00		MEDICAL SUPPLIES CHARGED TO PAT	0	Ō	d	Ö	Ō	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73. 00	-	DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	0	0		0	0	90.00
90.00	1	EMERGENCY					l .	
92. 00	1	OBSERVATION BEDS (NON-DISTINCT)		92. 00
		REIMBURSABLE COST CENTERS						
95. 00		AMBULANCE SERVICES	0		C	ή	0	
	09910		0					
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	C) 0	0	101. 00
113 00		INTEREST EXPENSE						113. 00
	4	HOSPI CE	O	О		0	О	116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	843	67, 616	C	4, 357	0	118. 00
		IMBURSABLE COST CENTERS	_	1	1			
		GIFT FLOWER COFFEE SHOP & CAN RESEARCH	0	0	C	0		190. 00 191. 00
		PHYSICIANS PRIVATE OFFICES						191.00
	1	DEKALB MEDICAL SERVICES	11, 071	83, 932		50, 580		192. 00
		PHARMACARE	0	0		0	l e	192. 02
		NONPALD WORKERS	0	0	(0		193. 00
		OTHER NONREIMBURSABLE COST CENT	0	0	(0		194. 00
		ADULT DAY CARE FOUNDATION	0	0		0		194. 01 194. 02
200.00		Cross Foot Adjustments		1		,		200. 00
200.00		Negative Cost Centers	n	0	(0	0	201. 00
202.00	1	TOTAL (sum lines 118-201)	11, 914	151, 548	0	54, 937		202. 00

| Peri od: | Worksheet B | From 10/01/2014 | Part II | To 09/30/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150045

					Т	o 09/30/2015	Date/Time Pre 2/23/2016 3:0	
			CAPI TAL				272372010 3.0	o piii
			RELATED COSTS					
		Cost Center Description	MVBLE EQUIP	Subtotal	EMPLOYEE	ADMI NI STRATI VE		
					BENEFITS	& GENERAL	PLANT	
			2.00	2A	DEPARTMENT 4.00	5. 00	7. 00	
	GENER	AL SERVICE COST CENTERS	2.00	ZN	1 4.00	5. 00	7.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1. 01
1.02		NORTH ANNEX - NEW						1. 02
1.03	1	GARRETT CLINIC - NEW						1.03
1. 04 1. 05		BUTLER - NEW MAC EAST - NEW						1. 04 1. 05
1.05	1	GARRETT LAB - NEW						1. 05
1. 07		MEDICAL ARTS - NEW						1. 07
1.08		DAY SPRING - NEW						1. 08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	0	C			4. 00
5.00	1	ADMINISTRATIVE & GENERAL	0	580, 875			4 045 000	5. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	1, 800, 038 26, 001			1, 845, 220 14, 179	7. 00 8. 00
9. 00	1	HOUSEKEEPI NG		41, 878			23, 572	9. 00
10. 00	1	DI ETARY		22, 645			14, 321	
10. 01	1	SNACK BAR	o	0	1		0	10. 01
11. 00	1	CAFETERI A	o	51, 326	C	5, 751	27, 990	11. 00
13. 00		NURSING ADMINISTRATION	0	23, 083	C	11, 672	12, 588	13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	0	27, 416			14, 951	14. 00
15.00		PHARMACY	0	25, 217			13, 751	
16.00	1	MEDICAL RECORDS & LIBRARY	0	62, 012			36, 563	
17. 00		SOCIAL SERVICE LENT ROUTINE SERVICE COST CENTERS	0	3, 571	<u> </u>	982	1, 948	17. 00
30. 00		ADULTS & PEDIATRICS	O	255, 346		31, 737	139, 247	30. 00
31. 00		INTENSIVE CARE UNIT	o	108, 423			59, 126	
43.00	04300	NURSERY	o	19, 424			10, 593	43. 00
		LARY SERVICE COST CENTERS						
50. 00	1	OPERATING ROOM	0	386, 330			210, 676	
52. 00		DELIVERY ROOM & LABOR ROOM	0	300, 423			163, 828	
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	0	202, 844 96, 526			110, 616 71, 120	
60. 00		BLOOD LABORATORY		90, 320 0	1		71, 120	60.00
65. 00		RESPI RATORY THERAPY		23, 779			12, 968	
66.00	06600	PHYSI CAL THERAPY	o	113, 584		14, 495	61, 940	
66. 01	06601	CARDI AC REHAB	0	59, 775	C	2, 539	32, 597	66. 01
69. 00		ELECTROCARDI OLOGY	0	0		.,	0	69. 00
70.00		ELECTROENCEPHALOGRAPHY	0	0			0	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PAT IMPL. DEV. CHARGED TO PATIENTS	0	0			0	71. 00 72. 00
73.00		DRUGS CHARGED TO PATTENTS		0			0	73.00
70.00		TIENT SERVICE COST CENTERS	<u> </u>			20, 101		70.00
90.00	09000	CLINIC	0	0		863	0	90. 00
		EMERGENCY	0	167, 589	C	21, 614	91, 391	
92. 00		OBSERVATION BEDS (NON-DISTINCT		0				92. 00
05 00		REI MBURSABLE COST CENTERS	0	20 241	1	17.055	20.045	05 00
	09910	AMBULANCE SERVICES	0	38, 261 0			20, 865 0	
		HOME HEALTH AGENCY		2, 420	•		32, 918	
		AL PURPOSE COST CENTERS	-1					
113.00		INTEREST EXPENSE						113. 00
		HOSPI CE	0	262				116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4, 439, 048	(416, 065	1, 181, 311	118. 00
100.00		IMBURSABLE COST CENTERS						100 00
		GIFT FLOWER COFFEE SHOP & CAN RESEARCH	0	0		0		190. 00 191. 00
	1	PHYSICIANS PRIVATE OFFICES		5, 357		1, 004	42, 453	
		DEKALB MEDICAL SERVICES		285, 108		117, 286	621, 456	
		PHARMACARE		0		46, 515		192. 02
	1	NONPALD WORKERS	0	0	(0		193. 00
		OTHER NONREIMBURSABLE COST CENT	0	0	(0		194. 00
		ADULT DAY CARE	0	0	9	0		194. 01
194. 02 200. 00		FOUNDATION Cross Foot Adjustments	0	0	(5	0	194. 02 200. 00
200.00	1	Negative Cost Centers		0	,		0	200. 00
201.00	1	TOTAL (sum lines 118-201)	0	4, 729, 513		580, 875	1, 845, 220	
30	1		, 9	.,, 5.0	,		, ,	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150045

| Peri od: | Worksheet B | From 10/01/2014 | Part II | To 09/30/2015 | Date/Time Prepared:

		,		To	09/30/2015	Date/Time Pre 2/23/2016 3:0	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	
		8.00	9. 00	10.00	10. 01	11. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 MAC WEST - NEW						1. 00 1. 01
1.01	00101 MAC WEST - NEW 00102 NORTH ANNEX - NEW						1.01
1. 03	00103 GARRETT CLINIC - NEW						1. 03
1. 04	00104 BUTLER - NEW						1. 04
1. 05	00105 MAC EAST - NEW						1. 05
1.06	00106 GARRETT LAB - NEW						1. 06
1.07	00107 MEDICAL ARTS - NEW						1. 07
1.08	00108 DAY SPRING - NEW						1. 08
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	41, 394					7. 00 8. 00
9. 00	00900 HOUSEKEEPING	3, 045	80, 827				9.00
10.00	01000 DI ETARY	0,043	640	42, 510			10.00
10. 01	01001 SNACK BAR	o	0	0	80		10. 01
11. 00	01100 CAFETERI A	0	1, 252	0	80	86, 399	1
13.00	01300 NURSI NG ADMI NI STRATI ON	0	563	0	0	2, 520	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	669	0	0	875	14. 00
15. 00	01500 PHARMACY	0	615	0	0	1, 431	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	1, 635	0	0	3, 633	1
17. 00	01700 SOCIAL SERVICE	0	87	0	0	265	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	12 020	4 227	22 221	0	10.070	20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	13, 030 3, 665	6, 227 2, 644	33, 221 9, 289	0	10, 978 4, 366	1
43. 00	04300 NURSERY	3,003	2, 044 474	9, 209	0		43.00
10.00	ANCI LLARY SERVI CE COST CENTERS	J	17.1	<u> </u>	<u> </u>	071	10.00
50.00	05000 OPERATING ROOM	6, 282	9, 421	0	0	7, 220	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	7, 326	0	0	1, 578	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 215	4, 947	0	0	6, 773	54. 00
60.00	06000 LABORATORY	0	3, 180	0	0	6, 926	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	1
65. 00	06500 RESPI RATORY THERAPY	100	580	0	0	2, 250	1
66. 00	06600 PHYSI CAL THERAPY	0	2, 770	0	0	1, 664	1
66. 01 69. 00	06601 CARDI AC REHAB 06900 ELECTROCARDI OLOGY	0	1, 458	0	0	819 551	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	142	0	0	0	230	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	226	0	0	0	294	
91. 00	09100 EMERGENCY	8, 197	4, 087	0	0	5, 701	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	1, 078	933	0	ol	7, 054	95. 00
	09910 CORF	1,078	933	0	0	7, 054	
	10100 HOME HEALTH AGENCY	0	1, 472	0	0		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	Ŭ.	1, 1,2	<u> </u>		0, 710	1.01.00
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	25	159		0	457	116. 00
118.00		41, 005	51, 139	42, 510	80	70, 451	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CLANS PRI VATE OFFI CES	0	1, 898		0		192. 00
	19201 DEKALB MEDI CAL SERVI CES 19202 PHARMACARE	389	27, 790	0	0		192. 01 192. 02
	19202 PHARMACARE 19300 NONPALD WORKERS		0		0		192. 02
	07950 OTHER NONREIMBURSABLE COST CENT		n		n		194. 00
	07951 ADULT DAY CARE	0	n	, o	o o		194. 01
	07952 FOUNDATION	0	o	o	Ö		194. 02
200.00							200. 00
201.00		0	0	0	O		201. 00
202.00	TOTAL (sum lines 118-201)	41, 394	80, 827	42, 510	80	86, 399	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150045

				09/30/2013	2/23/2016 3:0	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	17. 00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	17.00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01 00101 MAC WEST - NEW						1. 01
1.02 00102 NORTH ANNEX - NEW						1. 02
1.03 O0103 GARRETT CLINIC - NEW						1. 03
1.04 00104 BUTLER - NEW						1. 04
1.05 00105 MAC EAST - NEW						1. 05
1.06 00106 GARRETT LAB - NEW						1. 06
1. 07 00107 MEDI CAL ARTS - NEW						1. 07
1. 08 00108 DAY SPRING - NEW						1. 08
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
10. 01 01001 SNACK BAR						10. 01
11. 00 01100 CAFETERI A						11. 00
13.00 01300 NURSING ADMINISTRATION	50, 426					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 184	48, 426				14. 00
15. 00 01500 PHARMACY	0	0	46, 661			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	112, 422		16. 00
17. 00 01700 SOCI AL SERVI CE	358	0	0	0	7, 211	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14.0(4	ما		40.00/	7.044	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	14, 864	0	0	10, 896	7, 211	30.00
31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY	5, 910 1, 206	0	0	5, 269 934	0	31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	1, 200	<u> </u>	U	934	0	43.00
50. 00 05000 OPERATING ROOM	9, 775	ol	0	22, 316	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 139	ő	Ö	1, 655	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	o	0	21, 412	0	54.00
60. 00 06000 LABORATORY	870	Ö	0	15, 961	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	o	0	4, 583	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	3, 531	0	66. 00
66. 01 06601 CARDI AC REHAB	0	0	0	434	0	66. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	1, 185	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	867	0	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	0	48, 426	0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	46, 661	19	0	73. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	398	o	0	318	0	90. 00
91. 00 09100 EMERGENCY	7, 720	0	0	11, 483	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	7,720	ĭ	J	11, 405	O	92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
99. 10 09910 CORF	0	o	0	o	0	•
101.00 10100 HOME HEALTH AGENCY	5, 384	0	0	o	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	618	0	0	636		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	50, 426	48, 426	46, 661	101, 499	7, 211	118. 00
NONREI MBURSABLE COST CENTERS		_1	_	_1		
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	0	0	0	10 023		192. 00
192.01 19201 DEKALB MEDICAL SERVICES 192.02 19202 PHARMACARE		0	0	10, 923		192. 01 192. 02
193. 00 19300 NONPALD WORKERS		0	0	0		192. 02
194. 00 07950 OTHER NONREIMBURSABLE COST CENT		o O	0	ol Ol		194. 00
194. 01 07951 ADULT DAY CARE		n	n	n N		194. 01
194. 02 07952 FOUNDATION		ol	Ö	ol		194. 02
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	o		201. 00
202.00 TOTAL (sum lines 118-201)	50, 426	48, 426	46, 661	112, 422	7, 211	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150045

					'	2/23/2016 3	
	Cost Cent	er Description	Subtotal	Intern &	Total		
				Residents Cost			
				& Post			
				Stepdown Adjustments			
			24. 00	25. 00	26.00		
G	ENERAL SERVICE	COST CENTERS	1				
1.00 0	0100 CAP REL C	OSTS-BLDG & FLXT					1. 00
1	0101 MAC WEST						1. 01
	0102 NORTH ANN						1. 02
	0103 GARRETT C						1. 03
	0104 BUTLER - 0105 MAC EAST						1. 04 1. 05
	0106 GARRETT L						1.05
	0107 MEDICAL A						1. 07
	0108 DAY SPRIN						1. 08
2.00 0	0200 CAP REL C	COSTS-MVBLE EQUIP					2. 00
1	1	BENEFITS DEPARTMENT					4. 00
		ATIVE & GENERAL					5. 00
1	0700 OPERATION						7.00
1	0900 HOUSEKEEP	LINEN SERVICE					8. 00 9. 00
1	1000 DI ETARY	TING					10.00
	1001 SNACK BAR						10. 01
1	1100 CAFETERI A						11. 00
13. 00 0	1300 NURSING A	DMI NI STRATI ON					13. 00
1	1	SERVICES & SUPPLY					14. 00
	1500 PHARMACY						15. 00
1	1	RECORDS & LI BRARY					16. 00
_	1700 SOCIAL SE						17. 00
	3000 ADULTS &	NE SERVICE COST CENTERS	522, 757	0	522, 757		30.00
1	3100 I NTENSI VE		215, 686	ł .			31.00
1	4300 NURSERY	ONICE ON T	37, 548	ł			43. 00
		CE COST CENTERS	,				
- 1	5000 OPERATI NG		687, 672	0	687, 672		50. 00
		ROOM & LABOR ROOM	487, 158	l e			52. 00
	5400 RADI OLOGY		389, 273	l e			54.00
	6000 LABORATOR		233, 720	0			60.00
	6001 BLOOD LAB		51, 898				60. 01 65. 00
	6600 PHYSI CAL		197, 984				66.00
1	6601 CARDI AC R		97, 622	0			66. 01
69.00 0	6900 ELECTROCA	RDI OLOGY	2, 987	0	2, 987		69. 00
	7000 ELECTROEN		2, 110	0			70. 00
		SUPPLIES CHARGED TO PAT	68, 298	l			71. 00
		CHARGED TO PATIENTS	11, 638				72. 00
		RGED TO PATIENTS /ICE COST CENTERS	73, 081	0	73, 081		73. 00
	9000 CLINIC	TICE COST CENTERS	2,099	0	2, 099		90.00
1	9100 EMERGENCY	,	317, 782	l e			91. 00
		ON BEDS (NON-DISTINCT		0			92. 00
		ABLE COST CENTERS					
	9500 AMBULANCE	SERVI CES	85, 246	0	85, 246		95. 00
	9910 CORF	THE ACENON	0	0			99. 10
	0100 HOME HEAL PECLAL PURPOSE		58, 855	0	58, 855		101. 00
	1300 I NTEREST						113. 00
	1600 HOSPI CE	LAFENSE	9, 967	0	9, 967		116.00
118. 00		(SUM OF LINES 1-117)	3, 553, 381	Ö			118. 00
	ONREI MBURSABLE		, , , , , , , , , , , , , , , , , , , ,				
		WER COFFEE SHOP & CAN	0	0	0		190. 00
	9100 RESEARCH		0	0			191. 00
		IS PRIVATE OFFICES	51, 704	l e			192. 00
		DI CAL SERVI CES	1, 077, 908	l e	, . ,		192. 01
	9202 PHARMACAR 9300 NONPALD W		46, 515		46, 515		192. 02 193. 00
		IREIMBURSABLE COST CENT					193.00
	7951 ADULT DAY		0	ا م			194. 01
	7952 FOUNDATIO		5	o	5		194. 02
200.00		t Adjustments	0	0	0		200. 00
201.00		Cost Centers	0	0			201. 00
202.00	TOTAL (su	m lines 118-201)	4, 729, 513	0	4, 729, 513		202. 00

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 150045

Peri od: Worksheet B-1 From 10/01/2014 To 09/30/2015 Date/Time Prepared:

2/23/2016 3:08 pm CAPITAL RELATED COSTS BLDG & FIXT MAC WEST - NEW NORTH ANNEX - GARRETT CLINIC BUTLER - NEW Cost Center Description (SOUARE FEET) NFW (SOUARE FEET) NEW (SQUARE FEET) (SQUARE FEET) (SQUARE FEET) 1.04 1.00 1.01 1.02 1.03 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 205, 077 1.00 00101 MAC WEST - NEW 1.01 1.01 0 16, 334 1.02 1.02 00102 NORTH ANNEX - NEW 0 4, 896 00103 GARRETT CLINIC - NEW 0 1.03 0 0 3, 750 1.03 0 00104 BUTLER - NEW 4, 977 1.04 0 1.04 0 00105 MAC EAST - NEW 0 1.05 0 Ω 1.05 1.06 00106 GARRETT LAB - NEW 0 C 0 0 0 1.06 1.07 00107 MEDICAL ARTS - NEW 0 0 0 0 1.07 o 00108 DAY SPRING - NEW 0 0 1 08 C 0 1 08 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 25, 743 0 0 5.00 0 00700 OPERATION OF PLANT 7 00 80 191 2 931 0 7 00 0 8.00 00800 LAUNDRY & LINEN SERVICE 1, 194 0 0 8.00 00900 HOUSEKEEPI NG 9.00 1,909 0 0 0 0 0 0 0 9.00 01000 DI ETARY 10 00 1,002 Ω 0 10 00 10.01 01001 SNACK BAR 0 10.01 01100 CAFETERI A 2, 357 11.00 11.00 0 13.00 01300 NURSING ADMINISTRATION 1,060 0 13.00 0 01400 CENTRAL SERVICES & SUPPLY 0 1, 259 14 00 Ω 0 14 00 0 15.00 01500 PHARMACY 1, 158 0 0 0 15.00 2, 795 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 164 0 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 726 0 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 4,979 0 31.00 04300 NURSERY 43.00 892 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 741 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 13, 796 0 52.00 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 9.315 0 0 0 0 54.00 06000 LABORATORY 0 60.00 4, 189 664 784 352 60.00 06001 BLOOD LABORATORY 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 1,092 0 0 0 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 5, 216 66.00 0 0 06601 CARDI AC REHAB 66.01 2.745 C 0 66.01 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 Λ 71.00 Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 7,696 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1,757 0 0 0 95.00 0 09910 CORF 0 99. 10 99. 10 C 0 0 0 101.00 10100 HOME HEALTH AGENCY 2.772 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 300 0 116.00 118 00 SUBTOTALS (SUM OF LINES 1-117) 199.976 3.595 3,072 784 352 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00 0 0 191.00 191. 00 19100 RESEARCH 0 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 3, 575 0 192 00 0 0 0 192. 01 19201 DEKALB MEDICAL SERVICES 5, 101 9, 164 1,824 2, 966 4, 625 192. 01 192. 02 19202 PHARMACARE 0 192. 02 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 0 194.00 07950 OTHER NONREIMBURSABLE COST CENT 0 0 194 00 0 C 194.01 07951 ADULT DAY CARE 0 C 0 0 0 194. 01 194. 02 07952 FOUNDATI ON 0 194. 02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 11, 914 202. 00 4, 465, 775 24, 478 4, 274 16, 587 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 21. 776089 1.498592 0.872958 4. 423200 2. 393812 203. 00 Cost to be allocated (per Wkst. B, 204. 00 204.00 Part II)

Health Financial Systems	DEKALB MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 10/01/2014		nanad.
				Го 09/30/2015	Date/Time Pre 2/23/2016 3:0	pared: 08 pm
		CAP	ITAL RELATED (OSTS		
Cost Center Description	BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX -	GARRETT CLINIC	BUTLER - NEW	
	(SQUARE FEET)		NEW	- NEW	(SQUARE FEET)	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
	1.00	1. 01	1. 02	1. 03	1. 04	
205.00 Unit cost multiplier (Wkst. B, Part						205. 00

Provi der CCN: 150045

Peri od: From 10/01/2014 To 09/30/2015 Date/Time Prepared: 2/23/2016 3: 08 pm

			CAP	TTAL RELATED CO		2/23/2016 3: 0	
	Cost Center Description	MAC FAST - NEW	GARRETT LAB -	MEDICAL ARTS -	DAY SPRING -	MVBLE EQUIP	
	5551 551161 25551 171 511		NEW	NEW	NEW	(SQUARE FEET)	
		(SQUARE FEET) 1.05	1.06	(SQUARE FEET) 1.07	(SQUARE FEET) 1.08	2. 00	
	GENERAL SERVI CE COST CENTERS						
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 MAC WEST - NEW						1. 00
1. 01	00101 WAC WEST - NEW						1. 02
1.03	00103 GARRETT CLINIC - NEW						1. 03
1.04	00104 BUTLER - NEW	27 401					1.04
1. 05 1. 06	00105 MAC EAST - NEW 00106 GARRETT LAB - NEW	37, 481	0				1. 05 1. 06
1. 07	00107 MEDICAL ARTS - NEW		Ö	8, 575			1. 07
1. 08	00108 DAY SPRING - NEW	0	0	0	0		1. 08
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0		_	0	205, 077 0	2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 019		0	0	25, 743	1
7. 00	00700 OPERATION OF PLANT	11, 140		680	0	80, 191	1
8.00	00800 LAUNDRY & LINEN SERVICE	0		l -	0	1, 194	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	76 204		0	0	1, 909 1, 002	1
10. 00	01001 SNACK BAR	204		0	0	1,002	1
11. 00	01100 CAFETERI A	0	0	0	0	2, 357	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	1, 060	1
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY		0	0	0	1, 259 1, 158	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	284	0	0	0	2, 795	1
17. 00	01700 SOCIAL SERVICE	0	0	0	0	164	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1 0		0	11 72/	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	l .				1
43. 00	04300 NURSERY	0	l .				1
	ANCILLARY SERVICE COST CENTERS	1	1				
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0		·		1	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C			0	_	9, 315	1
60.00	06000 LABORATORY	0	0	0	0	4, 189	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	0	0	1, 092 5, 216	
66. 01	06601 CARDI AC REHAB		0	0	0	2, 745	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS			·	_	ő	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C 09100 EMERGENCY	0					90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT			0	0	7,090	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0	_	0	_	.,	
	09910 CORF 10100 HOME HEALTH AGENCY	0					99. 10 101. 00
101.00	SPECIAL PURPOSE COST CENTERS						101.00
	11300 INTEREST EXPENSE						113. 00
116. 00 118. 00	11600 HOSPI CE	16, 723					116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	10,723	0	680	0	199, 976]118.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	1	0	_		191. 00
	19200 PHYSICIANS PRIVATE OFFICES 19201 DEKALB MEDICAL SERVICES	20. 750	ļ	0 7, 895	_		192. 00 192. 01
	19201 DERALB MEDICAL SERVICES	20, 758		7, 895 0	0		192. 01
	19300 NONPALD WORKERS	0	Ö	0	0	•	193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194. 00
	07951 ADULT DAY CARE 07952 FOUNDATION	0	0	0	0		194. 01 194. 02
200.00							200. 00
201.00							201. 00
202.00	Cost to be allocated (per Wkst. B,	151, 548	0	54, 937	0	0	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	4. 043329	0. 000000	6. 406647	0. 000000	0. 000000	202 00
203.00		4. 043329	0.000000	0.400047	0.00000	0.00000	203.00
	Part II)						
-							

Health Financial Systems	DEKALB MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1		
				From 10/01/2014 Fo 09/30/2015	Date/Time Pre 2/23/2016 3:0	pared: 8 pm	
		CAP	ITAL RELATED (OSTS			
Cook Cooks Doors at to	MAC FACT NEW	CARRETT LAR	MEDICAL ADTO	DAY CDDING	MANDLE FOLLID		
Cost Center Description	MAC EAST - NEW	NFW	NFW	- DAY SPRING - NEW	MVBLE EQUIP (SQUARE FEET)		
	(SQUARE FEET)		(SQUARE FEET)		(SQUARE TELT)		
	1. 05	1. 06	1. 07	1. 08	2. 00		
205.00 Unit cost multiplier (Wkst. B, Part						205. 00	

	LOCATION - STATISTICAL BASIS	DERAED WEWORT		CCN: 150045 P	'eri od:	Worksheet B-1	
				T	rom 10/01/2014 o 09/30/2015	Date/Time Pre 2/23/2016 3:0	pared:
	Cost Center Description	EMPLOYEE F BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	J P
	DENIEDAL CEDIU OF COCT CENTEDO	4.00	5A	5. 00	7. 00	8. 00	
1. 00	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT D0101 MAC WEST - NEW D0102 NORTH ANNEX - NEW D0103 GARRETT CLINIC - NEW D0104 BUTLER - NEW D0105 MAC EAST - NEW D0106 GARRETT LAB - NEW						1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06
1. 07	DO107 MEDICAL ARTS - NEW DO108 DAY SPRING - NEW DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL DO700 OPERATION OF PLANT DO800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION	26, 681, 366 3, 554, 125 642, 064 28, 346 601, 897 202, 446 27, 233 334, 640 726, 485	-8, 411, 109 0 0 0 0 0 0	49, 878, 594 3, 879, 636 104, 284 1, 058, 925 421, 050 6, 830 493, 792 1, 002, 205	155, 386 1, 194 1, 985 1, 206 0 2, 357	287, 361 21, 139 0 0 0	1. 07 1. 08 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
15. 00 0 16. 00 0 17. 00 0	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	90, 762 441, 807 495, 498 66, 584	0 0 0 0		1, 158 3, 079	0 0 0 0	15. 00 16. 00
30. 00 0 31. 00 0 43. 00 0	030000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	1, 964, 192 930, 199 209, 778	0 0 0	1, 459, 231	4, 979	90, 467 25, 440 0	31.00
52. 00 0 54. 00 0 60. 01 0 65. 00 0 66. 01 0 69. 00 0	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM D5400 RADIOLOGY-DIAGNOSTIC D6000 LABORATORY D6001 BLOOD LABORATORY D6500 RESPIRATORY THERAPY D6600 PHYSICAL THERAPY D6601 CARDIAC REHAB D6900 ELECTROCARDIOLOGY	1, 656, 799 371, 888 1, 576, 531 1, 324, 116 0 463, 272 297, 695 141, 853 84, 135	0 0 0 0 0 0 0	3, 360, 517 0 655, 805 1, 244, 647 217, 976 107, 435	13, 796 9, 315 5, 989 0 1, 092 5, 216 2, 745	43, 613 0 36, 200 0 0 692 0 0	52. 00 54. 00 60. 00 60. 01 65. 00 66. 00 66. 01 69. 00
71. 00 0 72. 00 0 73. 00 0	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	46, 077 0 0 0	0 0 0	74, 787 1, 706, 314 999, 275 2, 267, 000	0 0 0	984 0 0 0	71. 00 72. 00 73. 00
91. 00 0 92. 00 0	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT 0THER REIMBURSABLE COST CENTERS	62, 271 1, 301, 998	0	74, 137 1, 855, 947		1, 568 56, 904	
95. 00 0 99. 10 0 101. 00 1	09500 AMBULANCE SERVICES 09910 CORF 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 122, 144 0 722, 932	0 0 0	C	0	7, 481 0 0	1
113. 00 1 116. 00 1 118. 00	11300 INTEREST EXPENSE 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	134, 238 19, 622, 005	0 -8, 411, 109	364, 684 35, 725, 903	99, 478	284, 660	1
191. 00 1 192. 00 1 192. 01 1 192. 02 1 193. 00 1 194. 00 0	19000 GIFT FLOWER COFFEE SHOP & CAN 19100 RESEARCH 19200 PHYSI CI ANS PRI VATE OFFICES 19201 DEKALB MEDI CAL SERVI CES 19202 PHARMACARE 19300 NONPAI D WORKERS 07950 OTHER NONREIMBURSABLE COST CENT 07951 ADULT DAY CARE 07952 FOUNDATI ON Cross Foot Adjustments	0 0 37,685 6,617,106 404,570 0 0 0	0 0 0 0 0 0 0	0 86, 198 10, 072, 020 3, 994, 077 0 0 0	52, 333 0 0 0 0	0 0 2, 701 0 0 0 0	190. 00 191. 00 192. 00 192. 01 192. 02 193. 00 194. 00 194. 01 194. 02 200. 00
201. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	1, 079, 451		8, 411, 109	4, 533, 867	156, 709	201.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 040457 0		0. 168632 580, 875		0. 545338 41, 394	203. 00 204. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1		
				rom 10/01/2014			
				o 09/30/2015	Date/Time Pre 2/23/2016 3:0	parea: 8 nm	
Cost Center Description	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	O PIII	
	BENEFITS		& GENERAL	PLANT	LINEN SERVICE		
	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF		
	(UNADJUSTED				LAUNDRY)		
	SALARY)						
	4.00	5A	5.00	7. 00	8. 00		
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000)	0. 011646	11. 875072	0. 144049	205. 00	
)		1					

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	DEKALB MEMORI		CCN: 150045 P	eri od:	u of Form CMS-: Worksheet B-1	2552-10
			T T	rom 10/01/2014 o 09/30/2015	Date/Time Pre 2/23/2016 3:0	
Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	SNACK BAR	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON	
	(SQUARE TEET)	(WLALS SERVED)	(WLALS SERVED)	(LIE3)		
	0.00	10.00	10.01	44.00	(DI RECT NRS I NG)	
GENERAL SERVICE COST CENTERS	9. 00	10. 00	10. 01	11. 00	13. 00	
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 MAC WEST - NEW 1.02 00103 GARRETT CLINIC - NEW 1.03 00103 GARRETT CLINIC - NEW 1.04 00104 BUTLER - NEW 1.05 00105 MAC EAST - NEW 1.06 00106 GARRETT LAB - NEW 1.07 00107 MEDICAL ARTS - NEW 1.08 00108 DAY SPRING - NEW 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING	152, 207					1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 1. 08 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00
10. 00 01000 DI ETARY	1, 206	27, 157				10. 00
10. 01 01001 SNACK BAR 11. 00 01100 CAFETERI A	0 2, 357	0	1 1	32, 298		10. 01 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	1, 060 1, 259	0	0	942 327	289, 563 6, 800	1
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 158 3, 079	0	0	535	0	15. 00
17. 00 01700 SOCI AL SERVI CE	164	0	0		2, 056	1
30.00 O3000 ADULTS & PEDIATRICS	11, 726	21, 223	0		85, 357	
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	4, 979 892	5, 934 0	0		33, 935 6, 927	1
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	17, 741	0	0		56, 132	
52.00 05200 DELIVERY ROOM & LABOR ROOM	13, 796	0	0	590	12, 280	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	9, 315 5, 989	0	0	2, 532 2, 589	0 4, 994	60.00
60. 01 06001 BL00D LABORATORY 65. 00 06500 RESPI RATORY THERAPY	1, 092	0	0	0 841	0	60. 01 65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 CARDI AC REHAB	5, 216 2, 745	0	0	622 306	0	66. 00 66. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	206	0	69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	86 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			-	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0	0		2, 284	90.00
91. 00 09100 EMERGENCY	7, 696		ő		44, 331	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVI CES 99. 10 09910 CORF	1, 757 0	0	0		0	
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	2, 772	O	0		-	101. 00
113.00 11300 I NTEREST EXPENSE						113. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	300 96, 299	0 27, 157	0		3, 548 289, 563	116. 00 118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
191.00 19100 RESEARCH 192.00 19200 PHYSI CI ANS PRI VATE OFFI CES	0	0		o	0	191. 00 192. 00
192. 01 19201 DEKALB MEDICAL SERVICES	3, 575 52, 333	0	0	371 5, 591	0	192. 01
192. 02 19202 PHARMACARE 193. 00 19300 NONPALD WORKERS	0	0	0	0 0		192. 02 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194. 00 194. 01
194. 01 07951 ADULT DAY CARE 194. 02 07952 FOUNDATION	0	0	0	0		194. 01
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 306, 941	537, 597	7, 982	674, 055	1, 230, 899	
203.00 Unit cost multiplier (Wkst. B, Part I)	8. 586602	19. 795891	7, 982. 000000		4. 250885	1
204.00 Cost to be allocated (per Wkst. B, Part II)	80, 827	42, 510	80	86, 399	50, 426	204. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1		
				From 10/01/2014 To 09/30/2015	Date/Time Pre 2/23/2016 3:0		
Cost Center Description	HOUSEKEEPI NG		SNACK BAR	CAFETERI A	NURSI NG		
	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED) (FTES)	ADMI NI STRATI ON		
					(DI RECT NRS		
					ING)		
	9. 00	10.00	10. 01	11.00	13. 00		
205.00 Unit cost multiplier (Wkst. B, Part	0. 531033	1. 565342	80.00000	0 2. 675057	0. 174145	205. 00	
1)							

	Financial Systems	DEKALB MEMORIA				U OF FORM CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 10/01/2014 To 09/30/2015	Worksheet B-1 Date/Time Prepared:
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	2/23/2016 3:08 pm
	<u>'</u>	SERVICES &	(COSTED	RECORDS &		
		SUPPLY (COSTED	REQUI S.)	LI BRARY (GROSS REVE	(TIME SPENT)	
		REQUIS.)		NUE)		
		14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS					
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FLXT OO101 MAC WEST - NEW					1.00
1.01	00101 MAC WEST - NEW					1.01
1. 03	00103 GARRETT CLINIC - NEW					1. 03
1.04	00104 BUTLER - NEW					1. 04
1.05	00105 MAC EAST - NEW					1. 05
1. 06 1. 07	OO106 GARRETT LAB - NEW OO107 MEDICAL ARTS - NEW					1.06
1.07	00107 MEDICAL ARTS - NEW					1.07
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	1				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY	1				10.00
10. 01	01001 SNACK BAR					10. 01
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	100				13.00
15. 00	01500 PHARMACY	0	100			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	126, 517, 564	ļ	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	C	100	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0	10 054 571	100	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0	12, 256, 571 5, 926, 778		30.00
43. 00	04300 NURSERY	0	0	1, 050, 185		43. 00
	ANCILLARY SERVICE COST CENTERS	,				
50.00	05000 OPERATI NG ROOM	0	0	25, 158, 800		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1, 861, 737		52.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	0	24, 085, 151 17, 954, 379		54. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	Ö	((((((((((((((((((((60. 01
65. 00	06500 RESPIRATORY THERAPY	0	0	5, 155, 423	o o	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	3, 972, 181	I .	66. 00
66. 01 69. 00	O6601 CARDI AC REHAB O6900 ELECTROCARDI OLOGY	0	0	488, 749 1, 333, 223		66. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	974, 990		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	100	0	,	o o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	100	21, 896	0	73. 00
90 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0	357, 782		90.00
91. 00	09100 EMERGENCY	0	0	12, 917, 290		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT					92. 00
	OTHER REIMBURSABLE COST CENTERS		_			
	09500 AMBULANCE SERVI CES 09910 CORF	0	0		1	95. 00 99. 10
	10100 HOME HEALTH AGENCY	0	0		1	101.00
	SPECIAL PURPOSE COST CENTERS				-1	
	11300 NTEREST EXPENSE					113. 00
	11600 HOSPI CE	0	0	715, 591		116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	100	100	114, 230, 726	100	118. 00
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		0	190. 00
	19100 RESEARCH	0	O	d	1	191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	192. 00
	19201 DEKALB MEDI CAL SERVI CES	0	0	12, 286, 838	0	192. 01
	19202 PHARMACARE 19300 NONPALD WORKERS	0	0			192. 02 193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0			194. 00
	07951 ADULT DAY CARE		0		ol ol	194. 01
194. 02	07952 FOUNDATI ON	0	0		o	194. 02
200.00	1 1					200. 00
201.00		417 570	(01 E/0	1 005 470	115 51/	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	417, 570	621, 563	1, 005, 470	115, 516	202. 00
		1		l	1	
203.00	Unit cost multiplier (Wkst. B, Part I)	4, 175. 700000	6, 215. 630000	0. 007947	1, 155. 160000	203. 00
203. 00 204. 00		4, 175. 700000 48, 426	6, 215. 630000 46, 661	0. 007947 112, 422		203. 00 204. 00

DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	Provi der			Worksheet B-1	
CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
SERVICES &	(COSTED	RECORDS &			
SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)		
(COSTED		(GROSS REVE			
REQUIS.)		NUE)			
14.00	15. 00	16. 00	17. 00		
484. 260000	466. 610000	0. 000889	72. 110000		205. 00
	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	CENTRAL PHARMACY SERVI CES & (COSTED SUPPLY REQUI S.) (COSTED REQUI S.) 14. 00 15. 00	Provi der CCN: 150045 F F	Provi der CCN: 150045	Provider CCN: 150045

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	Peri od: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/23/2016 3:08 pm

					10 09/30/2015	Date/lime Pre 2/23/2016 3:0	
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
Cost C	Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	•	(from Wkst. B,	Ādj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT RO	DUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS	S & PEDIATRICS	4, 758, 389		4, 758, 38	9 0	4, 758, 389	30.00
31. 00 03100 I NTENS	SIVE CARE UNIT	2, 250, 091		2, 250, 09	1 0	2, 250, 091	31.00
43.00 04300 NURSER	RY	482, 391		482, 39	1 0	482, 391	43.00
ANCILLARY SE	ERVICE COST CENTERS						
50. 00 05000 OPERAT	ING ROOM	4, 766, 213		4, 766, 21	3 0	4, 766, 213	50.00
52. 00 05200 DELI VE	RY ROOM & LABOR ROOM	1, 624, 696		1, 624, 69	6 0	1, 624, 696	52.00
54. 00 05400 RADI OL	LOGY-DI AGNOSTI C	4, 375, 319		4, 375, 31	9 0	4, 375, 319	54.00
60. 00 06000 LABORA	ATORY	4, 371, 325		4, 371, 32	5 0	4, 371, 325	60.00
60. 01 06001 BL00D	LABORATORY	0			0	0	60. 01
65. 00 06500 RESPIR	RATORY THERAPY	866, 533	0	866, 53	3 0	866, 533	65. 00
66. 00 06600 PHYSI C	CAL THERAPY	1, 696, 063	0	1, 696, 06	3 0	1, 696, 063	66. 00
66. 01 06601 CARDI A	AC REHAB	368, 668	0	368, 66	8 0	368, 668	66. 01
69. 00 06900 ELECTR	ROCARDI OLOGY	140, 446		140, 44	6 0	140, 446	69. 00
70. 00 07000 ELECTR	ROENCEPHALOGRAPHY	97, 478		97, 47	8 0	97, 478	70. 00
71. 00 07100 MEDI CA	AL SUPPLIES CHARGED TO PAT	2, 411, 623		2, 411, 62	3 0	2, 411, 623	71. 00
72.00 07200 I MPL.	DEV. CHARGED TO PATIENTS	1, 167, 785		1, 167, 78	5 0	1, 167, 785	72. 00
73. 00 07300 DRUGS	CHARGED TO PATIENTS	3, 271, 026		3, 271, 02	6 0	3, 271, 026	73. 00
	SERVICE COST CENTERS				<u> </u>		
90. 00 09000 CLI NI C		102, 342		102, 34	2 0	102, 342	90.00
91.00 09100 EMERGE	ENCY	2, 826, 162		2, 826, 16	2 0	2, 826, 162	91.00
92. 00 09200 OBSERV	ATION BEDS (NON-DISTINCT	748, 727		748, 72	7	748, 727	92.00
OTHER REIMBL	JRSABLE COST CENTERS						
95. 00 09500 AMBULA	ANCE SERVICES	1, 836, 886		1, 836, 88	6 0	1, 836, 886	95. 00
99. 10 09910 CORF		0			0	0	99. 10
101.00 10100 HOME H	HEALTH AGENCY	1, 540, 166		1, 540, 16	6	1, 540, 166	101. 00
SPECIAL PURF	POSE COST CENTERS						
113. 00 11300 I NTERE	ST EXPENSE						113. 00
116. 00 11600 HOSPI 0	Œ	461, 942		461, 94	2	461, 942	116. 00
200. 00 Subtot	al (see instructions)	40, 164, 271	0	40, 164, 27	1 0	40, 164, 271	200.00
201.00 Less 0	Observation Beds	748, 727		748, 72	7	748, 727	201.00
202.00 Total	(see instructions)	39, 415, 544	0	39, 415, 54	4 0	39, 415, 544	202. 00
		•	•	•	•	•	•

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: Worksheet C From 10/01/2014 Part I To 09/30/2015 Date/Ti me Prepared:

						0 09/30/2015	Date/lime Pre 2/23/2016 3:0	
				Ti tl	e XVIII	Hospi tal	PPS	o piii
				Charges				
		Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·		·	+ col. 7)	Ratio	Inpati ent	
							Rati o	
			6.00	7. 00	8. 00	9. 00	10.00	
		IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10, 061, 482		10, 061, 482	2		30. 00
31.00	03100	INTENSIVE CARE UNIT	4, 425, 869		4, 425, 869			31. 00
43.00	04300	NURSERY	1, 036, 425		1, 036, 425	5		43. 00
		LARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3, 173, 293	13, 441, 538	16, 614, 831	0. 286865	0.000000	50. 00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1, 830, 612	8, 409	1, 839, 021	0. 883457	0.000000	52. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	2, 016, 192	21, 510, 994	23, 527, 186	0. 185969	0.000000	54.00
60.00	06000	LABORATORY	3, 050, 056	17, 881, 093	20, 931, 149	0. 208843	0.000000	60.00
60. 01	06001	BLOOD LABORATORY	0	0	(0.000000	0.000000	60. 01
65.00	06500	RESPI RATORY THERAPY	3, 617, 449	920, 417	4, 537, 866	0. 190956	0.000000	65. 00
66.00	06600	PHYSI CAL THERAPY	834, 136	3, 080, 909	3, 915, 045	0. 433217	0.000000	66. 00
66. 01	06601	CARDI AC REHAB	5, 867	475, 244	481, 11°	0. 766285	0.000000	66. 01
69.00	06900	ELECTROCARDI OLOGY	253, 325	1, 060, 553	1, 313, 878	0. 106894	0.000000	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	585	959, 098	959, 683	0. 101573	0.000000	70. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1, 716, 550	4, 153, 775	5, 870, 325	0. 410816	0.000000	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2, 741, 584	1, 124, 969	3, 866, 553	0. 302022	0.000000	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	2, 381, 554	4, 310, 677	6, 692, 231	0. 488780	0.000000	73. 00
	OUTPA	TIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	170	234, 544	234, 714	0. 436029	0. 000000	90. 00
91.00	09100	EMERGENCY	2, 284, 787	10, 197, 205	12, 481, 992	0. 226419	0.000000	91. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2, 118, 399	2, 118, 399	0. 353440	0.000000	92. 00
	OTHER	REIMBURSABLE COST CENTERS						
		AMBULANCE SERVICES	0	5, 757, 465	5, 757, 465	0. 319044	0. 000000	
99. 10	09910	CORF	0	0	(99. 10
101.00	0 10100	HOME HEALTH AGENCY	0	1, 016, 253	1, 016, 253	3		101. 00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113. 00
116.00	0 11600	HOSPI CE	22, 097	682, 396	704, 493	3		116. 00
200.00	0	Subtotal (see instructions)	39, 452, 033	88, 933, 938	128, 385, 97			200. 00
201.00	0	Less Observation Beds						201. 00
202.00	0	Total (see instructions)	39, 452, 033	88, 933, 938	128, 385, 97			202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Fo	orm CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	From 10/01/2014 Part I To 09/30/2015 Date/	I

				2/23/2016 3:08 pr	<u>m</u>
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	0. 00
31.00 03100 INTENSIVE CARE UNIT				31	. 00
43. 00 04300 NURSERY				43	3. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 286865			50	0. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 883457			52	2. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 185969			54	1. 00
60. 00 06000 LABORATORY	0. 208843			60	0. 00
60. 01 06001 BLOOD LABORATORY	0. 000000			60	0. 01
65. 00 06500 RESPI RATORY THERAPY	0. 190956			65	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 433217			66	6. 00
66. 01 06601 CARDI AC REHAB	0. 766285			66	5. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 106894			69	9. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 101573			70	0. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 410816			71	. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 302022			72	2. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 488780			73	3. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 436029			90	0. 00
91. 00 09100 EMERGENCY	0. 226419			91	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 353440			92	2. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 319044			95	5. 00
99. 10 09910 CORF				99	9. 10
101.00 10100 HOME HEALTH AGENCY				101	. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 NTEREST EXPENSE				113	3. 00
116. 00 11600 HOSPI CE				116	o. 00
200.00 Subtotal (see instructions)				200	0. 00
201.00 Less Observation Beds				201	. 00
202.00 Total (see instructions)				202	2. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	From 10/01/2014	Worksheet C Part I Date/Time Prepared: 2/23/2016 3:08 pm
	T1.11 V1.V		0 1

					10 09/30/2015	2/23/2016 3:0	
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4, 758, 389		4, 758, 38	9 0	4, 758, 389	30.00
31. 00 03100	INTENSIVE CARE UNIT	2, 250, 091		2, 250, 09	1 0	2, 250, 091	31.00
43. 00 04300	NURSERY	482, 391		482, 39	1 0	482, 391	43.00
ANCI LL	ARY SERVICE COST CENTERS						1
50.00 05000	OPERATING ROOM	4, 766, 213		4, 766, 21	3 0	4, 766, 213	50.00
52. 00 05200	DELIVERY ROOM & LABOR ROOM	1, 624, 696		1, 624, 69	6 0	1, 624, 696	52.00
54. 00 05400	RADI OLOGY-DI AGNOSTI C	4, 375, 319		4, 375, 31	9 0	4, 375, 319	54. 00
60.00 06000	LABORATORY	4, 371, 325		4, 371, 32	5 0	4, 371, 325	60.00
60. 01 06001	BLOOD LABORATORY	0			0	0	60. 01
65.00 06500	RESPI RATORY THERAPY	866, 533	0	866, 53	3 0	866, 533	65. 00
66.00 06600	PHYSI CAL THERAPY	1, 696, 063	0	1, 696, 06	3 0	1, 696, 063	66. 00
66. 01 06601	CARDI AC REHAB	368, 668	0	368, 66	8 0	368, 668	66. 01
69.00 06900	ELECTROCARDI OLOGY	140, 446		140, 44	6 0	140, 446	69. 00
70.00 07000	ELECTROENCEPHALOGRAPHY	97, 478		97, 47	8 0	97, 478	70.00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PAT	2, 411, 623		2, 411, 62	3 0	2, 411, 623	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	1, 167, 785		1, 167, 78		1, 167, 785	
73. 00 07300	DRUGS CHARGED TO PATIENTS	3, 271, 026		3, 271, 02	6 0	3, 271, 026	
	TIENT SERVICE COST CENTERS				•		1
90. 00 09000	CLINIC	102, 342		102, 34	2 0	102, 342	90.00
91. 00 09100	EMERGENCY	2, 826, 162	l e	2, 826, 16		2, 826, 162	1
92.00 09200	OBSERVATION BEDS (NON-DISTINCT	748, 727		748, 72		748, 727	
	REI MBURSABLE COST CENTERS				•		1
	AMBULANCE SERVICES	1, 836, 886		1, 836, 88	6 0	1, 836, 886	95. 00
99. 10 09910		0		, ,		0	99. 10
	HOME HEALTH AGENCY	1, 540, 166		1, 540, 16	6	1, 540, 166	101.00
	L PURPOSE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	l	, , , , , , ,		, ,	1
	INTEREST EXPENSE						113. 00
116. 00 11600		461, 942		461, 94	2	461, 942	116, 00
	Subtotal (see instructions)	40, 164, 271	0			40, 164, 271	1
	Less Observation Beds	748, 727		748, 72		748, 727	
	Total (see instructions)	39, 415, 544	l e			'	
1	•		-		1		1 1 1 1 1

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	Period: Worksheet C From 10/01/2014 Part I
		To 09/30/2015 Date/Time Prepared:

				j	To 09/30/2015	Date/Time Pre 2/23/2016 3:0	pared: 8 pm
			Ti t	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	10, 061, 482		10, 061, 482			30.00
31.00	03100 INTENSIVE CARE UNIT	4, 425, 869		4, 425, 869			31. 00
43.00	04300 NURSERY	1, 036, 425		1, 036, 425	5		43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 173, 293	13, 441, 538	16, 614, 831		0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 830, 612	8, 409	1, 839, 021	0. 883457	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 016, 192	21, 510, 994	23, 527, 186	0. 185969	0.000000	54.00
60.00	06000 LABORATORY	3, 050, 056	17, 881, 093	20, 931, 149	0. 208843	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(0.000000	0.000000	60. 01
65.00	06500 RESPI RATORY THERAPY	3, 617, 449	920, 417	4, 537, 866	0. 190956	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	834, 136	3, 080, 909	3, 915, 045	0. 433217	0.000000	66. 00
66. 01	06601 CARDI AC REHAB	5, 867	475, 244	481, 111	0. 766285	0.000000	66. 01
69.00	06900 ELECTROCARDI OLOGY	253, 325	1, 060, 553	1, 313, 878	0. 106894	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	585	959, 098	959, 683	0. 101573	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 716, 550	4, 153, 775	5, 870, 325	0. 410816	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 741, 584	1, 124, 969	3, 866, 553	0. 302022	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 381, 554	4, 310, 677	6, 692, 231	0. 488780	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	170	234, 544	234, 714	0. 436029	0.000000	90.00
91.00	09100 EMERGENCY	2, 284, 787	10, 197, 205	12, 481, 992	0. 226419	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	2, 118, 399	2, 118, 399	0. 353440	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	5, 757, 465	5, 757, 465	0. 319044	0.000000	95. 00
99. 10	09910 CORF	0	0				99. 10
101.00	10100 HOME HEALTH AGENCY	0	1, 016, 253	1, 016, 253	3		101. 00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>		•	<u>'</u>		
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	22, 097	682, 396	704, 493	3		116. 00
200.00		39, 452, 033	88, 933, 938				200. 00
201.00	, ,						201. 00
202.00		39, 452, 033	88, 933, 938	128, 385, 971			202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/23/2016 3:08 pm

					2/23/2016 3:08 pm	n
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Rati o				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00						0. 00
31. 00						. 00
43.00					43.	3. 00
	ANCILLARY SERVICE COST CENTERS					
50.00		0. 000000				0. 00
52.00		0. 000000			I -	2. 00
54.00		0. 000000			54.	. 00
60.00		0. 000000				0. 00
60. 01	06001 BLOOD LABORATORY	0. 000000			60.	0. 01
65.00	06500 RESPIRATORY THERAPY	0. 000000			65.	6. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000			66.	. 00
66. 01	06601 CARDI AC REHAB	0. 000000			66.	. 01
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69.	0. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.	0. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000			71.	. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.	2. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	3. 00
	OUTPATIENT SERVICE COST CENTERS	·				
90.00	09000 CLI NI C	0. 000000			90.	0. 00
91.00	09100 EMERGENCY	0. 000000			91.	. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000			92.	2. 00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0. 000000			95.	5. 00
99. 10	09910 CORF				99.	. 10
101.00	0 10100 HOME HEALTH AGENCY				101.	. 00
	SPECIAL PURPOSE COST CENTERS	•				
113.00	11300 NTEREST EXPENSE				113.	. 00
116.00	0 11600 HOSPI CE				116.	. 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	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 10/01/2014 To 09/30/2015	Part I Date/Time Pre	narod:
				10 09/30/2013	2/23/2016 3:0	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	522, 757	0	522, 75	7 5, 885	88. 83	30. 00
31.00 INTENSIVE CARE UNIT	215, 686		215, 68	1, 461	147. 63	31.00
43. 00 NURSERY	37, 548		37, 54	950	39. 52	43.00
200.00 Total (lines 30-199)	775, 991		775, 99	1 8, 296		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00 ADULTS & PEDIATRICS	1, 715					30. 00
31.00 INTENSIVE CARE UNIT	557	82, 230				31. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	2, 272	234, 573				200. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150045	Peri od:	Worksheet D	
				From 10/01/2014		
				To 09/30/2015	Date/Time Pre 2/23/2016 3:0	
		Ti +I	e XVIII	Hospi tal	PPS	ο μιι
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				col umn 4)	
	Part II, col.	8)	2)	. onar goo	001 4	
	26)	",				
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATING ROOM	687, 672	16, 614, 831	0. 04138	734, 789	30, 412	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	487, 158	1, 839, 021	0. 26490	7, 324	1, 940	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	389, 273	23, 527, 186	0. 01654	1, 280, 825	21, 193	54.00
60. 00 06000 LABORATORY	233, 720	20, 931, 149	0. 01116	1, 436, 328	16, 038	60.00
60. 01 06001 BL00D LABORATORY	0	O	0. 00000	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	51, 898	4, 537, 866	0. 01143	1, 762, 830	20, 161	65. 00
66. 00 06600 PHYSI CAL THERAPY	197, 984	3, 915, 045	0. 05057	0 315, 483	15, 954	66. 00
66. 01 06601 CARDI AC REHAB	97, 622	481, 111	0. 20291	0 1, 044	212	66. 01
69. 00 06900 ELECTROCARDI OLOGY	2, 987	1, 313, 878	0.00227	103, 669	236	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 110	959, 683	0.00219	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	68, 298	5, 870, 325	0. 01163	564, 194	6, 564	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 638	3, 866, 553	0. 00301	0 814, 035	2, 450	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	73, 081	6, 692, 231	0. 01092	929, 182	10, 147	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	2, 099	234, 714	0. 00894	3 0	0	90.00
91. 00 09100 EMERGENCY	317, 782	12, 481, 992	0. 02545	861, 936	21, 944	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	82, 255	2, 118, 399	0. 03882	.9 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	2, 705, 577	105, 383, 984		8, 811, 639	147, 251	200.00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Period: From 10/01/2014 To 09/30/2015		
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	31.00
43. 00 04300 NURSERY	0	0	1	0	0	43.00
200.00 Total (lines 30-199)	0	0	1	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col . 6)	Program Days	Program		
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6.00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 885	0.00	1, 71	5 0		30.00
31.00 03100 INTENSIVE CARE UNIT	1, 461	0.00	55	7 0		31.00
43. 00 04300 NURSERY	950	0.00	1	0 0		43.00
200.00 Total (lines 30-199)	8, 296		2, 27	2 0		200.00
		'	•	•	'	•

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PAS		CCN: 150045	Peri od: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Pre 2/23/2016 3:0	pared:
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Healt	h All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	()	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	(0 0	0	54. 00
60.00	06000 LABORATORY	0	(0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	(0 0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	()	0	0	66. 00
66. 01	06601 CARDI AC REHAB	0	()	0	0	66. 01
69. 00	06900 ELECTROCARDI OLOGY	0	()	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	()	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0)	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0)	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	()	0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		1	,			
90.00	09000 CLI NI C	0		2	0	0	
91.00	09100 EMERGENCY	0			0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT		1	<u> </u>	0 0	0	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS						05 00
95. 00	09500 AMBULANCE SERVICES			,			95. 00
200.00	Total (lines 50-199)	0	(4	0 0	l 0	200. 00

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUG	H COSTS				From 10/01/2014 To 09/30/2015	Part IV Date/Time Pre	nanad.
					10 09/30/2015	2/23/2016 3:0	
	Title XVIII Hospital PPS						
	Cost Center Description	Total	Total Charges	Ratio of Cos	0utpatient	Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	16, 614, 831	•			
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 839, 021				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	23, 527, 186	1			54. 00
60.00	06000 LABORATORY	0	20, 931, 149				
60. 01	06001 BLOOD LABORATORY	0	C	0.00000			60. 01
65. 00	06500 RESPI RATORY THERAPY	0	4, 537, 866	1			
66. 00	06600 PHYSI CAL THERAPY	0	3, 915, 045	1			
66. 01	06601 CARDI AC REHAB	0	481, 111				66. 01
69. 00	06900 ELECTROCARDI OLOGY	0	1, 313, 878				
70.00	07000 ELECTROENCEPHALOGRAPHY	0	959, 683	l .		l	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	5, 870, 325	l .			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 866, 553				
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 692, 231	0.00000	0. 000000	929, 182	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	234, 714	0.00000			, 0. 00
91.00	09100 EMERGENCY	0	12, 481, 992	0.00000	0. 000000	861, 936	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	2, 118, 399	0.00000	0. 000000	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	105, 383, 984			8, 811, 639	200.00

Health Financial Systems	DEKALB MEMORIAL HO	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared:

							2/23/2016 3:0	08 pm
				Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outp	oati ent	Outpati ent			
		Program		ogram	Program			
		Pass-Through	Ch	arges	Pass-Through			
		Costs (col. 8			Costs (col. 9			
		x col. 10)			x col. 12)			
		11. 00	1	2.00	13. 00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0	2	2, 412, 085	C)		50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0	C			52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		4, 115, 326				54.00
60. 00	06000 LABORATORY	0		1, 436, 784	C			60.00
60. 01	06001 BLOOD LABORATORY	0		0	C)		60. 01
65. 00	06500 RESPI RATORY THERAPY	0		174, 144	C)		65. 00
66. 00	06600 PHYSI CAL THERAPY	0		967	C)		66. 00
66. 01	06601 CARDI AC REHAB	0		133, 414)		66. 01
69. 00	06900 ELECTROCARDI OLOGY	0		248, 490	C)		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		247, 526	C)		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0		480, 297	C)		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		188, 281	C)		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		1, 431, 192	C)		73. 00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0		63, 257	C)		90. 00
91.00	09100 EMERGENCY	0		1, 681, 787	C			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0		549, 907	C)		92. 00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES							95. 00
200.00	Total (lines 50-199)	0	13	3, 163, 457	C)		200. 00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		1	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pre 2/23/2016 3:0	pared: 8 pm
			Ti tl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
		1.00	0.00	(see inst.)	(see inst.)		
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	0.20/0/5	2 412 005			(01,042	FO 00
50.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0. 286865 0. 883457			0	691, 943	
52. 00 54. 00		0. 883457			0	745 222	52. 00 54. 00
	05400 RADI OLOGY - DI AGNOSTI C				0	765, 323	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0. 208843 0. 000000		1, 41	0	300, 062 0	
					0		60. 01 65. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0. 190956			0	33, 254	
		0. 433217			0	419	
66. 01	O6601 CARDI AC REHAB O6900 ELECTROCARDI OLOGY	0. 766285 0. 106894			0	102, 233	
69. 00 70. 00	07000 ELECTROENCEPHALOGRAPHY				0	26, 562	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 101573 0. 410816			0	25, 142 197, 314	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 410816			0	56, 865	
	07300 DRUGS CHARGED TO PATIENTS	0. 302022			0 13, 592		
73.00	OUTPATIENT SERVICE COST CENTERS	0.400700	1,431,192		0 13, 392	099, 330	73.00
90. 00	09000 CLINIC	0. 436029	63, 257		0 0	27, 582	90.00
91. 00	09100 EMERGENCY	0. 436027				380, 789	
	09200 OBSERVATION BEDS (NON-DISTINCT	0. 353440	,		0 0		
72.00	OTHER REIMBURSABLE COST CENTERS	0.000110	017,707		<u> </u>	171,007	72.00
95. 00	09500 AMBULANCE SERVI CES	0. 319044			0		95. 00
200.00			13, 163, 457	1, 41	5 13, 592	3, 501, 385	
201.00	,	1	12, 122, 10,	.,	0 0]	201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		13, 163, 457	1, 41	13, 592	3, 501, 385	202. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 150045	Peri od: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Pre 2/23/2016 3:00	
		Ti tl	e XVIII	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(ccc : nc+)	(coo inct)				

	Cost Center Description	LOST	Cost	
		Rei mbursed	Rei mbursed	
		Servi ces	Services Not	
		Subject To	Subject To	
		Ded. & Coins.	Ded. & Coins.	
		(see inst.)	(see inst.)	
		6. 00	7.00	
	ICI LLARY SERVI CE COST CENTERS			
	5000 OPERATING ROOM	0	0	50. 00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0	0	52. 00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0	0	54.00
60.00 06	6000 LABORATORY	296	0	60.00
60. 01 06	5001 BLOOD LABORATORY	0	0	60. 01
65.00 06	5500 RESPIRATORY THERAPY	0	0	65. 00
66.00 06	6600 PHYSI CAL THERAPY	0	0	66. 00
66. 01 06	6601 CARDI AC REHAB	0	0	66. 01
69.00 06	5900 ELECTROCARDI OLOGY	0	0	69. 00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	0	o	70. 00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PAT	0	o	71. 00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	o	72. 00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	0	6, 643	73. 00
OU	JTPATIENT SERVICE COST CENTERS			1
90.00 09	9000 CLI NI C	0	0	90. 00
91.00 09	P100 EMERGENCY	0	l ol	91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT	0	o	92.00
ОТ	THER REIMBURSABLE COST CENTERS			1
95.00 09	9500 AMBULANCE SERVICES	0		95. 00
200.00	Subtotal (see instructions)	296	6, 643	200. 00
201.00	Less PBP Clinic Lab. Services-Program	0		201. 00
	Only Charges			
202. 00	Net Charges (line 200 +/- line 201)	296	6, 643	202. 00

Health Financial Systems	DEKALB MEMORIAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150045	Peri od: From 10/01/2014	Worksheet D-1
				Date/Time Prepared: 2/23/2016 3:08 pm
		Title XVIII	Hospi tal	PPS

PRILITARY DESCRIPTION PRICE				10 077 007 2010	2/23/2016 3:0	8 pm
			Title XVIII	Hospi tal	PPS	
IREAL TERM LONG IREAL TERM LONG Impattent days (Including private room days and saing-bed days, excluding newborn) 5,885 2,00 Impattent days (Including private room days, excluding saing-bed and membern days) 5,885 2,00 Impattent days (Including private room days, excluding saing-bed and membern days) 5,885 2,00 Impattent days (Including private room days) 5,885 2,00 Impattent days (Including private room days) 5,885 2,00 Impattent days (Including private room days) 5,885 2,00 Impattent days (Including private room days) 6,800 6,00 Impattent days (Including private room days) 6,800 6,00 Impattent days (Including private room days) 6,800 6,90 Impattent days (Including private room days) 6,90 6,90 Impattent days (Including private room days) 6,90 6,90 Impattent days (Including private room days) 7,90		Cost Center Description			1 00	
Inpart Incidence Inpart Inci		DADT I _ ALL DROWINED COMPONENTS			1.00	
Impattent days (including private room days and swing-bed days, excluding newborn)						
Impatient days (including private room days, excluding swing-bed and newborn days) 5,885 2,00	1.00		excluding newborn)		5, 885	1.00
do not complete this line. 4. 05 Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SPE type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 7. 00 Total swing-bed SPE type inpatient days (including private room days) after December 31 of the cost reporting period (if culendar year, enter 0 on this line) 7. 00 Total swing-bed SPE type inpatient days (including private room days) through December 31 of the cost reporting period (if culendar year, enter 0 on this line) 8. 00 Total swing-bed SPE type inpatient days (including private room days) after December 31 of the cost reporting period Total Inpatient days including private room days, after December 31 of the cost reporting period Total Inpatient days including private room days, after December 31 of the cost reporting period Total Inpatient days including private room days, after December 31 of the cost reporting period Total Inpatient days including private room days, after December 31 of the cost reporting period (see instruction) Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days) Intrough December 31 of the cost reporting period (see instruction) Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days) 14. 00 Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days) 15. 00 Swing-bed SNE type inpatient days applicable to title XVIII only (including private room days) 16. 00 Swing-bed SNE type inpatient days applicable to swing-bed SNE services applicable to swi	2.00				5, 885	2. 00
Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total sing-bed Skr type inpatient days (including private room days) after December 31 of the cost reporting period (Fe alendare year, enter 0 on this 1 ine) 1.00 Total sing-bed Nr type inpatient days (including private room days) after December 31 of the cost reporting period (Fe alendare year, enter 0 on this 1 ine) 1.00 Total sing-bed Nr type inpatient days (including private room days) after December 31 of the cost reporting period (Fe alendare year, enter 0 on this 1 ine) 1.00 Total sing-bed Nr type inpatient days (including private room days) after December 31 of the cost reporting period (Fe alendare year, enter 0 on this 1 ine) 1.00 Swing-bed Skr type inpatient days applicable to the Program (excluding swing-bed and 1.715 9.00 through December 31 of the cost reporting period (I real endar year, enter 0 on this 1 ine) 1.00 Swing-bed Skr type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (I real endar year, enter 0 on this 1 ine) 1.00 Swing-bed Nr type inpatient days applicable to title XVII only (including private room days) 1.00 Swing-bed Nr type inpatient days applicable to title SV I NX (and y) (including private room days) 1.00 Swing-bed Nr type inpatient days applicable to title SV I NX (and y) (including private room days) 1.00 Swing-bed Nr type inpatient days applicable to services after December 31 of the cost reporting period (I real endar year, enter 0 on this 1 ine) 1.00 Total universy days (title V or XX (and y)) 1.00 December 31 of the cost reporting period (I real endar year, enter 0 on this 1 ine) 1.00 Number days (title V or XX (and y)) 1.00 December 31 of the cost reporting period (I not services after December 31 of the cost reporting period (I not period period of the cost reporting period (I not period period of the cost reporting period (I not period period of the cost reporting period (I not period period of the period p	3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Coperating period (if cal endar year, enter 0 on this line) reporting period (if cal endar year, enter 0 on this line) reporting period (if cal endar year, enter 0 on this line) reporting period (if cal endar year, enter 0 on this line) so the period swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) so the period reporting period (if cal endar year, enter 0 on this line) seed on the period of it cal endar year, enter 0 on this line) seed on the period (if cal endar year, enter 0 on this line) seed on the period (if cal endar year, enter 0 on this line) seed on the period (if cal endar year, enter 0 on this line) seed on the period (if cal endar year, enter 0 on this line) seed on the period (if cal endar year, enter 0 on this line) seed on the period (if cal endar year, enter 0 on this line) seed on the period (if cal endar year, enter 0 on this line) seed of type inpatient days applicable to title swill only (including private room days) after becember 31 of the cost reporting period (if cal endar year, enter 0 on this line) seed of type inpatient days applicable to titles vor XIX enly (including private room days) seed the type inpatient days applicable to titles vor XIX enly (including private room days) seed the type inpatient days applicable to the period in the seed of the period (if cal endar year, enter 0 on this line) seed of type inpatient days applicable to the period (if cal endar year, enter 0 on this line) seed on the seed of the		· ·				
reporting period (if calendar year, enter 0 on this line) 7.00 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1 period (if calendar year, enter 0 on this line) 8.00 Total inpatient days including private room days) after December 31 of the cost 1 period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost 1 period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost 1 period (if calendar year, enter 0 on this line) 9.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 1,715 9,00 newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 shing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 SN type-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 SN type-bed SNF type-bed SNF type sprivate room days applicable to services through December 31 of the cost 1.00 SN type-bed SNF type sprivate room days 11.00 SN type-bed SNF type-bed SNF type sprivates applicable to services after December 31 of the cost 1.00 SN type-bed cost applicable to SNF type services applicable to servic						
Total swing-bed NN type inpatient days (including private room days) after December 31 of the cost reporting period (if ceil endar years, enter 0 on this line)	5.00		days) through Decembe	r 31 of the cost	0	5.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mr type inpatient days (including private room days) after December 31 of the cost 1 8.00 Total inpatient days (including private room days) after December 31 of the cost 1 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,715 9,00 newborn days) 9.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 0 through December 31 of the cost reporting period (see Instructions) 11.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (inclendar year, enter 0 on this line) 12.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after 10 becember 31 of the cost reporting period (inclendar year, enter 0 on this line) 12.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 12.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 12.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 12.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 13.00 Swing-bed SMr type inpatient days applicable to title XV or XX only (including private room days) 14.00 Medically necessary private room days applicable to title XV or XX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Total nursery days (title V or XIX only) 18.00 Nedicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period (line 8 Nedicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (line 9 Nedicare rate for swing-bed SMF services applicable to services after December 31 of the cost report	4 00		days) after December	21 of the cost	0	4 00
Total swing-bed NF type inpatient days (Including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (Including private room days) after December 31 of the cost reporting period (Ir calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding private room days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days) Total inpatient days including private room days applicable to the program (excluding private room days) Total inpatient days applicable to the Itile XVII long (Including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line) Total inpatient days applicable to titles V or XIX only (including private room days) Total inpatient days applicable to titles V or XIX only (including private room days) Total inpatient days applicable to titles V or XIX only (including private room days) Total inpatient days applicable to the Program (excluding swing-bed days) Total inpatient days applicable to the Program (excluding swing-bed days) Total inpatient days applicable to the Program (excluding swing-bed days) Total inpatient days applicable to services through December 31 of the cost Total inpatient days (title V or XIX only) Total inpatient days (title V or	6.00		days) at tel beceliber	31 OF THE COST	U	0.00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Sking-bed Swit type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed Swit type inpatient days applicable to title XVIII only (including private room days) after the cost reporting period (including private room days) after the December 31 of the cost reporting period (including private room days) after the December 31 of the cost reporting period (including private room days) after the December 31 of the cost reporting period (including private room days) after the December 31 of the cost reporting period (including private room days) after the December 31 of the cost reporting period (including private room days) after the December 31 of the cost reporting period (including private room days) after the December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room days) after December 31 of the cost (including private room day	7. 00		davs) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 0.0			,			
1.715 9.00	8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
newborn days) newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 bring-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (isee instructions) 12.00 Swing-bed SNF type inpatient days applicable to titlet V Or XIX only (including private room days) and through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titlet V or XIX only (including private room days) 14.00 Ided cally necessary private room days applicable to the Program (excluding private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 New Symbol DAUJSWINT 17.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
10.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) 10.00 through December 31 of the cost reporting period (See instructions) 11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (Including private room days) 12.00 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 0 13.00 3.00	9. 00		the Program (excluding	swing-bed and	1, 715	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 becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.00 Swing-bed NF type (including private room days) 1.00 Swing-bed NF type (including private room days) 1.00 Swing-bed NF type (including private room days) 1.00 Swing-bed NF type (including private room days) 1.00 Swing-bed NF type (including private room days) 1.00 Swing-bed NF type (including private room days) 1.00 Swing-bed (including private room days) 1.00 Swing-bed (including private room days) 1.00 Swing-bed (including private room days) 1.00 Swing-bed (including private room days) 1.00 Swing-bed (including private room days) 1.00 Swing-bed (including private room days) 1.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Swing-bed (including private room days) 1.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Swing-bed (including private room days days (including private room days) 1.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 1.00 Swing-bed cost applicable to SWF type services through December 31 of the cost reporting period (line 6 x line 18) 1.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 1.00 Swing-bed (10.00					10.00
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 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 titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days	10.00			oom days)	U	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 12.00 12.00 13.00 13.00 14.00 14.00 15.00	11 00			oom days) after	0	11 00
12.00 Swing-bed NF type inpatient days applicable to titles \(\tilde{\tilde{V}}\) or XIX only (including private room days) through December 31 of the cost reporting period after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicare 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 6 x line 18) 23.00 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 NF type services after December 31 of the cost reporting period (line 6 x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost (see instructions) 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Optinate room cost differentia				oom dayo, areo	Ü	00
13.00 Swing-bed NF Type inpatient days applicable to titles V or XIX only (Including privater room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 15.0	12.00			e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 16.00 Nursery days (title V or XIX only) 16.00 17.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Modical rate rate for swing-bed SNF services applicable to services through December 31 of the cost 17.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Modicare rate for swing-bed NF services applicable to services through December 31 of the cost 18.00 reporting period 19.00 Modicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modicaid rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 20.00 Total swing-bed cost (see instructions) 20.00 Total swing-bed cost applicable to NF type service oather period (line 21 minus line 26) 20.00 Total swing-bed cost (see instructions) 20.00 Total swing-bed cost (see instructions) 20.00 Total swing-bed co		1 31				
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 10.10 nursery days (title V or XIX only) 0 15.00 15	13. 00				0	13. 00
15.00 Total nursery days (title V or XIX only) 17.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period sung the cost reporting period reporting rep	14 00				0	14 00
16.00 Nursery days (title V or XIX only) MR BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting repo			(excluding swing-bed	uays)		
SWING BED ADJUSTMENT 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 0.00 18.00 reporting period (Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period (1.00 10 10 10 10 10 10 10 10 10 10 10 10 1						
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost of the cost reporting period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (21.00 Total general inpatient routine service cost (see instructions) 21.00 Total general inpatient routine service safter December 31 of the cost reporting period (11.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (11.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (11.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (11.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (11.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11.00 Swing-bed cost (see instructions) 24.00 Total swing-bed cost (see instructions) 25.00 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 (11.00 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed dost (11.00 21 minus line 26) 28.00 Swing-bed cost (20.00 21.0						
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00	17.00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0. 00	17. 00
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 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) 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 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 29 + line 3) 31.00 Average per diem private room charge differential (line 32 minus line 23) 32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential alloustment (line 3 x line 38) 37.00 Average semi-private room cost differential (line 34 x line 31) 38.00 Algusted general inpatient routine service cost per diem (see instructions) 39.00 Average menal supplient routine service cost per diem (see instructions) 39.00 Program general inpatie						
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (100 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (101 Medicaid rate for swing-bed NF services cost (see instructions) (100 Total general inpatient routine service cost (see instructions) (101 Medicaid rate for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) (101 Medicaid rate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) (101 Mine 18) (101 Mine 19) (18. 00		after December 31 of	the cost	0.00	18.00
reporting period 20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 26. 00 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 service cost enter December 31 of the cost reporting period (line 8 x line 20) 28. 00 Total swing-bed cost (see instructions) 29. 00 Total swing-bed cost (see instructions) 20. 00 Total swing-bed cost (see instructions) 20. 00 Total swing-bed cost (see instructions) 20. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 20. 00 General inpatient routine service cost enterges (excluding swing-bed and observation bed charges) 20. 00 Private room charges (excluding swing-bed charges) 20. 01 Osemi-private room charges (excluding swing-bed charges) 20. 02 Osemi-private room charges (excluding swing-bed charges) 20. 03. 03 Osemi-private room per diem charge (line 29 + line 3) 20. 04 Overage perivate room per diem charge (line 29 + line 3) 20. 05 Osemi-private room per diem charge (line 30 + line 4) 20. 00 Osemi-private room cost differential (line 32 minus line 33)(see instructions) 21. 01 Osemeral inpatient routine service cost net of swing-bed cost and private room cost differential (line 32 minus line 33) 22. 01 Osemeral inpatient routine service cost (per diem (see instructions) 23. 02 Osemeral inpatient routine service cost (per diem (see instructions) 24. 05 Osemi-private room cost	10 00		through Docombor 21 of	the cost	0.00	10 00
20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 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) 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 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) 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 charge differential (line 3 x line 31) 34. 00 Average per diem private room charge differential (line 3 x line 31) 35. 00 Average per diem private room charge differential (line 3 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 Average per diem private room charge decost differential (line 3 x line 31) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Adjusted general inpatient routine service cost per diem (see instructions) 30. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Adjusted general inpatient routine service cost per diem (see instructions) 30. 00 Adjusted general inpatient routine service cost (line 9 x line	17.00		till odgir becelliber 31 of	the cost	0.00	19.00
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 7 x line 19) 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 general inpatient routine service cost net of swing-bed 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 28.00 General inpatient routine service charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 36.00 Private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00	20.00		after December 31 of t	he 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 6 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average per diem private room cost differential (line 34 x line 31) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) 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) 39. 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) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		reporting period				
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 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) 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 per diem charge (line 30 * line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 36.00 Private room cost differential diptematical (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 33)(see instructions) 38.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Private room Charges (excluding swing-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 29 + line 3) 30.00 Average per diem private room cost differential (line 32 minus line 23) 31.00 Average per diem private room cost differential (line 34 x line 31) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 35) 34.00 Average per diem private room cost differential (line 34 x line 35) 35.00 Average per diem private room cost differential (line 34 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) 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)	22. 00		31 of the cost report	ing period (line	0	22. 00
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 3 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 4, 758, 389) 38.00 Alysted general inpatient routine service cost per diem (see instructions) 38.00 Alysted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22 00	1	1 of the cost reportin	a ported (line 6	0	22 00
24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25. 00 x line 20) 25. 00 Total swing-bed cost (see instructions) Ceneral 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) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) 30. 00 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 3 x line 31) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Addjusted general inpatient routine service cost (line 9 x line 38) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine service cost per diem (see instructions) Addjusted general inpatient routine servi	23.00		Tot the cost reportin	g period (Title o	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	24. 00	1	31 of the cost reporti	ng period (line	0	24. 00
x line 20) 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) Private room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 29. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0 .000000 32. 00 Average private room per diem charge (line 29 + line 3) 0 .00 33. 00 Average semi-private room per diem charge (line 30 + line 4) 0 .00 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0 .00 35. 00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) 0 .00 Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) Average line adjustment routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) 80. 00 Average per diem private room cost differential (line 3 x line 35) Degeneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 4, 758, 389) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x			·			
Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERNTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 minus line 33)(see instructions) 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) Agjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Average 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) 26.00 Average per diem private room cost applicable to the Program (line 14 x line 35) Average per diem private room cost applicable to the Program (line 14 x line 35)	25. 00		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) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Comeral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions	0/ 00					0, 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 3 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) 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) 9.00 Program general inpatient routine service cost (line 9 x line 38) 1, 386, 680 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 28.00 29.00 20.00 30.00			ino 21 minus lino 24)			1
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 10	27.00		THE 21 IIITHUS TITTLE 20)		4, 730, 309	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) 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) 0 29.00 20.00 30.00 30.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 34.00 0.00 0.00 34.00 0.00 0.00	28. 00		and observation bed ch	arges)	0	28.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 758, 389) 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) 0 1 30.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				g)		
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 4, 758, 389) 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) 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 0.00 32.00 0 0.00 33.00 0 0.00 34.00 0 35.00 0 36.0	30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
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 4, 758, 389) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.00 0.00 34.00 37.00 36.00 37.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 1,386,680 39.00 40.00	31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4,758,389) 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) 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	32.00			0.00	32. 00	
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4,758,389) 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
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 4,758,389) 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) 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 36.00 4,758,389 37.00 808.56 38.00 1,386,680 39.00 40.00						
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 758, 389) 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) 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) 37.00 4, 758, 389 4, 758, 389 37.00 4, 758, 389 37.00 4, 758, 389 37.00 4, 758, 389 37.00 4, 758, 389 37.00		,				
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) 808.56 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						
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) 808.56 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	37.00		u private room cost di	rrentral (IINe	4, /58, 389	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 808.56 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						1
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 808.56 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) 808.56 38.00 1,386,680 39.00 40.00			TMENTS			1
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) 1,386,680 39.00 40.00	38. 00				808. 56	38. 00
	39. 00	Program general inpatient routine service cost (line 9 x line 3	8)		1, 386, 680	1
41.00 Iotal Program general inpatient routine service cost (line 39 + line 40) 1,386,680 41.00						1
	41. 00		line 40)		1, 386, 680	41.00

Heal th	h Financial Systems DEKALB MEMORIAL HOSPITAL	In Li∈	eu of Form CMS-2	2552-10
	JTATION OF INPATIENT OPERATING COST Provider CCN: 150045	Period: From 10/01/2014	Worksheet D-1	
		To 09/30/2015		
	Title XVIII	Hospi tal	2/23/2016 3: 08 PPS	8 pm_
	Cost Center Description Total Total Average Per	Program Days	Program Cost (col. 3 x col.	
	Inpatient Cost Inpatient Days Diem (col. 1 col. 2)	-	4)	
42.00	1.00 2.00 3.00 NURSERY (title V & XIX only) 0 0.00	4. 00 0 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0 0	0	42.00
43.00	D INTENSIVE CARE UNIT 2, 250, 091 1, 461 1, 540. 1	0 557	857, 836	43.00
44. 00 45. 00				44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT			46. 00
47. 00	O OTHER SPECIAL CARE (SPECIFY) Cost Center Description			47. 00
			1. 00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		2, 367, 555 4, 612, 071	•
47.00	PASS THROUGH COST ADJUSTMENTS		4,012,071	47.00
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum III)	of Parts I and	234, 573	50. 00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, s	um of Parts II	147, 251	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)		381, 824	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesth	etist, and	4, 230, 247	
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION			
54. 00	Program di scharges		0	54. 00
55. 00			1	55.00
56. 00 57. 00	,	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	•	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and commarket basket	mpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		0. 00	
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of		0	61. 00
	amount (line 56), otherwise enter zero (see instructions)	the target		
62. 00 63. 00	0	62. 00 63. 00		
00.00				
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporti instructions)(title XVIII only)	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVII	l only). For	o	66. 00
<i>(</i> 7, 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost re	nanting namind		<i>(</i> 7, 00
67. 00	(line 12 x line 19)	portring perrou		67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost repo (line 13 x line 20)	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)			70. 00
71. 00				71.00
72. 00 73. 00				72.00
74.00				73. 00 74. 00
75. 00		art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)			76. 00
77. 00				77. 00
78. 00 79. 00				78. 00 79. 00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 min	us line 79)		80. 00
81. 00 82. 00	· '			81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)			83. 00
84. 00 85. 00				84. 00 85. 00
86. 00				86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		004	07.00
87. 00 88. 00			926 808. 56	
89. 00	Observation bed cost (line 87 x line 88) (see instructions)		748, 727	89. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2014 To 09/30/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	522, 757	4, 758, 389	0. 10986	0 748, 727	82, 255	90.00
91.00 Nursing School cost	0	4, 758, 389	0. 00000	0 748, 727	0	91.00
92.00 Allied health cost	0	4, 758, 389	0. 00000	0 748, 727	0	92.00
93.00 All other Medical Education	0	4, 758, 389	0. 00000	0 748, 727	0	93.00

Health Financial Systems	DEKALB MEMORIAL HO	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 150045	Peri od: From 10/01/2014	Worksheet D-1
				Date/Time Prepared: 2/23/2016 3:08 pm
		Title XIX	Hospi tal	Cost

		Title XIX	Hospi tal	2/23/2016 3:0 Cost	8 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		5, 885	1. 00
2.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days	d and newborn days)	vate room days,	5, 885 0	2. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		4, 959	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period		r 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)		0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period			0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)			316	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi	ons)	,	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent	er O on this line)	, ,	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	3 .	,	0	12.00
13. 00 14. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	r, enter O on this line	e)	0	13. 00 14. 00
15. 00	Total nursery days (title V or XIX only)	(excluding swing-bed to	uays)	950	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 or	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	0.00	19. 00		
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	0.00	20. 00		
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	4, 758, 389 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7×1 ine 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		4, 758, 389	27. 00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28. 00 29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34. 00	Average per diem private room charge differential (line 32 minu		tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	a private room cost di	rrerential (line	4, 758, 389	37. 00
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			808. 56	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1)	•		255, 505	39. 00
40. 00	Medically necessary private room cost applicable to the Program	•		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		255, 505	41. 00

Heal th	Financial Systems DEKALB MEMORIAL HOSPITAL In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST Provider CCN: 150045 Period: From 10/01/2014	Worksheet D-1	
	To 09/30/2015	Date/Time Prep	
	Title XIX Hospital	2/23/2016 3:08 Cost	3 pm
	Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷	Program Cost (col. 3 x col.	
	col. 2)	4)	
42.00	1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 482,391 950 507.78 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0	42.00
43. 00 44. 00	INTENSI VE CARE UNI T 2, 250, 091 1, 461 1, 540. 10 0 CORONARY CARE UNI T	0	43. 00 44. 00
45. 00			44. 00 45. 00
46.00			46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		47. 00
40.00	Desgram inputions and llarge consists and (West D.2 and 2 Line 200)	1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	236, 087 491, 592	48. 00 49. 00
	PASS THROUGH COST ADJUSTMENTS		F0 00
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)	0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0 0. 00	58. 00 59. 00
	market basket		
60. 00 61. 00		0. 00 0	60. 00 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions)	0	62. 00
63. 00	0	63. 00	
64. 00		0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
	instructions)(title XVIII only)		
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
40.00	(line 13 x line 20)	0	69. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	07.00
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)		72. 00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00	Program capital related costs (line 9 x line 76)		77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)		78. 00 79. 00
80. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)		83. 00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	926	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	808. 56	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see instructions)	748, 727	89. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2014 To 09/30/2015	Date/Time Prep 2/23/2016 3:0	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	522, 757	4, 758, 389	0. 10986	0 748, 727	82, 255	90. 00
91.00 Nursing School cost	0	4, 758, 389	0.00000	0 748, 727	0	91. 00
92.00 Allied health cost	0	4, 758, 389	0.00000	0 748, 727	0	92.00
93.00 All other Medical Education	0	4, 758, 389	0. 00000	0 748, 727	0	93. 00

Health Financial Systems DEKAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	B MEMORIAL HOSPITAL Provider	CCN: 150045	Peri od:	u of Form CMS- Worksheet D-3	
WITH ENT THOUGHT SERVICE GOOT THE OWN CHARACTER	11 ovi dei	0014. 100010	From 10/01/2014		
			To 09/30/2015		
				2/23/2016 3:0)8 pm
	li ti	e XVIII	Hospi tal	PPS	_
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3.00	1
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			3, 470, 962		30.00
31. 00 03100 NTENSI VE CARE UNI T			1, 784, 055		31.00
43. 00 04300 NURSERY			1, 701, 000		43. 00
ANCILLARY SERVICE COST CENTERS		I.		l.	1
50. 00 05000 OPERATING ROOM		0. 28686	55 734, 789	210, 785	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 88345	7, 324		
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 18596	59 1, 280, 825	238, 194	54.0
00. 00 06000 LABORATORY		0. 20884	1, 436, 328	299, 967	60.0
00. 01 06001 BLOOD LABORATORY		0.00000	00		
5. 00 06500 RESPIRATORY THERAPY		0. 19095	56 1, 762, 830	336, 623	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 4332	17 315, 483	136, 673	66.0
6. 01 06601 CARDI AC REHAB		0. 76628	1, 044	800	66.0
9. 00 06900 ELECTROCARDI OLOGY		0. 10689	94 103, 669	11, 082	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 10157	73 0	0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 41081		231, 780	71. 0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30202			
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 48878	929, 182	454, 166	73.0
OUTPATIENT SERVICE COST CENTERS					4
90. 00 09000 CLI NI C		0. 43602		0	
01. 00 09100 EMERGENCY		0. 22641			
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT		0. 35344	40 0	0	92. 0
OTHER REIMBURSABLE COST CENTERS		1			
5. 00 09500 AMBULANCE SERVICES					95. 0
700.00 Total (sum of lines 50-94 and 96-98)			8, 811, 639	2, 367, 555	
201.00 Less PBP Clinic Laboratory Services-Program o	nly charges (line 61)		0		201. 0
202.00 Net Charges (line 200 minus line 201)			8, 811, 639		202. 0

Health Financial Systems	DEKALB MEMORIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150045	Peri od:	Worksheet D-3	3
			From 10/01/2014 To 09/30/2015		narad.
			10 09/30/2015	2/23/2016 3:0	
	Ti	tle XIX	Hospi tal	Cost	- p
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	-
INDATI ENT. DOUTLING CERVILOE COCT. CENTERO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			200 110		30.00
31. 00 03000 ADDLTS & PEDIATRICS			209, 110 194, 424	l	31.00
43. 00 04300 NURSERY			401, 916	l	43.00
ANCI LLARY SERVI CE COST CENTERS			401, 910		43.00
50. 00 05000 OPERATING ROOM		0. 2868	65 27, 586	7, 913	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 8834			
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1859			
60. 00 06000 LABORATORY		0. 2088			
60. 01 06001 BLOOD LABORATORY		0.0000	00 0		1
65. 00 06500 RESPIRATORY THERAPY		0. 1909	56 162, 787	31, 085	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4332	17 48, 915	21, 191	66.00
66. 01 06601 CARDI AC REHAB		0. 7662	85 246	189	66. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 1068		721	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1015		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 4108		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3020		0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 4887	80 92, 441	45, 183	73. 00
90.00 OUTPATIENT SERVICE COST CENTERS		0.4260	20 0		90.00
91. 00 09100 CLI NI C 91. 00 09100 EMERGENCY		0. 4360 0. 2264			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		0. 2284		17, 427	
OTHER REIMBURSABLE COST CENTERS		0. 3534	40 0		92.00
95. 00 09500 AMBULANCE SERVI CES					95. 00
200.00 Total (sum of lines 50-94 and 96-98)			753, 280	236, 087	
201.00 Less PBP Clinic Laboratory Services-Pi	ogram only charges (line 61)		7,55, 200	200,007	201.00
202.00 Net Charges (line 200 minus line 201)	-g j ca. gcc (. / 11c 01)		753, 280		202. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150045		Peri od: From 10/01/2014 To 09/30/2015	Date/Time Prepared	
			20.011		2/23/2016 3:0	
		liti	e XVIII before 1/1	Hospi tal on/after 1/1	PPS	
		0	1.00	1. 01	2. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0		1. 00
1. 01	DRG amounts other than outlier payments for discharges			0		1. 01
1. 02	occurring prior to October 1 (see instructions) DRG amounts other than outlier payments for discharges		3, 391, 47	6		1. 02
1.02	occurring on or after October 1 (see instructions)		3,371,47			1.02
1.03	DRG for federal specific operating payment for Model 4			0		1. 03
	BPCI for discharges occurring prior to October 1 (see					
1 04	instructions)			0		1 04
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see			U		1.04
	instructions)					
2.00	Outlier payments for discharges. (see instructions)		42, 44			2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0		2. 02
3.00	Managed Care Simulated Payments			0		3.00
4. 00	Bed days available divided by number of days in the cost		34.4	6		4. 00
	reporting period (see instructions)					
F 00	Indirect Medical Education Adjustment		0.0			F 00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before		0.0	10		5. 00
	12/31/1996. (see instructions)					
6.00	FTE count for allopathic and osteopathic programs which		0.0	0		6. 00
	meet the criteria for an add-on to the cap for new					
7. 00	programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as		0.0	0		7. 00
7.00	specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.0			7.00
7. 01	ACA Section 5503 reduction amount to the IME cap as		0.0	0		7. 01
	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the					
0.00	cost report straddles July 1, 2011 then see instructions.			10		8.00
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated		0.0	10		8.00
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR					
0.01	50069 (August 1, 2002).			.0		0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report		O. C	10		8. 01
	straddles July 1, 2011, see instructions.					
8. 02	The amount of increase if the hospital was awarded FTE cap		0.0	0		8. 02
	slots from a closed teaching hospital under section 5506					
9. 00	of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		0.0	10		9. 00
7. 00	lines (8, 8,01 and 8,02) (see instructions)		0.0			7.00
10.00	FTE count for allopathic and osteopathic programs in the		0.0	0		10. 00
	current year from your records					
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		0.0			11.00
12. 00 13. 00	Total allowable FTE count for the prior year.		0.0			12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that		0.0			14. 00
	year ended on or after September 30, 1997, otherwise enter					
45.00	zero.					45.00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program		0. C 0. C			15. 00 16. 00
17. 00	Adjustment for residents in the years of the program Adjustment for residents displaced by program or hospital		0.0			17. 00
	closure					
18. 00	Adjusted rolling average FTE count		0.0			18. 00
19. 00	Current year resident to bed ratio (line 18 divided by		0.00000	00		19. 00
20. 00	line 4). Prior year resident to bed ratio (see instructions)		0. 00000	0		20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0.00000			21. 00
22. 00	IME payment adjustment (see instructions)			0		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0		22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Secti Number of additional allopathic and osteopathic IME FTE	on 422 of t	he MMA 0. C			23. 00
23.00	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.0	10		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.0	0		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter		0.0	0		25. 00
24 00	the lower of line 23 or line 24 (see instructions)		0.00000	10		24 00
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)		0. 00000 0. 00000			26. 00 27. 00
28. 00	IME add-on adjustment amount (see instructions)		0.00000	0		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see			0		28. 01
00	instructions)					00
29. 00	Total IME payment (sum of lines 22 and 28)		I	0		29. 00

	ATLON OF DELMOUDSEMENT SETTLEMENT	DEKALB MEMORI		CCN: 150045 5		Washabaat F	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der	F	eriod: from 10/01/2014 fo 09/30/2015	Worksheet E Part A Date/Time Pre 2/23/2016 3:0	
			Ti tl	e XVIII	Hospi tal	PPS	5 piii
			0	before 1/1 1.00	on/after 1/1 1.01	2. 00	
29. 01	Total IME payment - Managed Care (sum of line	es 22.01 and	-	C			29. 01
	28.01) Di sproporti onate Share Adj ustment						
30. 00	Percentage of SSI recipient patient days to M A patient days (see instructions)	Medicare Part		3. 01			30. 00
31.00	Percentage of Medicaid patient days (see inst	tructi ons)		21. 62			31.00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage ((see		24. 63 9. 53			32. 00 33. 00
34 00	instructions) Disproportionate share adjustment (see instru	ictions)		80, 802			34. 00
0 11 00	proproportionate share as as astimore (ess this in			Prior to		On/After	0 11 00
		()	0ctober 1 1.00	1. 01	0ctober 1 2.00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see					7, 647, 644, 885	35. 00
33.00	instructions)					7, 047, 044, 665	
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If			0. 000000000		0. 000044923 343, 555	
00. 02	line 34 is zero, enter zero on this line)					310, 330	00.02
35. 03	(see instructions) Pro rata share of the hospital uncompensated			c		343, 555	35. 03
36. 00	care payment amount (see instructions) Total uncompensated care (sum of columns 1			343, 555			36. 00
30.00	and 2 on line 35.03)						30.00
40. 00	Additional payment for high percentage of ESF Total Medicare discharges on Worksheet S-3,	D beneficiary	discharges (Li	nes 40 through	46)		40. 00
	Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)						
41. 00	Total ESRD Medicare discharges excluding			С	0		41. 00
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)						
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683,			C	0		41. 01
	684 an 685. (see instructions)						
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0. 00			42. 00
43. 00	Total Medicare ESRD inpatient days excluding			С			43. 00
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)						
44. 00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7			0. 000000			44. 00
45.00	days)						45.00
45. 00	Average weekly cost for dialysis treatments (see instructions)			0.00	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41.01)			C			46. 00
	Subtotal (see instructions)			3, 858, 273			47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals			(48. 00
49. 00	only (see instructions) Total payment for inpatient operating costs			3, 858, 273			49. 00
	(see instructions)						
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			271, 597			50. 00
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			C			51. 00
52. 00	Direct graduate medical education payment			c			52. 00
53. 00	(from Wkst. E-4, line 49 see instructions). Nursing and Allied Health Managed Care			C			53. 00
54. 00	payment Special add-on payments for new technologies			l			54. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt.			C			55. 00
56. 00	III, col. 1, line 69) Cost of physicians' services in a teaching			C			56. 00
E7 00	hospital (see intructions)			(E7 00
57. 00	(from Wkst. D, Pt. III, column 9, lines 30						57. 00
58. 00	through 35). Ancillary service other pass through costs						58. 00
	from Wkst. D, Pt. IV, col. 11 line 200)						
59. 00	Total (sum of amounts on lines 49 through 58)			4, 129, 870			59. 00
60. 00 61. 00	Primary payer payments Total amount payable for program			4, 601 4, 125, 269			60. 00 61. 00
	beneficiaries (line 59 minus line 60)						
62. 00	Deductibles billed to program beneficiaries			596, 780	'		62. 00

| Period: | Worksheet E | From 10/01/2014 | Part A | Date/Time Prepared: | 2/23/2016 3:08 pm Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150045

						2/23/2016 3:0	08 pm
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
		0		0ctober 1 1.00	1. 01	0ctober 1 2.00	
63. 00	Coinsurance billed to program beneficiaries	0		18, 574	1.01	2.00	63. 00
64. 00	Allowable bad debts (see instructions)			74, 237			64. 00
65.00	Adjusted reimbursable bad debts (see			48, 254			65. 00
	instructions)						
66. 00	Allowable bad debts for dual eligible			27, 372			66. 00
(7.00	beneficiaries (see instructions)			2 550 1/0			47.00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3, 558, 169			67. 00
68. 00	Credits received from manufacturers for			0			68. 00
	replaced devices for applicable to MS-DRGs						
	(see instructions)						
69. 00	Outlier payments reconciliation (sum of			0			69. 00
	lines 93, 95 and 96). (For SCH see instructions)						
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS)			0			70. 00
70.00	(SPECIFY)						70.00
70. 50	RURAL DEMONSTRATION PROJECT			0			70. 50
70. 89	Pioneer ACO demonstration payment adjustment			0			70. 89
70.00	amount (see instructions)						70.00
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0			70. 90
70. 91	HSP bonus payment HRR adjustment amount (see			0			70. 91
70. 71	instructions)						70.71
70. 92	Bundled Model 1 discount amount (see			0			70. 92
	instructions)						
70. 93	HVBP payment adjustment amount (see			3, 818			70. 93
70. 94	instructions) HRR adjustment amount (see instructions)			0			70. 94
70. 95	Recovery of accelerated depreciation			Ö			70. 95
70. 96	Low volume adjustment for federal fiscal		0	0			70. 96
	year (yyyy) (Enter in column O the						
	corresponding federal year for the period						
70. 97	prior to 10/1) Low volume adjustment for federal fiscal		2015	488, 948			70. 97
70. 77	year (yyyy) (Enter in column 0 the		2013	400, 740			70. 97
	corresponding federal year for the period						
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			0			70. 98
70. 99	HAC adjustment amount (see instructions)			4 050 035			70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			4, 050, 935			71. 00
71. 01	Sequestration adjustment (see instructions)			81, 019			71. 01
72. 00	Interim payments			4, 051, 775		•	72. 00
73.00	Tentative settlement (for contractor use			0			73. 00
74.00	onl y)			04 050			74.00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			-81, 859			74. 00
75. 00	Protested amounts (nonallowable cost report			148, 223			75. 00
	items) in accordance with CMS Pub. 15-2,						
	chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR (lines 90 throu	gh 96)		_			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0			90. 00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2			0			91. 00
92. 00	Operating outlier reconciliation adjustment			Ö			92.00
	amount (see instructions)						
93. 00	Capital outlier reconciliation adjustment			0			93. 00
04.00	amount (see instructions)			0.00			04.00
94. 00	The rate used to calculate the time value of money (see instructions)			0.00			94. 00
95. 00	Time value of money for operating expenses			0			95. 00
	(see instructions)						
96. 00	Time value of money for capital related			0			96. 00
	expenses (see instructions)			I		I	I

Health Financial Systems	DEKALB MEMORIAL HO	EKALB MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 150045	Peri od: From 10/01/2014	Worksheet E Part A		
				To 09/30/2015		pared: 8 pm	
		Ti tl	e XVIII	Hospi tal	PPS		
			Prior to 10/	1	On/After 10/1		
			1.00	1. 01	2. 00		
HSP Bonus Payment Amount							
100.00 HSP bonus amount (see instructions)					0	100. 00	
HVBP Adjustment for HSP Bonus Payment							
101.00 HVBP adjustment factor (see instructions)					0	101.00	
102.00 HVBP adjustment amount for HSP bonus payment ((see instructions)				0	102. 00	
HRR Adjustment for HSP Bonus Payment							
103.00 HRR adjustment factor (see instructions)					0.0000	103. 00	
104.00 HRR adjustment amount for HSP bonus payment (s	see instructions)				0	104. 00	

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 150045

				Ti +I	e XVIII	Hospi tal	2/23/2016 3:0 PPS	8 pm
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1. 00	DRG amounts other than outlier	1. 00	1.00	2. 00	3.00	4. 00	5. 00 0	1. 00
1.00	payments	1.00	Ĭ		0			1.00
1.01	DRG amounts other than outlier	1. 01	0	0	0	0	0	1. 01
	payments for discharges occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	3, 391, 476	0	0	3, 391, 476	3, 391, 476	1. 02
	payments for discharges							
	occurring on or after October							
1.03	DRG for Federal specific	1. 03	0	0	0	0	0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to October 1							
1.04	DRG for Federal specific	1. 04	o	0	0	0	0	1. 04
	operating payment for Model 4							
	BPCI occurring on or after							
2. 00	October 1 Outlier payments for	2. 00	42, 440	0	0	42, 440	42, 440	2. 00
	discharges (see instructions)		,		_	,	,	
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
3.00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3. 00
0.00	reconciliation	2.01	Ĭ	J	O O	J		0.00
4.00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
	payments Indirect Medical Education Adju	Istmant						
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
	A, line 21 (see instructions)							
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	I ME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see	-						
	instructions)			-+: 122 -5 +	11110			
7. 00	Indirect Medical Education Adju IME payment adjustment factor	27.00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
7.00	(see instructions)	27.00	0. 000000	0. 000000	0. 000000	0. 000000		7.00
8.00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
0.01	for managed care (see	20.01		J	O	J		0.01
	instructions)		_	_	_	_	_	
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	O	0	0	0	9. 00
9. 01	Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and							
	8.01) Di sproporti onate Share Adjustmo	nt nt						
10. 00	Allowable disproportionate	33. 00	0. 0953	0. 0953	0. 0953	0. 0953		10. 00
	share percentage (see							
11. 00	instructions) Disproportionate share	34. 00	80, 802	0	0	80, 802	90 903	11. 00
11.00	adjustment (see instructions)	34.00	80, 802	O	Ü	80, 802	80, 802	11.00
11. 01	Uncompensated care payments	36. 00	343, 555	0	0	343, 555	343, 555	11. 01
12.00	Additional payment for high per	centage of ESF 46.00	RD beneficiary	di scharges 0	0	0	0	12.00
12. 00	Total ESRD additional payment (see instructions)	46.00	U	0	U	U	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	3, 858, 273	0	0	3, 858, 273	3, 858, 273	
14. 00	Hospital specific payments	48. 00	0	0	0	0	0	14. 00
	(completed by SCH and MDH, small rural hospitals only.)							
	(see instructions)							
15. 00	Total payment for inpatient	49. 00	3, 858, 273	0	0	3, 858, 273	3, 858, 273	15. 00
	operating costs (see instructions)							
16. 00	Payment for inpatient program	50. 00	271, 597	0	0	271, 597	271, 597	16. 00
	capi tal							
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01	Net organ aquisition cost	55.00	0	0	0	o	0	17. 01
17. 02	Credits received from	68. 00	o	O	0	o	0	
	manufacturers for replaced							
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation	93. 00	o	0	0	n	0	18. 00
. 5. 55	adjustment amount (see	75.00			0			. 5. 55
_	instructions)	<u> </u>	<u> </u>			<u> </u>	<u> </u>	<u> </u>

						To 09/30/2015		pared:
				Ti 1	le XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
19.00	SUBTOTAL				0	0 4, 129, 870	4, 129, 870	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	266, 802		0	0 266, 802	266, 802	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0		o	o	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	4, 795		o	0 4, 795	4, 795	21.00
21. 01	Model 4 BPCI Capital DRG	2. 01	0		o	o	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0.000	0. 000	0. 0000		22. 00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0		o	o o	0	23. 00
	adjustment (see instructions)							
24.00	, ,	10.00	0. 0000	0.000	0.000	0. 0000		24.00
	share percentage (see							
	instructions)							
25. 00	Di sproporti onate share	11.00	0		ol	ol o	l o	25. 00
	adjustment (see instructions)							
26.00	Total prospective capital	12.00	271, 597		o	0 271, 597	271, 597	26. 00
	payments (see instructions)						·	
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.00000	0. 118393		27. 00
28. 00	Low volume adjustment	70. 96				o	1 0	1
	(transfer amount to Wkst. E,						_	
	Pt. A, line)							
29. 00		70. 97				488, 948	488, 948	29. 00
	(transfer amount to Wkst. E,					·		
	Pt. A, line)							
100.00	Transfer low volume		Υ	•				100.00
	adjustments to Wkst. E, Pt. A.							
	,	!	!		1	į.	ļ.	'

	AL ACCURACY CONSTITUTE (TIAC) RESCETTOR CALCULA	TTON EXITED T	T T OVI del	F	rom 10/01/2014 o 09/30/2015	2/23/2016 3:0	pared:
			Titl	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	0	С		0	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 391, 476		3, 391, 476	3, 391, 476	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	О	C		О	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00	42, 440	C	42, 440	42, 440	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	C	0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0	0	_	3. 00 4. 00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	o	C	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	C	0	0	6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8.00	IME adjustment (see instructions)	28. 00	O	C	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	C	0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	C	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	C	0	0	
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0953	0. 0953	0. 0953		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	80, 802	C	80, 802	80, 802	11. 00
11. 01	Uncompensated care payments	36.00	343, 555	C	343, 555	343, 555	11. 01
	Additional payment for high percentage of ESF		di scharges				
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	C	0	0	12. 00
13.00	Subtotal (see instructions)	47. 00	3, 858, 273	C	3, 858, 273	3, 858, 273	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	0	C	0	0	14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	3, 858, 273	С	3, 858, 273	3, 858, 273	15. 00
16.00	Payment for inpatient program capital	50. 00	271, 597	C	271, 597	271, 597	16. 00
17. 00	Special add-on payments for new technologies	54.00	0	C	0	0	17. 00
17. 01	Net organ aquisition cost	55. 00	0	C	0	0	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	C	0	0	18. 00
19. 00	SUBTOTAL			C	4, 129, 870	4, 129, 870	19. 00

Health Financial Systems	DEKALB MEMORI.	AL HO	SPI TAL			In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		Provi der	CCN: 150045			Worksheet E Part A Exhibi Date/Time Pre 2/23/2016 3:0	pared:
			Titl	e XVIII		Hospi tal	PPS	
	Wkst. L, line	(Am	it. from					
		Wk	st. L)					
	0		1.00	2.00		3. 00	4.00	
20.00 Capital DRG other than outlier	1.00		266, 802		0	266, 802	266, 802	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01		0		0	0	0	20. 01
21.00 Capital DRG outlier payments	2.00		4, 795		0	4, 795	4, 795	21. 00

			e AVIII	поѕрі таі	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1. 00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1. 00	266, 802	0	266, 802	266, 802	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	4, 795	0	4, 795	4, 795	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0.0000	0.0000	0. 0000		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	0	0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0.0000	0. 0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	0	0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12.00	271, 597	0	271, 597	271, 597	26. 00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
		A)				
	0	1.00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0	0		0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	488, 948		488, 948	488, 948	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	3, 818	0	3, 818	3, 818	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	0	0	0	0	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99		0	0	0	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150045	Peri od: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Ti me Prepared: 2/23/2016 3:08 pm

		10	09/30/2015	2/23/2016 3:0	
		Title XVIII Ho	ospi tal	PPS	о рііі
			Jop. tu.		
				1. 00	
-	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6, 939	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		3, 501, 385	1
3.00	PPS payments			2, 940, 609	1
4.00	Outlier payment (see instructions)			6, 074	1
5.00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	•
6. 00 7. 00	Line 2 times line 5			0.00	
8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	1
10.00	Organ acqui si ti ons	, 661. 16, 11116 266		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 939	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12. 00	Ancillary service charges			15, 007	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			15, 007	14. 00
15 00	Customary charges			0	1 1 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa			0	15. 00 16. 00
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e)	payment for services on a cri	ar gebasi s	U	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17 00
18. 00	Total customary charges (see instructions)			15, 007	1
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds line 11)	(see	8, 068	1
	instructions)				
20.00					20. 00
	instructions)			6. 939	
21. 00					
22. 00					22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 8 and 9)	Ctrons)		0 2, 946, 683	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		2, 940, 003	24.00	
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		675, 543	•
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22 and 2	3] (see	2, 278, 079	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29)			2, 278, 079	1
32.00	Primary payer payments Subtotal (line 30 minus line 31)			661 2, 277, 418	ı
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	5)		2, 277, 410	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	7		0	33. 00
34.00	Allowable bad debts (see instructions)			130, 246	34. 00
35.00	Adjusted reimbursable bad debts (see instructions)			84, 660	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		74, 102	36. 00
37. 00	Subtotal (see instructions)			2, 362, 078	
					38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98 39. 99	Partial or full credits received from manufacturers for replace	d devices (see instructions)		0	
40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			2, 362, 102	1
40. 01	Sequestration adjustment (see instructions)			47, 242	1
41. 00	Interim payments			2, 230, 645	•
42. 00					42.00
43.00	Balance due provider/program (see instructions)			84, 215	1
44.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, chapte	r 1,	0	1
	§115. 2	·			
00	TO BE COMPLETED BY CONTRACTOR				00.5-
90.00	,			0	•
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	1
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)		}		94.00
74.00	Trotal (Sam of Fries / and 75)		I	U	1 /4.00

Health Financial Systems DEK.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Period: Worksheet E-1
From 10/01/2014 Part I
To 09/30/2015 Date/Time Prepared: 2/23/2016 3:08 pm Provider CCN: 150045

					2/23/2016 3:08	3 pm
			e XVIII	Hospi tal	PPS	
		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		4, 051, 77	5	2, 230, 645	1. 00
2.00	Interim payments payable on individual bills, either			Ō	0	2. 00
2.00	submitted or to be submitted to the contractor for					2.00
	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
3.00	amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER			0		3. 01
					l .	
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provi der to Program			_1	_	
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 051, 77	5	2, 230, 645	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			_		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER			0	84, 215	6. 01
6.02	SETTLEMENT TO PROGRAM		81, 85	9	0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 969, 91	6	2, 314, 860	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8.00	Name of Contractor					8. 00
	·					

Heal th	Financial Systems DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150045 Period: From 10/01/2014 To 09/30/2015 Date/Time P 2/23/2016 3							
		Title XVIII	Hospi tal	PPS			
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00							
2.00							
3.00							
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 6,420						
5.00	5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 128,385,971						
6.00	6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 1,149,563						
7. 00	CAH only - The reasonable cost incurred for the purchase of ce line 168	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00		
8.00	.00 Calculation of the HIT incentive payment (see instructions)						
9.00	Sequestration adjustment amount (see instructions)	6, 758	9. 00				
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		331, 153	10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions)			267, 448	30. 00		
31.00	Other Adjustment (specify)			0	31. 00		
22 00	00 Pelanes due providen (line 0 (on line 10) minus line 20 and line 21) (occ instructions)						

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

267, 448 30. 00 0 31. 00 63, 705 32. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150045	Peri od: Worksheet E-3 From 10/01/2014 Part VII To 09/30/2015 Date/Time Prepared:

Title XIX Hospital Cost PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COWERD SERVICES Inpatient hospital /SNF/NF services Nedical and other services Organ acquisition (certified transplant centers only) Organ acquisition (certified transplant centers only) Outpatient primary payer payments Outpatient pri	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES Inpatient hospital/SNF/NF services Inpatient hospital/SNF/NF services Need and other services Need and other services Need and other services Need and other services Need and other services Need and supplied the financy payer payments Need and other pa	
COMPUTATION OF NET COST OF COVERED SERVICES	
1,00	
Medical and other services 0	
3.00 Organ acquisition (certified transplant centers only) 0 4.00 Subtotal (sum of lines 1, 2 and 3) 491,592 5.00 Inpatient primary payer payments 0 0 0 0 0 0 0 0 0	1.00
491,592 Inpatient primary payer payments Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER DF COST OR CHARGES Reasonable Charges Routine service on services on a charge basis Routine asonable charges (sum of lines 8 through 11) Loutine services on a charge basis Routine services on a charge Routine services on a charge Routine services on a charge Routine services on a charge Routine services on a charge Routine services on a charge Routine services on a charge services on a charge Routine services on a charge services on a charge Routine services on a charge services on a charge Routine services on a charge services on a charge Routine services on a charge services on a charge services on a charge services on a charge service on a charge service on a charge service on a charge service on a charge service on a charge service on a charge service on s	2.00
Inpatient primary payer payments 0 0 0 0 0 0 0 0 0	3.00
6.00 Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges Rea	4.00
Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES	5.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 10.00 Incentive from target amount computation 10.00 Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 10.00 Total customary charges (see instructions) 10.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 16) (see instructions) 10.00 Interns and Residents (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10.00 Cost of payments 10.00 Cost of payments (see instructions)	6.00
Reasonable Charges Routine service charges Routillary service charges Routine from target amount computation Customary charges (sum of lines 8 through 11) CUSTOMARY CHARCES Roundary charges Routine from patients liable for payment for services on a charge basis Routine from a charge basis had such payment been made in accordance with 42 CFR §413. 13(e) Routine fine 13 to line 14 (not to exceed 1.000000) Ratio of line 13 to line 14 (not to exceed 1.000000) Routine for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e) Routine fine 13 to line 14 (not to exceed 1.000000) Routine fine fine fine fine fine fine fine f	7. 00
8.00 Routine service charges 9.00 Ancillary service charges 9.00 Ancillary service charges 9.00 Ancillary service charges 9.00 Ancillary service charges 9.00 Ancillary service charges 9.00 Organ acquisition charges, net of revenue 9.00 Incentive from target amount computation 9.00 Incentive from target amount computation 9.00 Total reasonable charges (sum of lines 8 through 11) 9.00 CUSTOMARY CHARGES 9.00 Amount actually collected from patients liable for payment for services on a charge basis 9.00 Amount sthat would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e) 9.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 9.00000 Total customary charges (see instructions) 9.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1, 067, 139 line 4) (see instructions) 9.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 9.00 Interns and Residents (see instructions) 9.00 Cost of physicians' services in a teaching hospital (see instructions) 9.00 Cost of covered services (enter the lesser of line 4 or line 16) 9.00 Cost of covered services (enter the lesser of line 4 or line 16) 9.00 Program capital payments 9.00 Outlier payments 9.00 Outlier payments 9.00 Outlier payments 9.00 Outlier payments 9.00 Outlier payments 9.00 Outlier payments 9.00 Outlier payments (see instructions) 9.00 Cost of payments (see instructions) 9.00 Outlier and Ancillary service other pass through costs 9.00 Outlier and Ancillary service other pass through costs 9.00 Subtotal (sum of lines 22 through 26) 9.00 Customary charges (title V or XIX PPS covered services only)	
9.00 Ancillary service charges 10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 16) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Cost of physicians' services in a teaching hospital (see instructions) 19.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Other than outlier payments 10.00 Other	
10.00 Organ acquisition charges, net of revenue 11.00 Incentive from target amount computation 12.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,067,139 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 10.00 Interns and Residents (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Ocst of covered services (enter the lesser of line 4 or line 16) 10.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Program capital payments 10.00 Ocat of physicians' service of line 4 or line 16) 10.00 Program capital payments 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of covered services (enter the lesser of line 4 or line 16) 10.00 Ocat of physicians' services (enter the lesser of line 4 or line 16) 10.00 Ocat of	8.00
11.00 Incentive from target amount computation 12.00 Total reasonable charges (sum of lines 8 through 11) 1,558,731 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 1,558,731 17.00 Excess of customary charges (see instructions) 1,558,731 1.001	9. 00
Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e) 16.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 17.00 Excess of customary charges (see instructions) 18.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 16) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10.00 Capital exception payments 10.00 Cost of covered services (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Cost of covered services other pass through costs 10.00 Cost of covered services other pass through costs 10.00 Customary charges (title V or XIX PPS covered services only)	10.00
CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 1,558,731 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,067,139 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10.00 Program capital payments 10.00 Outlier payments 10.00 Program capital payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions) 10.00 Capital exception payments (see instructions)	11. 00
Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 20.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments 23.00 Outlier payments 24.00 Program capital payments (see instructions) 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	12.00
basis Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line line 4) (see instructions) 19.00 Interns and Residents (see instructions) 20.00 Cost of physicians' services in a teaching hospital (see instructions) 21.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments 23.00 Outlier payments Program capital payments (see instructions) 24.00 Program capital payments (see instructions) 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	
Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 21.00 Other than outlier payments 22.00 Other than outlier payments 23.00 Outlier payments 24.00 Program capital payments 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	13. 00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 18.00 Cost of covered services (enter the lesser of line 4 or line 16) 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 22.00 Other than outlier payments 22.00 Outlier payments 23.00 Outlier payments 24.00 Program capital payments 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	
Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 6) (see instructions) Interns and Residents (see instructions) 19.00 Cost of physicians' services in a teaching hospital (see instructions) Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Cost of covered services (enter the lesser of line 4 or line 16) Program capital payments Capital exception payments (see instructions) Capital exception payments (see instructions) Capital exception payments (see instructions) Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)	14. 00
Total customary charges (see instructions) 1,558,731 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 20.00 Cost of physicians' services in a teaching hospital (see instructions) 21.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Outlier payments 0 Outlier payments 0 Program capital payments (see instructions) 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	45 00
17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions) 18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19. 00 Interns and Residents (see instructions) 20. 00 Cost of physicians' services in a teaching hospital (see instructions) 21. 00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22. 00 Outlier payments 0 Outlier payments 1, 067, 139 1, 067, 139 1 Outline 16 exceeds line 17 0 Description of lines 20 instructions) 0 Cost of covered services in a teaching hospital (see instructions) 22. 00 Outlier payments Amount - Lines 22 through 26 must only be completed for PPS providers. 22. 00 Outlier payments 0 Outlier payments 0 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 0 Outline and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only)	15.00
line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 20.00 Cost of physicians' services in a teaching hospital (see instructions) Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments Outlier payments Outlier payments Orogram capital payments Capital exception payments (see instructions) Condition and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26) Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)	16.00
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 20.00 Cost of physicians' services in a teaching hospital (see instructions) 21.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments 0 Utlier payments 0 Very capital payments 0 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	17. 00
16) (see instructions) 19.00 Interns and Residents (see instructions) 20.00 Cost of physicians' services in a teaching hospital (see instructions) 21.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments 0 Outlier payments 0 Outlier payments 0 Program capital payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	18. 00
19.00 Interns and Residents (see instructions) 20.00 Cost of physicians' services in a teaching hospital (see instructions) 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 22.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Outlier payments 23.00 Outlier payments 24.00 Program capital payments 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	16.00
20.00 Cost of physicians' services in a teaching hospital (see instructions) 21.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments Outlier payments Outlier payments Capital payments Capital exception payments (see instructions) Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	19. 00
21. 00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22. 00 Other than outlier payments 0 Outlier payments 1 Program capital payments 25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only)	20.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22. 00 Other than outlier payments 0 Outlier payments 0 Program capital payments 25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 0 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 0 Outlier of PPS providers. 0 Outlier PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.	21. 00
22. 00 Other than outlier payments 0 23. 00 Outlier payments 0 24. 00 Program capital payments (see instructions) 0 25. 00 Capital exception payments (see instructions) 0 26. 00 Routine and Ancillary service other pass through costs 0 27. 00 Subtotal (sum of lines 22 through 26) 0 28. 00 Customary charges (title V or XIX PPS covered services only) 0	21.00
23.00 Outlier payments 24.00 Program capital payments 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only)	22. 00
24.00 Program capital payments Capital exception payments (see instructions) Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26) Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)	23. 00
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 0	24. 00
26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 0	25. 00
27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 0	26. 00
28.00 Customary charges (title V or XIX PPS covered services only)	27. 00
	28. 00
	29. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT	
30.00 Excess of reasonable cost (from line 18)	30.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 491,592	31.00
32.00 Deductibles	32.00
33. 00 Coi nsurance	33.00
34.00 Allowable bad debts (see instructions)	34.00
35.00 Utilization review	35.00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 491,592	36.00
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	37.00
38.00 Subtotal (line 36 ± line 37) 491,592	38.00
39.00 Direct graduate medical education payments (from Wkst. E-4)	39.00
40.00 Total amount payable to the provider (sum of lines 38 and 39) 491,592	40.00
41.00 Interim payments 587,877	41.00
42.00 Balance due provider/program (line 40 minus line 41) -96, 285	42.00
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0	43.00
chapter 1, §115.2	

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

Provi der CCN: 150045 | Peri od: From 10/01/2014 | To 09/30/2015

Period: Worksheet G From 10/01/2014 To 09/30/2015 Worksheet G Date/Time Prepared: 2/23/2016 3:08 pm

					2/23/2016 3:0	8 pm
		General Fund		Endowment Fund	Plant Fund	
		1 00	Purpose Fund	0.00	4 00	
	CHIDDENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	29, 899	0		0	1.00
2. 00	Temporary investments	37, 166	l .		0	2.00
3.00	Notes recei vabl e	07,100	l	0	0	3. 00
4. 00	Accounts receivable	19, 161, 780	1	o	Ö	ł
5.00	Other recei vable	351, 690	1	0	0	ł
6.00	Allowances for uncollectible notes and accounts receivable	-11, 472, 912	1	0	0	6. 00
7.00	Inventory	1, 596, 794	0	0	0	7. 00
8.00	Prepai d expenses	721, 293	0	0	0	8. 00
9.00	Other current assets	133, 011	1		0	9. 00
10. 00	Due from other funds	0			0	10. 00
11. 00	Total current assets (sum of lines 1-10)	10, 558, 721	0	0	0	11. 00
10.00	FIXED ASSETS	202 110	1		0	10.00
12. 00 13. 00	Land improvements	393, 118 1, 781, 970	1		0	1
14. 00	Accumulated depreciation	-1, 423, 790	1		0	
15. 00	Buildings	60, 294, 655	1	-	0	15. 00
16. 00	Accumulated depreciation	-27, 425, 168	1	-	0	16. 00
17. 00	Leasehold improvements	0	ō	0	0	17. 00
18.00	Accumulated depreciation	-1, 493, 579	0	0	0	18. 00
19.00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumulated depreciation	-209, 343	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0		0	
22. 00	Accumul ated depreciation	0	0		0	22. 00
23. 00	Maj or movable equipment	24, 276, 380	1		0	23. 00
24. 00	Accumulated depreciation	-15, 157, 030	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	204 027	0	0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	-206, 027		0	0	26. 00 27. 00
28. 00	Accumulated depreciation		0	0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e		Ö		0	ł
30.00	Total fixed assets (sum of lines 12-29)	40, 831, 186			0	
	OTHER ASSETS	127 22 17 122	-	-1		
31.00	Investments	17, 575, 039	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	0	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	17, 575, 039	1		0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	68, 964, 946	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	1 050 505	0	O	0	37. 00
38.00	Salaries, wages, and fees payable	1, 858, 585 3, 334, 369			0	38.00
39. 00	Payroll taxes payable	3, 334, 309		0	0	39.00
40. 00	Notes and Loans payable (short term)	1, 713, 540	0	0	0	40.00
41. 00	Deferred income	0	Ö	o	Ö	41.00
42. 00	Accel erated payments	Ö	_		_	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1, 000, 682	0	0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	7, 907, 176	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0		0	
47. 00	Notes payable	13, 276, 305	1		0	ł
48. 00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	12 274 205	0	0	0	ł
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49 Total liabilites (sum of lines 45 and 50)	13, 276, 305 21, 183, 481	1		0	1
31.00	CAPITAL ACCOUNTS	21, 103, 401		U	U	31.00
52. 00	General fund balance	47, 781, 465				52. 00
53. 00	Specific purpose fund	17,701,100	0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	47, 781, 465	1	0	0	ł
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	68, 964, 946	0		0	60. 00
	J 7 /	I	I			I

Provider CCN: 150045

					To 09/30/201	5 Date/Time Pre 2/23/2016 3:0	
		General	Fund	Special F	Purpose Fund	Endowment Fund	5 piii
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1.00	2. 00 49, 374, 669	3. 00	4.00	5. 00	1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		-2, 589, 874		'	٩	2. 00
3. 00	Total (sum of line 1 and line 2)		46, 784, 795				3. 00
4. 00	NET ASSETS RELEASED FROM RESTRICTION	1, 530, 360	40, 704, 793		0	o	4. 00
5. 00	CONTRIBUTIONS RECEIVED	1, 051, 118			0	0	5. 00
6. 00	SOUTH BOTTONG NEGET VEB	0			0	0	6. 00
7. 00		l ol			o	0	7. 00
8.00		O			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		2, 581, 478			o	10.00
11.00	Subtotal (line 3 plus line 10)		49, 366, 273			o	11. 00
12.00	NET ASSETS RELEASED FROM RESTRICTION	1, 584, 808			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)		1, 584, 808		(0	18. 00
19. 00	Fund balance at end of period per balance		47, 781, 465		(0	19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Endownerre Turia	Trunt	T dila			
		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	NET ASSETS RELEASED FROM RESTRICTION		0				4. 00
5.00	CONTRI BUTI ONS RECEI VED		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9. 00 10. 00	Total additions (sum of line 4-9)	0	٥		0		9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				0		11. 00
12. 00	NET ASSETS RELEASED FROM RESTRICTION		0		9		12. 00
13. 00	NET ASSETS RELEASED FROM RESTRICTION		0				13. 00
10.00		1	0				14. 00
14.00							
14. 00 15. 00			ol				
14. 00 15. 00 16. 00			0				15. 00 16. 00
15. 00			0 0				15. 00
15. 00 16. 00	Total deductions (sum of lines 12-17)	0	0 0		0		15. 00 16. 00
15. 00 16. 00 17. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0	0 0		0		15. 00 16. 00 17. 00
15. 00 16. 00 17. 00 18. 00			0		-		15. 00 16. 00 17. 00 18. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150045

		-	To 09/30/2015	Date/Time Pre 2/23/2016 3:0	
	Cost Center Description	I npati ent	Outpati ent	Total	o piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	11, 097, 90	7	11, 097, 907	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)	11, 097, 90	7	11, 097, 907	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	4, 425, 86	9	4, 425, 869	11. 00
12. 00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	4, 425, 86	9	4, 425, 869	16. 00
17 00	11-15)	15 500 77	,	15 500 77/	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	15, 523, 77		15, 523, 776	17.00
18.00	Ancillary services	21, 621, 20		90, 522, 247	18.00
19. 00	Outpatient services	2, 284, 95		14, 835, 107	
20.00	RURAL HEALTH CLINIC		0 0	0	20. 00 21. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	'		0	21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULANCE SERVICES		1, 016, 253	1, 016, 253	
24. 00	AMBULANCE SERVICES	'	5, 757, 465	5, 757, 465	23. 00 24. 00
24. 00	CORF		0	0	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	'		U	25. 00
26. 00	HOSPICE	22, 09	7 682, 396	704, 493	
27. 00	DI ETARY	1		26, 859	27.00
27. 00	DHMG PHYSI CI ANS	1	12, 286, 838	12, 286, 838	•
27. 01	SELF-I NSURANCE	377, 61		1, 796, 029	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	39, 829, 66		142, 469, 067	
20.00	G-3, line 1)	37, 027, 00	102, 037, 407	142, 407, 007	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		62, 665, 523		29. 00
30. 00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00			o		33. 00
34.00					34.00
35.00			o		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		C		37.00
38. 00		1	c		38. 00
39. 00		1	c		39. 00
40.00		1	c		40. 00
41.00			C		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)(transfer		62, 665, 523		43. 00
	to Wkst. G-3, line 4)	1			l

	Financial Systems DEKALB MEMORIAL ENT OF REVENUES AND EXPENSES	Provider CCN: 150045	Period:	u of Form CMS-2 Worksheet G-3	
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 150045	From 10/01/2014	worksneet G-3	
			To 09/30/2015		
				2/23/2016 3:0	8 pm
1.00		00)		1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			142, 469, 067	1.00
2.00	Less contractual allowances and discounts on patients' account	:S		86, 675, 292	2.00
3.00	Net patient revenues (line 1 minus line 2)	10)		55, 793, 775	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	13)		62, 665, 523	
5. 00	Net income from service to patients (line 3 minus line 4)			-6, 871, 748	5. 00
	OTHER I NCOME			0	, ,,
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			-1, 542, 122	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	
13.00	Revenue from laundry and linen service			0	
14.00	Revenue from meals sold to employees and guests			0	
15.00	Revenue from rental of living quarters			0	
16.00	Revenue from sale of medical and surgical supplies to other th	ian patients			16.00
17. 00	Revenue from sale of drugs to other than patients				17. 00
18.00	Revenue from sale of medical records and abstracts				18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)				19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropri ati ons			0	
24. 00	MI SCELLANEOUS I NCOME			5, 823, 996	
25. 00	Total other income (sum of lines 6-24)			4, 281, 874	
26. 00	Total (line 5 plus line 25)			-2, 589, 874	
27. 00	OTHER EXPENSES (SPECIFY)			0	
28. 00	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 28)		ļ	-2, 589, 874	29.00

		on	Trial Balance	,	for Allocation	
			(col. 6 +		(col. 8 + col.	
			col . 7)		9)	
		7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. &	0	0	0	0	1. 00
	Fi xtures					
2.00	Capital Related - Movable	0	0	0	0	2. 00
	Equi pment					
3.00	Plant Operation & Maintenance	0	0	0	0	3. 00
4.00	Transportation	0	0	0	0	4. 00
5.00	Administrative and General	9, 707	721, 925	-48, 395	673, 530	5. 00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	182, 225	0	182, 225	6. 00
7.00	Physi cal Therapy	0	111, 220	0	111, 220	7. 00
8.00	Occupational Therapy	0	4, 420	0	4, 420	8. 00
9.00	Speech Pathology	0	4, 923	0	4, 923	9. 00
10.00	Medical Social Services	0	23, 947	0	23, 947	10. 00
11. 00	Home Health Aide	0	57, 406	0	57, 406	11. 00
12.00	Supplies (see instructions)	0	0	0	0	12. 00
13.00	Drugs	0	0	0	0	13. 00
14.00	DME	0	0	0	0	14. 00
	HHA NONREIMBURSABLE SERVICES					
15. 00	Home Dialysis Aide Services	0	0	0	0	15. 00
	Respiratory Therapy	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	0	18. 00
19. 00	Health Promotion Activities	0	0	0	0	19. 00
20.00	Day Care Program	0	0	0	0	20. 00
	Home Delivered Meals Program	0	0	0	0	21. 00
	Homemaker Service	0	0	0	0	22. 00
	All Others (specify)	0	0	0	0	23. 00
24.00	Total (sum of lines 1-23)	9, 707	1, 106, 066	-48, 395	1, 057, 671	24. 00

			Net Expenses	Bl dgs &	Movabl e	Plant	Transportati on		
			for Cost	Fi xtures	Equi pment	Operation &		(cols. 0-4)	
			Allocation			Mai ntenance			
			(from Wkst. H,						
			col . 10) 0	1. 00	2. 00	3. 00	4. 00	4A. 00	
	GENED	AL SERVICE COST CENTERS	0 1	1.00	2.00	3.00	4.00	4A. 00	
1.0		al Related - Bldg. &	I 0	0				0	1.00
1. 0	Fixtu			Ö				Ĭ	1.00
2.0	4	al Related - Movable	0		C			0	2. 00
	Equi p								
3.0		Operation & Maintenance	O	0	C	0		0	3. 00
4. C	00 Trans	portati on	0	0	C	0	0		4. 00
5.0	00 Admin	istrative and General	673, 530	0	C	0	0	673, 530	5. 00
		EIMBURSABLE SERVICES	,						
6.0		ed Nursing Care	182, 225	0	C	0	0	182, 225	6. 00
7. C	1 -	cal Therapy	111, 220	0	C				1
8.0		ational Therapy	4, 420	0	C	ή		., .=-	
9.0		h Pathol ogy	4, 923	0	C	0		., . = -	1
10.		al Social Services	23, 947	0	C	0	_	,	1
11.		Heal th Ai de	57, 406	0	C	0	_	57, 406	1
12.	1	ies (see instructions)	0	0	C	0	_	0	12.00
13.	5		0	0	C			0	
14.		ONREIMBURSABLE SERVICES	0	0	C) 0	0	0	14. 00
15.		Dialysis Aide Services	l ol	0	C	0	0	0	15. 00
16.		ratory Therapy		0	C	•		l .	1
17.		te Duty Nursing		0					1
18.	4			0				ĺ	1
19.		h Promotion Activities		Ö	C	ol o	_	ĺ	1
20.	1	are Program	o	O	C	ol o		Ö	1
21.	1 -	Delivered Meals Program	o	0	C	o	0	0	1
22.	1	aker Servi ce	0	0	C	0	0	0	22. 00
23.	00 AII 0	thers (specify)	0	0	C	0	0	0	23. 00
24.	00 Total	(sum of lines 1-23)	1, 057, 671	0	C	0	0	1, 057, 671	24. 00
			Admi ni strati ve						
			& General	4A + 5)					
	CENED	AL CEDVICE COST CENTEDS	5. 00	6. 00					
1. C		AL SERVICE COST CENTERS al Related - Bldg. &							1.00
1. 0	Fixtu								1.00
2.0	1	al Related - Movable							2. 00
	Equi p								
3.0		Operation & Maintenance							3. 00
4. C	00 Trans	portation							4. 00
5. C	OO Admin	istrative and General	673, 530						5. 00
		EIMBURSABLE SERVICES							
6.0		ed Nursing Care	319, 502	501, 727					6. 00
7. C	1 -	cal Therapy	195, 007	306, 227					7. 00
8.0		ational Therapy	7, 750	12, 170					8. 00
9.0	1 '	h Pathology	8, 632	13, 555					9.00
10.	1	al Social Services	41, 987 100, 652	65, 934 158, 058					10. 00 11. 00
		Health Aide ies (see instructions)	100, 652	158, 058					12.00
13.		,		0					13. 00
14.		•		0					14. 00
14.	-	ONREI MBURSABLE SERVI CES	. 0	U _I					1 17.00
15.		Dialysis Aide Services	l ol	0					15. 00
16.	1	ratory Therapy	0	o					16. 00
		te Duty Nursing	0	O					17. 00
18.	4	3	0	o					18. 00
19.	4	h Promotion Activities	0	o					19. 00
20.	00 Day C	are Program	0	o					20. 00
		Delivered Meals Program	0	o					21. 00
	1	aker Servi ce	0	0					22. 00
		thers (specify)	0	0					23. 00
24.	00 Total	(sum of lines 1-23)		1, 057, 671					24. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BASIS	Provi der CCN: 150045		Worksheet H-1
	HHA CCN: 157157	From 10/01/2014 To 09/30/2015	Date/Time Prepared: 2/23/2016 3:08 pm
		Home Health	PPS
		Agency I	

						Home Health Agency I	PPS	
		Canital Rel	ated Costs			Agency i		
		Capi tai Kei	atea costs					
		Bl dgs &	Movabl e	PI ant	Transportation	Reconciliation	Administrative	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
			(DOLLAR VALUE)	Mai ntenance	(===)		(ACCUM. COST)	
		,	,	(SQUARE FEET)			,	
		1.00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	•			1			
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	C		0		3. 00
4.00	Transportation (see	0	0	C				4. 00
	instructions)							
5.00	Administrative and General	0	0	C) (-673, 530	384, 141	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	C) (0	182, 225	6. 00
7.00	Physi cal Therapy	0	0	C) (0	111, 220	7. 00
8.00	Occupational Therapy	0	0	C) (0	4, 420	
9.00	Speech Pathology	0	0	C) (0	4, 923	
10. 00	Medical Social Services	0	0	C) (0	23, 947	
11. 00	Home Health Aide	0	0	C) (0	57, 406	
12.00	Supplies (see instructions)	0	0	C) (0	0	12.00
13. 00	Drugs	0	0	C)	0	0	13. 00
14. 00	DME	0	0	C) (0	0	14. 00
	HHA NONREIMBURSABLE SERVICES	T			Г			
15. 00	Home Dialysis Aide Services	0	0	C	1	-	0	
16. 00	Respiratory Therapy	0	0	C		0	0	16. 00
17. 00	Private Duty Nursing	0	0	C		0	0	17. 00
18. 00	Clinic	0	0	C		0	0	18. 00
19. 00	Health Promotion Activities	0	0	C) (0	0	19. 00
20. 00	Day Care Program	0	0	C) (0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	C) (0	0	21. 00
22. 00	Homemaker Service	0	0	C		0	0	22. 00
23. 00	All Others (specify)	0	0	C		0	0	23. 00
24. 00	Total (sum of lines 1-23)	0	0	C		-673, 530	384, 141	24. 00
25. 00	Cost To Be Allocated (per	0	0	C)	673, 530	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000)	1. 753341	26. 00

							Home Health Agency I	PPS	
			CAPI TAL			1			
	Cost Center Description	HHA Trial	RELATED COSTS BLDG & FLXT	MAC WEST -	- NEW	NORTH ANNEX -	GARRETT CLINIC	BUTLER - NEW	
	·	Bal ance (1)	4.00	4.04		NEW	- NEW	1.04	
1.00	Administrative and General	0	1.00	1.01	0	1. 02 2, 420	1.03	1. 04 0	1. 00
2. 00	Skilled Nursing Care	501, 727	C	l l	0	2, 120 C	o o	ő	2. 00
3.00	Physi cal Therapy	306, 227	C	l .	0	C	0	0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	12, 170 13, 555	C	l l	0	C	0	0	4. 00 5. 00
6. 00	Medical Social Services	65, 934		l l	0	C	0	0	
7.00	Home Health Aide	158, 058	C	l .	0	C	0	0	7. 00
8.00	Supplies (see instructions)	0	C	l .	0	C	0	0	
9. 00 10. 00	Drugs DME	0	C	ł	0	(0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	Ö	C	ł	Ö	C	Ö	Ö	11. 00
12. 00	Respiratory Therapy	0	C	l .	0	C	0	0	12. 00
13. 00 14. 00	Private Duty Nursing Clinic	0	0	ł	0	C	_	0	13. 00 14. 00
15. 00	Health Promotion Activities	0	C	ł	0	C	_	0	15. 00
16. 00	Day Care Program	0	C	l .	0	C	0	0	16. 00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	C	ł .	0	C	0	0	17. 00 18. 00
	All Others (specify)	0		l .	0	C	0	0	19. 00
20. 00	Total (sum of lines 1-19) (2)	1, 057, 671	C		0	2, 420	0	0	20. 00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum								21. 00
	of column 26, line 20 minus								
	column 26, line 1, rounded to								
	6 decimal places.		CAP	 TAL_RELAT	ED CO	STS			
		MAG FACT NEW	CARRETT LAR	MEDIONI M).TC	DAY CDDING	IN IDLE FOLLID	EMBL OVEE	
	Cost Center Description	MAC EAST - NEW	NEW -	MEDICAL AF	(15 -	DAY SPRING - NEW	MVBLE EQUIP	EMPLOYEE BENEFITS	
								DEPARTMENT	
1. 00	Administrative and General	1. 05 0	1.06	1.07	0	1. 08	2.00	4. 00 29, 248	1. 00
2. 00	Skilled Nursing Care	Ö	C	1	0	C	0	0	2. 00
3.00	Physi cal Therapy	0	C)	0	C	0	0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	C)	0	C	0	0	4. 00 5. 00
6. 00	Medical Social Services	0	C	l .	0	C	0	0	
7.00	Home Health Aide	0	C	l .	0	C	0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	C	ŀ	0	C	0	0	8. 00 9. 00
10. 00	DME		C	ŀ	0	C	0	0	10.00
11. 00	Home Dialysis Aide Services	0	C		0	C	0	0	11. 00
12.00	Respiratory Therapy	0	C		0	C	0	0	12.00
13. 00 14. 00	Private Duty Nursing Clinic	0	C)	0	(0	0	13. 00 14. 00
	Health Promotion Activities	0	C		0	C	0	0	
16.00	Day Care Program	0	C	1	0	C	-	· -	
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	C)	0	C	0	0	17. 00 18. 00
19. 00	All Others (specify)	o o	C		0	C	o o	ő	
20. 00	Total (sum of lines 1-19) (2)	0	C)	0	C	0	29, 248	
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum								21. 00
	of column 26, line 20 minus								
	column 26, line 1, rounded to								
	6 decimal places.	I		I	ļ		1	l	I

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

From 10/01/2014 Part I HHA CCN: 157157 То 09/30/2015 Date/Time Prepared: 2/23/2016 3:08 pm Home Health Agency I ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY Cost Center Description Subtotal LINEN SERVICE & GENERAL **PLANT** 10.00 8.00 9.00 4A 5.00 7.00 1.00 Administrative and General 31, 668 5, 340 80, 882 23, 802 1.00 501, 727 84, 606 0 2.00 2.00 Skilled Nursing Care Physical Therapy 51, 640 3.00 306, 227 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 3.00 12, 170 0 Occupational Therapy 4.00 2,052 C 4.00 Speech Pathology 0 5.00 13, 555 2, 286 5.00 Medical Social Services 65, 934 11, 119 0 0 6.00 6.00 7.00 0 Home Health Aide 158, 058 0 26,654 0 7.00 0 8.00 Supplies (see instructions) 0 0 8.00 9.00 Drugs 0 0 0 0 9.00 10.00 DME 0 0000000 0 10.00 0 Home Dialysis Aide Services 0 11.00 0 11.00 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 13.00 0 0 14.00 0 14.00 Clinic Health Promotion Activities 0 0 15.00 15.00 16.00 Day Care Program 0 16.00 Home Delivered Meals Program 0 0 0 0 17.00 17.00 0 0 Homemaker Service 0 0 0 18.00 18 00 C All Others (specify) 19.00 0 19.00 20.00 Total (sum of lines 1-19) (2) 1,089,339 183, 697 80, 882 23, 802 20.00 Unit Cost Multiplier: column 0.000000 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

Cost Center Description SNACK BAR CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL SERVICES & RECORDS & ADMI NI STRATI ON SUPPLY LI BRARY 10.01 11.00 13.00 14.00 15.00 16.00 1.00 Administrative and General 0 31, 013 131, 433 0 0 1.00

1.00	Admin in Strati ve and deneral	ı v	31,013	131, 433		0	1	1.00
2.00	Skilled Nursing Care	0	0	0	C	0	0	2. 00
3.00	Physi cal Therapy	0	0	0	C	0	0	3. 00
4.00	Occupational Therapy	0	0	0	C	0	0	4. 00
5.00	Speech Pathology	0	0	0	C	0	0	5. 00
6.00	Medical Social Services	0	0	0	C	0	0	6. 00
7.00	Home Health Aide	0	0	0	C	0	0	7. 00
8.00	Supplies (see instructions)	0	0	0	C	0	0	8. 00
9.00	Drugs	0	0	0	C	0	0	9. 00
10.00	DME	0	0	0	C	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	C	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	C	0	0	12.00
13.00	Private Duty Nursing	0	0	0	C	0	0	13.00
14.00	Clinic	0	0	0	C	0	0	14.00
15. 00	Health Promotion Activities	0	0	0	C	0	0	15. 00
16.00	Day Care Program	0	0	0	C	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	C	0	0	17. 00
18. 00	Homemaker Service	0	0	0	C	0	0	18. 00
19. 00	All Others (specify)	0	0	0	C	0	0	19. 00
20.00	Total (sum of lines 1-19) (2)	0	31, 013	131, 433	C	0	0	20.00
21. 00	Unit Cost Multiplier: column							21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.

⁽²⁾ Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Worksheet H-2 Part I Date/Time Prepared: 2/23/2016 3:08 pm Provi der CCN: 150045 Peri od: From 10/01/2014 To 09/30/2015 HHA CCN: 157157 Home Health PPS Agency I Cost Center Description SOCIAL SERVICE

	Cost Center Description	SOCIAL SERVICE		Intern &	Subtotal	Allocated HHA	Total HHA	
				Residents Cost		A&G (see Part	Costs	
				& Post		11)		
				Stepdown				
		17.00	0.4.00	Adjustments	2/ 22	07.00		
	1	17. 00	24. 00	25. 00	26. 00	27. 00	28. 00	
1.00	Administrative and General	0	304, 138	l .	304, 138			1. 00
2.00	Skilled Nursing Care	0	586, 333	l	586, 333		730, 607	2. 00
3.00	Physi cal Therapy	0	357, 867	l	357, 867			3. 00
4.00	Occupational Therapy	0	14, 222	0	14, 222		17, 721	4. 00
5.00	Speech Pathology	0	15, 841	0	15, 841		19, 739	
6.00	Medical Social Services	0	77, 053	l	77, 053		96, 013	6. 00
7. 00	Home Health Aide	0	184, 712	0	184, 712	45, 450	230, 162	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9. 00
10. 00	DME	0	0	0	0	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18. 00	Homemaker Service	0	0	0	0	0	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	1, 540, 166	0	1, 540, 166	304, 138	1, 540, 166	20.00
21. 00	Unit Cost Multiplier: column					0. 246061		21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	DEKALB MEMORIAL HO	SPI TAL	In Lieu	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO BASIS	O HHA COST CENTERS STATISTICAL	Provi der CCN: 150045 HHA CCN: 157157	From 10/01/2014	Worksheet H-2 Part II Date/Time Prepared: 2/23/2016 3:08 pm
			Home Health	DDS

						Home Health	PPS	
		CAPI TAL				Agency I		
		RELATED COSTS						
	Cost Center Description		MAC WEST - NEW				MAC EAST - NEW	
		(SQUARE FEET)	(SQUARE FEET)	NEW	- NEW (SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	
		1.00	1. 01	(SQUARE FEET) 1.02	1. 03	1. 04	1. 05	
1. 00	Administrative and General	0				0 0		1. 00
2.00	Skilled Nursing Care	0	0		0	0	0	2. 00
3.00	Physi cal Therapy	0	0	(1	0		3. 00
4.00	Occupational Therapy	0	0	l .	1	0		4. 00
5.00	Speech Pathology	0	0	l		0		5. 00
6. 00 7. 00	Medical Social Services Home Health Aide	0	0	l			_	6. 00 7. 00
8.00	Supplies (see instructions)	0	0	l	-			8.00
9. 00	Drugs	0	o o					9. 00
10.00	DME	0	0		0	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	l .		0		11. 00
12. 00	Respiratory Therapy	0	0	l .		0		12. 00
13. 00	Private Duty Nursing	0	0	l		0	_	13.00
14. 00 15. 00	Clinic Health Promotion Activities	0	0	l	-		_	14. 00 15. 00
16. 00	Day Care Program		0	l	-		_	16. 00
17. 00	Home Delivered Meals Program	l ő	0	l	-		_	17. 00
18. 00	Homemaker Service	0	0		0	0	0	18. 00
19. 00	All Others (specify)	0	0	(0	0	0	19. 00
20.00	Total (sum of lines 1-19)	0	0	2, 77	1	0	_	20. 00
21. 00	Total cost to be allocated	0	0 000000	2, 42	•	0	0	21. 00
22. 00	Unit cost multiplier	0. 000000		O. 87301 ATED COSTS	6 0.00000	0. 000000	0. 000000	22. 00
			OALLIAE REI	_ATED 00313				
	Cost Center Description	GARRETT LAB -	MEDICAL ARTS -	DAY SPRING -	MVBLE EQUIP	EMPLOYEE	Reconciliation	
		NEW	NEW	NEW	(SQUARE FEET)	BENEFITS		
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		DEPARTMENT (UNADJUSTED		
						SALARY)		
		1.06	1. 07	1. 08	2.00	4. 00	5A	
1.00	Administrative and General	0	_	l		722, 932	0	1. 00
2.00	Skilled Nursing Care	0	0	l .		0		2. 00
3.00	Physical Therapy	0	0	l .	I			3. 00 4. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	l	I			5. 00
6. 00	Medical Social Services	0	0	l			_	6. 00
7. 00	Home Health Aide	0	0	l	1	0		7. 00
8.00	Supplies (see instructions)	0	0		0	0	0	8. 00
9.00	Drugs	0	0	l		0		9. 00
10. 00	DME	0	0			0	_	10.00
11. 00	Home Dialysis Aide Services	0	0	l	1			11.00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	l e	•			12. 00 13. 00
14. 00	Clinic	0	0	l				14. 00
15. 00	Health Promotion Activities	0	Ö	l .		0		15. 00
16.00	Day Care Program	0	0		0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	l	1	0	_	17. 00
18. 00	Homemaker Service	0	0		-	0	_	18. 00
19. 00 20. 00	All Others (specify) Total (sum of lines 1-19)	0	0		-	0 722, 932		19. 00 20. 00
21. 00	Total cost to be allocated				1	722, 932 29, 248	l .	20.00
	Unit cost multiplier	0. 000000	0. 000000	0. 00000	-	,		22. 00
	•			,		•	•	

Provi der CCN: 150045 BASIS HHA CCN: 157157

						Home Health	PPS	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	Agency I DI ETARY	SNACK BAR	
	cost center bescription	& GENERAL	PLANT	LI NEN SERVI CE	(SQUARE FEET)		(MEALS SERVED)	
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	(SQUARE TELT)	(WLALS SLRVLD)	(WLALS SLKVLD)	
		(ACCOW. COST)	(SQUARE TELT)	LAUNDRY)				
		5. 00	7. 00	8. 00	9. 00	10.00	10. 01	
1. 00	Administrative and General	31, 668	2,772	0	2, 772			1. 00
2.00	Skilled Nursing Care	501, 727	, o	0	· c			2. 00
3. 00	Physi cal Therapy	306, 227	0	0		0	-	3. 00
4. 00	Occupational Therapy	12, 170	0	0		0	0	4. 00
5. 00	Speech Pathology	13, 555	0	0	ĺ	0	0	5. 00
6. 00	Medical Social Services	65, 934	Ö	0		0	o o	6. 00
7. 00	Home Heal th Ai de	158, 058	0	0	ĺ	_	0	7. 00
8. 00	Supplies (see instructions)	0	0	n			0	8. 00
9.00	Drugs	0	0	0			0	9. 00
10.00	DME	0	0	0		_		10.00
11. 00	Home Dialysis Aide Services	0	0	0		1	0	11. 00
12. 00	Respiratory Therapy		0	0		ή	0	12. 00
13. 00	Private Duty Nursing	0	0	0		_	0	13. 00
14. 00	Clinic		0	0			0	14. 00
15. 00	Health Promotion Activities		0	0			0	15. 00
16. 00	Day Care Program		0	0		ή	0	16. 00
17. 00	Home Delivered Meals Program		0	0			0	17. 00
18. 00	Homemaker Service		0	0			0	18.00
19. 00	1		0	0			0	19. 00
20. 00	All Others (specify)	1, 089, 339	2,772	0	2, 772		0	20. 00
21. 00	Total (sum of lines 1-19) Total cost to be allocated	183, 697	80, 882	0	23, 802		0	21. 00
22. 00	Unit cost multiplier	0. 168632	29. 178211	0. 000000			0. 000000	22. 00
22.00	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	22.00
	0001 0011101 20001 Ptro						0001712 021111 02	
		(FIES)	ADMINISTRATION	SERVICES &	I (COSTED	RECORDS &		
		(FTES)	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	LI BRARY	(TIME SPENT)	
		(FIES)	(DIRECT NRS				(TIME SPENT)	
			(DI RECT NRS I NG)	SUPPLY (COSTED REQUI S.)	REQUIS.)	LI BRARY (GROSS REVE NUE)		
		11. 00	(DI RECT NRS I NG) 13.00	SUPPLY (COSTED REQUIS.) 14.00	REQUI S.)	LI BRARY (GROSS REVE NUE) 16. 00	17. 00	
1.00	Administrative and General	11.00	(DI RECT NRS I NG) 13. 00 30, 919	SUPPLY (COSTED REQUIS.) 14.00	15. 00	LI BRARY (GROSS REVE NUE) 16. 00	17.00	1.00
2.00	Skilled Nursing Care	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919	SUPPLY (COSTED REQUIS.) 14.00	15. 00	LI BRARY (GROSS REVE NUE) 16. 00	17.00	2. 00
2.00 3.00	Skilled Nursing Care Physical Therapy	11.00	(DI RECT NRS I NG) 13. 00 30, 919 0	SUPPLY (COSTED REQUIS.) 14.00	15. 00	LI BRARY (GROSS REVE NUE) 16. 00	17.00	2. 00 3. 00
2. 00 3. 00 4. 00	Skilled Nursing Care Physical Therapy Occupational Therapy	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0	SUPPLY (COSTED REQUIS.) 14.00	15. 00 C	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0	SUPPLY (COSTED REQUIS.) 14.00	15. 00 C	LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0	17. 00 0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0	SUPPLY (COSTED REQUIS.) 14.00	15. 00	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00	15. 00 CC CC CC CC CC CC CC CC CC CC CC CC	LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00	15. 00 CCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCC	LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0	15. 00 CC CC CC CC CC CC CC CC CC CC CC CC	LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00	15. 00 CC CC CC CC CC CC CC CC CC CC CC CC	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0	15. 00 CC CC CC CC CC CC CC CC CC CC CC CC	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	11. 00 1, 486 0	(DIRECT NRS ING) 13.00 30,919 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	15. 00 CC CC CC CC CC CC CC CC CC CC CC CC	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	11. 00 1, 486 0	(DIRECT NRS ING) 13. 00 30, 919 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0	15. 00	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	15. 00 CC CC CC CC CC CC CC CC CC CC CC CC	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	11. 00 1, 486 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	15. 00	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	11. 00 1, 486 0	(DI RECT NRS I NG) 13.00 30, 919 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	REQUIS.)	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	11. 00 1, 486 0	(DI RECT NRS I NG) 13.00 30,919 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	15. 00	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	11. 00 1, 486 0	(DI RECT NRS I NG) 13.00 30, 919 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	REQUIS.)	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00 19.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	11. 00 1, 486 0 0 0 0 0 0 0 0 0 0 0 0 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	REQUIS.)	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19)	11. 00 1, 486 0 0 0 0 0 0 0 0 0 0 0 0 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	REQUIS.)	LI BRARY (GROSS REVE NUE) 16. 00	17. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00 19.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) Total cost to be allocated	11. 00 1, 486 0 0 0 0 0 0 0 0 0 0 0 0 0	(DI RECT NRS I NG) 13. 00 30, 919 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SUPPLY (COSTED REQUIS.) 14.00 0 0 0 0 0 0 0 0 0 0 0	REQUIS.) 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LI BRARY (GROSS REVE NUE) 16. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Heal th	Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150045	Period: From 10/01/2014	Worksheet H-3 Part I	
				HHA CCN:	157157	To 09/30/2015		
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.	Ancillary Costs (from	Costs (cols. + 2)	1	Per Visit (col. 3 ÷ col.	
		20, 11110	11 2, 141 (1)	Part II)	1 2)		4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COSI, A	GGREGATE OF IT	HE PROGRAM LIN	MITATION COST, O	R	
1. 00	Cost Per Visit Computation Skilled Nursing Care	2. 00	730, 607		730, 60	07 3, 853	189. 62	1.00
2. 00	Physical Therapy	3. 00	· ·					
3.00	Occupational Therapy	4. 00		C				
4.00	Speech Pathology	5. 00	19, 739	(19, 7			
5. 00 6. 00	Medical Social Services Home Health Aide	6. 00 7. 00			96, 0° 230, 10			
7. 00	Total (sum of lines 1-6)	7.00	1, 540, 166		1			7. 00
					Program Visi			
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject Deductibles Coinsurance	& Deductibles		
		0	1.00	2.00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	I						
8. 00 8. 01	Skilled Nursing Care Skilled Nursing Care		99915 50031	(90		8. 00 8. 01
9. 00	Physical Therapy		99915	(70		9.00
9. 01	Physical Therapy		50031	Č		71		9. 01
10. 00	Occupational Therapy		99915	C	1	5		10. 00
10. 01	Occupational Therapy		50031	(1	13		10. 01
11. 00 11. 01	Speech Pathology Speech Pathology		99915 50031	(1	11 8		11. 00 11. 01
12. 00	Medical Social Services		99915	(1	23		12. 00
12. 01	Medical Social Services		50031	Č		29		12. 01
13.00	Home Health Aide		99915	(1	49		13. 00
13. 01	Home Health Aide		50031	(36		13. 01
14. 00	Total (sum of lines 8-13)	From Wkst. H-2	Facility Costs	Shared	2, 98		Ratio (col. 3	14. 00
	Cost Center Description	Part I, col.	(from Wkst.	Ancillary	Total HHA Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)		
		0	1.00	Part II) 2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa		1.00	2.00	3.00	4.00	5.00	
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00			1	0 0		
			Program Visits		Cost of			
			Par	† R	_ Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	·		Deductibles &	Deductibles &		Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	0.00	7.00	8.00	9.00	10.00	11.00	
	BENEFICIARY COST LIMITATION	OF AGGREGATE F	TOOKAW COST, A		IL TROOKAW ET	17(110)(0031, 0		
	Cost Per Visit Computation					_1		
1.00	Skilled Nursing Care	0	1, 717			0 325, 578		1.00
2. 00 3. 00	Physical Therapy Occupational Therapy	0	641 18			0 206, 530 0 5, 800		2. 00 3. 00
4. 00	Speech Pathology	0	19			0 9, 376		4.00
5. 00	Medical Social Services	0	52			0 43, 040		5. 00
6.00	Home Heal th Aide	0	535			0 105, 604		6. 00
7.00	Total (sum of lines 1-6)	0	2, 982		1	0 695, 928		7. 00

	Financial Systems		DEKALB MEMORI		001 450015	•	u of Form CMS-	
APPORT	TONMENT OF PATIENT SERVICE COST	S			CCN: 150045	Peri od: From 10/01/2014	Worksheet H-3	
				HHA CCN:	157157	To 09/30/2015	Date/Time Pre 2/23/2016 3:0	
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	6.00	7. 00	9,00	0.00		11. 00	
	Limitation Cost Computation	6.00	7.00	8. 00	9. 00	10.00	11.00	
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00
13. 01	Home Health Aide							13. 01
14. 00	Total (sum of lines 8-13)							14.00
		Progi	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles &		Part A	Part B Not Subject to Deductibles &	Subject to Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	Cumpling and Drugg Cost Comput	6.00	7. 00	8. 00	9. 00	10.00	11. 00	
15. 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	0	0	0		0 0	C	15.00
	Cost of Drugs		0	l .	l .	o o	C	1
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	ROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
1.00	Skilled Nursing Care	325, 578						1.00
2.00	Physi cal Therapy	206, 530						2.00
3. 00 4. 00	Occupational Therapy Speech Pathology	5, 800 9, 376						3.00
5. 00	Medical Social Services	43, 040						5.00
6.00	Home Health Aide	105, 604						6.00
7. 00	Total (sum of lines 1-6)	695, 928						7. 00
	Cost Center Description	10.00						-
	Limitation Cost Computation	12. 00						
8. 00	Skilled Nursing Care							8.00
8. 01	Skilled Nursing Care							8. 01
9.00	Physical Therapy							9.00
9. 01	Physical Therapy							9.0
10. 00 10. 01	Occupational Therapy Occupational Therapy							10. 00 10. 0
11. 00	Speech Pathology							11.00
11. 01	Speech Pathology							11.0
12. 00	Medical Social Services							12. 00
12. 01	Medical Social Services							12. 0
	Home Health Aide							13.00
13.00		•						1
13. 01	Home Health Aide Total (sum of lines 8-13)							13. 0°

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-25						2552-10		
APPORTIONMENT OF PATIENT SERVICE COSTS				Provi der	CCN: 150045	Peri od:	Worksheet H-3	
						From 10/01/2014		
				HHA CCN:	157157	To 09/30/2015		
				T: ±1	- \/\/	11 111 +1-	2/23/2016 3:0	8 piii
				11 11	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Rati o	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNISHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physi cal Therapy	66. 00	0. 433217	0		Ocol. 2, line 2	. 00	1.00
1.01	Physical Therapy 1	66. 01	0. 766285	0)	Ocol. 2, line 2	. 01	1. 01
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3. 00
4.00	Cost of Medical Supplies	71. 00	0. 410816	0)	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 488780	0)	0 col. 2, line 1	6. 00	5. 00

_CUL#	Financial Systems DEKALB MEMORIAL HO	Provi der	CCN: 150045	Peri od:	eu of Form CMS- Worksheet H-4	
		HHA CCN:	157157	From 10/01/201 To 09/30/201		
		Ti tl	e XVIII	Home Health Agency I	PPS	, , , , , , , , , , , , , , , , , , ,
				P	art B	
			Part A	Not Subject of Deductibles Coinsurance	& Deductibles &	
			1. 00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA	ARY CHARGE				
- +	Reasonable Cost of Part A & Part B Services		Т		ما	١.
- 1	Reasonable cost of services (see instructions)			0	0 0	
	Total charges Customary Charges			0	0 0) 2
	Amount actually collected from patients liable for payment for s	servi ces		0	0 0	3
	on a charge basis (from your records)					
	Amount that would have been realized from patients liable for pa for services on a charge basis had such payment been made in acc with 42 CFR §413.13(b)			0	0 0) 4
0	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 00000	0. 000000	
	Total customary charges (see instructions)			0	0	
0	Excess of total customary charges over total reasonable cost (coolly if line 6 exceeds line 1)	ompiete		0	0 0) 7
	Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	ifline		0	0 0	
0	Primary payer amounts			0	0 0	
				Part A Services	Part B Services	
				1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)				0 0	
	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				0 408, 501 0 9, 103	
	Total PPS Reimbursement - LUPA Episodes				0 7, 597	
	Total PPS Reimbursement - PEP Episodes				0 7, 119	
- 1	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0 2, 226	
1	Total PPS Outlier Reimbursement - PEP Episodes				0	
	Total Other Payments DME Payments				0 0	
- 1	Oxygen Payments					
- 1	Prosthetic and Orthotic Payments				0 0	
	Part B deductibles billed to Medicare patients (exclude coinsura	ance)			0	
- 1	Subtotal (sum of lines 10 thru 20 minus line 21)				0 434, 546	
- 1	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)				0 0 434, 546	
- 1	Coinsurance billed to program patients (from your records)				434, 346	1 .
	Net cost (line 24 minus line 25)				0 434, 546	
00	Reimbursable bad debts (from your records)					2
	Reimbursable bad debts for dual eligible beneficiaries (see inst					28
	Total costs - current cost reporting period (line 26 plus line 2	27)			0 434, 546	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)				0 0	
- 1	Subtotal (see instructions)				0 434, 546	
	Sequestration adjustment (see instructions)				0 8, 691	
01	Interim payments (see instructions)				0 425, 855	
00				1	0	1 2
00	Tentative settlement (for contractor use only)				0	
00 00 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, and Protested amounts (nonallowable cost report items) in accordance	,	Pub 15-2			3

In Lieu of Form CMS-2552-10

Heal th Financial Systems DEKALB MEMORIAL HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO Provide Peri od: From 10/01/2014 To 09/30/2015 Date/Time Prepared: 2/23/2016 3:08 pm PPS Provi der CCN: 150045 PROGRAM BENEFICIARIES HHA CCN: 157157

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			o o	425, 855 0	1. 00 2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	1 Tog. am to 1 Total			O	0	3. 01
3. 02		•		0	l ol	3. 02
3. 03				o o	0	3. 03
3.04				0	0	3. 04
3.05				O	0	3.05
	Provider to Program			_		
3.50				O	0	3. 50
3. 51				O	0	3. 51
3. 52				O	0	3. 52
3.53				0	0	3. 53
3. 54 3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines			0	0	3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		·		١	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,		(0	425, 855	4. 00
	line 32)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after			1		5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5. 01				O	0	5. 01
5. 02				O	0	5. 02
5. 03	Dravi dan ta Dragnam			0	0	5. 03
5. 50	Provider to Program				0	5. 50
5. 51				0		5. 51
5. 52				Ö	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	Ö	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	o	6. 01
6.02	SETTLEMENT TO PROGRAM			O	0	6. 02
7.00	Total Medicare program liability (see instructions)			O	425, 855	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
	To the second se	()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

			Hospi ce (CN: 151559 1	0 09/30/2015	Date/IIme Pre 2/23/2016 3:0	
					Hospi ce I	2/23/2010 3.0	Орш
		Salaries (from	Employee	Transportation		Other	
			Benefits (from		Services (from		
		,	Wkst. K-2)	(, , , , , , , , , , , , , , , , , , ,	Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	•					
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2. 00
3.00	Plant Operation and Maintenance	0	O	0	0	0	3. 00
4.00	Transportation - Staff	0	Ö	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	Ö	0	0	0	5. 00
6.00	Administrative and General	1, 854	o	11, 103	95, 782	116, 979	6.00
	I NPATI ENT CARE SERVI CE			<u> </u>			
7.00	Inpatient - General Care	0	O	0	0	0	7. 00
8.00	Inpatient - Respite Care	0	Ö	0	0	0	8. 00
	VI SI TI NG SERVI CES	•			•		1
9.00	Physi ci an Servi ces	20, 803	O	0	0	0	9. 00
10.00	Nursing Care	87, 678	Ö	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	Ö	0	0	0	11. 00
12.00	Physi cal Therapy	69	Ö	0	0	0	12. 00
13.00	Occupational Therapy	0	Ö	0	0	0	13. 00
14.00	Speech/ Language Pathology	0	Ö	0	0	0	14. 00
15.00		0	Ö	0	0	0	15. 00
16.00	Spiritual Counseling	3, 392	Ö	0	0	0	16. 00
17.00	Di etary Counseling	0	0	0	0	0	17. 00
18.00	Counseling - Other	0	0	0	0	0	18. 00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	20, 536	0	0	0	0	20. 00
21.00	Other	0	0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						1
22.00	Drugs, Biological and Infusion Therapy	0	O	0	0	0	22. 00
23.00	Anal gesi cs	0	0	0	0	0	23. 00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24. 00
25.00	Other - Specify	0	0	0	0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26. 00
27.00	Patient Transportation	0	0	0	0	0	27. 00
28.00	I maging Services	0	0	0	0	0	28. 00
29.00	Labs and Diagnostics	0	0	0	0	0	29. 00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33. 00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	O	0	0	0	35. 00
36.00	Volunteer Program Costs	0	0	0	0	0	36. 00
37.00	Fundrai si ng	0	0	0	0	0	37. 00
38. 00	Other Program Costs	0	0	0	0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	134, 332	O	11, 103	95, 782	116, 979	39. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10		
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150045			
	Hospi co CCN: 151550	From 10/01/2014 Data/Time Propagate		

Hospi ce CCN: 151559 | To 09/30/2015 | Date/Time Prepared: 2/23/2016 3:08 pm Hospi ce I Total (cols. Reclassificati Subtotal (col. Total (col. 8 Adiustments ± col. 9) 1-5)on 6 ± col. 7) 9. 00 7 00 6 00 8 00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 0 1.00 0 0 Capital Related Costs-Movable Equip. 0 2.00 0 0 2.00 0 3 00 3 00 Plant Operation and Maintenance 0 0 4.00 Transportation - Staff 0 0 0 0 0 4.00 Volunteer Service Coordination 5.00 5.00 1, 012 6.00 Administrative and General 225, 718 226, 730 217 226, 513 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 0 7.00 8.00 Inpatient - Respite Care 0 0 0 0 8.00 VISITING SERVICES 9.00 Physi ci an Servi ces 20, 803 0 20, 803 0 20, 803 9.00 10.00 Nursing Care 87,678 0 87, 678 0 87,678 10.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 11.00 0 0 11.00 0 69 0 12.00 Physical Therapy 69 69 12.00 13.00 Occupational Therapy 0 0 0 0 13.00 0 14.00 Speech/ Language Pathology 0 14.00 0 15.00 Medical Social Services 0 0 0 15.00 16.00 Spiritual Counseling 3.392 0 3, 392 3.392 16.00 17.00 Dietary Counseling 0 17.00 0 18.00 Counseling - Other 0 0 0 18.00 Home Health Aide and Homemaker 19.00 0 0 0 0 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 20, 536 0 20, 536 20, 536 20.00 21.00 21.00 0 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 0 Λ 22.00 0 0 23.00 Anal gesi cs 0 0 0 23.00 Sedatives / Hypnotics 0 24.00 0000000000 0 0 0 0 0 0 24.00 0 0 25.00 Other - Specify 0 25.00 0 Durable Medical Equipment/Oxygen 0 26.00 0 26.00 27.00 Patient Transportation 0 27.00 0 28. 00 Imaging Services 0 28.00 0 29 00 Labs and Diagnostics 29.00 0 30.00 Medical Supplies 0 0 30.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 31.00 Radiation Therapy 0 32.00 0 0 0 32.00 0 0 33.00 Chemotherapy 0 33.00 34.00 0ther 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 n O 0 n 35 00 Bereavement Program Costs 0 0 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 38.00 358, 196 1, 012 359, 208 -217 358, 991 39.00 Total (sum of lines 1 thru 38) 39.00

			Hospi ce CCN	l: 151559 To	09/30/2015	Date/Time Pre 2/23/2016 3:0	
					Hospi ce I	27 207 2010 0.0	<u> </u>
		Admi ni strator	Director	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1. 00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	
5.00	Volunteer Service Coordination	0	0	0	0	0	0.00
6.00	Administrative and General	1, 854	0	0	0	0	6. 00
	I NPATI ENT CARE SERVI CE		ما		اء		
7.00	Inpatient - General Care	0	0	0	0	0	
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
0.00	VI SI TI NG SERVI CES		ما	0	ام	0	0.00
9.00	Physician Services	0	0	0	0	07 (70	
10. 00 11. 00	Nursing Care Nursing Care-Continuous Home Care	0	0	0	0	87, 678 0	10.00 11.00
12. 00		0	0	0	0	0	12.00
13. 00	Occupational Therapy		0	0	0	0	13.00
14. 00			0	0	0	0	14.00
15. 00			0	0	0	0	15. 00
	Spiritual Counseling		0	0	0	0	16.00
	Di etary Counsel i ng			0	0	0	17. 00
	Counseling - Other		Ö	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	ol	0	0	0	19. 00
20. 00	1	O	o	0	0	0	20. 00
21. 00	Other	O	o	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	<u>. </u>	<u> </u>	<u>.</u>			1
22.00	Drugs, Biological and Infusion Therapy						22. 00
23.00	Anal gesi cs						23. 00
24.00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Patient Transportation	0	0	0	0	0	27. 00
	I maging Services	0	0	0	0	0	28. 00
	Labs and Diagnostics	0	0	0	0	0	
30. 00	Medical Supplies	0	0	0	0	0	30. 00
	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31. 00
32. 00	Radiation Therapy	0	0	0	0	0	32. 00
33. 00	Chemotherapy	0	0	0	0	0	
34. 00	Other	0	0	0	0	0	34. 00
05.00	HOSPI CE NONREI MBURSABLE SERVI CE		ما		ام		05.00
35. 00	Bereavement Program Costs	0	0	0	0	0	
36. 00	9		0	0	O O	0	00.00
37. 00 38. 00	Fundrai si ng		0	0	9	0	
	Other Program Costs Total (sum of lines 1 thru 38)	1, 854	ol Ol	0	0	ū	39.00
37.00	Tiotai (Sum of Titles I till u 30)	1,004	Ų	U	Ų	01,018	J 37. UU

Health Financial Systems	DEKALB MEMORI	AL HO	SPI TAL		In Lie	u of Form CMS-	2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES			Provi der	CCN: 150045	Peri od: From 10/01/2014	Worksheet K-1	
			Hospi ce (CCN: 151559	To 09/30/2015	Date/Time Pre 2/23/2016 3:0	
					Hospi ce I		
<u> </u>	Total	1	Ai des	All-Other	Total (1)		
	Therapi sts						
	6. 00		7.00	8. 00	9. 00		
GENERAL SERVICE COST CENTERS							
1 00 Capital Related Costs-Bldg and Fixt							1.00

Total Therapists						HOSPICE I	
CENERAL SERVICE COST CENTERS			Total	Ai des	All-Other	Total (1)	
CENERAL SERVICE COST CENTERS			Therapi sts				
1.00			6.00	7. 00	8. 00	9. 00	
2.00		GENERAL SERVICE COST CENTERS					
2.00	1.00	Capital Related Costs-Bldg and Fixt.					1. 00
1.00	2.00						2.00
A. 00				٥	0	٥	
5.00 Volunteer Service Coordination 0 0 0 1,854 6.00				Ö	0	0	
Administrative and General 0 0 0 1,854 6.00				0	0	0	
IMPATIENT CARE SERVICE					0	1 054	
Type Type	6.00			U	U	1, 854	6.00
Inpatient - Respite Care 0 0 0 8.00 VISTING SERVICES				_	_	_1	
VISITING SERVICES							
9,00 Physician Services	8. 00			0	0	0	8. 00
10.00 Nursing Care		VISITING SERVICES					
11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00	Physi ci an Servi ces		0	20, 803	20, 803	9. 00
11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	Nursi ng Care		o	0	87, 678	10.00
12.00 Physical Therapy 69 0 0 69 12.00 13.00 Occupational Therapy 0 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 15.00 Medical Social Services 0 0 0 0 16.00 Spiritual Counseling 0 3,392 3,392 16.00 17.00 Dietary Counseling 0 0 0 0 18.00 Counseling - Other 0 0 0 0 19.00 Home Health Aide and Homemaker 0 0 0 0 19.00 Home Health Aide and Homemaker - Cont. Home Care 20,536 0 20,536 20.00 10.00 Other 0 0 0 0 10.00 Other 0 0 0 10.00 Other 0 0 0 0 10.00 Oth	11. 00			ol	0		11.00
13.00			69	0	0	69	12 00
14.00 Spech Language Pathology 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 15.00 16.00 Spiritual Counseling 0 3,392 3,392 16.00 17.00 Dietary Counseling 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 18.00 Counseling 0 0 0 0 19.00 Home Health Aide and Homemaker 0 0 0 0 19.00 Hild & Homemaker - Cont. Home Care 20,536 0 20,536 20.00 19.00 Other Dietary Dietary Dietary Dietary 19.00 Dietary Dietary Dietary Dietary Dietary 19.00 Dietary Dietary Dietary Dietary Dietary 19.00 Dietary Dieta			ار	0	Ô	0	•
15.00 Medical Social Services 0 0 0 0 15.00 16.00 Spiritual Counseling 0 3,392 3,392 16.00 17.00 Dietary Counseling 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 17.00 19.00 Home Health Aide and Homemaker 0 0 0 0 19.00 19.00 HH Aide & Homemaker - Cont. Home Care 20,536 0 20,536 20.00 21.00 Other 0 0 0 0 21.00 22.00 DTHER HOSPICE SERVICE COSTS 22.00 23.00 Anal gesics 23.00 24.00 Sedatives / Hypnotics 23.00 25.00 Other - Specify 25.00 26.00 Durable Medical Equipment/Oxygen 26.00 27.00 Patient Transportation 0 0 0 27.00 28.00 Imaging Services 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 29.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 32.00 Radiation Therapy 0 0 0 0 33.00 Other HOSPICE SERVICE SERVICE 0 0 0 33.00 Other Hospida 0 0 0 0 34.00 Other Hospida 0 0 0 0 35.00 Bereavement Program Costs 0 0 0 0 36.00 Other Program Costs 0 0 0 0 37.00 Other Program Costs 0 0 0 0 38.00 Other Program Costs 0 0 0 0 39.00 Other Program Costs 0 0 0 0 39.00 Other Program Costs 0 0 0 0 39.00 Other Program Costs 0				0	0	0	•
16. 00 Spiritual Counseling 0 3,392 3,392 16. 00 17. 00 Dietary Counseling 0 0 0 0 18. 00 Counseling - Other 0 0 0 0 19. 00 Home Health Aide and Homemaker 0 0 0 0 20. 00 HI Aide & Homemaker - Cont. Home Care 20,536 0 20,536 20. 00 21. 00 Other 0 0 0 0 22. 00 Other OTHER HOSPICE SERVICE COSTS			١	o o	0	~	•
17. 00 Di etary Counsel ing 0 0 0 0 17. 00 18. 00 Counsel ing - Other 0 0 0 0 18. 00 Counsel ing - Other 0 0 0 18. 00 Home Heal th Aide and Homemaker 0 0 0 20. 00 HH Ai de & Homemaker - Cont. Home Care 20,536 0 20,536 20. 00 Other 0 0 0 0 OTHER HOSPICE SERVICE COSTS				U	2 202	9	
18. 00 Counseling - Other 0 0 0 0 18. 00 19. 00 Home Health Aide and Homemaker 20,536 0 0 0 20. 00 HIA Aide & Homemaker - Cont. Home Care 20,536 0 20,536 20. 00 21. 00 Other 0 0 0 0 21. 00 Other Oth				O ₁	3, 392	3, 392	
19.00 Home Heal th Ai de and Homemaker 0 0 0 0 20,536 20.00 20.00 HI Ai de & Homemaker - Cont. Home Care 20,536 0 20,536 20.00 20.00 Other 0 0 0 0 0 0 0 0 0 21.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				O	0	O	
20.00				0	0	0	•
21.00 Other OTHER HOSPICE SERVICE COSTS	19. 00	Home Health Aide and Homemaker		0	0	0	19. 00
DTHER HOSPICE SERVICE COSTS 22.00 23.00 24.00 25.00 25.00 25.00 26.00 25.00 26.00 26.00 27.00 26.00 27.00 26.00 27.00 28.00 27.00 28.00 28.00 28.00 29.00 28.00	20.00	HH Aide & Homemaker - Cont. Home Care		20, 536	0	20, 536	20.00
22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 24.00 Sedatives / Hypnotics 24.00 25.00 24.00 25.00 24.00 25.00 25.00 25.00 26.00 25.00 26.00 26.00 27.00 26.00 27.00 27.00 28.00 29.	21.00	Other		0	0	o	21. 00
22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 24.00 Sedatives / Hypnotics 24.00 25.00 24.00 25.00 24.00 25.00 25.00 25.00 26.00 25.00 26.00 26.00 27.00 26.00 27.00 27.00 28.00 29.		OTHER HOSPICE SERVICE COSTS	·	•	<u>"</u>		
23.00 Anal gesics 23.00 24.00 24.00	22.00	Drugs. Biological and Infusion Therapy					22.00
24.00 Sedatives / Hypnotics 24.00 25.00 Other - Specify 25.00 Other - Specify 26.00 Other - Specify Other - Other	23 00						23 00
25.00 Other - Specify 25.00 26.00 26.00							
26.00 Durable Medical Equipment/Oxygen 26.00				1			
27.00							
28. 00 Imaging Services 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 33. 00 34. 00 Other 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 0 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 0 36. 00 37. 00 Fundraising 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 38. 00					0		
29. 00 Labs and Diagnostics 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 33. 00 34. 00 Other 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 0 36. 00 37. 00 Fundraising 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 38. 00				U	0	U	
30.00 Medical Supplies 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 33.00 34.00 Other HOSPICE NONREIMBURSABLE SERVICE				O	0	O	
31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00				0	0	0	
32.00 Radiation Therapy 0 0 0 32.00 33.00 Chemotherapy 0 0 0 33.00 34.00 Other 0 0 0 0 HOSPICE NONREIMBURSABLE SERVICE	30. 00			0	0	0	
33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 34.00 Other	31. 00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 34.00 Other	32.00	Radi ati on Therapy		o	0	ol	32.00
34.00 Other	33.00			ol	0	ol	33.00
HOSPI CE NONREI MBURSABLE SERVI CE		1			-		•
35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00	5 50		·	<u> </u>	٥	٥	51.00
36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00	35 00			٥	n	٥	35.00
37.00 Fundraising 38.00 Other Program Costs 0 0 0 0 0 0 0 0 0 0				-	0		
38.00 Other Program Costs 0 0 0 38.00				U O	0	U O	•
				O ₁	0	0	
39.00 lotal (sum or lines 1 thru 38) 69 20,536 24,195 134,332 39.00				0	0	0	•
	39.00	liotal (sum of lines 1 thru 38)	[69	20, 536	24, 195	134, 332	39. 00

 Heal th
 Financial
 Systems
 DEKALB
 MEMORIAL
 HOSPICE

 HOSPICE
 COMPENSATION
 ANALYSIS
 CONTRACTED
 SERVICES/PURCHASED
 SERVICES
 Period: Workshee: From 10/01/2014 To 09/30/2015 Date/Time Prepared: 2/23/2016 3:08 pm Provider CCN: 150045 Hospi ce CCN: 151559

Administrator Director Social Supervisors Nurses
Capital Related Costs-Bid gand Fixt. 1.00 2.00 3.00 4.00 5.00
1.00
CENERAL SERVICE COST CENTERS
1.00
2.00
Piant Operation and Maintenance
4.00
5.00
Administrative and General 0 0 0 0 0 0 0 0 0
INPATIENT CARE SERVICE
Tool
Tool
8.00 Inpatient - Respite Care O O O O O O O VISITING SERVICES
VISITING SERVICES 9.00 Physician Services 0 0 0 0 0 0 0 0 0
9.00 Physician Services 0 0 0 0 0 0 0 0 10.00 10.00 10.00 Nursing Care 0 0 0 0 0 0 0 11.00
10.00 Nursi ng Care
11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 0 0 13.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 15.00 17.00 Dietary Counseling 0 0 0 0 0 0 0 16.00 17.00 Counseling - Other 0 0 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 0 0 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
12. 00 Physical Therapy
13.00 Occupational Therapy 0 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 0 16.00 17.00 Di etary Counseling 0 0 0 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 0 0 17.00 19.00 Home Health Aide and Homemaker 0 0 0 0 0 0 18.00 19.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 19.00 20.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
14. 00 Speech/ Language Pathology 0 0 0 0 0 14. 00 15. 00 Medical Social Services 0 0 0 0 0 0 0 0 15. 00 16. 00 Spiritual Counseling 0 0 <t< td=""></t<>
15.00 Medical Social Services 0 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 0 16.00 17.00 Dietary Counseling 0 0 0 0 0 0 0 0 17.00 18.00 Counseling - Other 0 0 0 0 0 0 0 0 18.00 19.00 Home Health Aide and Homemaker 0 0 0 0 0 0 0 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 20.00 21.00 Other 0 0 0 0 0 0 0 0 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 23.00 Anal gesics 2 23.00 24.00 Sedatives / Hypnotics 2 25.00 25.00 Other - Specify 2 25.00 26.00 Durable Medical Equipment/Oxygen 26.00 27.00 Patient Transportation 0 0 0 0 0 0 0 0 27.00
16.00 Spiritual Counseling 0 0 0 0 0 16.00 17.00 Dietary Counseling 0 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 21.00 Other 0 0 0 0 0 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 24.00 Sedatives / Hypnotics 24.00 25.00 Other - Specify 24.00 26.00 Durable Medical Equipment/Oxygen 26.00 27.00 Patient Transportation 0 0 0 0 0 27.00 Other Transportation 0 0 0 0 28.00 0 0 0 0 0 29.00 0 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 20.00 0 0 20.00 0 20.00 0 0 20.00 0 20.
17. 00 Di etary Counseling 0 0 0 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 0 0 0 18. 00 19. 00 Home Health Aide and Homemaker 0 0 0 0 0 0 0 19. 00 20. 00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 20. 00 21. 00 Other 0 0 0 0 0 0 0 0 0 21. 00 OTHER HOSPICE SERVICE COSTS 22. 00 Drugs, Biological and Infusion Therapy 23. 00 Anal gesics 22. 00 Sedatives / Hypnotics 22. 00 25. 00 Other - Specify 25. 00 26. 00 Durable Medical Equipment/Oxygen 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 0 0 27. 00
18.00 Counseling - Other O O O O O O 18.00 19.00 Home Health Aide and Homemaker O O O O O O 20.00 HH Aide & Homemaker - Cont. Home Care O O O O O O 21.00 Other O O O O O O OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 23.00 Analgesics 24.00 Sedatives / Hypnotics 25.00 Other - Specify 26.00 Durable Medical Equipment/Oxygen 27.00 Patient Transportation 28.00 O O O 29.00 O O 20.00 O 20.00 O 20.00 20.00 O 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.00 28.00 29.00 20.
19.00 Home Heal th Ai de and Homemaker 0 0 0 0 0 0 0 0 20.00 20.00 21.00 Other 0 0 0 0 0 0 0 0 0 0 0 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 Sedatives / Hypnotics 24.00 Sedatives / Hypnotics 25.00 Other - Specify 25.00 Durable Medical Equipment/Oxygen 27.00 Patient Transportation 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
20. 00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 20. 00
21. 00 Other O O O O O O O O O O O O O O O O O O O
OTHER HOSPICE SERVICE COSTS
22. 00 Drugs, Biological and Infusion Therapy 22. 00 23. 00 Anal gesics 23. 00 24. 00 Sedatives / Hypnotics 24. 00 25. 00 Other - Specify 25. 00 26. 00 Durable Medical Equipment/Oxygen 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0
23. 00 Anal gesics 23. 00 24. 00 Sedatives / Hypnotics 24. 00 24. 00 25. 00 0 0 0 0 0 0 0 0 0
24. 00 Sedatives / Hypnotics 24. 00 25. 00 Other - Specify 25. 00 26. 00 Durable Medical Equipment/Oxygen 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0
25. 00 Other - Specify 25. 00 26. 00 Durable Medical Equipment/Oxygen 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0
26. 00 Durable Medical Equipment/Oxygen 26. 00 27. 00 Patient Transportation 0 0 0 0 0 0 27. 00
27. 00 Patient Transportation 0 0 0 0 27. 00
28. 00 Imaging Services 0 0 0 28. 00
29. 00 Labs and Diagnostics 0 0 0 0 29. 00
30.00 Medical Supplies 0 0 0 30.00
31.00 Outpatient Services (including E/R Dept.)
32.00 Radiation Therapy 0 0 0 0 32.00
33.00 Chemotherapy 0 0 0 0 33.00
34.00 Other 0 0 0 0 34.00
HOSPI CE NONREI MBURSABLE SERVI CE
35. 00 Bereavement Program Costs 0 0 0 0 35. 00
35. 00 Bel eaveliefft Frogram Costs 0 0 0 36. 00 36. 00
37. 00 Fundrai si ng
39.00 Total (sum of lines 1 thru 38) 0 0 0 0 39.00

Heal th	Financial Systems	DEKALB MEMORIA	L HOSPITA	۱L		In Lie	u of Form CMS-	2552-10
HOSPI C	E COMPENSATION ANALYSIS CONTRACTED SERVICES/P	URCHASED SERVI CE	S Provi	der	CCN: 150045	Peri od:	Worksheet K-3	
			Hospi	ice C	CN: 151559	From 10/01/2014 To 09/30/2015		
							2/23/2016 3:0	8 pm
						Hospi ce I		
		Total	Ai des		All-Other	Total (1)		
		Therapi sts						
	I	6. 00	7. 00		8. 00	9. 00		
	GENERAL SERVICE COST CENTERS	T						
1.00	Capital Related Costs-Bldg and Fixt.							1. 00
2.00	Capital Related Costs-Movable Equip.							2. 00
3.00	Plant Operation and Maintenance			O		0 0		3. 00
4.00	Transportation - Staff			0		0		4. 00
5.00	Volunteer Service Coordination			0		0		5. 00
6.00	Administrative and General			0	95, 78	95, 782		6. 00
	INPATIENT CARE SERVICE							
7.00	Inpatient - General Care			0		0 0		7. 00
8.00	Inpatient - Respite Care			0		0 0		8. 00
	VISITING SERVICES							
9.00	Physi ci an Servi ces			0		0 0		9. 00
10.00	Nursi ng Care			o		o o		10.00
11. 00	Nursing Care-Continuous Home Care			o		o o		11. 00
12.00	Physical Therapy	l ol		o		o o		12.00
13. 00	Occupational Therapy	0		0		0		13. 00
14. 00	Speech/ Language Pathology	اً		ō		0		14. 00
15. 00	Medical Social Services	١		0		0 0		15. 00
16. 00	Spiritual Counseling			0		0 0		16. 00
17. 00	Di etary Counsel i ng			0		0 0		17. 00
18. 00	Counseling - Other			0				18.00
19. 00	Home Health Aide and Homemaker			0				19.00
20. 00	HH Ai de & Homemaker - Cont. Home Care			0				20.00
21. 00	Other			0				21.00
21.00	OTHER HOSPICE SERVICE COSTS			<u> </u>		O ₁		21.00
22. 00	Drugs, Biological and Infusion Therapy							22. 00
23. 00	Anal gesi cs			-				23.00
24. 00	Sedatives / Hypnotics			-				24.00
25. 00				-				25.00
	Other - Specify			-				
26. 00 27. 00	Durable Medical Equipment/Oxygen Patient Transportation							26. 00 27. 00
	•			0		٥		28.00
28. 00	I maging Services			0		0 0		
29. 00	Labs and Diagnostics			0		0 0		29. 00
30.00	Medical Supplies			0		0 0		30.00
31. 00	Outpatient Services (including E/R Dept.)			0		0 0		31.00
32. 00	Radiation Therapy			O		0		32. 00
33. 00	Chemotherapy			0		0		33. 00
34. 00	Other			0		0 0		34. 00
	HOSPICE NONREIMBURSABLE SERVICE							
35. 00	Bereavement Program Costs			0		0		35. 00
36. 00	Volunteer Program Costs			0		0		36. 00
37. 00	Fundrai si ng			0		0 0		37. 00
38. 00	Other Program Costs			0		0 0		38. 00
39. 00	Total (sum of lines 1 thru 38)	0		0	95, 78	95, 782		39. 00

						2/23/2016 3:0	8 pm
					Hospi ce I		
			CAPI TAL RE	LATED COST			
		NET EXPENSES FOR COST ALLOCATION	BUI LDI NGS & FI XTURES	MOVABLE EQUI PMENT	PLANT OPERATION & MAINT.	TRANSPORTATI ON	
		0	1.00	2.00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1. 00
2.00	Capital Related Costs-Movable Equip.	o			0		2. 00
3.00	Plant Operation and Maintenance	o	0		0 0		3. 00
4.00	Transportation - Staff	o	0		0 0	0	4. 00
5.00	Volunteer Service Coordination	o	0		0 0	0	5. 00
6.00	Administrative and General	226, 513	0		0 0	0	6. 00
	I NPATI ENT CARE SERVI CE	<u> </u>			<u>'</u>		
7.00	Inpatient - General Care	0	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	o	0		0 0	0	8. 00
	VI SI TI NG SERVI CES	,			<u>'</u>	•	
9.00	Physi ci an Servi ces	20, 803	0		0 0	0	9. 00
10.00	Nursi ng Care	87, 678	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	o	0		0 0	0	11. 00
12.00	Physical Therapy	69	0		0 0	0	12. 00
13.00	Occupational Therapy	o	0		0 0	0	13. 00
14.00	Speech/ Language Pathology	o	0		0 0	0	14.00
15.00	Medical Social Services	o	0		0 0	0	15. 00
16.00	Spiritual Counseling	3, 392	0		0 0	0	16. 00
17. 00	Di etary Counseling	o	0		o o	o	17. 00
18. 00	Counseling - Other	o	0		o o	o	18. 00
19.00	Home Health Aide and Homemaker	o	0		0 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	20, 536	0		0 0	0	20. 00
21. 00	Other	O	0		0 0	o	21. 00
	OTHER HOSPICE SERVICE COSTS	-1	-				
22. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
23.00	Anal gesi cs	o	0		0 0	0	23. 00
24.00	Sedatives / Hypnotics	o	0		0 0	0	24. 00
25.00	Other - Specify	o	0		0 0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	o	0		0 0	0	26. 00
27. 00	Patient Transportation	o	0		0 0	0	27. 00
28. 00	Imaging Services	o	0		0 0	0	28. 00
29. 00	Labs and Diagnostics	o	0		0 0	0	29. 00
30.00	Medical Supplies	o	0		0 0	0	30. 00
31.00	Outpatient Services (including E/R Dept.)	o	0		0 0	0	31. 00
32.00	Radi ati on Therapy	o	0		0 0	0	32. 00
33.00	Chemotherapy	o	0		0 0	0	33. 00
34.00	Other	o	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	<u> </u>			<u>'</u>		
35.00	Bereavement Program Costs	0	0		0 0	0	35. 00
36.00	Volunteer Program Costs	o	0		0 0	0	36. 00
37.00	Fundrai si ng	o	0		0 0	0	37. 00
38. 00	Other Program Costs	o	0		0 0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	358, 991	0		0 0	0	39. 00

			Hospi ce (CIN: 151559	10 09/30/2015	2/23/2016 3:08 pm
					Hospi ce I	272372010 3.00 piii
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI VI	TOTAL (col. 5A	
		SERVI CES	(col s. 0 - 5)	& GENERAL	± col. 6)	
		COORDI NATOR	(33.3. 3 3)			
		5. 00	5A	6. 00	7. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5. 00
6.00	Administrative and General	0	226, 513	226, 513	3	6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	0	(0	7. 00
8.00	Inpatient - Respite Care	0	0	(0	8. 00
	VISITING SERVICES					
9.00	Physi ci an Servi ces	0	20, 803	35, 569	56, 372	9. 00
10.00	Nursing Care	0	87, 678	149, 913	237, 591	10.00
11. 00	Nursing Care-Continuous Home Care	0	0) (11.00
12.00	Physi cal Therapy	0	69	118	187	12. 00
13.00	Occupational Therapy	0	0	(0	13. 00
14.00	Speech/ Language Pathology	0	0) (0	14. 00
15. 00	Medical Social Services	0	0		0	15. 00
16. 00	Spiritual Counseling	0	3, 392	5, 800		16. 00
17. 00	Di etary Counseling	0	0	1	0	17. 00
18. 00	Counseling - Other	0	0	1	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0		0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	20, 536			20. 00
21. 00	Other	0	0	(0	21. 00
00.00	OTHER HOSPICE SERVICE COSTS					00.00
22. 00	Drugs, Biological and Infusion Therapy	0	1	1	0	22. 00
23. 00	Anal gesi cs	0	0		0	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	24. 00
25. 00	Other - Specify	0	0	1	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0			0	26.00
27. 00	Patient Transportation	0		1		27. 00 28. 00
28. 00	I maging Services	0		1		28.00
29. 00	Labs and Diagnostics	0		1		30.00
30.00	Medical Supplies	0		1		31.00
31. 00 32. 00	Outpatient Services (including E/R Dept.) Radiation Therapy	0		1		31.00
33. 00	Chemotherapy	0		l .		33.00
34. 00	Other	0		1		34. 00
34.00	HOSPI CE NONREI MBURSABLE SERVI CE			1	<u> </u>	34.00
35. 00	Bereavement Program Costs	1 0	0		ol o	35, 00
36. 00	Volunteer Program Costs					36. 00
37. 00	Fundrai si ng			l .		37. 00
38. 00	Other Program Costs			1		38. 00
	Total (sum of lines 1 thru 38)	1	358, 991	1	358, 991	39. 00
07.00	1.11.1. (1.1	1	1 222, 771	1	555, 771	1 37.00

						2/23/2016 3:0	18 pm
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION		
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
				FT.)		(HOURS)	
	I	1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	_		ı			
1.00	Capital Related Costs-Bldg and Fixt.	0	_				1. 00
2.00	Capital Related Costs-Movable Equip.	0	0	•			2. 00
3.00	Plant Operation and Maintenance	0	0	C			3. 00
4.00	Transportation - Staff	0	0	[C	0		4. 00
5.00	Volunteer Service Coordination	0	0		-	0	
6.00	Administrative and General	0	0	C	0	0	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0			0	
8.00	Inpatient - Respite Care	0	0	C	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0	C	0	0	9. 00
10.00	Nursi ng Care	0	0	C	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	C	0	0	11. 00
12.00	Physical Therapy	0	0	C	o	0	12.00
13.00	Occupational Therapy	0	0	C	o	0	13.00
14.00	Speech/ Language Pathology	0	0	l	o	0	14. 00
15.00	Medical Social Services	0	0	l c	ol	0	15. 00
16.00	Spiritual Counseling	0	0	l	ol	0	16. 00
17. 00	Di etary Counseling	0	0	l c	ol	0	17. 00
18. 00	Counseling - Other	0	0		o	0	1
19. 00	Home Health Aide and Homemaker	0	0		o	0	1
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0	l d	ol	0	
21. 00	Other	0	0	l d	ol	0	
	OTHER HOSPICE SERVICE COSTS		_	<u> </u>	-	_	
22. 00	Drugs, Biological and Infusion Therapy	0	0	C	0	0	22. 00
23. 00	Anal gesi cs	0	0		-	0	
	Sedatives / Hypnotics	0	0		1	0	1
25. 00	Other - Specify	0	0		o o	0	
26. 00	Durable Medical Equipment/Oxygen	0	0	ĺ	-	0	1
27. 00	Pati ent Transportation	0	0		o o	0	1
28. 00	Imaging Services	0	0			0	1
29. 00	Labs and Diagnostics	0	0	· -		0	
30. 00	Medical Supplies	0	0			0	
31. 00	Outpatient Services (including E/R Dept.)	0	0			0	1
32. 00	Radi ati on Therapy		0			0	
33. 00	Chemotherapy	0	0			0	
34. 00	Other	0	0	· -	-	0	
34.00	HOSPI CE NONREI MBURSABLE SERVI CE		U) _[U	34.00
35. 00	Bereavement Program Costs	0	0	C	ol	0	35. 00
36. 00	Volunteer Program Costs	0	0			0	
37. 00	Fundrai si ng		0			0	
38. 00	Other Program Costs		0			0	38.00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		0			0	1
	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000	_	1
40.00	John C Gost Mar ti pri er	0.00000	0.000000	1 0.000000	, 0.000000	0.000000	1 40.00

						2/23/2016 3:	08 pm
					Hospi ce I		
		RECONCI LI ATI ON	ADMI NI STRATI VE				
			& GENERAL				
			(ACC. COST)				
		6A	6. 00				
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1. 00
2.00	Capital Related Costs-Movable Equip.	0					2. 00
3.00	Plant Operation and Maintenance	0					3. 00
4.00	Transportation - Staff	0					4. 00
5.00	Volunteer Service Coordination						5. 00
6.00	Administrative and General	-226, 513	132, 478				6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0				7. 00
8.00	Inpatient - Respite Care	0	0				8. 00
	VI SI TI NG SERVI CES			·			
9.00	Physi ci an Servi ces	0	20, 803				9.00
10.00	Nursing Care	0	87, 678				10.00
11. 00	Nursing Care-Continuous Home Care	0	0	1			11. 00
12. 00	Physical Therapy	0	69	1			12. 00
13. 00	Occupational Therapy	0	0	1			13. 00
14. 00	Speech/ Language Pathology	0	0				14. 00
15. 00	Medical Social Services	0	1				15. 00
16. 00	Spiritual Counseling	0	3, 392				16.00
17. 00	Di etary Counsel i ng	0	3, 372				17. 00
18. 00	Counseling - Other	0	0				18.00
19. 00	Home Health Aide and Homemaker	0	0				19.00
20. 00	·		20 524				20.00
20.00	HH Aide & Homemaker - Cont. Home Care Other	0	20, 536 0	1			21. 00
21.00	OTHER HOSPICE SERVICE COSTS	0	0				21.00
22.00	Drugs, Biological and Infusion Therapy			1			
22. 00		0					22. 00
23. 00	Anal gesi cs	0	0				
24. 00	Sedatives / Hypnotics	0	0				24. 00
25. 00	Other - Specify	0	0				25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0				26. 00
27. 00	Pati ent Transportation	0	0				27. 00
28. 00	I maging Services	0	0				28. 00
29. 00	Labs and Diagnostics	0	0				29. 00
30.00	Medical Supplies	0	0	1			30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0	1			31. 00
32.00	Radiation Therapy	0	0				32. 00
33.00	Chemotherapy	0	0				33. 00
34.00	Other	0	0				34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0				35. 00
36.00	Volunteer Program Costs	0	0				36. 00
37.00	Fundrai si ng	0	0				37. 00
38.00	Other Program Costs	0	0				38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		226, 513				39. 00
40.00	Unit Cost Multiplier		1. 709816				40.00
	The state of the s	1		•			1

Provi der CCN: 150045

Hospi ce CCN: 151559

Hospi ce I

					Hospi ce T		
				CAPITAL R	ELATED COSTS		
			DI DO A FINT	han went we	W NORTH ANNEY	lovenert over	
	Cost Center Description	Hospi ce Tri al	BLDG & FIXT	MAC WEST - NE	W NORTH ANNEX -		
		Bal ance (1)	1. 00	1. 01	NEW 1. 02	- NEW 1.03	
1. 00	Administrative and General	U	1.00	1.01	0 262		1. 00
2.00	Inpatient - General Care		0		202	0	2.00
3. 00	Inpatient - General Care	0	0			0	3.00
4. 00	Physician Services	56, 372	0			0	4.00
5. 00	Nursing Care	237, 591	0			0	5.00
6. 00	Nursing Care-Continuous Home Care	237, 391	0			0	6.00
7. 00	Physical Therapy	187	0			0	
8. 00	Occupational Therapy	107	0			0	
9. 00	Speech/ Language Pathology	0	0			0	9.00
10.00	Medical Social Services	0	0			0	10.00
11. 00	Spiritual Counseling	9, 192	0			0	11.00
12. 00	Di etary Counseling	7, 172	0			0	12.00
13. 00	Counseling - Other	0	0			0	
14. 00	Home Health Aide and Homemaker	0	0			0	14. 00
15. 00	HH Ai de & Homemaker - Cont. Home Care	55, 649	0			0	15. 00
16. 00	Other	33, 049	0			0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0			0	17. 00
18. 00	Anal gesi cs	0	0			0	18. 00
19. 00	Sedatives / Hypnotics	0	0			0	
20. 00	Other - Specify	0	0			0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0			Ö	21. 00
22. 00	Pati ent Transportation	0	0			0	22.00
23. 00	Imaging Services	0	0			0	23. 00
24. 00	Labs and Diagnostics	0	0			0	24. 00
25. 00	Medical Supplies	0	0			ő	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0			ő	26.00
27. 00	Radi ati on Therapy	0	0			Ö	27. 00
28. 00	Chemotherapy	0	0			Ö	28. 00
29. 00	Other	0	0			ő	29.00
30. 00	Bereavement Program Costs	0	0			Ö	30.00
31. 00	Volunteer Program Costs	0	0			ő	31.00
32. 00	Fundrai si ng		n			0	32.00
33. 00	Other Program Costs		n			0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	358, 991	n		0 262		34.00
	Unit Cost Multiplier (see instructions)	330, 771	0		202		35. 00
55. 50	John C 303 C Mar El pirlor (300 This ir dott 0113)	1 1		I	T.	I	1 55. 55

Provi der CCN: 150045 Hospi ce CCN: 151559

Hospi ce I

					ноѕрі се т		
			CAF	ITAL RELATED CO	OSTS		
	Cost Center Description	BUTLER - NEW	MAC FAST - NEV	GARRETT LAB -	MEDICAL ARTS -	DAY SPRING -	
				NEW	NEW	NEW	
		1.04	1. 05	1.06	1. 07	1. 08	
1.00	Administrative and General	C	(0	0	0	1. 00
2.00	Inpatient - General Care	C	(0	0	0	2. 00
3.00	Inpatient - Respite Care	C	(0	0	0	3. 00
4.00	Physi ci an Servi ces	C	(0	0	0	4.00
5.00	Nursi ng Care	C	(0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	C	(0	0	0	6. 00
7.00	Physi cal Therapy	C	(0	0	0	7. 00
8.00	Occupational Therapy	C	(0	0	0	8. 00
9.00	Speech/ Language Pathology	C	(0	0	0	9. 00
10.00	Medical Social Services	C	(0	0	0	10.00
11. 00	Spiritual Counseling	C	(0	0	0	11. 00
12.00	Di etary Counseling	C	(0	0	0	12. 00
13.00	Counseling - Other	C	(0	0	0	13. 00
14.00	Home Health Aide and Homemaker	C	(0	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	C	(0	0	0	
16. 00	Other	C	(0	0	0	
17. 00	Drugs, Biological and Infusion Therapy	C	(0	0	0	17. 00
18. 00	Anal gesi cs	C	(0	0	0	
19. 00	Sedatives / Hypnotics	C	(0	0	0	
20.00	Other - Specify	C	(0	0	0	
21. 00	Durable Medical Equipment/Oxygen	C	(0	0	0	
22. 00	Patient Transportation	C	(0	0	0	00
23. 00	I maging Services	C	(0	0	0	23. 00
24. 00	Labs and Diagnostics	C	(0	0	0	24. 00
25. 00	Medical Supplies	C	(0	0	0	
26.00	Outpatient Services (including E/R Dept.)	C	(0	0	0	
27. 00	Radiation Therapy	C	(0	0	0	
28. 00	Chemotherapy	C	(0	0	0	
29. 00	Other	C	(0	0	0	29. 00
30.00	Bereavement Program Costs	C	(0	0	0	30.00
31.00	Volunteer Program Costs	C	(0	0	0	
32. 00	Fundrai si ng	C	(0	0	0	
33. 00	Other Program Costs	C	(0	0	0	
34. 00	Total (sum of lines 1 thru 33) (2)	C	(0	0	0	1 0 11 00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

Health Financial Systems DEKALB !
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

CAPITAL RELATED COSTS WWBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT 2.00 4.00 4A 5.00 7.00							2/23/2016 3:0	s pm
Cost Center Description RELATED COSTS MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT 2.00 4.00 4A 5.00 7.00						Hospi ce I		
Cost Center Description								
BENEFITS BENEFITS								
DEPARTMENT 2.00 4.00 4A 5.00 7.00 1.00 Administrative and General 0 5,431 5,693 960 8,753 1.00 2.00 1 npatient - General Care 0 0 0 0 0 0 0 2.00 3.00 1 npatient - Respite Care 0 0 0 0 0 0 3.00 4.00 Physician Services 0 0 0 56,372 9,506 0 4.00		Cost Center Description	MVBLE EQUIP		Subtotal			
2.00 4.00 4A 5.00 7.00				BENEFITS		& GENERAL	PLANT	
1.00 Administrative and General 0 5,431 5,693 960 8,753 1.00 2.00 Inpatient - General Care 0 0 0 0 0 0 2.00 3.00 Inpatient - Respite Care 0 0 0 0 0 0 3.00 4.00 Physician Services 0 0 56,372 9,506 0 4.00				DEPARTMENT				
2.00 Inpatient - General Care 0 0 0 0 0 2.00 3.00 Inpatient - Respite Care 0 0 0 0 0 3.00 4.00 Physician Services 0 0 56,372 9,506 0 4.00			2.00					
3.00 Inpatient - Respite Care	1.00	Administrative and General	0	5, 431	5, 693	960	8, 753	1. 00
4.00 Physician Services 0 0 56, 372 9, 506 0 4.00	2.00	Inpatient - General Care	0	0	C	0	0	2.00
	3.00	Inpatient - Respite Care	0	0	C	0	0	3.00
F 00 Niveri as 0	4.00	Physi ci an Servi ces	0	0	56, 372	9, 506	0	4.00
5. UU NUTSI NG CARE U U U 237, 591 40, 065 U 5. 00	5.00	Nursing Care	0	0	237, 591	40, 065	0	5. 00
6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 6.00	6.00	Nursing Care-Continuous Home Care	0	0	C	0	0	6. 00
7.00 Physical Therapy 0 0 187 32 0 7.00	7.00	Physi cal Therapy	0	0	187	32	0	7. 00
8.00 Occupational Therapy 0 0 0 0 0 8.00	8.00	Occupational Therapy	0	0	l c	0	0	8. 00
9.00 Speech/ Language Pathology 0 0 0 0 9.00	9.00	Speech/ Language Pathology	0	0	l c	0	0	9. 00
10.00 Medical Social Services 0 0 0 0 0 10.00	10.00	Medi cal Soci al Servi ces	0	0	C	0	0	10.00
11.00 Spiritual Counseling 0 0 9,192 1,550 0 11.00	11.00	Spiritual Counseling	0	0	9, 192	1, 550	0	11. 00
12.00 Di etary Counsel i ng 0 0 0 0 0 12.00	12.00	Di etary Counseling	0	0	C	0	0	12.00
13.00 Counsel i ng - Other 0 0 0 0 13.00	13.00	Counseling - Other	0	0	l c	0	0	13.00
14.00 Home Health Aide and Homemaker 0 0 0 0 0 14.00	14.00	Home Health Aide and Homemaker	0	0	l c	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0 0 55,649 9,384 0 15.00	15.00	HH Aide & Homemaker - Cont. Home Care	0	0	55, 649	9, 384	0	15. 00
16.00 Other 0 0 0 0 16.00	16.00	Other	0	0		0	0	16. 00
17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00	17.00	Drugs, Biological and Infusion Therapy	0	0	l	0	0	17. 00
18.00 Anal gesics 0 0 0 0 18.00	18.00	Anal gesi cs	0	0	l	0	0	18. 00
19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00	19.00	Sedatives / Hypnotics	0	0	l	0	0	19. 00
20.00 Other - Specify 0 0 0 0 0 20.00	20.00	Other - Specify	0	0	l	0	0	20.00
21.00 Durable Medical Equipment/0xygen 0 0 0 0 0 21.00	21.00	Durable Medical Equipment/Oxygen	0	0	l	0	0	21. 00
22.00 Pati ent Transportation 0 0 0 0 22.00	22. 00	Patient Transportation	0	0	l	0	0	22. 00
23.00 Imaging Services 0 0 0 0 0 23.00	23.00	I maging Services	0	0	l	0	0	23. 00
24.00 Labs and Diagnostics 0 0 0 0 0 24.00	24.00	Labs and Diagnostics	0	0	l	0	0	24. 00
25.00 Medical Supplies 0 0 0 0 25.00	25.00	Medical Supplies	0	0	l	0	0	25. 00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 26.00	26.00	Outpatient Services (including E/R Dept.)	0	0	l	0	0	26. 00
27. 00 Radi ati on Therapy 0 0 0 0 0 27. 00	27.00	Radi ati on Therapy	0	0	l	0	0	27. 00
28.00 Chemotherapy 0 0 0 0 0 28.00	28.00	Chemotherapy	0	0	l	0	0	28. 00
29. 00 Other 0 0 0 0 29. 00	29.00	Other	0	0	l	0	0	29. 00
30.00 Bereavement Program Costs 0 0 0 0 0 30.00	30.00	Bereavement Program Costs	0	0	l	0	0	30.00
31.00 Volunteer Program Costs 0 0 0 0 0 31.00	31.00		0	0	[c	0	0	31. 00
32.00 Fundraising 0 0 0 0 0 32.00	32.00		o	0		0	0	32.00
33.00 Other Program Costs 0 0 0 0 0 33.00	33.00		o	0		0	0	33. 00
34.00 Total (sum of lines 1 thru 33) (2) 0 5,431 364,684 61,497 8,753 34.00			0	5, 431	364, 684	61, 497	8, 753	
35.00 Unit Cost Multiplier (see instructions) 0.000000 35.00	35.00				0.000000			

Health Financial Systems DEKALB !
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Peri od: Worksheet K-5
From 10/01/2014
To 09/30/2015 Part I
Date/Time Prepared: 2/23/2016 3:08 pm Provi der CCN: 150045 Hospi ce CCN: 151559

						2/23/2010 3.00	ο μιιι
					Hospi ce I		
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	SNACK BAR	CAFETERI A	
		8. 00	9.00	10.00	10. 01	11. 00	
1.00	Administrative and General	94	2, 576) (0	3, 569	1. 00
2.00	Inpatient - General Care	0) c		0	0	2. 00
3.00	Inpatient - Respite Care	0) c		0	0	3.00
4.00	Physi ci an Servi ces	0) c		0	0	4. 00
5.00	Nursing Care	0) c		0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0) c		0	0	6.00
7.00	Physi cal Therapy	0) c		0	0	7. 00
8.00	Occupational Therapy	0) c		0	0	8. 00
9.00	Speech/ Language Pathology	0) c		0	0	9. 00
10.00	Medical Social Services	0) c		0	0	10.00
11.00	Spiritual Counseling	0	o		o	0	11. 00
12.00	Di etary Counseling	0	ol c		o	0	12. 00
13.00	Counseling - Other	0	ol c		o	0	13. 00
14.00	Home Health Aide and Homemaker	0	ol c		o	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	ol c		o	0	15. 00
16.00	0ther	0) c		0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	ol c		o	0	17. 00
18.00	Anal gesi cs	0	o c		o	0	18. 00
19.00	Sedatives / Hypnotics	0) c		0	0	19. 00
20.00	Other - Specify	0) c		0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0) c		0	0	21. 00
22.00	Patient Transportation	0) C		0	0	22. 00
23.00	I maging Services	0) C		0	0	23. 00
24.00	Labs and Diagnostics	0) C		0	0	24. 00
25.00	Medical Supplies	0) C) (0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0) C) (0	0	26. 00
27. 00	Radi ati on Therapy	0) C) (0	0	27. 00
28.00	Chemotherapy	0) C		0	0	28. 00
29. 00	0ther	0) C) (0	0	29. 00
30.00	Bereavement Program Costs	0) C) (0	0	30. 00
31.00	Volunteer Program Costs	0) C) (0	0	31. 00
32.00	Fundrai si ng	0) C) (0	0	32. 00
33.00	Other Program Costs	0) C) (0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	94	2, 576	6	0	3, 569	34. 00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

Health Financial Systems DEKALB !
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						2/23/2016 3:0	8 pm
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16. 00	17. 00	
1.00	Administrative and General	15, 082	(D	0 5, 687	0	1. 00
2.00	Inpatient - General Care	0	(o l	0 0	0	2. 00
3.00	Inpatient - Respite Care	0	(o l	0 0	0	3. 00
4.00	Physi ci an Servi ces	O	(o c	0	4. 00
5.00	Nursing Care	O	(o c	0	5. 00
6.00	Nursing Care-Continuous Home Care	O	(o c	0	6. 00
7.00	Physi cal Therapy	O	(o c	0	7. 00
8.00	Occupational Therapy	O	(o c	0	8. 00
9.00	Speech/ Language Pathology	O	(o c	0	9. 00
10.00	Medical Social Services	O	(o c	0	10.00
11.00	Spiritual Counseling	0	(o l	0 0	0	11. 00
12.00	Di etary Counseling	0	(o l	0 0	0	12.00
13.00	Counseling - Other	0	(o l	0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	(o l	0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	(o l	0 0	0	15. 00
16.00	Other	0	(o l	0 0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	()	0 0	0	17. 00
18.00	Anal gesi cs	0	()	0 0	0	18. 00
19. 00	Sedatives / Hypnotics	0	(0	0 0	0	19. 00
20.00	Other - Specify	0	(0	0 0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	(0	0 0	0	21. 00
22. 00	Patient Transportation	0	()	O C	0	22. 00
23. 00	I magi ng Servi ces	0	()	O C	0	23. 00
24. 00	Labs and Diagnostics	0	()	O C	0	24. 00
25. 00	Medical Supplies	0	()	0 0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	()	0 0	0	26. 00
27. 00	Radiation Therapy	0	()	0 0	0	27. 00
28. 00	Chemotherapy	0	()	0 0	0	28. 00
29. 00	Other	0	()	O C	0	29. 00
30.00	Bereavement Program Costs	0	()	O C	0	30. 00
31. 00	Volunteer Program Costs	0	()	0 0	0	31. 00
32. 00	Fundrai si ng	0	(P	0 0	0	32. 00
33. 00	Other Program Costs	0	(P	0 0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	15, 082	(P	0 5, 687	0	34. 00
35. 00	Unit Cost Multiplier (see instructions)					1	35. 00

Health Financial Systems DEKALB !
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						2/23/2016 3:0	8 pm
					Hospi ce I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
	·	(col s. 4A-23)	Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
			& Post	25)	(See Part II)	26 ± 27)	
			Stepdown				
			Adjustments				
		24.00	25.00	26. 00	27. 00	28. 00	
1.00	Administrative and General	42, 414					1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	65, 878	0	65, 878		72, 538	4. 00
5.00	Nursing Care	277, 656	0	277, 656	28, 071	305, 727	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	219	0	219	22	241	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	10, 742	0	10, 742	1, 086	11, 828	11. 00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	65, 033	0	65, 033	6, 575	71, 608	15. 00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22.00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27.00	Radi ati on Therapy	0	0	0	0	0	27. 00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29.00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30. 00
31.00	Volunteer Program Costs	0	0	0	0	0	31. 00
32.00	Fundrai si ng	0	0	0	0	0	32. 00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	461, 942	0	461, 942		461, 942	34.00
35.00	Unit Cost Multiplier (see instructions)				0. 101099		35. 00

Health Financial Systems DEKALB MALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150045

Peri od: Worksheet K-5
From 10/01/2014
To 09/30/2015 Part II
Date/Time Prepared: 2/23/2016 3:08 pm STATISTICAL BASIS Hospi ce CCN: 151559

						Hospi ce I	27 207 2010 0:0	<u> </u>
				CADI	TAL DELATED CO			
			(CAPI	TAL RELATED CO	3515		
	Coat Canton Dagonintian	BLDG & FIXT	MAC WEST	MEW	NODTH ANNEY	GARRETT CLINIC	BUTLER - NEW	
	Cost Center Description	(SQUARE FEET)	WAC WEST - I	INEW	NEW NEW	- NEW	(SQUARE FEET)	
		(SQUARE FEET)	(COLLADE EEE	\		(SQUARE FEET)	(SQUARE FEET)	
		1.00	(SQUARE FEE	=1)	(SQUARE FEET) 1.02	1. 03	1 04	
1. 00	Administrative and General	1.00		0	300	1.03	1. 04	1. 00
					300	0	0	
2.00	Inpatient - General Care			U	0	U	0	2. 00 3. 00
3.00	Inpatient - Respite Care			U	0	U		
4.00	Physi ci an Servi ces			U	0	U	0	4. 00
5.00	Nursing Care		2	U	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care		2	0	0	0	0	6. 00
7. 00	Physi cal Therapy)	0	0	0	0	7. 00
8.00	Occupational Therapy	C)	O	0	0	0	8. 00
9.00	Speech/ Language Pathology	C)	0	0	0	0	9. 00
10. 00	Medical Social Services	C)	0	0	0	0	10. 00
11. 00	Spiritual Counseling	C)	0	0	0	0	11. 00
12. 00	Di etary Counseling	C		0	0	0	0	12. 00
13. 00	Counseling - Other	C)	0	0	0	0	13. 00
14. 00	Home Health Aide and Homemaker	C		0	0	0	0	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	C)	0	0	0	0	15. 00
16. 00	Other	C)	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	C		0	0	0	0	17. 00
18. 00	Anal gesi cs	C		0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	C		0	0	0	0	19. 00
20.00	Other - Specify	C		0	0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	C		0	0	0	0	21. 00
22. 00	Patient Transportation	C		0	0	0	0	22. 00
23. 00	I maging Services	C		0	0	0	0	23. 00
24. 00	Labs and Diagnostics	C		0	0	0	0	24. 00
25. 00	Medical Supplies	C		0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	C		0	0	o	0	26. 00
27. 00	Radi ati on Therapy	C		0	0	o	0	27. 00
28. 00	Chemotherapy	l c		o	0	o	0	28. 00
29. 00	Other			o	0	o	0	29. 00
30.00	Bereavement Program Costs			o	0	o	0	30. 00
31. 00	Volunteer Program Costs			ol	0	ol	0	31. 00
32. 00	Fundrai si ng			o	0	o	0	32. 00
33. 00	Other Program Costs	1	ol	ol	0	ol	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	1		ō	300	ol	0	34. 00
35. 00	Total cost to be allocated	1		ol	262	ol Ol	0	35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000	000	0. 873333	0. 000000		
55. 50	James 3332 mar trpiror (300 matraotrons)	0.00000	., 5. 500	200	0.070000	0.00000	0.00000	30.00

Health Financial Systems DEKALB MALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS DEKALB MEMORIAL HOSPITAL

STATISTICAL BASIS

					Hospi ce I		
			CAP	ITAL RELATED C	OSTS		
	Cost Center Description	MAC EAST - NEW	GARRETT LAB -		DAY SPRING -	MVBLE EQUIP	
			NEW	NEW	NEW	(SQUARE FEET)	
		(SQUARE FEET)	(SQUARE FEET)				
	To a contract of the contract	1.05	1.06	1. 07	1. 08	2. 00	
1.00	Administrative and General	0	~	· -	0	0	
2.00	Inpatient - General Care	0	0	0	0	0	
3.00	Inpatient - Respite Care	0	0	0	0	0	
4.00	Physician Services	0	0	0	0	0	
5.00	Nursing Care	0	0	0	0	0	
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	
7.00	Physi cal Therapy	0	0	0	0	0	
8.00	Occupational Therapy	0	0	0	0	0	
9.00	Speech/ Language Pathology	0	0	0	0	0	
10. 00	Medical Social Services	0	0	0	0	0	
11. 00	Spiritual Counseling	0	0	0	0	0	
12. 00	Di etary Counseling	0	0	0	0	0	
13. 00	Counseling - Other	0	0	0	0	0	
14. 00	Home Health Aide and Homemaker	0	0	0	0	0	
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	
16. 00	Other	0	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	
18. 00	Anal gesi cs	0	0	0	0	0	
19. 00	Sedatives / Hypnotics	0	0	0	0	0	
20. 00	Other - Specify	0	0	0	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	
22. 00	Patient Transportation	0	0	0	0	0	
23. 00	I maging Services	0	0	0	0	0	
24. 00	Labs and Diagnostics	0	0	0	0	0	24. 00
25. 00	Medical Supplies	0	0	0	0	0	
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	
29. 00	Other	0	0	0	0	0	
30.00	Bereavement Program Costs	0	0	0	0	0	
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00
32.00	Fundrai si ng	0	0	0	0	0	
33. 00	Other Program Costs	0	0	0	0	0	
34. 00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34. 00
35. 00	Total cost to be allocated	0	0	0	0	0	
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	0. 000000	0.000000	36. 00

STATISTICAL BASIS Hospi ce CCN:

						2/23/2016 3:0	8 pm
					Hospi ce I		
	Cost Center Description	BENEFITS DEPARTMENT (UNADJUSTED	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		SALARY)	E 4	F 00	7.00	0.00	
1.00		4.00	5A	5.00	7. 00	8. 00	4 00
1.00	Administrative and General	134, 238	0	5, 693	300	172	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	56, 372	0	0	4. 00
5. 00	Nursing Care	0	0	237, 591	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7. 00	Physi cal Therapy	0	0	187	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10. 00	Medical Social Services	0	0	0	0	0	10. 00
11. 00	Spiritual Counseling	0	0	9, 192	0	0	11. 00
12. 00	Di etary Counseling	0	0	0	0	0	12.00
13. 00	Counseling - Other	0	0	0	0	0	13. 00
14. 00	Home Health Aide and Homemaker	0	0	0	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	55, 649	0	0	15. 00
16. 00	Other	0	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18. 00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	134, 238		364, 684	300	172	34.00
35. 00	Total cost to be allocated	5, 431		61, 497		94	35. 00
36. 00		0. 040458		0. 168631	•	0. 546512	

STATISTICAL BASIS

						2/23/2016 3:0	8 pm
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	NURSI NG	
	'	(SQUARE FEET)	(MEALS SERVE) (MEALS SERVE	D) (FTES)	ADMI NI STRATI ON	
		(,	1			
						(DI RECT NRS	
						I NG)	
		9. 00	10.00	10. 01	11.00	13.00	
1.00	Administrative and General	300)	0	0 171	3, 548	1. 00
2.00	Inpatient - General Care	l c		o	0 0	0	2. 00
3.00	Inpatient - Respite Care			o	0 0	0	3.00
4.00	Physi ci an Servi ces			o	0 0	0	4.00
5.00	Nursing Care			o	0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care		j	ol	0 0	0	6.00
7.00	Physical Therapy		o i	ol	0 0	0	7.00
8.00	Occupational Therapy		o i	ol	0 0	0	8.00
9.00	Speech/ Language Pathology			ol	0 0	0	9. 00
10.00	Medical Social Services			ol	0 0	0	10.00
11. 00	Spiritual Counseling			ol	0 0	0	11.00
12.00	Di etary Counsel i ng			ol	0 0	0	12.00
13.00	Counseling - Other			ol	0 0	0	13. 00
14.00	Home Health Aide and Homemaker			o	0 0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care			ol	0 0	0	15. 00
16. 00	Other			ol	0 0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy			o	0 0	0	17. 00
18.00	Anal gesi cs			o	0 0	0	18. 00
19.00	Sedatives / Hypnotics			o	0 0	0	19.00
20.00	Other - Specify	l c		o	0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	l c		o	0 0	0	21. 00
22.00	Patient Transportation	C)	o	0 0	0	22. 00
23.00	I maging Services	C)	o	0 0	0	23. 00
24.00	Labs and Diagnostics	C)	o	0 0	0	24. 00
25.00	Medical Supplies	C)	0	0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	C		0	0 0	0	26. 00
27.00	Radi ati on Therapy	C)	o	0 0	0	27. 00
28.00	Chemotherapy	C)	o	0 0	0	28. 00
29.00	Other	C)	o	0 0	0	29. 00
30.00	Bereavement Program Costs	C		0	0 0	0	30. 00
31.00	Volunteer Program Costs	C)	0	0	0	31. 00
32.00	Fundrai si ng	C		0	0 0	0	32.00
33.00	Other Program Costs	C)	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	300		0	0 171	3, 548	34. 00
35.00	Total cost to be allocated	2, 576		0	0 3, 569		35. 00
36. 00	Unit Cost Multiplier (see instructions)	8. 586667	0. 00000	0. 0000	20. 871345	4. 250846	36. 00

						2/23/2016 3:08 pm
					Hospi ce I	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(COSTED		(GROSS REVE		
		REQUIS.)		NUE)		
		14. 00	15. 00	16. 00	17. 00	
1.00	Administrative and General	0	0	715, 59 ⁻	1 0	1. 00
2.00	Inpatient - General Care	0	0		0	2. 00
3.00	Inpatient - Respite Care	0	0		0	3. 00
4.00	Physi ci an Servi ces	0	0		0	4. 00
5.00	Nursing Care	0	0		0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	6. 00
7.00	Physi cal Therapy	0	0		0	7. 00
8.00	Occupational Therapy	0	0		0	8. 00
9.00	Speech/ Language Pathology	0	0		0	9. 00
10.00	Medical Social Services	0	0		0	10.00
11.00	Spiritual Counseling	0	0		0	11. 00
12.00	Di etary Counsel i ng	0	0		0	12. 00
13.00	Counseling - Other	0	0		0	13. 00
14.00	Home Health Aide and Homemaker	0	0		0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		o o	15. 00
16.00	Other	O	0		o o	16. 00
17.00	Drugs, Biological and Infusion Therapy	O	0		o o	17. 00
18.00	Anal gesi cs	o	0		o o	18. 00
19.00	Sedatives / Hypnotics	o	0		ol ol	19. 00
20.00	Other - Specify	o	0		o o	20. 00
21.00	Durable Medical Equipment/Oxygen	o	0		ol ol	21. 00
22.00	Pati ent Transportation	o	0		ol ol	22. 00
23.00	I maging Services	o	0		ol ol	23. 00
24.00	Labs and Diagnostics	o	0		ol ol	24. 00
25.00	Medical Supplies	o	0		ol ol	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0		ol ol	26. 00
27.00	Radi ati on Therapy	o	0		ol ol	27. 00
28.00	Chemotherapy	o	0		ol ol	28. 00
29.00	Other	o	0		ol ol	29. 00
30.00	Bereavement Program Costs	o	0		ol ol	30.00
31.00	Volunteer Program Costs	o	0		ol ol	31.00
32.00	Fundrai si ng	o	0		ol ol	32.00
33. 00	Other Program Costs	l	0		ol ol	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	l	0	715, 59	1 0	34.00
35. 00	Total cost to be allocated	o	0	5, 68		35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000		1	36.00

Health Financial Systems DEKALB			B MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150045	Peri od:	Worksheet K-5			
			Hospi ce (CCN: 151559	From 10/01/2014 To 09/30/2015	Date/Time Pre	pared:		
					Hospi ce I	2/23/2016 3:0	8 piii		
	Cost Center Description	Wks	t. C, Part	Cost to Char	ge Total Hospice	Hospi ce Shared			
	'		col . 11	Ratio	Charges	Ancillary			
			line		(Provi der	Costs (cols. 1			
					Records)	x 2)			
			0	1.00	2. 00	3. 00			
	ANCILLARY SERVICE COST CENTERS								
1.00	PHYSI CAL THERAPY		66. 00	0. 4332	17 0	0	1. 00		
1.01	CARDI AC REHAB		66. 01	0. 7662	35 0	0	1. 01		
2.00	OCCUPATI ONAL THERAPY		67. 00				2. 00		
3.00	SPEECH PATHOLOGY		68. 00				3. 00		
4.00	DRUGS CHARGED TO PATIENTS		73. 00	0. 4887	30 0	0	4. 00		
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5. 00		
6.00	LABORATORY		60.00	0. 2088	43 0	0	6. 00		
6. 01	BLOOD LABORATORY		60. 01	0.0000	00	0	6. 01		
7.00	MEDICAL SUPPLIES CHARGED TO PAT		71.00	0. 4108	16 0	0	7. 00		
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8. 00		
9.00	RADI OLOGY-THERAPEUTI C		55.00				9. 00		
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76.00				10.00		
11. 00	Totals (sum of lines 1-10)					0	11. 00		

Heal th	Financial Systems DEKALB MEMORI	AL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST		Provi der	CCN: 150045	Peri od:	Worksheet K-6	
					From 10/01/2014		
			Hospi ce (CCN: 151559	To 09/30/2015		
						2/23/2016 3:0	8 pm
					Hospi ce I		
		Ti t	le XVIII	Title XIX	Other	Total	
			1.00	2.00	3. 00	4. 00	
1.00	Total cost (see instructions)					461, 942	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)					3, 676	2. 00

		Title XVIII	Title XIX	0ther	Total	
		1.00	2.00	3. 00	4.00	
1.00	Total cost (see instructions)				461, 942	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3, 676	2.00
3.00	Average cost per diem (line 1 divided by line 2)				125. 66	3.00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line	3, 676				4.00
	5)					
5. 00	Aggregate Medicare cost (line 3 time line 4)	461, 926				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line		0			6.00
	5)					
7. 00	Aggregate Medicaid cost (line 3 time line 60)		0			7. 00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	856				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	107, 565				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13. 00	Aggregate cost for other days (line 3 times line 12)			0		13.00

Heal th	Financial Systems DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150045	Peri od: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Pre	pared:		
		Title XVIII	Hospi tal	2/23/2016 3:0 PPS	8 piii		
		THE AVIII	1103pi tai	113			
				1. 00			
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT						
1.00	Capital DRG other than outlier			266, 802	1.00		
1. 01	Model 4 BPCI Capital DRG other than outlier			200, 002	1. 01		
2.00	Capital DRG outlier payments			4, 795			
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01		
3.00	Total inpatient days divided by number of days in the cost rep	orting period (see inst	ructions)	18. 22	1		
4.00	Number of interns & residents (see instructions)	· · · · · · · · · · · · · · · · ·		0.00	1		
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00		
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.01	, columns 1 and	0	6. 00		
	1.01) (see instructions)						
7. 00	Percentage of SSI recipient patient days to Medicare Part A pa 30) (see instructions)	tient days (Worksheet E	, part A line	0.00	7. 00		
8.00	Percentage of Medicaid patient days to total days (see instruc	tions)		0.00	8. 00		
9. 00	Sum of lines 7 and 8	,		0.00			
10.00	Allowable disproportionate share percentage (see instructions)			0.00	10.00		
11.00	Disproportionate share adjustment (see instructions)			0	11. 00		
12.00	Total prospective capital payments (see instructions)			271, 597	12.00		
				1. 00			
	PART II - PAYMENT UNDER REASONABLE COST						
1.00	Program inpatient routine capital cost (see instructions)			0	1.00		
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00		
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00		
4.00	Capital cost payment factor (see instructions)			0	4. 00		
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00		
				1. 00			
	PART III - COMPUTATION OF EXCEPTION PAYMENTS						
1.00	Program inpatient capital costs (see instructions)			0	1. 00		
2.00	Program inpatient capital costs for extraordinary circumstance	s (see instructions)		0	2. 00		
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00		
4.00	Applicable exception percentage (see instructions)			0.00	4. 00		
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00		
6.00	Percentage adjustment for extraordinary circumstances (see ins			0.00	1		
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	line 6)	0			
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00		
9.00	Current year capital payments (from Part I, line 12, as applic			0	9. 00		
10.00	Current year comparison of capital minimum payment level to ca			0	10. 00		
11. 00	Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)	pital payment (from pri	or year	0	11. 00		
12.00	Net comparison of capital minimum payment level to capital pay	ments (line 10 plus lin	e 11)	0	12. 00		
13.00	Current year exception payment (if line 12 is positive, enter	the amount on this line)	0	13. 00		
14. 00	Carryover of accumulated capital minimum payment level over capital payment for the following period 0 14.00 (if line 12 is negative, enter the amount on this line)						
15.00	Current year allowable operating and capital payment (see inst	ructions)		0	15. 00		
16.00	Current year operating and capital costs (see instructions)			0	16. 00		
17. 00	Current year exception offset amount (see instructions)			0	17. 00		