ioai en i i nanoi i	a. Gyoromo	DETAILED INCINOTATIVE	11001 1 1712	00	OI TOTAL ONE LOOP TO
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Fai	Ture to report can res	sult in all interim	FORM APPROVED
payments made	since the beginning of the co	st reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 03-31-2022
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provider CCN: 15-0045	Peri od: From 10/01/2018	Worksheet S Parts I-III
AND SETTLEMENT	SUMMART				Date/Time Prepared: 2/25/2020 11:43 am
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 2/25/20	20 Time: 11:43 am
use only	2. [] Manually submitted co	st report			
	3. [0] If this is an amended 4. [F] Medicare Utilization.			resubmitted this o	ost report
Contractor use only	(1) As Submitted (2) Settled without Audit	6. Date Received: 7. Contractor No. 8. [N]Initial Report fo 9. [N]Final Report for	11 or this Provider CCN 12		or Code: 4 Jumn 1 is 4: Enter les reopened = 0-9.

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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEKALB MEMORIAL HOSPITAL (15-0045) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	198, 413	56, 612	0	-281, 811	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	198, 413	56, 612	0	-281, 811	200.00

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

Health FinancialSystemsDEKALB MEMORIALHOSPITALHOSPITALIn Lieu of Form CMS-2552-10HOSPITAL AND HOSPITAL HEALTH CARECOMPLEX IDENTIFICATION DATAProvider CCN: 15-0045Period: Worksheet S-2

From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 11:43 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1316 EAST 7TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: AUBURN Zi p Code: 46706-County: DEKALB 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)
/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal DEKALB MEMORIAL 150045 99915 07/01/1966 N 0 3.00 HOSPI TAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospital -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital-Based HHA DEKALB HOME HEALTH 157157 99915 07/09/1985 Ν Ρ Ν 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce DEKALB HOSPICE 151559 99915 11/06/1996 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital -Based (CORF) I 17. 10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2018 09/30/2019 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care N Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

If line 56 is yes, is this the first cost reporting period during which residents in approved

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

57.00

58.00

59.00

Ν

57.00

	ACA Provisions Affecting the Health Resources and Services Administration	n (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost	reporting per	iod for which	0.00	62.00				
	your hospital received HRSA PCRE funding (see instructions)								
62. 01	Enter the number of FTE residents that rotated from a Teaching Health Cer		your hospital	0. 00	62. 01				
	during in this cost reporting period of HRSA THC program. (see instruction	ns)							
	Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	3.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N								
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through	67. (see instr	uctions)						
		Unwei ghted	Unwei ghted	Ratio (col.					
		FTEs	FTEs in	1/ (col. 1 +					
		Nonprovi der	Hospi tal	col. 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	1				
	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	0.00	0. 00	0. 000000	64.00				
	in the base year period, the number of unweighted non-primary care								
	resident FTEs attributable to rotations occurring in all nonprovider				1				
	settings. 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)				1				

	4)). (see instructions)								
						1.00	2.00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	sychiatric Facility (IPF), or does it cont	ain an IPF sub	provi der?	N			70.00
	Enter "Y" for yes or "N" for no).							
71.00	If line 70 is yes: Column 1: Dic	I the facility have a	n approved GME teachi	ng program in	the most			0	71.00
	recent cost report filed on or b	oefore November 15, 2	004? Enter "Y" for y	es or "N" for	no. (see				
	42 CFR 412. 424(d)(1)(iii)(c)) Co	olumn 2: Did this fac	ility train residents	in a new teac	hi ng				
	program in accordance with 42 CF	R 412.424 (d)(1)(iii)(D)? Enter "Y" for y	es or "N" for	no.				
	Column 3: If column 2 is Y, indi	cate which program y	ear began during this	cost reportin	g period.				
	(see instructions)								
	Inpatient Rehabilitation Facilit	ty PPS							
	Is this facility an Inpatient Re		y (IRF), or does it c	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes	and "N" for no.							

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

106. 00

107.00

108.00

Ν

Ν

Ν

106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment

108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.

training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost

107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R

for outpatient services? (see instructions)

reimbursed. If yes complete Wkst. D-2, Pt. II.

All Providers

Health Financial Systems	DEKALB MI	EMORIAL HOSPITA	٩L				In Lieu	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I DENTIFICATION DATA	A Provid	der CCN	: 15-0045			/01/2018 /30/2019	Worksheet S- Part I Date/Time Pr 2/25/2020 11	epared:
					_	1	. 00	2.00	+
140.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h	for no in column	1. If yes, and	home o	office c		'	N	2.00	140. 00
1.00		2. 00			·		3. 00		
If this facility is part of a chain office and enter the home office co				gh 143 t	he nam	ne and	address	of the home	
141. 00 Name:	Contractor's Na		ei.	Contr	actor'	s Num	ber:		141.00
142.00 Street:	PO Box:								142.00
143. 00 Ci ty:	State:			Zi p C	ode:				143.00
								1. 00	\dashv
144.00 Are provider based physicians' costs	s included in Works	heet A?						Υ	144.00
					-		00	0.00	
145.00 f costs for renal services are clai	med on Wkst Δ li	ne 74 are the	costs	for		ı	. 00	2. 00	145.00
inpatient services only? Enter "Y" ino, does the dialysis facility incluperiod? Enter "Y" for yes or "N" for 146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in o	For yes or "N" for ude Medicare utiliz or no in column 2. changed from the p column 1. (See CMS	no in column 1 cation for this previously file	. If coct in discost	olumn 1 i reporting report?	g		N		146. 00
yes, enter the approval date (mm/dd/	yyyy) in column 2.								
								1. 00	
147.00 Was there a change in the statistica								N	147. 00
148.00 Was there a change in the order of a					6			N	148.00
149.00 Was there a change to the simplified	a cost finding meth	Part		Part			tle V	N Title XIX	149.00
		1.00		2. 00			. 00	4.00	
Does this facility contain a provide or charges? Enter "Y" for yes or "N"									
155. 00 Hospi tal	TOT TO TOT EACH C	N	ai t A	N	D. (3	JCC 42	N S41	N N	155.00
156. 00 Subprovi der – IPF		N		N	1		N	N	156.00
157.00 Subprovi der – I RF 158.00 SUBPROVI DER		N		N			N	N	157. 00 158. 00
159. 00 SNF		N		N			N	N	159.00
160.00 HOME HEALTH AGENCY		N	İ	N			N	N N	160.00
161.00 CMHC				N			N	N	161.00
161. 10 CORF				N			N	N	161. 10
								1. 00	
Multicampus 165.00 s this hospital part of a Multicamp	ous hospital that h	uas one or more	campus	ses in di	iffere	nt CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	<u> </u>								1.55.55
	Name O	County 1.00		State 2.00	Zi p C 3. 0		4. 00	FTE/Campus 5.00	-
166.00 f line 165 is yes, for each	<u> </u>	1.00		2.00	3.0	,,,	4.00		00 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									
								1. 00	-
Health Information Technology (HIT)						Act			
167.00 s this provider a meaningful user o 168.00 f this provider is a CAH (line 105	is "Y") and is a m	eaningful user				enter	the	Υ	167. 00 168. 00
reasonable cost incurred for the HI ⁻ 168.01 If this provider is a CAH and is no	Γassets (see instr ta meaningful user	ructions) r, does this pr	ovi der	qual i fy	for a				168. 01
exception under §413.70(a)(6)(ii)? E 169.00 If this provider is a meaningful use	er (line 167 is "Y"					l"), eı	nter the	0.0	00169.00
transition factor. (see instructions	S)					Beai	nni ng	Endi ng	
							. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginner of respectively (mm/dd/yyyy)	ginning date and en	ding date for	the rep	oorti ng					170. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lieu	of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-0045		d: 10/01/2018	Worksheet S-2	
					Date/Time Pre	
					2/25/2020 11:	<u>43 am</u>
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provide	er have any days for indi	viduals enrolled in		N	C	171.00
section 1876 Medicare cost plans repo	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter				
"Y" for yes and "N" for no in column	on					
1876 Medicare days in column 2. (see	instructions)					

Heal th	Financial Systems DEKALB MEMORI	AL HOSPLTAL		Inlie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Peri od: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II	epared:
		<u>'</u>		Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	enoneee Ent	1.00	2. 00	
	mm/dd/yyyy format.	- I OI all NO IV	esponses. Lift		the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					+
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	the cost	N		1.00
	preporting period: IT yes, enter the date of the change ITI	corumir 2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	N			3.00	
	Transfer (eda Friatrade alla)		Y/N	Туре	Date	
	Einancial Data and Poports		1. 00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certaccountant? Column 2: If yes, enter "A" for Audited, "C" to "R" for Reviewed. Submit complete copy or enter date avaicolumn 3. (see instructions) If no, see instructions.	Y	A	11/29/2018	4.00	
5. 00	Are the cost report total expenses and total revenues differenthese on the filed financial statements? If yes, submit reconstructions		N			5. 00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is t	he provider i	s N		6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated of		the current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11.00
					Y/N 1.00	
	Bad Debts					4.5
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12.00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see ins t A	tructions.	Y t B	15.00
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	12/17/2019	Y	12/17/2019	16.00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17.00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00
	, , , , , , , , , , , , , , , , , , , ,	ı	•	1		•

Health Fir	nancial Systems DEKALB MEMORI	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10			
	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0045	Peri od: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II	epared:			
		Descr	iption	Y/N	Y/N	10 4			
20 00 1.5	1 - 1/ - 17		0	1. 00	3.00	20.00			
	line 16 or 17 is yes, were adjustments made to PS&R port data for Other? Describe the other adjustments:			N	N	20.00			
11.00	or t data for other besseries the other day dother to	Y/N	Date	Y/N	Date				
		1.00	2.00	3. 00	4. 00				
	s the cost report prepared only using the provider's cords? If yes, see instructions.	N		N		21.00			
					1. 00				
	PLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)						
	ital Related Cost								
	ve assets been relifed for Medicare purposes? If yes, se				N	22.00			
	ve changes occurred in the Medicare depreciation expense porting period? If yes, see instructions.	e due to apprai	Sai S illade dui	ing the cost	N	23.00			
24.00 Wer	re new leases and/or amendments to existing leases enter yes, see instructions	ed into during	this cost re	eporting period?	N	24. 00			
25. 00 Hav	we there been new capitalized leases entered into during structions.	Plf yes, see	N	25. 00					
26.00 Wer	re assets subject to Sec. 2314 of DEFRA acquired during t structions.	he cost report	ing period? I	f yes, see	N	26. 00			
27. 00 Has	s the provider's capitalization policy changed during th by.	ne cost reporti	ng period? If	yes, submit	N	27. 00			
	erest Expense re new Loans, mortgage agreements or Letters of credit e	entered into du	ring the cost	reporting	Υ	28. 00			
29. 00 Di c	period? If yes, see instructions. Ou Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)								
30. 00 Has	treated as a funded depreciation account? If yes, see instructions 100 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see								
31. 00 Has	instructions. .00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.								
Pur	chased Services ve changes or new agreements occurred in patient care se	ervices furnish	ed through co	ontractual	N	32.00			
33.00 If	rangements with suppliers of services? If yes, see instr line 32 is yes, were the requirements of Sec. 2135.2 ap see instructions.	ructi ons.	· ·			33.00			
	vi der-Based Physi ci ans								
	e services furnished at the provider facility under an a	arrangement wit	h provider-ba	sed physicians?	Υ	34.00			
35.00 lf	yes, see instructions. line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based	N	35.00			
phy	vsicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date				
				1. 00	2. 00				
	e Office Costs								
	re home office costs claimed on the cost report? line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N		36. 00 37. 00			
38.00 lf	yes, see instructions. line 36 is yes , was the fiscal year end of the home of			=		38. 00			
39.00 If	e provider? If yes, enter in column 2 the fiscal year en line 36 is yes, did the provider render services to oth			5,		39. 00			
40.00 If	e instructions. line 36 is yes, did the provider render services to the	e home office?	If yes, see			40. 00			
II ns	i nstructi ons.								
		1.	00	2.	00				
	t Report Preparer Contact Information	1							
hel	ter the first name, last name and the title/position d by the cost report preparer in columns 1, 2, and 3, spectively.	MI CHAEL		ALESSANDRI NI		41.00			
42. 00 Ent	1 3	BLUE AND CO.,	LLC			42.00			
43. 00 Ent		317-713-7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00			

Heal th	Financial Systems	DEKALB MEMORIA	AL HOSPITAL			In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	UESTI ONNAI RE	Provi der	CCN: 15-0045	Peri From To	n 10/01/2018	Worksheet S-2 Part II Date/Time Pre 2/25/2020 11:	pared:	
			<u> </u>	3.00					
	Cost Report Preparer Contact Information			0.00					
41. 00	Enter the first name, last name and the titheld by the cost report preparer in columns respectively.		OI RECTOR					41. 00	
42.00	Enter the employer/company name of the cost	t report						42.00	
43. 00	preparer. Enter the telephone number and email addres report preparer in columns 1 and 2, respect							43. 00	

| Peri od: | Worksheet S-3 | From 10/01/2018 | Part | | To 09/30/2019 | Date/Time Prepared:
 Health Financial
 Systems
 DEKALB

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provi der CCN: 15-0045

					1	o 09/30/2019	Date/Time F 2/25/2020		
							I/P Days /	, <u> </u>	ro alli
							0/P Visits		
							Tri ps		
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V		
		Line Number			Avai I abl e				
		1. 00		2.00	3.00	4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		29	10, 585	0. 00		0	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)								2 00
2.00	HMO and other (see instructions)								2. 00 3. 00
3. 00 4. 00	HMO IPF Subprovider 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
7.00	beds) (see instructions)			21	10, 300	0.00		٩	7.00
8. 00	INTENSIVE CARE UNIT	31.00		8	2, 920	0.00		0	8. 00
9. 00	CORONARY CARE UNIT	01.00		J	2, ,20	0.00		Ĭ	9. 00
10.00	BURN INTENSIVE CARE UNIT								10.00
11. 00	SURGICAL INTENSIVE CARE UNIT								11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)		İ					İ	12.00
13.00	NURSERY	43.00						0	13.00
14.00	Total (see instructions)			37	13, 505	0.00		0	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	404.00							21.00
22. 00	HOME HEALTH AGENCY	101. 00						0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	444 00			_				23.00
24. 00	HOSPI CE	116.00	1	0	C)			24. 00 24. 10
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00							25. 00
25. 00	CMHC - CMF	99. 10						0	25. 00
26. 00	RURAL HEALTH CLINIC	99. 10						۷	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		37				Ĭ	27. 00
28. 00				37				0	28. 00
29. 00	Ambulance Trips							Ĭ	29. 00
30. 00	Employee discount days (see instruction)								30.00
31. 00	Employee discount days - IRF					1			31. 00
32.00	Labor & delivery days (see instructions)		İ	0	C)			32.00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days								33.00
33. 01	LTCH site neutral days and discharges					1			33. 01

Peri od: Worksheet S-3 From 10/01/2018 Part I To 09/30/2019 Date/Time Prepared: 2/25/2020 11:43 am

						2/25/2020 11:	43 am_
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	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, 106	158	3, 222			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 167	902				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	1, 106	158	3, 222			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	282	O	1, 122			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	673			13.00
14.00	Total (see instructions)	1, 388	158	5, 017	0.00	466. 97	14.00
15. 00	CAH visits	0	0	0			15.00
16. 00	SUBPROVIDER - 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	2, 209	0	6, 403	0.00	12. 21	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	2,20,	Ŭ.	0, 100	0.00		23.00
24. 00	HOSPI CE	0	0	O	0.00	1. 12	1
24. 10	HOSPICE (non-distinct part)		Ŭ	Ö		1. 12	24. 10
25. 00	CMHC - CMHC			, and the second			25.00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	
26. 00	RURAL HEALTH CLINIC	١	Ü	0	0.00	0.00	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	O	0.00	0.00	
27. 00	Total (sum of lines 14-26)		U		0.00		
28. 00	Observation Bed Days		0	2, 309		400. 30	28.00
29. 00	Ambul ance Trips	1, 003	U	2, 309			29.00
30. 00	Employee discount days (see instruction)	1,003		54			30.00
31. 00	Employee discount days (see Histruction)			0			31.00
		0	10	32			32.00
32.00	Labor & delivery days (see instructions)	١	18	32			
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	1 .	0					33.00
	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
JJ. UI	LETON SELECTION LAYS AND UISCHALGES	ı V			I	I	J 33. U I

| Peri od: | Worksheet S-3 | From 10/01/2018 | Part I | Date/Time | Prepared: | | Part | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | Prepared: | P Provi der CCN: 15-0045

				To	09/30/2019	Date/Time Pre 2/25/2020 11:	
		Full Time		Di sch	arges	27 207 2020	10 diii
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	473	42	1, 672	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			074	070		0.00
2.00	HMO and other (see instructions)			374	272		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO IRF Subprovi der				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
8. 00	beds) (see instructions) 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						13.00
14. 00	Total (see instructions)	0.00	0	473	42	1, 672	14. 00
15. 00	CAH visits	0.00	J	473	72	1,072	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
25. 10	CMHC - CORF	0.00					25. 10
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	,						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33. 01

| Peri od: | Worksheet S-3 | From 10/01/2018 | Part II | To 09/30/2019 | Date/Time Prepared: | Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0045

Report Moment Report R						To	09/30/2019	Date/Time Pre 2/25/2020 11:	
Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross Salaries Cross			Wkst. A Line		Recl assi fi cat			Average	TO GIII
PART II - ANGE DIATA SALARIES 1,00 2,00 28,584,062 3,00 4,00 5,00 6,00 6,00 7,			Number	Reported					
New York New York								,	
MART 1 - BMGE DATA						3)	COI. 4	COI. 5)	
SAMPHES SAMP			1. 00	2. 00		4. 00	5. 00	6. 00	
Total salaries (see 200.00 28.584,062 0 28.584,062 980.965.00 29.14 1.00									
1	1 00		200.00	20 504 062	1 0	20 504 062	090 065 00	20 14	1 00
Non-physician anesthetist Part 0	1.00		200.00	20, 304, 002		26, 364, 002	700, 703. 00	27. 14	1.00
4. 00 Physician-Part A - Teaching	2.00			0	0	0	0. 00	0. 00	2.00
4. 00 Physician-Part A - Teaching		A							0.00
Administrative Action Administrative Action Act	3.00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3.00
Administrative Action Administrative Action Act	4. 00	Physician-Part A -		171, 031	0	171, 031	1, 208, 00	141. 58	4.00
Physic is an and Non		Admi ni strati ve					·		
Physician-Part B				0	-	_			
Non-physician-Part B For Non-physician-Part	5.00			0	0	0	0.00	0.00	5.00
hospital -based Rict and FORC services services services services services services linterns a residents (In an approved program) 0 0 0 0 0 0 0 0 0	6. 00			0	0	0	0. 00	0. 00	6. 00
1.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0									
approved program	7 00		21 00	0			0.00	0.00	7 00
7.01 Contracted interns and residents (in an approved programs) 8.00 Home office and/or related	7.00		21.00	Ü		U	0.00	0.00	7.00
Book Contract Co	7. 01			0	0	О	0. 00	0. 00	7. 01
Home office and/or related organization personnel 44.00 0 0 0 0 0 0 0 0 0									
Organization personnel Auto O O O O O O O O O	9 00			0			0.00	0.00	9 00
9,00 SNF	8.00			O			0.00	0.00	0.00
Instructions OTHER WAGES & RELATED COSTS			44. 00	0	0	0	0. 00	0. 00	9. 00
OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 168, 987 0 168, 987 2, 487.00 67.95 11.00 Contract labor: Top level 0 0 0 0 0.00 0.00 12.00 12.00 13.00 Contract labor: Top level 0 0 0 0 0 0.00 12.00 13.00 Contract labor: Physician-Part 680, 452 0 680, 452 4, 450.00 152.91 13.00 Contract labor: Physician-Part 680, 452 0 680, 452 4, 450.00 152.91 13.00 Contract labor: Physician Part A A - Administrative A - A - Administrative A - Administrative	10.00			9, 822, 061	-21, 031	9, 801, 030	290, 986. 00	33. 68	10.00
11.00 Contract Labor: Direct Patient 168,987 0 168,987 2,487.00 67.95 11.00 Care 12.00 Contract Labor: Top Level 0 0 0 0 0 0.00 0.00 12.00									
12.00 Contract Labor: Top level management and other management and other management and other management and administrative services 13.00 Contract Labor: Physician-Part 6.80, 452 0 6.80, 452 4, 450.00 152, 91 13.00 A - Administrative 14.00 Home office and/or related organization salaries and wage-related costs 0 0 0 0 0 0 0 0 0	11. 00			168, 987	О	168, 987	2, 487. 00	67. 95	11. 00
management and other management and odn in Istrative services		1							
management and administrative services	12. 00			0	0	0	0. 00	0. 00	12.00
Services Services									
A - Admin istrative									
14.00 Home office and/or related organization sall aries and wage-related costs 0 0 0 0 0 0 0 0 0	13.00			680, 452	0	680, 452	4, 450. 00	152. 91	13.00
Organization salaries and wage-related costs	14 00			0		0	0.00	0.00	14 00
14. 01 Home office salaries 0 0 0 0 0 0 0 0 0	14.00			O			0.00	0.00	14.00
14. 02 Rel ated organization sal aries 0 0 0 0 0.00 0.00 14. 02									
15.00 Home office: Physician Part A 0 0 0 0 0 0 0 0 0		l		0	1				
- Admin istrative Home office and Contract Home office and Contract Home office and Contract Home office and Contract Home office and Contract Home office and Contract Home office and Contract Home office and Contract Home office and Contract Home office wage-rel ated costs (core) (see Instructions) 17. 00 Wage-rel ated costs (core) (see Instructions) 18. 00 Wage-rel ated costs (other) (see Instructions) 19. 00 Excluded areas 20. 00 Non-physician anesthetist Part A A A D D D D D D D D D D D D D D D D				0		_			
Physicians Part A - Teaching		- Administrative							
WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see instructions) 17.00 wage-related costs (core) (see instructions) 18.00 wage-related costs (other) (see instructions) 18.00 wage-related costs (other) (see instructions) 19.00 Excluded areas 2,822,834 0 2,822,834 19.00 20.00 Non-physician anesthetist Part 0 0 0 0 21.00 Non-physician anesthetist Part 8 8 19.00 22.00 22.00 22.00 22.00 22.00 23.00 23.00 24.00 24.00 25.00 25.00 25.00 25.00 25.50 10 10 10 10 25.50 25.51 Related organization 25.52 25.53 25.53 25.53 25.53 25.53 25.53 25.53 25.55 2	16. 00			0	0	0	0. 00	0. 00	16.00
17. 00 Wage-related costs (core) (see instructions) 18. 00 Wage-related costs (other) (see instructions) 19. 00 Excluded areas 2, 822, 834 20. 00 Non-physician anesthetist Part Andministrative 22. 00 Physician Part A - Teaching Andministration Andministr									
Instructions Wage-related costs (other) (see instructions) 18.00 (see instructions) 19.00 (see	17. 00			6, 535, 492	О	6, 535, 492			17. 00
19.00 Excluded areas 2,822,834 0 2,822,834 19.00 20.00 Non-physician anesthetist Part 0 0 0 0 0 21.00 Non-physician anesthetist Part 0 0 0 0 0 21.00 Non-physician anesthetist Part 0 0 0 0 0 0 21.00 Non-physician Part A - 18,532 0 18,532 22.00 Non-physician Part A - Teaching 0 0 0 0 0 22.01 Non-physician Part B 0 0 0 0 0 0 22.01 Non-physician Part B 0 0 0 0 0 0 0 0 0		instructions)							
19.00 Excluded areas 2,822,834 0 2,822,834 20.00 2,822,834 20.00 20.	18. 00								18. 00
20.00 Non-physician anesthetist Part 0 0 0 0 21.00 21.00 Non-physician anesthetist Part 0 0 0 0 22.00 Physician Part A - 18,532 0 18,532 22.00 Administrative 22.01 Physician Part A - Teaching 0 0 0 0 23.00 Physician Part B 0 0 0 0 24.00 Wage-related costs (RHC/FOHC) 0 0 0 0 25.00 Interns & residents (In an approved program) 0 0 0 25.50 Home office wage-related 0 0 0 25.51 Related organization 0 0 0 25.52 Home office: Physician Part A 0 0 0 25.53 Home office & Contract 0 0 0 25.53 Home office & Contract 0 0 0 25.53 Physicians Part A - Teaching - 0 0 0 25.53 Physicians Part A - Teaching - 0 0 0 25.53 Physicians Part A - Teaching - 0 0 0 25.53 0 0 0 0 25.53 0 0 0 0 25.53 0 0 0 0 25.53 0 0 0 25.53 0 0 0 25.53 0 0 0 25.53 0 0 0 25.53 0 0 0 25.53 0 0 0 25.53 0 0 0 25.53 0 0 0 25.55 0 0 0 0 25.55 0 0 0 25.55 0 0 0 0 25.55 0 0 0 0 25.55 0 0 0 0 25.55 0	19. 00			2, 822, 834	0	2, 822, 834			19. 00
B		1		0					
B	04 00	A		=	_				24 66
Administrative 22. 01 Physician Part A - Teaching 23. 00 Physician Part B 0 0 0 23. 00 Physician Part B 0 0 0 24. 00 Wage-related costs (RHC/FQHC) 25. 00 Interns & residents (in an approved program) Home office wage-related (core) 25. 51 Related organization wage-related (core) 45. 52 Home office: Physician Part A - Administrative - wage-related (core) 45. 53 Physicians Part A - Teaching -	21.00	Non-physician anesthetist Part		0	0	9			21.00
Administrative 22. 01 Physician Part A - Teaching 23. 00 Physician Part B 0 0 0 23. 00 Physician Part B 0 0 0 24. 00 Wage-related costs (RHC/FQHC) 25. 00 Interns & residents (in an approved program) Home office wage-related (core) 25. 51 Related organization wage-related (core) 45. 52 Home office: Physician Part A - Administrative - wage-related (core) 45. 53 Physicians Part A - Teaching -	22. 00	Physician Part A -		18, 532	0	18, 532			22. 00
23.00 Physician Part B		Admi ni strati ve		-,					
24. 00 Wage-related costs (RHC/FQHC) 0 0 0 0 24. 00 25. 00 Interns & residents (in an approved program) 0 0 0 0 0 25. 00 25. 50 Home office wage-related (core) 0 0 0 0 25. 50 25. 51 Related organization wage-related (core) 0 0 0 25. 51 25. 52 Home office: Physician Part A - Administrative - wage-related (core) 0 0 0 0 25. 52 25. 53 Physicians Part A - Teaching - 0 0 0 0 25. 53		3		0	0	0			
25. 00				0		0			
approved program) Home office wage-related (core) 25. 51 Related organization wage-related (core) 45. 52 Home office: Physician Part A Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching -		1 9		0	0	o o			
(core) (core) 25. 51 Rel ated organization 0 0 wage-related (core) 0 0 Home office: Physician Part A - Teaching - 0 0 25. 52 0 0 Wage-related (core) 0 0 Home office & Contract 0 0 Physicians Part A - Teaching - 0 0		approved program)							
25. 51 Related organization wage-related (core) Home office: Physician Part A - Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching -	25. 50			0	0	9			25. 50
wage-related (core) Home office: Physician Part A - Administrative - wage-related (core) Home office & Contract Physicians Part A - Teaching -	25. 51			Λ	1	n			25. 51
25. 52 Home office: Physician Part A	20.01			O					20.01
wage-related (core) Home office & Contract Physicians Part A - Teaching -	25. 52	Home office: Physician Part A		0	0	0			25. 52
25. 53 Home office & Contract 0 0 0 25. 53 Physicians Part A - Teaching -									
Physicians Part A - Teaching -	25. 53			0		o			25. 53
wage-related (core)		Physicians Part A - Teaching -							
		wage-related (core)			l				

| Period: | Worksheet S-3 | From 10/01/2018 | Part II | To 09/30/2019 | Date/Time Prepared:

Wkst. A Line Number Reported Reported Salaries Col. 2 ± col. Salaries Col. 2 ± col. Salaries Col. 4 ± col. 5 Col. 4 ± col. 5 Col. 5 ± col. 5 Col. 5 ± col. 5 ± col. 5 Col. 5 ± col. 5 ± col. 5 ± col. 5 ± col. 5 ± col. 5 ± col. 5 ± col. 5 ± col. 5 ± col.						1	0 09/30/2019		
Number Reported Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 4 ± col. 5 Salaries Gol. 4 ± col. 5 Salaries Gol. 4 ± col. 5 Salaries Gol. 4 ± col. 5 Salaries Gol. 4 ± col. 5 Salaries Gol. 4 ± col. 5 Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 4 ± col. 5 Salaries Gol. 4 ± col. 5 Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 2 ± col. Salaries Gol. 4 ± col. 5 Salaries Gol. 2 ± col. Salaries Gol. 4 ± col. 5 Salaries Gol. 4 ± col. 5 Salaries Gol. 5 ± col. Salaries Gol. 6 ± col. Salaries Gol. 6 ± col. Salaries Gol. 6 ± col. 5 ± col. Salaries Gol. 6 ± col. Salaries Gol. 6 ± co		·	Wkst Aline	Amount	Reclassi fi cat	Adiusted	Paid Hours		43 alli
Sal ari es (from Wist. A-6) Sal ari es in col. 4 col. 5)									
OVERHEAD COSTS - DIRECT SALARIES 1.00 2.00 3.00 4.00 5.00 6.00			Train 501	opor tou					
1.00 2.00 3.00 4.00 5.00 6.00						`		`	
1.00 2.00 3.00 4.00 5.00 6.00					,			33.1. 3)	
26. 00 Employee Benefits Department 4. 00 198, 807 0 198, 807 6, 133. 00 32. 42 26. 00 27. 00 Administrative & General 5. 00 4, 129, 630 0 4, 129, 630 154, 165. 00 26. 79 27. 00 28. 00 Administrative & General under contract (see inst.) 29. 00 Maintenance & Repairs 6. 00 0 0 0 0. 00 0. 00 29. 00 30. 00 0 0 0 0 0 0 0 0			1. 00	2. 00		4. 00	5. 00	6. 00	
27. 00 Administrative & General 5. 00 4, 129, 630 0 4, 129, 630 154, 165. 00 26. 79 27. 00 28. 00 Administrative & General under contract (see inst.) 29. 00 Maintenance & Repairs 6. 00 0 0 0 0 0 0 0 0 0		OVERHEAD COSTS - DIRECT SALARI	ES						
28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 0.00 Operation of Plant 7.00 Alministrative & General under contract (see inst.) 29.00 Maintenance & Repairs 0.00 Operation of Plant 7.00 Alministrative & General under contract (see inst.) 29.00 Administrative & General under contract (see inst.) 29.00 Alministrative & General under contract (see inst.) 29.00 Alministrative & General under contract (see inst.) 29.00 Alministrative & General under contract (see inst.) 29.00 Alministration Service & General under contract (see inst.) 29.00 Alministration Service & General under contract (see inst.) 29.00 Alministration Service & General under contract (see instructions) 30.00 Alministration Service & General under contract (see instructions) 30.00 Alministration Service & General under contract (see instructions) 30.00 Alministration Service & General under contract (see instructions) 30.00 Alministration Service Serv	26.00	Employee Benefits Department	4. 00	198, 807	0	198, 807	6, 133. 00	32. 42	26. 00
Contract (see inst.) Contract (see inst.)	27.00	Administrative & General	5. 00	4, 129, 630	0	4, 129, 630	154, 165. 00	26. 79	27. 00
29.00 Maintenance & Repairs 6.00 0 0 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 613,519 0 613,519 23,519.00 26.09 30.00 31.00 Laundry & Linen Service 8.00 0 29,999 29,999 1,657.00 18.10 31.00 29.00 859,120 0 859,120 0 859,120 0 57,211.00 15.02 32.00 Housekeeping under contract (see instructions) 10.00 496,202 -385,352 110,850 6,365.00 17.42 34.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28.00	Administrative & General under		420, 959	0	420, 959	1, 838. 00	229. 03	28. 00
30.00 Operation of Plant 7.00 613,519 0 613,519 23,519.00 26.09 30.00 31.00 Laundry & Linen Service 8.00 0 29,999 29,999 1,657.00 18.10 31.00 32.00 Housekeeping 9.00 859,120 0 859,120 57,211.00 15.02 32.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		contract (see inst.)							
31. 00 Laundry & Linen Service	29.00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	29. 00
32. 00 Housekeeping Housekeeping under contract (see instructions) 34. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 11. 00 Medi cal Records & Medi cal Records Library 42. 00 Soci al Service 30. 00 Housekeeping under contract (see show the start of the sta	30.00	Operation of Plant	7. 00	613, 519	0	613, 519	23, 519. 00	26. 09	30.00
33. 00 Housekeeping under contract (see instructions) 34. 00 Di etary 35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 37. 00 Maintenance of Personnel 38. 00 Nursing Administration 39. 00 Central Services and Supply 40. 00 Medical Records & Medical Records Library 42. 00 Social Service 10. 00 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 496, 202 598, 352 598, 353 598,	31.00	Laundry & Linen Service	8. 00	0	29, 999	29, 999	1, 657. 00	18. 10	31.00
See instructions See instruc	32.00	Housekeepi ng	9. 00	859, 120	0	859, 120	57, 211. 00	15. 02	32.00
34. 00 Di etary Under contract (see instructions) 36. 00 Cafeteria 11. 00 0 355, 353 355, 353 22, 187. 00 0 0.00 35. 00 38. 00 Mai ntenance of Personnel 12. 00 0 0 0.00 0.00 37. 00 38. 00 Nursi ng Administration 13. 00 505, 591 0 505, 591 13, 588. 00 37. 21 38. 00 39. 00 Central Services and Supply 14. 00 102, 560 0 102, 560 5, 886. 00 17. 42 34. 00 40. 00 Pharmacy 15. 00 591, 122 0 591, 122 13, 162. 00 44. 91 40. 00 41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 17. 00 Soci al Service 17. 00 73, 384 0 73, 384 2, 080. 00 35. 28 42. 00	33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
35. 00 Di etary under contract (see i nstructions) 36. 00 Cafeteria 11. 00 0 355, 353 355, 353 22, 187. 00 16. 02 36. 00 37. 00 Mai ntenance of Personnel 12. 00 0 0 0 0. 00 0. 00 37. 00 38. 00 Nursi ng Administrati on 13. 00 505, 591 0 505, 591 13, 588. 00 37. 21 38. 00 39. 00 Central Services and Supply 14. 00 102, 560 0 102, 560 5, 886. 00 17. 42 39. 00 40. 00 Pharmacy 15. 00 591, 122 0 591, 122 13, 162. 00 44. 91 40. 00 41. 00 Medical Records & Medical 16. 00 215, 593 0 215, 593 14, 444. 00 14. 93 41. 00 Records Li brary 42. 00 Soci al Service 17. 00 73, 384 0 73, 384 2, 080. 00 35. 28 42. 00		(see instructions)							
instructions) 36. 00 Cafeteria	34.00	Di etary	10.00	496, 202	-385, 352	110, 850	6, 365. 00	17. 42	34.00
36. 00 Cafeteria 11. 00 0 355, 353 355, 353 22, 187. 00 16. 02 36. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0. 00 37. 00 38. 00 Nursi ng Admi ni strati on 13. 00 505, 591 0 505, 591 13, 588. 00 37. 21 38. 00 Central Services and Supply 14. 00 102, 560 0 102, 560 5, 886. 00 17. 42 39. 00 40. 00 Pharmacy 15. 00 591, 122 0 591, 122 13, 162. 00 44. 91 40. 00 41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary Social Service 17. 00 73, 384 0 73, 384 2, 080. 00 35. 28 42. 00	35.00	Dietary under contract (see		0	0	0	0. 00	0. 00	35.00
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 37. 00 38. 00 Nursing Administration 13. 00 505, 591 0 505, 591 13, 588. 00 37. 21 38. 00 39. 00 Central Services and Supply 14. 00 102, 560 0 102, 560 5, 886. 00 17. 42 39. 00 40. 00 Pharmacy 15. 00 591, 122 0 591, 122 13, 162. 00 44. 91 40. 00 41. 00 Medical Records & Medical Records & Medical Records Library Social Service 17. 00 73, 384 0 73, 384 2, 080. 00 35. 28 42. 00		instructions)							
38.00 Nursi ng Admi ni strati on 13.00 505, 591 0 505, 591 13, 588.00 37.21 38.00 39.00 Central Servi ces and Supply 14.00 102, 560 0 102, 560 5, 886.00 17.42 39.00 40.00 Pharmacy 15.00 591, 122 0 591, 122 13, 162.00 44.91 40.00 41.00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 42.00 Soci al Servi ce 17.00 73, 384 0 73, 384 2, 080.00 35.28 42.00	36.00	Cafeteri a	11. 00	0	355, 353	355, 353	22, 187. 00	16. 02	36.00
39. 00 Central Services and Supply 14. 00 102, 560 0 102, 560 5, 886. 00 17. 42 39. 00 40. 00 Pharmacy 15. 00 591, 122 0 591, 122 13, 162. 00 44. 91 40. 00 41. 00 Medical Records & Medical Records & Medical Records Li brary 21. 00 73, 384 0 73, 384 2, 080. 00 35. 28 42. 00 42. 00 43. 00 44. 91 40. 00 41. 91 40. 00 41. 91	37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0. 00	37.00
40. 00 Pharmacy 15. 00 591, 122 0 591, 122 13, 162. 00 44. 91 40. 00 41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 16. 00 215, 593 0 215, 593 14, 444. 00 14. 93 41. 00 42. 00 Soci al Servi ce 17. 00 73, 384 0 73, 384 2, 080. 00 35. 28 42. 00	38.00	Nursing Administration	13.00	505, 591	0	505, 591	13, 588. 00	37. 21	38.00
41. 00 Medi cal Records & Medi cal Records & Medi cal Records Li brary 42. 00 Soci al Servi ce 17. 00 73, 384 0 73, 384 2, 080. 00 35. 28 42. 00	39.00	Central Services and Supply	14. 00	102, 560	0	102, 560	5, 886. 00	17. 42	39. 00
Records Li brary	40.00	Pharmacy	15. 00	591, 122	0	591, 122	13, 162. 00	44. 91	40.00
42. 00 Soci al Servi ce 17. 00 73, 384 0 73, 384 2, 080. 00 35. 28 42. 00	41.00	Medical Records & Medical	16. 00	215, 593	0	215, 593	14, 444. 00	14. 93	41.00
		Records Li brary							
42 00 Other Congret Services 1 19 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42.00	Social Service	17. 00	73, 384	0	73, 384	2, 080. 00	35. 28	42.00
43.00 01.1101 361 43.00 43.00 43.00	43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

near th	Tribulcius Systems		DEIGNED WEWORT	AL HOSELIAL		III LI C	d of form one z	.552 10
HOSPI T	AL WAGE INDEX INFORMATION			Provider Co		Period: From 10/01/2018 To 09/30/2019		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Sal ari es in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		29, 005, 021	0	29, 005, 02	1 982, 803. 00	29. 51	1.00
	instructions)							
2.00	Excluded area salaries (see		9, 822, 061	-21, 031	9, 801, 03	0 290, 986. 00	33. 68	2.00
	instructions)							
3.00	Subtotal salaries (line 1		19, 182, 960	21, 031	19, 203, 99	1 691, 817. 00	27. 76	3.00
	minus line 2)							
4.00	Subtotal other wages & related		849, 439	0	849, 43	9 6, 937. 00	122. 45	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		6, 554, 024	0	6, 554, 02	4 0.00	34. 13	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		26, 586, 423	21, 031	26, 607, 45	4 698, 754. 00	38. 08	6.00
7.00	Total overhead cost (see		8, 206, 487	0	8, 206, 48	7 322, 235. 00	25. 47	7.00
	instructions)							

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CM	IS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0045	Peri od: Worksheet S	S-3
		From 10/01/2018 Part IV	Prenared:

	16 09/30/2019	2/25/2020 11:4	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	ol	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	ol	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	ol	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	122, 454	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	5, 995, 787	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	517, 832	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)	0	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	92, 635	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)		ı
	TAXES		
17. 00	FICA-Employers Portion Only	2, 415, 937	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	19.00
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))		
22. 00	Day Care Cost and Allowances	0	22.00
		232, 214	
24. 00	,	9, 376, 859	24. 00
0= 0-	Part B - Other than Core Related Cost		05.00
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	l l	25. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0045	Period: Worksheet S-3 From 10/01/2018 Part V
		To 09/30/2019 Date/Time Prepared

		To 09/30/2019	Date/Time Pre 2/25/2020 11:	
	Cost Center Description	Contract	Benefit Cost	
	·	Labor		
		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	168, 987	9, 376, 859	1.00
2.00	Hospi tal	168, 987	9, 376, 859	2.00
3.00	Subprovi der - IPF			3.00
4.00	Subprovi der - I RF			4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7.00
8. 00	Hospi tal -Based SNF			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 Di al ysi s			17.00
18. 00	Other	0	0	18.00

	Financial Systems HEALTH AGENCY STATISTICAL DATA	DEKALB MEMORI	Provi der C	CN: 15-0045 CCN: 15-7157	In Lie Period: From 10/01/2018 To 09/30/2019		
					Home Health	2/25/2020 11: PPS	43 am
					Agency I		
					1.	00	-
0. 00	County		T	1	0.11		0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	<u>Total</u> 5. 00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00		1	0 0		1.00 2.00
					ployees (Full Ti		
		Enter the number your normal		Staff	Contract	Total	
		youoar	nor it moon				
		C)	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		10.00	0.9	0.00	0. 94	4.00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			1.8			
7. 00	Nursi ng Supervi sor			0.0			
8.00	Physical Therapy Service			1. 6			1
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0.0			1
11. 00	Occupational Therapy Supervisor			0.0			1
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0.0			1
14. 00	Medical Social Service			0. 5			
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0.0			1
17. 00	Home Health Aide Supervisor			1. 6			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		19. 00
	you provided services during the cost						
20. 00	reporting period. List those CBSA code(s) in column 1 serviced	ĺ		34620			20. 00
	during this cost reporting period (line 20						
20. 01	contains the first code).			99915			20. 01
		Full Ep					
		Wi thout Outliers	With Outliers	LUPA Episode	s PEP Only Epi sodes	Total (cols. 1-4)	
		1. 00	2.00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	831	258		27 13	1, 129	21.00
22. 00	Skilled Nursing Visit Charges	183, 797	57, 033				22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	318 108, 463		1	8 16 34 5, 449		
25. 00	Occupational Therapy Visits	92		1	0 5	177	1
26.00	Occupational Therapy Visit Charges	31, 552		1	0 1, 716		
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	700	10 3, 399	1	0 0	. –	
29. 00	Medical Social Service Visits	24	16		0 0		29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	8, 070 295		1	0 0 5		1
32. 00	Home Health Aide Visit Charges	38, 738		1	0 660	55, 238	
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1, 562	573	3	39	2, 209	33.00
34. 00	Other Charges	O	0		0 0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	371, 320	139, 482	8, 72	25 10, 716	530, 243	35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	103		1	13 2	118	36.00
27 00	outlier)				_		
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	12, 291	17 3, 553	1	0 94		37. 00 38. 00
				•	•		

Heal th	Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lieu of Form CMS-2552-		
H0SPI	TAL-BASED HOSPICE IDENTIFICATION	I DATA		Provi der C	CN: 15-0045	Peri od:	Worksheet S-9	
				Hoopi on CC	N. 1E 1EEO	From 10/01/2018		
				HOSPI CE CC	N: 15-1559	To 09/30/2019	Date/Time Pre 2/25/2020 11:	
						Hospi ce I	272072020 111	10 4111
		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				
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	OBER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3. 00 4. 00	Hospice Inpatient Respite Care Hospice General Inpatient Care			•				3. 00 4. 00
4. 00 5. 00	Total Hospice Days			•				5.00
5.00	Part II - CENSUS DATA FOR COST	DEDODTING DED	LODS BECLINITING	DEEUDE OCTOBE	D 1 2015			3.00
6. 00	Number of patients receiving	KLFOKIING FLK	I ODS BEGINNING	BLIOKE OCTOBE	1, 2015			6.00
0.00	hospi ce care							0.00
7. 00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
	/line 6)							
9. 00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2 $$	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST_REPORTIN	G PERLODS BEGI	NNING ON OR AF	TER OCTOBER 1		_	
10.00	1			0		0 0		10.00
11.00				2, 607		0 24		11.00
12. 00 13. 00				31		0 0 2		12. 00 13. 00
	Total Hospice Days			2, 648	1	0 26	l e	14.00
14.00	PART IV - CONTRACTED STATISTIC	AL DATA FOR CO	ST DEDODTING D					14.00
15. 00			JI KLEUKTING P	CRIODS BEGINNI		0 0		15. 00
	Hospice General Inpatient Care					0 0		16.00
10.00	1ssp. ss denoral ripation our			1	ı	91		

Heal th	Financial Systems	DEKALB MEMORIAL	HOSPI TAI		In lie	u of Form CMS-2	2552-10	
	TAL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der CC	CN: 15-0045	Peri od:	Worksheet S-1		
					From 10/01/2018 To 09/30/2019	Data/Timo Dro	narodi	
					To 09/30/2019	Date/Time Pre 2/25/2020 11:		
	·							
	h	11				1. 00		
1. 00	Uncompensated and indigent care cost computa Cost to charge ratio (Worksheet C, Part I li		ividad by Li	no 202 colum	n 0)	0.244504	1.00	
1.00	Medicaid (see instructions for each line)	THE 202 COLUMN 3 U	TVI ded by II	TIE 202 COT UIII	11 0)	0. 244586	1.00	
2.00	Net revenue from Medicaid					870, 312	2.00	
3.00	Did you receive DSH or supplemental payments	s from Medicaid?					3.00	
4.00	If line 3 is yes, does line 2 include all DS				ai d?		4. 00	
5.00	If line 4 is no, then enter DSH and/or suppl	emental payments	from Medicai	d		0		
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)					21, 311, 710 5, 212, 546		
8. 00	Difference between net revenue and costs for	Medicaid program	(line 7 min	nus sum of li	nes 2 and 5: if	4, 342, 234		
	< zero then enter zero)					., ,		
	Children's Health Insurance Program (CHIP) (see instructions	for each lin	ne)				
9.00	Net revenue from stand-alone CHIP					0		
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)					0 0		
12. 00	Difference between net revenue and costs for		(line 11 mi	nus line 9:	if < zero then	0	1	
	enter zero)		(_		
	Other state or local government indigent car				,			
13.00	Net revenue from state or local indigent car						13.00	
14. 00	Charges for patients covered under state or 10)	rocar indigent ca	re program (Not included	in lines 6 or	0	14.00	
15. 00	State or local indigent care program cost (I	ine 1 times line	14)			0	15.00	
16.00	Difference between net revenue and costs for			program (li	ne 15 minus line	0	1	
	13; if < zero then enter zero)							
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)							
17. 00							17. 00	
18. 00 19. 00	Government grants, appropriations or transfer				- (6 1!	0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP 8, 12 and 16)	and State and roc	ar indigent	care program	s (sull of fines	4, 342, 234	19.00	
	107 12 and 107			Uni nsured	Insured	Total (col. 1		
				pati ents	pati ents	+ col . 2)		
		I. 12		1. 00	2. 00	3. 00		
20. 00	Uncompensated Care (see instructions for eac Charity care charges and uninsured discounts		acility	3, 572, 14	183, 973	3, 756, 114	20 00	
20.00	(see instructions)	s for the entire i	activity	3, 372, 12	103, 773	3, 730, 114	20.00	
21.00	1 '	and uninsured disc	ounts (see	873, 69	183, 973	1, 057, 669	21.00	
	instructions)							
22. 00	Payments received from patients for amounts charity care	previously writte	n off as		0 0	0	22.00	
23. 00	1)		873, 69	183, 973	1, 057, 669	23 00	
20.00	post or sharrey sars (rins 21 minus rins 22)			0,0,0	100,770	1,007,007	20.00	
						1. 00		
24. 00	Does the amount on line 20 column 2, include				of stay limit	N	24.00	
25. 00	imposed on patients covered by Medicaid or of If line 24 is yes, enter the charges for pat				m's length of	0	25. 00	
24 00	stay limit	tal complay (sat !	nc+ruc+: ^~-\			0 440 300	24 00	
	Total bad debt expense for the entire hospit Medicare reimbursable bad debts for the enti		,			9, 440, 398 62, 033	26.00	
27. 00			•				27.00	
28. 00				,		9, 344, 962	1	
29. 00			xpense (see	instructions)	2, 319, 050	1	
30 00	Cost of uncompensated care (line 23 column 3	3 plus line 29)				3, 376, 719	1 30 00	
	Total unreimbursed and uncompensated care co	not (line 10 rl::-	line 20)			7, 718, 953		

Heal th	Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 10/01/2018 To 09/30/2019	Date/Time Pre	pared:
						2/25/2020 11:	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Reclassi fied	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1. 00	2.00	3. 00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS		2.00	0.00		0.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		4, 716, 053	4, 716, 053	0	4, 716, 053	1.00
1.01	00101 MOB WEST		34, 169	34, 169	0	34, 169	1. 01
1. 02	00102 NORTH ANNEX		5, 337		0	5, 337	1. 02
1. 03	00103 GARRETT CLINIC		27, 336				
1.04	00104 BUTLER		8, 816	1		8, 816	
1. 05 1. 07	00105 MOB EAST 00107 MEDICAL ARTS		192, 000 66, 060			192, 000 66, 060	
1. 07	00107 MEDICAL ARTS		4, 996			4, 996	
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0,770	1, , ,	o o	0	2.00
3.00	00300 OTHER CAP REL COSTS		0	C	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	198, 807	7, 439, 206	7, 638, 013	0	7, 638, 013	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	4, 129, 630	7, 704, 279			11, 828, 663	
7.00	00700 OPERATION OF PLANT	613, 519	1, 762, 839	1		2, 376, 358	
8. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 120	404 721	1			
9. 00 10. 00	01000 DI ETARY	859, 120 496, 202	406, 731 396, 309			1, 265, 851 200, 191	
10. 00	01001 SNACK BAR	470, 202	370, 307	1		200, 191	1
11. 00	01100 CAFETERI A	Ö	0		662, 321	662, 321	
13.00	01300 NURSING ADMINISTRATION	505, 591	71, 630	577, 221		577, 221	1
14.00	01400 CENTRAL SERVICES & SUPPLY	102, 560	125, 906	228, 466	0	228, 466	14. 00
	01500 PHARMACY	591, 122	43, 424			634, 546	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	215, 593	53, 277				1
17. 00	01700 SOCI AL SERVI CE	73, 384	5, 623	79, 007	' O	79, 007	17.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 580, 788	553, 819	3, 134, 607	-744, 953	2, 389, 654	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 003, 425	341, 403			1, 344, 828	
43. 00	04300 NURSERY	0	0	1			1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 686, 601	1, 378, 969	3, 065, 570		3, 065, 570	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(,		
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 769, 774	709, 328			2, 479, 102	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	1, 189, 354 0	1, 802, 593 0	1		2, 991, 947 0	1
65. 00	06500 RESPIRATORY THERAPY	611, 602	107, 690	1	-	719, 292	
66. 00	06600 PHYSI CAL THERAPY	297, 908	992, 040			1, 289, 948	
66. 01	06601 CARDI AC REHAB	144, 121	19, 583			184, 735	
69. 00	06900 ELECTROCARDI OLOGY	139, 662	10, 922	150, 584	0	150, 584	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	35, 396	21, 981				
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PAT	0	1, 553, 673			1, 553, 673	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	970, 613 3, 352, 485	1			
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	3, 332, 463	3, 332, 460)	3, 332, 463	73.00
90.00	09000 CLINIC	54, 019	37, 209	91, 228	3 0	91, 228	90.00
	09100 EMERGENCY	1, 463, 823	203, 753				1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES 09910 CORF	1, 221, 686	335, 226				1
	10100 HOME HEALTH AGENCY	0 694, 164	0 140, 343				
101.00	SPECIAL PURPOSE COST CENTERS	074, 104	140, 343	034, 307	0	034, 307	1101.00
113.00	11300 I NTEREST EXPENSE		0	(0	0	113.00
116.00	11600 HOSPI CE	127, 312	300, 072	427, 384	0	427, 384	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	20, 805, 163	35, 895, 693	56, 700, 856	15, 785	56, 716, 641	118. 00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		-		190.00
	19100 RESEARCH 19200 PHYSICIANS PRIVATE OFFICES	0	0	(0		191. 00 192. 00
	19201 DEKALB MEDICAL SERVICES	6, 720, 836	1, 083, 918	7, 804, 754	-		
	19202 PHARMACARE	816, 038	6, 182, 465			6, 998, 503	
	19203 OUTSOURCED DIETICIAN	31, 855	2, 426				192. 03
192. 04	19204 BUSI NESS HEALTH	143, 726	81, 813		0	225, 539	192. 04
	19300 NONPALD WORKERS	0	0	(0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0	(-		194.00
	07951 ADULT DAY CARE 07952 FOUNDATI ON	0 66, 444	79, 074	145, 518	0 0		194.01
200.00		28, 584, 062	43, 325, 389	1			
200.00	1.5 (55 5. 2 116 till odgi 177)	20, 00 1, 002	.5, 525, 507	7.,707,40	١	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,_00.00

 Health Financial
 Systems
 DEKALB MEM

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0045 | Peri od: From 10/01/20

Peri od: Worksheet A From 10/01/2018 To 09/30/2019 Date/Time Prepared:

				2/25/2020	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	00100 CAP REL COSTS-BLDG & FLXT	-367, 144	4, 348, 909		1.00
1. 01	00101 MOB WEST	-34, 169	0		1. 01
1. 02	00102 NORTH ANNEX	-5, 337	o l		1. 02
1. 03	00103 GARRETT CLINIC	-27, 336	o		1.03
1. 04	00104 BUTLER	0	8, 816		1.04
1.05	00105 MOB EAST	-192, 000	0		1.05
1.07	00107 MEDI CAL ARTS	0	66, 060		1.07
1.08	00108 SMALTZ WAY	0	4, 996		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	-608, 475	7, 029, 538		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-4, 111, 066	7, 717, 597		5. 00
7. 00	00700 OPERATION OF PLANT	-3, 497	2, 372, 861		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	29, 999		8. 00
9. 00	00900 HOUSEKEEPI NG	-528	1, 265, 323		9. 00
10.00	01000 DI ETARY	0	200, 191		10.00
10. 01	01001 SNACK BAR	0	0		10. 01
11.00	01100 CAFETERI A	-251, 656	410, 665		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	577, 221		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	228, 466		14.00
15. 00	01500 PHARMACY	1 024	634, 546		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-1, 034	267, 836		16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	79, 007		17. 00
30. 00	03000 ADULTS & PEDIATRICS	-7, 719	2, 381, 935		30.00
31. 00	03100 INTENSIVE CARE UNIT	-7, 719 -7, 719			31.00
43. 00	04300 NURSERY	-7,717			43.00
43.00	ANCILLARY SERVICE COST CENTERS		200, 170		
50. 00	05000 OPERATING ROOM	-858, 934	2, 206, 636		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	538, 783		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-33, 182	2, 445, 920		54.00
60.00	06000 LABORATORY	-11, 704	2, 980, 243		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
65.00	06500 RESPIRATORY THERAPY	0	719, 292		65.00
66.00	06600 PHYSI CAL THERAPY	-16, 491	1, 273, 457		66. 00
66. 01	06601 CARDI AC REHAB	-11, 264	173, 471		66. 01
69.00	06900 ELECTROCARDI OLOGY	0	150, 584		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	57, 377		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1, 553, 673		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	970, 613		72.00
73. 00		-9, 450	3, 343, 035		73. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0			90.00
91.00	09100 EMERGENCY	0	1, 667, 576		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT				92. 00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	-250, 746	1, 306, 166		95.00
	09910 CORF	-230, 740	1, 300, 100		99. 10
	10100 HOME HEALTH AGENCY	-172	834, 335		101.00
101.00	SPECIAL PURPOSE COST CENTERS	172	034, 333		101.00
113. 00	11300 I NTEREST EXPENSE	0	0		113.00
116.00	11600 H0SPI CE	-98	427, 286		116.00
118.00		-6, 809, 721	49, 906, 920		118.00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		190. 00
191.00	19100 RESEARCH	0	0		191.00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0	0		192. 00
	1 19201 DEKALB MEDICAL SERVICES	0	7, 788, 969		192. 01
	2 19202 PHARMACARE	0	6, 998, 503		192. 02
	19203 OUTSOURCED DIETICIAN	0	34, 281		192. 03
	1 19204 BUSI NESS HEALTH	0	225, 539		192. 04
	19300 NONPALD WORKERS	0	0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0		194. 00
	07951 ADULT DAY CARE	0	0		194. 01
	2 07952 FOUNDATION	0	145, 518		194.02
200. 00	TOTAL (SUM OF LINES 118 through 199)	-6, 809, 721	65, 099, 730		200. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0045	Peri od: From 10/01/2018 To 09/30/2019

					2/25/2020 11:	: 43 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - CAFETERIA RECLASS					
1.00	CAFETERI A	1100	<u>355, 3</u> 53	306, 968		1.00
	0		355, 353	306, 968]
	B - LABOR DELIVERY NURSERY					
1.00	NURSERY	43. 00	177, 282	28, 888		1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	<u>463, 2</u> 91	7 <u>5, 4</u> 92		2.00
	0		640, 573	104, 380]
	C - NORTH ANNEX RECLASS					
1. 00	DEKALB MEDICAL SERVICES	1 <u>92.</u> 01	0_	<u>5, 2</u> 46		1.00
	0		0	5, 246]
	E - PHYSICIAN RECLASS					
1. 00	CARDI AC REHAB	6601	2 <u>1, 0</u> 31	0		1.00
	0		21, 031	0]
	F - LAUNDRY SALARY RECLASS					
1. 00	LAUNDRY & LINEN SERVICE	8. 00	+	0		1.00
	0		29, 999	0		
500.00	Grand Total: Increases		1, 046, 956	416, 594		500.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN: 15-0045	Period: Worksheet A-6

					То	09/30/2019 Date/Time Pr 2/25/2020 11	epared: :43 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	1000	35 <u>5, 3</u> 53	306, 968	0		1.00
	0		355, 353	306, 968			
	B - LABOR DELIVERY NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	640, 573	104, 380	0		1.00
2.00		0.00	0_	0	0		2.00
	0		640, 573	104, 380			
	C - NORTH ANNEX RECLASS						
1.00	ADMI NI STRATI VE & GENERAL		0	<u>5, 2</u> 46			1.00
	0		0	5, 246			
	E - PHYSICIAN RECLASS						
1. 00	DEKALB MEDICAL SERVICES	1 <u>92.</u> 01	2 <u>1, 0</u> 31	0	0		1.00
	0		21, 031	0			_
	F - LAUNDRY SALARY RECLASS						
1. 00	DI ETARY	1000	<u> </u>	0	0		1.00
	0		29, 999	0			
500.00	Grand Total: Decreases		1, 046, 956	416, 594			500.00

				To	09/30/2019	Date/Time Pre 2/25/2020 11:	
				Acqui si ti ons		2/23/2020 11.	45 diii
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	393, 118	0	0	0	45, 326	1.00
2.00	Land Improvements	1, 808, 464	49, 450	0	49, 450	0	2.00
3.00	Buildings and Fixtures	61, 162, 990	155, 060	0	155, 060	0	3.00
4.00	Building Improvements	203, 151	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	27, 312, 434	1, 845, 676	0	1, 845, 676	582, 826	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	90, 880, 157	2, 050, 186	0	2, 050, 186	628, 152	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	90, 880, 157	2, 050, 186	0	2, 050, 186	628, 152	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	347, 792	0				1.00
2.00	Land Improvements	1, 857, 914	0				2.00
3.00	Buildings and Fixtures	61, 318, 050	0				3.00
4. 00	Building Improvements	203, 151	0				4. 00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	28, 575, 284	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	92, 302, 191	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	92, 302, 191	0				10.00

Period: Worksheet A-7
From 10/01/2018 Part II

				To	09/30/2019	Date/Time Pre 2/25/2020 11:	pared: 43 am
			SU	MMARY OF CAPITA	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9. 00	10. 00	11. 00	12. 00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00	CAP REL COSTS-BLDG & FIXT	4, 372, 322	0	343, 731	0	0	1.00
1. 01	MOB WEST	34, 169	o	0	0	0	1. 01
1.02	NORTH ANNEX	5, 337	0	0	0	0	1.02
1.03	GARRETT CLINIC	27, 336	0	0	0	0	1.03
1.04	BUTLER	8, 816	0	0	0	0	1. 04
1. 05	MOB EAST	192, 000	0	0	0	0	1.05
1. 07	MEDI CAL ARTS	66, 060	0	0	0	0	1. 07
1. 08	SMALTZ WAY	4, 996	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)	4, 711, 036	0	343, 731	0	0	3.00
		SUMMARY OF	CAPI TAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM		ınd 2			
1. 00	CAP REL COSTS-BLDG & FIXT	0	4, 716, 053				1.00
1. 01	MOB WEST	0	34, 169				1.01
1. 02	NORTH ANNEX	0	5, 337				1.02
1.03	GARRETT CLINIC	0	27, 336				1.03
1.04	BUTLER	0	8, 816				1.04
1. 05 1. 07	MOB EAST MEDICAL ARTS		192, 000 66, 060				1. 05 1. 07
1. 07	SMALTZ WAY		4, 996				1.07
2. 00	CAP REL COSTS-MVBLE EQUIP		4, 996				2.00
3. 00	Total (sum of lines 1-2)	0	5, 054, 767				3.00
3.00	Total (Sum Of Titles 1-2)	ı o	5,054,707				J 3.00

Health	i Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0045 P	eri od:	Worksheet A-7	
				F	rom 10/01/2018		
				T	o 09/30/2019	Date/Time Pre	oared:
						2/25/2020 11:	43 am_
		COM	PUTATION OF RAT	TLOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance	
	cost center bescription	01033 733613				i iisui ance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	92, 302, 191	0	92, 302, 191	1. 000000	0	1.00
1. 01	MOB WEST	72,002,171	Ö		0. 000000	Ö	1. 01
			l .	1		1	
1. 02	NORTH ANNEX	0	0			0	1. 02
1. 03	GARRETT CLINIC	0	0	0	0. 000000	0	1. 03
1.04	BUTLER	0	0	0	0.000000	0	1.04
1.05	MOB EAST	0	0	0	0.000000	0	1.05
1. 07	MEDI CAL ARTS		0	0		ol	1. 07
1. 08	SMALTZ WAY		٥	0	0. 000000	0	1. 08
		0	0	_			
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	_	0. 000000	0	2.00
3.00	Total (sum of lines 1-2)	92, 302, 191	0		1. 000000		3.00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	, , , , , , , , , , , , , , , , , , ,		Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	DART III DECONCILIATION OF CARLTAL COSTS O		7.00	0.00	7.00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C				4 040 000		4 00
1. 00	CAP REL COSTS-BLDG & FIXT	0	1	1	· · ·	0	1.00
1. 01	MOB WEST	0	0	0	0	0	1. 01
1. 02	NORTH ANNEX	0	0	0	0	0	1.02
1.03	GARRETT CLINIC	0	0	0	0	0	1.03
1.04	BUTLER	0	0	0	8, 816	0	1.04
1. 05	MOB EAST	1	0	1	0,010	o o	1. 05
1. 07	MEDICAL ARTS		0	_	66, 060	o o	1. 07
			-	_			
1. 08	SMALTZ WAY	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, 428, 781	0	3.00
			Sl	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)	Tristractions)		9 through 14)	
			I listi ucti olis)			7 till ough 14)	
		11 00	12.00	12.00	instructions)	15.00	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	0	0	0	0	4, 348, 909	1.00
1.01	MOB WEST	0	0	0	0	0	1. 01
1. 02	NORTH ANNEX	0	l o	0	0	l ol	1.02
1. 03	GARRETT CLINIC	1	0			0	1. 03
1. 04	BUTLER		0	1		8, 816	1. 03
			1	1			
1. 05	MOB EAST	0	0	_		0	1. 05
1. 07	MEDI CAL ARTS	0	0	1		66, 060	1. 07
1.08	SMALTZ WAY	0	0	0	0	4, 996	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	0	4, 428, 781	3.00
	1	'	'	'	'	.,,, .	

	Financial Systems		DEKALB MEMORIAL			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES			Provi der CCN: 15-0045	Peri od: From 10/01/2018 To 09/30/2019		pared:
			То	L Expense Classification of From Which the Amount i		2/25/2020 11:	43 am
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	040.05	1. 00	2.00	3.00	4.00	5. 00	4 00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	·	P REL COSTS-BLDG & FIXT B WEST	1.00	11	1. 00 1. 01
1. 01 1. 02	Investment income - MOB WEST (chapter 2) Investment income - NORTH			RTH ANNEX	1. 01	0	1.01
1. 02	ANNEX (chapter 2) Investment income - GARRETT			RRETT CLINIC	1. 02	0	1. 02
1. 03	CLINIC (chapter 2) Investment income - BUTLER			TLER	1. 03	0	1.03
1. 04	(chapter 2) Investment income - MOB EAST			B EAST	1. 04	0	1. 04
1. 03	(chapter 2) Investment income - MEDICAL			DICAL ARTS	1. 05	0	1. 03
1. 07	ARTS (chapter 2) Investment income - SMALTZ WAY			ALTZ WAY	1. 07	0	1.07
2. 00	(chapter 2) Investment income - CAP REL			P REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0	F REE COSTS-WINDER EQUIF	0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay				0. 00	0	7. 00
	stations excluded) (chapter 21)					·	
8. 00	Television and radio service (chapter 21)		o		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -906, 797		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	o			0	
13. 00	transactions (chapter 10) Laundry and linen service		o		0. 00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-251, 656 CA	FETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical		o		0. 00	0	
	supplies to other than patients						
17. 00	Sale of drugs to other than patients	В	-9, 450 DR	UGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-1, 034 ME	DICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00 0. 00	0	20. 00 21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		o		0.00	0	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	O RE:	SPI RATORY THERAPY	65. 00		23. 00
24. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	O PH'	YSI CAL THERAPY	66. 00		24. 00

Peri od: Peri od: From 10/01/2018 To 09/30/2019 Date/Time Prepared: 2/25/2020 11:43 am

						2/25/2020 11:	43 am_
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					,		
	Coot Conton December on	Dool o /Codo	Amount	Cost Center	line #	Wkst. A-7	
	Cost Center Description	Basi s/Code	Amount	cost center	Li ne #		
		(2)	0.00	0.00		Ref.	
	I	1. 00	2. 00	3. 00	4. 00	5. 00	
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
	(chapter 21)						
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
	COSTS-BLDG & FLXT						
26. 01	Depreciation - MOB WEST		0	MOB WEST	1. 01	0	26. 01
26. 02	Depreciation - NORTH ANNEX			NORTH ANNEX	1. 02	0	1
	Depreciation - GARRETT CLINIC			GARRETT CLINIC	1. 03	0	26. 03
	1 -				1	0	
26. 04	Depreciation - BUTLER			BUTLER	1. 04	0	
26. 05	Depreciation - MOB EAST			MOB EAST	1. 05	0	
	Depreciation - MEDICAL ARTS			MEDICAL ARTS	1. 07	0	26. 07
26. 08	Depreciation - SMALTZ WAY		0	SMALTZ WAY	1. 08	0	26. 08
27.00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27.00
	COSTS-MVBLE EQUIP						
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0	0001 0011101 2010104	0.00	0	
	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	67. 00	O	30.00
30.00		H-0-3	0	Cost center bereted	07.00		30.00
	therapy costs in excess of						
20.00	limitation (chapter 14)			ADULTO A DEDLATRICO	20.00		00.00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	i nstructi ons)						
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
	Depreciation and Interest						
33.00	MI'SC HUMAN RESOURCE REVENUE	В	2, 597	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.00
	MISCELLANEOUS INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	ı
33. 02	MISC. MAINTENANCE INCOME	В	· ·	OPERATION OF PLANT	7. 00	0	1
	MISC. HOUSEKEEPING INCOME	В		HOUSEKEEPI NG	9. 00	0	1
	1	В		1		-	•
33. 04	MI SC SUGERY REVENUE			OPERATING ROOM	50. 00	0	
	MISC X-RAY REVENUE	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	
33. 06	MISC LAB REVENUE	В		LABORATORY	60. 00	0	
33. 07	MISC. ST REVENUE	В	-16, 491	PHYSI CAL THERAPY	66. 00	0	33. 07
33. 08	MISC. CARDIAC REHAB REVENUE	В		CARDI AC REHAB	66. 01	0	33. 08
33. 09	EMS COUNTY SUBSIDY	В	-250, 746	AMBULANCE SERVICES	95. 00	0	33. 09
	RENTAL INCOME	В		MOB WEST	1. 01	9	33. 10
33. 11	RENTAL I NCOME	В		MOB EAST	1. 05	9	
	RENTAL INCOME	В		NORTH ANNEX	1. 02	9	
	1	В			•	9	1
	RENTAL INCOME			GARRETT CLINIC	1. 03		
	RENTAL INCOME	В		CAP REL COSTS-BLDG & FLXT	1. 00	9	00. 11
33. 15	NON-ALLOWABLE MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
33. 16		А	-74	HOSPI CE	116. 00	0	33. 16
	- HOS						
33. 17	FLOWER/GI FTS	Α	-24	HOSPI CE	116. 00	0	33. 17
	FLOWER/GI FTS	Α	-4, 070	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
	HAF FEE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	1
	SELF-INSURANCE EXP	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 21	DONATION EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
	4				•		1
33. ZZ	LOBBYING PORTION OF LAHHC DUES	А	-1/2	HOME HEALTH AGENCY	101. 00	0	33. 22
FO 00	- HHA		/ 000 701				F0 00
50.00	TOTAL (sum of lines 1 thru 49)		-6, 809, 721				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						<u> </u>
(1) Do	scription - all chapter referen	coc in this co	lump portoin t	o CMC Dub 1E 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.

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 10/01/2018 To 09/30/2019 Date/Time Prepared: Provi der CCN: 15-0045

					-	Γο 09/30/2019	Date/Time Pre 2/25/2020 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	75 am
		I denti fi er	Remuneration	Component	Component	THE THIOGHT	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	32, 897			271, 900	0	1.00
2.00	50.00	OPERATING ROOM	638, 809	638, 809		2077 100	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	2, 673	0	2, 673	239, 400	81	3.00
4.00		ADULTS & PEDIATRICS	153, 375			197, 500	1, 534	4.00
5.00		INTENSIVE CARE UNIT	153, 375	0	153, 375			5.00
6.00	50.00	OPERATING ROOM	714		714			6.00
7.00		OPERATING ROOM	254, 500	0	254, 500	197, 500	367	7.00
8.00	50.00	OPERATING ROOM	22, 875	0	22, 875	211, 500	229	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0		0	10.00
200.00			1, 259, 218					200.00
	Wkst. A Line #	1	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1 00	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	1.00
1.00		RADI OLOGY-DI AGNOSTI C	0		_	-	0	1.00
2.00		OPERATING ROOM	0 222	0			0	2.00
3.00		ADMINISTRATIVE & GENERAL	9, 323		_	1	0	3.00
4. 00		ADULTS & PEDIATRICS	145, 656			_	0	4.00
5. 00	1	INTENSIVE CARE UNIT	145, 656					5.00
6. 00		OPERATING ROOM	1, 709			0	0	6.00
7. 00 8. 00		OPERATING ROOM OPERATING ROOM	34, 847 23, 285			0	0	7. 00 8. 00
9. 00	0.00		23, 285	1, 164 0		0	0	9. 00
10.00	0.00	1		0	0	0	0	10. 00
200.00	0.00		360, 476	1	_	1	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		Tueller Tref	Share of col.		Di Sai i Gwanee			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		RADI OLOGY-DI AGNOSTI C	0	0	0	32, 897		1.00
2.00	50.00	OPERATING ROOM	0	0	0	638, 809		2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	0	9, 323	0	0		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	145, 656	7, 719	7, 719		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	145, 656	7, 719	7, 719		5.00
6.00		OPERATING ROOM	0	1, 709				6.00
7.00	50.00	OPERATING ROOM	0	34, 847	219, 653	219, 653		7.00
8.00	50.00	OPERATING ROOM	0	23, 285	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	360, 476	235, 091	906, 797		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 10/01/2018 | Part I | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-0045

				To 09/30/2019 Date/Time Pro 2/25/2020 11:				
					CAPI TAL REI	LATED COSTS		
		Cost Center Description	Net Expenses	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT	
			for Cost Allocation				CLINIC	
			(from Wkst A					
			col. 7)	1.00	1 01	1.00	1 02	
	GENER	AL SERVICE COST CENTERS	0	1. 00	1. 01	1. 02	1. 03	
1.00	00100	CAP REL COSTS-BLDG & FIXT	4, 348, 909					1.00
1. 01 1. 02		MOB WEST NORTH ANNEX	0	0 0	0	0		1. 01 1. 02
1. 03		GARRETT CLINIC	0	o	0	o	0	1
1. 04		BUTLER	8, 816	0	0	O	0	
1. 05 1. 07		MOB EAST MEDICAL ARTS	0 66, 060		0	0	0	
1. 08	1	SMALTZ WAY	4, 996	o	0	o	0	1
2.00		CAP REL COSTS-MVBLE EQUIP	7 020 520		0		0	2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	7, 029, 538 7, 717, 597	456, 179	0	0	0	
7. 00	00700	OPERATION OF PLANT	2, 372, 861	1, 751, 395	0	o	0	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	29, 999 1, 265, 323		0	0	0	1
10.00		DI ETARY	1, 265, 323 200, 191	41, 693 21, 884	0		0	1
10. 01	1	SNACK BAR	0	0	0	O	0	
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	410, 665 577, 221	67, 530 23, 151	0	0	0	
14.00		CENTRAL SERVICES & SUPPLY	228, 466		0	0	0	1
15.00	01500	PHARMACY	634, 546	25, 291	0	0	0	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	267, 836 79, 007	28, 349 3, 582	0	0	0	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS	79,007	3, 302	0	<u> </u>	0	17.00
		ADULTS & PEDIATRICS	2, 381, 935		0	0	0	
31. 00 43. 00	1	INTENSIVE CARE UNIT NURSERY	1, 337, 109 206, 170		0	I I	0	
43.00		LARY SERVICE COST CENTERS	200, 170	17, 402	0	<u> </u>	0	43.00
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	2, 206, 636		0	I I	0	
54.00		RADI OLOGY-DI AGNOSTI C	538, 783 2, 445, 920		0	0	0	1
60.00	06000	LABORATORY	2, 980, 243	91, 489	0	O	0	1
60. 01 65. 00	1	BLOOD LABORATORY RESPI RATORY THERAPY	0 719, 292	0 23, 850	0	0	0	60. 01 65. 00
66.00	1	PHYSI CAL THERAPY	1, 273, 457	113, 919	0	ő	0	1
66. 01		CARDI AC REHAB	173, 471	59, 952	0	0	0	
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	150, 584 57, 377	0	0	0	0	
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1, 553, 673	O	0	Ö	0	1
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	970, 613	0	0	0	0	
73.00		TIENT SERVICE COST CENTERS	3, 343, 035	0	0	l ol	0	73. 00
	09000	CLI NI C	91, 228		O	١		90.00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT	1, 667, 576	168, 083	0	0	0	91. 00 92. 00
	OTHER	REIMBURSABLE COST CENTERS						
95. 00 99. 10		AMBULANCE SERVICES	1, 306, 166	17, 931 0	0	0		95. 00 99. 10
101.00	10100	HOME HEALTH AGENCY	834, 335		0			101.00
	SPECI	AL PURPOSE COST CENTERS						1
		I NTEREST EXPENSE HOSPI CE	427, 286	6, 552	0	0	0	113. 00 116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49, 906, 920		0			118.00
100.00		IMBURSABLE COST CENTERS GIFT FLOWER COFFEE SHOP & CAN	0	٥	0		0	100.00
		RESEARCH	0	0 0	0	0		190. 00 191. 00
		PHYSICIANS PRIVATE OFFICES	0	О	0	O	0	192. 00
	1	DEKALB MEDICAL SERVICES PHARMACARE	7, 788, 969 6, 998, 503		0	0		192. 01 192. 02
		OUTSOURCED DIETICIAN	34, 281	o	0	o		192. 02
192. 04	19204	BUSINESS HEALTH	225, 539	0	0	O		192.04
		NONPALD WORKERS OTHER NONREIMBURSABLE COST CENT	0	0	0	0		193. 00 194. 00
194. 01	07951	ADULT DAY CARE	0	o	0	0	0	194. 01
		FOUNDATION	145, 518	0	0	0	0	194. 02
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers		0	0	o	0	200. 00 201. 00
202.00		TOTAL (sum lines 118 through 201)	65, 099, 730	4, 348, 909	0	o		202. 00

1.03 00103 CARRETT CLINIC				CAF	PITAL RELATED CO	STS	2/25/2020 11:	43 am
CEMERAL SERVICE COST CENTERS 1.04 1.05 1.07 1.08 2.00		Cost Center Description	BUTI FR	MOB FAST	MEDICAL ARTS	SMALTZ WAY	MVBLE FOLLE	
1.00		,						
1. 0.0 00100 MOST MEST	4 00		1					1 00
1. 02 00102 NORTH ANNEX 1. 10		1						
1.03 00103 GARRETT CLINIC 1.04 00104 BUTLER 8,816 1.0 0.0104 BUTLER 1.0 0.0105 MOB EAST 0 0 0 0 0.0 0.0 0.0 1.0 0.0105 MOB EAST 0 0 0 0 0.0								1.02
1.05	1.03	1						1.03
1. 07 00107 MEDICAL ARTS 0		1						1. 04
1. 08 00108 SMALTZ WAY 0 0 0 4,996 1.00 2.00 00200 CAP PEL COSTS-MYBLE EQUIP 0 0 0 0 0 0 0 0 0			0	(1.05
2. 00 00200 CAP REL COSTS-MBILE EQUIP 0 0 0 0 0 0 0 0 0			0	(06,060	4 996		
4.00 00400 EMPLOYCE BENEFITS DEPARTMENT 0				,]	4, 770	0	
7. OO 00700 00FRATI ON OF PLANT		1 1	o	(o	0	0	
8. 00 00800 LAUNDRY & LINEN SERVICE			0	(0	0		1
9.00 00900 HOUSEKEEPING		1 1	0	(6, 217	0		
10.0 01000 DI TARY 0 0 0 0 0 0 0 0 0			0	(0		1
10.0 01001 SNACK BAR		1		(0		
13.00 01300 NURSING ADMINISTRATION 0 0 0 0 13.00 14.00 101400 (ENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 15.00 01500 PHARMACY 0 0 0 0 0 0 15.00 01500 PHARMACY 0 0 0 0 0 16.00 01500 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 17.00 10700 SOCIAL SERVICE 0 0 0 0 0 17.00 10700 SOCIAL SERVICE COST CENTERS			O	(o o	0		
14. 00 01400 CENTRAL SERVICES & SUPPLY			0	(0	0		
15. 00 01500 PHARMACY 0 0 0 0 0 0 0 15. 0 16. 00 01600 MEDI CAL RECORDS & LIBRARY 0 0 0 0 0 0 0 17. 00 01700 SOCI AL SERVICE 0 0 0 0 0 0 18. 00 01700 SOCI AL SERVICE COST CENTERS			0	(0	0		
16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 0 0 16. 00 17. 00 01700 SOCI AL SERVI CE 0 0 0 0 0 0 0 INPATI ENT ROUTINE SERVI CE COST CENTERS			0	(0		
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 17.00			1 1	(0		
INPATIENT ROUTINE SERVICE COST CENTERS			- 1	(0		
31.00 03100 INTENSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS						
43. 00					1			
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 DERATI NG ROOM 0 0 0 0 0 0 50.00 52. 00 05000 DELYERY ROOM & LABOR ROOM 0 0 0 0 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 52. 00 60. 00 06000 LABORATORY 624 0 0 0 0 0 660. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 660. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 660. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 660. 00 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 660. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					
50, 00 05000 OPERATI NG ROOM 0 0 0 0 0 0 0 0 0	43.00		<u> </u>		<u> </u>			43.00
54. 00	50.00		0	(0	0	0	50.00
60. 00 06000 LABORATORY 624 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	(0	0		
60. 01		1	1	(0	0		
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 66. 00 66. 01 06601 CARDI AC REHAB 0 0 0 0 0 0 0 0 0 0 0 66. 00 0 0 0 0 0			1 1	(0		1
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 66. 01 06601 CARDI AC REHAB 0 0 0 0 0 0 0 0 0			0	(0		
69. 00			o o	(0		1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70. 00 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0		1 1	0	(0	0		
71. 00			0	(0	0		1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			0	(0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00				(0		1
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 92. 00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 95. 00 09910 CORF 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 10100 HOME HEALTH AGENCY 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 1600 HOSPI CE 0 0 0 0 0 116. 00 116. 00 116. 00 1000 HOSPI CE 0 0 0 0 0 0 0 117. 00 09100 09100 00 0 0 0 0 0 0 118. 00 116. 00 00 0 0 0 0 0 0 119. 00 00 00 00 00 0 110. 00 00 00 00 00 0 110. 00 00 00 00 0 110. 00 00 00 00 00 110. 00 00 00 00 00 110. 00 00 00 00 110. 00 00 00 00 110. 00 00 00 00 110. 00 00 00 00 110. 00 00 00 00 110. 00 00 00 00 110. 00 00 00 00 110. 00 00 00 00 110. 00 00 00 110. 00 00 00 00 110. 00 00 00 00 110. 00				(0		
91. 00								
92. 00			1					1
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 0 0 0 0 0 116. 00			0	(O	0	
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 95. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 99. 11 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 0 0 0 0 0 0 116. 00 116.	92.00							92.00
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116.00 HOSPI CE 0 0 0 0 0 0 116.00		09500 AMBULANCE SERVICES	0	(0	0	0	95.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 116.00 11600 HOSPI CE 0 0 0 0 116.00			0	(0	0		
113. 00 11300 NTEREST EXPENSE 116. 00 1 1600 HOSPI CE 113. 00 0 0 0 0 0 0 116. 00	101. 00		0	(0	0	0	101.00
116. 00 11600 HOSPI CE 0 0 0 0 0 0 116. 0	112 00							112 00
			0	(0	0	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 624 0 6,217 0 0 118.00	118. 00		624			0		118.00
NONREI MBURSABLE COST CENTERS								
190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 0 0 190. 00				(0	0		
191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192. 00			1	(0		
192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 192. 00		1 1		(59 843	4 996		
192. 02 19202 PHARMACARE 0 0 0 0 0 0 192. 0.	192. 02	19202 PHARMACARE	0, 1,2	(0 0	0		
192. 03 19203 OUTSOURCED DIETICIAN 0 0 0 0 0 192. 0.	192. 03	19203 OUTSOURCED DIETICIAN	0	(0	0	0	192. 03
192. 04 19204 BUSI NESS HEALTH 0 0 0 192. 0		1 1	0	(0	0		
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 0 0 0 194. 00 0 0 0 194. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	(0		
194. 00 07950 0THER NONKETMBURSABLE COST CENT 0 0 0 0 0 194. 01 194. 01 07951 ADULT DAY CARE 0 0 0 0 0 0 194. 0				(0		
194. 02 07952 FOUNDATION 0 0 0 0 194. 0				(0		
200.00 Cross Foot Adjustments 200.00	200.00	Cross Foot Adjustments						200.00
201.00 Negative Cost Centers 0 0 0 0 201.00			0			0		
202.00 TOTAL (sum lines 118 through 201) 8,816 0 66,060 4,996 0 202.00	202.00		ا 8, 816	(ال 66, 060	4, 996	0	1202.00

Peri od: Worksheet B From 10/01/2018 Part I To 09/30/2019 Date/Ti me Prepared:

				''	0 09/30/2019	2/25/2020 11:	
	Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		DEPARTMENT 4. 00	4A	5. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS			0.00	7.00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 MOB WEST						1. 01
1. 02	00102 NORTH ANNEX						1. 02
1. 03	00103 GARRETT CLINIC						1. 03
1.04	00104 BUTLER						1.04
1. 05 1. 07	OO105 MOB EAST OO107 MEDICAL ARTS						1. 05 1. 07
1. 07	00107 MEDICAL ARTS						1.07
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	7, 029, 538					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 022, 695	9, 196, 471	9, 196, 471			5. 00
7.00	00700 OPERATION OF PLANT	151, 937	4, 282, 410	704, 486	4, 986, 896		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	7, 429	63, 505	10, 447	39, 731	113, 683	8. 00
9.00	00900 HOUSEKEEPI NG	212, 759	1, 519, 775	250, 014	66, 052	4, 726	9. 00
10.00	01000 DI ETARY	27, 452	249, 527			794	10.00
10. 01	01001 SNACK BAR	0	0	0	0	0	10. 01
11.00	01100 CAFETERI A	88, 002	566, 197	93, 143		0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	125, 209 25, 399	725, 581	119, 363		0	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	146, 390	281, 362 806, 227			0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	53, 391	349, 576			0	16.00
17. 00	01700 SOCIAL SERVICE	18, 173	100, 762			0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			,	27 . 5 .]		
30.00	03000 ADULTS & PEDIATRICS	480, 490	3, 118, 525	513, 019	390, 191	23, 007	30.00
31.00	03100 INTENSIVE CARE UNIT	248, 496	1, 694, 348	278, 732	165, 680	9, 853	31.00
43.00	04300 NURSERY	43, 904	269, 556	44, 344	29, 682	1, 617	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	417, 683	3, 011, 788			20, 282	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	114, 733	954, 825			4, 410	52.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	438, 281 294, 541	3, 087, 644 3, 366, 897	507, 939 553, 878		13, 295 69	54. 00 60. 00
60. 00	06001 BLOOD LABORATORY	294, 541	3, 300, 697 0	0 0 0	177, 193	09	60.00
65. 00	06500 RESPI RATORY THERAPY	151, 462	894, 604	147, 169		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	73, 776	1, 461, 152			2, 299	66.00
66. 01	06601 CARDI AC REHAB	40, 900	274, 323			645	66. 01
69.00	06900 ELECTROCARDI OLOGY	34, 587	185, 171	30, 462	o	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	8, 766	66, 143	10, 881	0	848	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1, 553, 673			0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	970, 613			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	3, 343, 035	549, 953	0	0	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	13, 378	104 (0)	17 200		007	00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	362, 513	104, 606 2, 198, 172		l	897 24, 859	90. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT	302, 313	2, 190, 172 O	301, 013	250, 090	24, 009	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	302, 548	1, 626, 645	267, 594	27, 319	4. 091	95. 00
	09910 CORF	0	0	0	0	0	99. 10
	10100 HOME HEALTH AGENCY	171, 908	1, 012, 795	166, 612	9, 983	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	31, 529	465, 367				116. 00
118.00		5, 108, 331	47, 801, 275	6, 350, 760	3, 149, 344	111, 781	118. 00
400.00	NONREI MBURSABLE COST CENTERS			1 0			100.00
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
	19100 RESEARCH 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		191. 00 192. 00
	19201 DEKALB MEDICAL SERVICES	1, 659, 180	9, 632, 587	1, 584, 622	1, 837, 552		192.00
	19202 PHARMACARE	202, 090	7, 200, 593				192. 02
	19203 OUTSOURCED DIETICIAN	7, 889	42, 170				192. 03
	19204 BUSI NESS HEALTH	35, 593	261, 132				192. 04
	19300 NONPALD WORKERS		0	0	o		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194. 00
	07951 ADULT DAY CARE	0	0	0	0		194. 01
	07952 FOUNDATI ON	16, 455	161, 973	26, 646	0	0	194. 02
200.00			0		.	_	200.00
201.00		7 000 500	0 4E 000 700	0 10/ 471	4 007 007		201.00
202.00	TOTAL (sum lines 118 through 201)	7, 029, 538	65, 099, 730	9, 196, 471	4, 986, 896	113, 683	µ∠∪∠. UU

| Peri od: | Worksheet B | From 10/01/2018 | Part I | To 09/30/2019 | Date/Time Prepared:

			To	09/30/2019	Date/Time Pre 2/25/2020 11:	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	NURSI NG ADMI NI STRATI O	
	9. 00	10. 00	10. 01	11.00	N 13. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.01 00101 MOB WEST						1. 00 1. 01
1. 02 00102 NORTH ANNEX						1.01
1. 03 00103 GARRETT CLINIC						1. 03
1. 04 00104 BUTLER						1.04
1. 05 00105 MOB EAST						1.05
1. 07 00107 MEDI CAL ARTS						1.07
1.08 00108 SMALTZ WAY 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 08 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						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	1, 840, 567					8. 00 9. 00
10. 00 01000 DI ETARY	15, 132	346, 632				10.00
10. 01 01001 SNACK BAR	0	0	0			10. 01
11. 00 01100 CAFETERI A	38, 797	0	0	801, 025		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	13, 300	0	0	16, 097	909, 613	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	15, 797 14, 530	0	0	6, 976	20, 581 0	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	19, 850	o	0	17, 108	0	16.00
17. 00 01700 SOCI AL SERVI CE	2, 058	0	0	2, 465	7, 273	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	147, 133	258, 542	0	74, 815	220, 703	30.00
31. 00 03100 NTENSI VE CARE UNI T 43. 00 04300 NURSERY	62, 474 11, 192	88, 090 0	0	36, 286 6, 113	107, 053 18, 053	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS	11, 172	<u> </u>	<u> </u>	0, 115	10, 033	43.00
50. 00 05000 OPERATING ROOM	222, 607	0	0	61, 356	181, 029	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	173, 106	0	0	15, 998	47, 179	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	116, 881	0	0	71, 684	14 000	54.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	66, 816	0	0	57, 461	14, 000 0	60. 00 60. 01
65. 00 06500 RESPIRATORY THERAPY	13, 702	0	0	24, 823	0	65.00
66. 00 06600 PHYSI CAL THERAPY	65, 448	0	0	13, 607	0	66.00
66. 01 06601 CARDI AC REHAB	34, 443	0	0	7, 420	0	66. 01
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	5, 472	16, 136	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT		o	0	1, 750 15, 604	0	70. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	o	O	0	0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS		ما	-	4 550		
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	96, 566	0	0	1, 553 59, 655	4, 598 176, 018	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	70, 300		J	37, 033	170,010	92.00
OTHER REIMBURSABLE COST CENTERS		1				
95. 00 09500 AMBULANCE SERVICES	10, 302	0	0	66, 557	0	95.00
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY	2 744	0	0	0 30, 099	0 88, 822	99. 10
SPECIAL PURPOSE COST CENTERS	3, 764	- υ _լ	U _I	30, 099	00, 022	101.00
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	3, 764	0	0	2, 761	·	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 147, 662	346, 632	0	595, 660	909, 613	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN		O	0	ol	0	190. 00
191. 00 19100 RESEARCH	0	o	0	0		190.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	O	0	ō		192.00
192.01 19201 DEKALB MEDICAL SERVICES	692, 905	0	0	177, 781		192. 01
192. 02 19202 PHARMACARE	0	0	0	25, 464		192.02
192. 03 19203 OUTSOURCED DI ETI CI AN 192. 04 19204 BUSI NESS HEALTH	0	0	0	0		192. 03 192. 04
193. 00 19300 NONPALD WORKERS		ol	0	ol		193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	o	0	194. 00
194. 01 07951 ADULT DAY CARE	0	0	0	0		194. 01
194. 02 07952 FOUNDATION		0	0	2, 120		194. 02 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		o	O	n		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 840, 567	346, 632	0	801, 025	909, 613	
	•		•	·		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 10/01/2018 | Part I | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-0045

			To	09/30/2019	Date/Time Pre 2/25/2020 11:	
Cost Center Description	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	Subtotal	45 diii
	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	24.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 MOB WEST 1. 02 00102 NORTH ANNEX						1. 01 1. 02
1. 03 00103 GARRETT CLI NI C						1.02
1. 04 00104 BUTLER						1.04
1.05 00105 MOB EAST						1. 05
1. 07 00107 MEDI CAL ARTS						1. 07
1. 08 00108 SMALTZ WAY						1.08
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 OO700 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 11. 00 01100 CAFETERI A						10. 01 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	412, 896					14.00
15. 00 01500 PHARMACY	0	991, 920				15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	496, 684			16. 00
17. 00 01700 SOCI AL SERVI CE	0	0	0	134, 591		17.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	O	ol	27, 792	134, 591	4, 908, 318	30.00
31. 00 03100 NTENSIVE CARE UNIT		o	13, 712	134, 341	2, 456, 228	31.00
43. 00 04300 NURSERY	o	o	2, 733	Ö	383, 290	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	86, 577	0	4, 669, 443	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	7, 141	0	1, 818, 806	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	0	90, 818 72, 747	0	4, 198, 224 4, 309, 061	54. 00 60. 00
60. 01 06001 BLOOD LABORATORY		Ö	72, 747	o	4, 307, 001	60.01
65. 00 06500 RESPIRATORY THERAPY	o	Ö	13, 393	o	1, 130, 028	65.00
66. 00 06600 PHYSI CAL THERAPY	O	0	18, 000	0	1, 974, 442	66.00
66. 01 06601 CARDI AC REHAB	0	0	1, 807	0	455, 108	66. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	917	0	238, 158	1
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	412, 896	0	2, 528 26, 458	0	82, 150 2, 264, 221	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	412, 070	0	20, 430	o	1, 130, 286	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	991, 920	20, 261	O	4, 905, 169	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	847	0	129, 709	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	54, 670	0	3, 227, 645	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	2, 002, 508	95. 00
99. 10 09910 CORF	O	О	0	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	1, 312, 075	101. 00
SPECIAL PURPOSE COST CENTERS						112 00
113. 00 11300 NTEREST EXPENSE 116. 00 11600 HOSPI CE	0	0	269	0	566, 957	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	412, 896	991, 920	440, 670	134, 591	42, 161, 826	
NONREI MBURSABLE COST CENTERS	,	, . = - ,	,		.=, , . = =	
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 PHYSICIANS PRIVATE OFFICES 192. 01 19201 DEKALB MEDICAL SERVICES	0	0	0 43, 746	O	0 13, 970, 587	192.00
192.01 1920 DENALD MEDICAL SERVICES 192.02 19202 PHARMACARE	0	0	12, 268	0	8, 422, 873	
192. 03 19203 OUTSOURCED DIETICIAN	o	o	0	Ö		192. 03
192. 04 19204 BUSI NESS HEALTH	o	ō	0	O	304, 598	192. 04
193. 00 19300 NONPALD WORKERS	0	o	0	0		193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194.00
194. 01 07951 ADULT DAY CARE 194. 02 07952 FOUNDATI ON		0	0	0	100 730	
200.00 Cross Foot Adjustments		٥	U	٩	190, 739 0	194. 02 200. 00
201.00 Negative Cost Centers	o	o	0	o		201.00
202.00 TOTAL (sum lines 118 through 201)	412, 896	991, 920	496, 684	134, 591	65, 099, 730	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet B | From 10/01/2018 | Part I | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-0045

			To 09/30/2019 Date/Time Pre	
Cost Center Description	Intern & Residents Cost & Post	Total	2, 25, 2525	
	Stepdown Adjustments			
GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1. 00				1.00 1.01 1.02 1.03 1.04 1.05
1. 07 00107 MEDICAL ARTS 1. 08 00108 SMALTZ WAY 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				1. 07 1. 08 2. 00 4. 00 5. 00 7. 00 8. 00
9. 00				9. 00 10. 00 10. 01 11. 00 13. 00 14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE				15. 00 16. 00 17. 00
30. 00 03000 ADULTS & PEDIATRICS	0	4, 908, 318		30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0 0	2, 456, 228 383, 290		31. 00 43. 00
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0 0	4, 669, 443 1, 818, 806 4, 198, 224		50. 00 52. 00 54. 00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0 0	4, 309, 061 0 1, 130, 028		60. 00 60. 01 65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 CARDI AC REHAB 69. 00 06900 ELECTROCARDI OLOGY	0 0 0	1, 974, 442 455, 108 238, 158		66. 00 66. 01 69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0	82, 150 2, 264, 221 1, 130, 286		70.00 71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	4, 905, 169		73. 00
90. 00 09000 CLI NI C	0	129, 709		90. 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	0	3, 227, 645		91. 00 92. 00
95. 00 09500 AMBULANCE SERVICES	0	2, 002, 508		95.00
99. 10 09910 CORF 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	0 0	1, 312, 075		99. 10 101. 00
113. 00 11300 I NTEREST EXPENSE				113. 00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0 0	566, 957 42, 161, 826		116. 00 118. 00
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 191.00 19100 RESEARCH	0	0		190. 00 191. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES 192.01 19201 DEKALB MEDICAL SERVICES	0	0 13, 970, 587		192. 00 192. 01
192. 02 19202 PHARMACARE	0	8, 422, 873		192. 02
192. 03 19203 OUTSOURCED DI ETI CI AN 192. 04 19204 BUSI NESS HEALTH	0	49, 107 304, 598		192. 03 192. 04
193.00 19300 NONPALD WORKERS 194.00 07950 OTHER NONRELMBURSABLE COST CENT	0	0		193. 00 194. 00
194. 01 07951 ADULT DAY CARE 194. 02 07952 FOUNDATI ON	0	100 730		194. 01
200.00 Cross Foot Adjustments	0	190, 739 0		194. 02 200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0	0 65, 099, 730		201. 00 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2018 Part II
To 09/30/2019 Date/Time Prepared: 2/25/2020 11:43 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045

						0 09/30/2019	2/25/2020 11:	
					CAPI TAL RE	LATED COSTS		
		Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT CLI NI C	
			Related Costs 0	1 00	1 01	1.02	1 02	
	GENER	AL SERVICE COST CENTERS	0	1. 00	1. 01	1. 02	1. 03	
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01		MOB WEST						1.01
1. 02 1. 03		NORTH ANNEX GARRETT CLINIC						1. 02 1. 03
1. 03		BUTLER						1.03
1. 05	1	MOB EAST						1. 05
1. 07		MEDICAL ARTS						1. 07
1. 08 2. 00		SMALTZ WAY						1. 08 2. 00
4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1
5. 00		ADMINISTRATIVE & GENERAL	Ö	456, 179		o	0	1
7. 00		OPERATION OF PLANT	0	1, 751, 395			0	
8.00		LAUNDRY & LINEN SERVICE	0	26, 077	0		0	
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	41, 693 21, 884			0	
10. 01		SNACK BAR	O	0		1	0	10.01
11. 00	1	CAFETERI A	0	67, 530			0	11.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	23, 151	0	0	0	
15. 00	1	PHARMACY	0	27, 497 25, 291			0	1
16. 00		MEDICAL RECORDS & LIBRARY	Ö	28, 349		1	0	
17. 00		SOCIAL SERVICE	0	3, 582	0	0	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	256, 100	0	O	0	30.00
31. 00		INTENSIVE CARE UNIT	0	108, 743			0	31.00
43.00	1	NURSERY	0	19, 482			0	1
50.00		LARY SERVICE COST CENTERS		007.440				
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	387, 469 301, 309			0	
54. 00		RADI OLOGY-DI AGNOSTI C	0	203, 443			0	
60.00	1	LABORATORY	Ö	91, 489			0	
60. 01		BLOOD LABORATORY	0	0			0	60. 01
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	23, 850 113, 919		1	0	65. 00 66. 00
66. 01	1	CARDI AC REHAB	0	59, 952			0	1
69. 00		ELECTROCARDI OLOGY	0	0	1	0	0	1
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PAT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1	0	
		DRUGS CHARGED TO PATIENTS	0	0		1	0	
	OUTPA	TIENT SERVICE COST CENTERS						
		CLINIC EMERGENCY	0	0 168, 083			0	
		OBSERVATION BEDS (NON-DISTINCT		100, 003	٥		0	92.00
		REIMBURSABLE COST CENTERS						
95. 00 99. 10		AMBULANCE SERVICES	0	17, 931	0		0	1
		HOME HEALTH AGENCY	0	6, 552				101.00
	SPECI	AL PURPOSE COST CENTERS						
	1	I NTEREST EXPENSE HOSPI CE	0	6, 552	0	o	0	113. 00 116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 237, 502				118.00
	NONRE	IMBURSABLE COST CENTERS		., . ,	-	-		
		GIFT FLOWER COFFEE SHOP & CAN	0	0				190.00
		RESEARCH PHYSICIANS PRIVATE OFFICES	0	0	0			191. 00 192. 00
		DEKALB MEDICAL SERVICES	Ö	111, 407	Ö	o		192. 01
		PHARMACARE	0	0	0	0		192. 02
		OUTSOURCED DIETICIAN BUSINESS HEALTH	0	0	0	0		192. 03 192. 04
		NONPALD WORKERS	0	0	0			192. 04
194.00	07950	OTHER NONREIMBURSABLE COST CENT	Ö	o	0			194. 00
		ADULT DAY CARE	0	0	0	0		194. 01
194. 02 200. 00		FOUNDATION Cross Foot Adjustments	0	0	0	0	0	194. 02 200. 00
200.00		Negative Cost Centers		0	0	o	0	200.00
202.00		TOTAL (sum lines 118 through 201)	О	4, 348, 909	0	o		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2018 | Part II | To 09/30/2019 | Date/Time Prepared: | 2/25/2020 11: 43 am

		CAP	ITAL RELATED CO	STS	2/25/2020 11:	43 am
Cost Center Description	BUTLER	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	
	1. 04	1. 05	1. 07	1. 08	2. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.01 00101 MOB WEST						1.00
1. 02 00101 MOD WEST						1.02
1. 03 00103 GARRETT CLINIC						1.03
1. 04 00104 BUTLER						1.04
1. 05 00105 MOB EAST						1.05
1. 07 00107 MEDI CAL ARTS						1.07
1. 08 00108 SMALTZ WAY 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 08 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	C	o	o	0	1
5. 00 00500 ADMINISTRATIVE & GENERAL	O	C	Ō	ō	0	
7.00 O0700 OPERATION OF PLANT	0	C	6, 217	0	0	
8. 00 00800 LAUNDRY & LINEN SERVICE	0	C	0	0	0	1
9. 00 00900 HOUSEKEEPI NG	0	C	0	0	0	
10. 00 01000 DI ETARY 10. 01 01001 SNACK BAR	0			0	0	
11. 00 01100 CAFETERI A	0	C		0	0	
13. 00 01300 NURSING ADMINISTRATION	O	C	Ō	ō	0	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	C	0	O	0	14.00
15. 00 01500 PHARMACY	0	C	0	0	0	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	C	0	0	0	
17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	C	0	0	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	0	C	O	O	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	o	C		ő	0	
43. 00 04300 NURSERY	O	C		ō	0	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	C	1	0	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	C		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0 624	(0	0	0	
60. 01 06001 BLOOD LABORATORY	024	0		0	0	1
65. 00 06500 RESPIRATORY THERAPY	o	C	Ö	o	0	
66. 00 06600 PHYSI CAL THERAPY	0	C	O	o	0	66.00
66. 01 06601 CARDI AC REHAB	0	C	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	C	0	0	0	1
70.00 O7000 ELECTROENCEPHALOGRAPHY 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PAT		C	0	0	0	
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATENTS	0	C		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	o o	C		ő	0	
OUTPATIENT SERVICE COST CENTERS			,			
90. 00 09000 CLI NI C	0	C		0	0	
91. 00 09100 EMERGENCY	0	C	0	0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT						92.00
95. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES	O	C	O	ol	0	95.00
99. 10 09910 CORF	o o	C		ő	0	1
101.00 10100 HOME HEALTH AGENCY	0	C	0	o		101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0 (04	C		0		116.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 11 NONREI MBURSABLE COST CENTERS	7) 624	C	6, 217	0	0	118.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN	O	C	0	ol	0	190. 00
191. 00 19100 RESEARCH	o	C	Ö	o		191.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	C	0	o		192.00
192. 01 19201 DEKALB MEDICAL SERVICES	8, 192	C	59, 843	4, 996		192. 01
192. 02 19202 PHARMACARE	0	C	0	0		192. 02
192. 03 19203 OUTSOURCED DI ETI CI AN	0	C	0	0		192.03
192. 04 19204 BUSI NESS HEALTH 193. 00 19300 NONPALD WORKERS	0		0	O O		192. 04 193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENT				0		194.00
194. 01 07951 ADULT DAY CARE		C	l ő	ől		194. 01
194. 02 07952 FOUNDATI ON	0	C	o	o		194. 02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	C	- 1	0		201.00
202.00 TOTAL (sum lines 118 through 201)	8, 816	C	66, 060	4, 996	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0045

Period: Worksheet B From 10/01/2018 Part II To 09/30/2019 Date/Time Prepared:

2/25/2020 11:43 am Cost Center Description Subtotal **EMPLOYEE** ADMINISTRATIV OPERATION OF LAUNDRY & LINEN SERVICE **BENEFITS** E & GENERAL **PLANT** DEPARTMENT 2A 5.00 7. 00 8. 00 4 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 MOB WEST 1.01 1.01 00102 NORTH ANNEX 1.02 1 02 1.03 00103 GARRETT CLINIC 1.03 00104 BUTLER 1.04 1.04 1.05 00105 MOB EAST 1.05 00107 MEDICAL ARTS 1.07 1 07 1.08 00108 SMALTZ WAY 1.08 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 456, 179 456, 179 5.00 7.00 00700 OPERATION OF PLANT 1, 757, 612 34, 944 1, 792, 556 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 26, 077 518 14, 282 40, 877 8.00 00900 HOUSEKEEPI NG 41, 693 12, 401 1,699 9 00 23, 743 9 00 0 10.00 01000 DI ETARY 21,884 2,036 14, 425 285 10.00 01001 SNACK BAR 10.01 10.01 01100 CAFETERI A 36, 984 11.00 67.530 0 4.620 0 11.00 01300 NURSING ADMINISTRATION 13 00 23.151 C 5.921 12.679 0 13.00 01400 CENTRAL SERVICES & SUPPLY 27, 497 2, 296 15, 059 14.00 14.00 0 15.00 01500 PHARMACY 25, 291 0 6,579 13, 851 0 15.00 01600 MEDICAL RECORDS & LIBRARY 2,853 16,00 28.349 0 18.922 0 16.00 17.00 01700 SOCIAL SERVICE 3,582 822 1, 962 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 256, 100 0 25, 447 140, 255 8, 273 30.00 03100 INTENSIVE CARE UNIT C 31.00 108, 743 13, 826 59, 554 3, 543 31.00 43.00 04300 NURSERY 19, 482 0 2, 200 10,669 582 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 387, 469 0 24, 576 212, 201 7. 293 50.00 05200 DELIVERY ROOM & LABOR ROOM 301, 309 7, 791 165, 015 1,586 52.00 C 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 203, 443 0 25, 195 111, 417 4,780 54.00 06000 LABORATORY 60.00 92, 113 0 27, 474 63, 693 25 60.00 60 01 06001 BLOOD LABORATORY 0 60 01 0 0 0 0 06500 RESPIRATORY THERAPY 7, 300 65.00 23,850 0 13,061 0 65.00 06600 PHYSI CAL THERAPY 113, 919 0 11, 923 62, 389 827 66.00 66.00 06601 CARDI AC REHAB 66.01 59, 952 0 2, 238 32, 833 232 66.01 06900 ELECTROCARDI OLOGY 1, 511 69 00 69 00 0 Ω 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 540 0 305 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 12,678 0 71.00 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 7 920 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 27, 279 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 854 322 90.00 0 09100 EMERGENCY 168, 083 0 92,052 91.00 91 00 17, 937 8.938 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 1, 471 95.00 17. 931 13, 273 9,820 99. 10 09910 CORF 99. 10 C 0 0 101.00 10100 HOME HEALTH AGENCY 6,552 0 8, 264 3,588 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 3, 797 116. 00 11600 HOSPI CE 6.552 32 116.00 0 3 588 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 244, 343 315, 013 1, 132, 042 40, 193 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00 0 0 191.00 191. 00 19100 RESEARCH 0 C 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192.00 0 0 192. 01 19201 DEKALB MEDICAL SERVICES 501 192. 01 184, 438 0 78, 612 660, 514 192. 02 19202 PHARMACARE 0 0 58, 757 0 0 192.02 192. 03 19203 OUTSOURCED DIETICIAN 0 C 344 0 0 192.03 192. 04 19204 BUSINESS HEALTH 0 2, 131 0 183 192.04 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194. 00|07950|OTHER NONREIMBURSABLE COST CENT 0 0 0 0 194, 00 0 194. 01 07951 ADULT DAY CARE 0 C 0 0 194. 01 0 0 0 194. 02 194. 02 07952 FOUNDATION 0 1, 322 0 Cross Foot Adjustments 200.00 0 200.00 201.00 Negative Cost Centers 0 C 0 201.00 TOTAL (sum lines 118 through 201) 1, 792, 556 40, 877 202. 00 202.00 4, 428, 781 456, 179

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0045

Period: Worksheet B From 10/01/2018 Part II To 09/30/2019 Date/Time Prepared:

2/25/2020 11:43 am Cost Center Description HOUSEKEEPI NG DI ETARY SNACK BAR CAFETERI A NURSI NG ADMI NI STRATI O Ν 9. 00 10.00 10.01 11.00 13 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 MOB WEST 1.01 1.01 00102 NORTH ANNEX 1.02 1 02 1.03 00103 GARRETT CLINIC 1.03 00104 BUTLER 1.04 1.04 1.05 00105 MOB EAST 1.05 00107 MEDICAL ARTS 1.07 1 07 1.08 00108 SMALTZ WAY 1.08 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 79,536 10.00 01000 DI ETARY 654 39, 284 10.00 01001 SNACK BAR 10.01 10.01 01100 CAFETERI A 11.00 1,677 110, 811 11.00 0 0 01300 NURSING ADMINISTRATION 0 13 00 575 C 2, 227 44, 553 13.00 01400 CENTRAL SERVICES & SUPPLY 965 1,008 14.00 14.00 683 0 15.00 01500 PHARMACY 628 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 2, 367 16,00 858 C 0 16.00 17.00 01700 SOCIAL SERVICE 89 341 356 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 358 29, 301 0 10, 350 10, 811 30.00 03100 INTENSIVE CARE UNIT 2, 700 9, 983 0 5, 243 31.00 5,020 31.00 43.00 04300 NURSERY 484 0 0 846 884 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 8. 488 8. 867 50.00 9, 619 05200 DELIVERY ROOM & LABOR ROOM 7,480 0 52.00 C 2, 213 2, 311 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 5,051 0 9, 917 0 54.00 06000 LABORATORY 0 60.00 2,887 0 7,949 686 60.00 60 01 06001 BLOOD LABORATORY 0 0 60 01 0 0 0 0 06500 RESPIRATORY THERAPY 592 65.00 0 3, 434 0 65.00 06600 PHYSI CAL THERAPY 2,828 0 0 1,882 0 66.00 66.00 06601 CARDI AC REHAB 66.01 1, 488 0 0 1,026 0 66.01 06900 ELECTROCARDI OLOGY 0 790 69 00 69 00 0 Ω 757 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 242 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 0 0 71.00 71.00 2, 159 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 215 225 90.00 0 09100 EMERGENCY 0 4, 173 91 00 Ω 8.621 91.00 8, 252 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 95.00 445 0 9, 207 99. 10 09910 CORF 0 99. 10 C 0 0 101.00 10100 HOME HEALTH AGENCY 163 0 0 4, 164 4, 351 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 400 116.00 116. 00 11600 HOSPI CE 163 Ω 0 382 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 49, 595 39, 284 0 44, 553 118. 00 82, 403 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00 0 0 191. 00 19100 RESEARCH 0 C 0 0 191.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 192.00 0 0 192. 01 19201 DEKALB MEDICAL SERVICES 0 192.01 29, 941 0 24, 592 192. 02 19202 PHARMACARE 0 0 0 3,523 0 192, 02 192. 03 19203 OUTSOURCED DIETICIAN 0 0 C 0 192.03 0 192. 04 19204 BUSINESS HEALTH 0 0 0 192.04 0 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194. 00 07950 OTHER NONREI MBURSABLE COST CENT 0 0 0 194, 00 C 0 194. 01 07951 ADULT DAY CARE 0 C 0 0 194. 01 0 194.02 194. 02 07952 FOUNDATION 0 C 0 293 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers Ω 0 0 201.00 TOTAL (sum lines 118 through 201) 79, 536 110, 811 44, 553 202. 00 202.00 39. 284

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS | Peri od: | Worksheet B | From 10/01/2018 | Part I I | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-0045

					10		Date/lime Pre 2/25/2020 11:	
		Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	45 diii
			14. 00	15. 00	16. 00	17. 00	24. 00	
		AL SERVICE COST CENTERS						
		CAP REL COSTS-BLDG & FIXT						1.00
		MOB WEST						1.01
		NORTH ANNEX GARRETT CLINIC						1. 02 1. 03
		BUTLER						1.03
		MOB EAST						1.04
		MEDICAL ARTS						1.07
		SMALTZ WAY						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
		EMPLOYEE BENEFITS DEPARTMENT						4.00
		ADMINISTRATIVE & GENERAL						5.00
		OPERATION OF PLANT						7.00
		LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG						8.00
		DI ETARY						9. 00 10. 00
		SNACK BAR						10.00
		CAFETERI A						11.00
		NURSING ADMINISTRATION						13.00
		CENTRAL SERVICES & SUPPLY	47, 508					14.00
15. 00	01500	PHARMACY	0	46, 349				15. 00
		MEDICAL RECORDS & LIBRARY	0	0				16.00
		SOCIAL SERVICE	0	0	0	7, 152		17. 00
		ENT ROUTINE SERVICE COST CENTERS	ما	٥	2.004	7 150	407.021	20.00
		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	0		7, 152 0	497, 031 210, 084	30. 00 31. 00
		NURSERY	0	0		0	35, 440	
		LARY SERVICE COST CENTERS	o _l	<u> </u>	275	<u> </u>	33, 440	1 43.00
		OPERATI NG ROOM	0	0	9, 294	0	667, 807	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	767	o	488, 472	52.00
		RADI OLOGY-DI AGNOSTI C	0	0	9, 779	0	369, 582	54.00
		LABORATORY	0	0	7, 810	0	202, 637	
		BLOOD LABORATORY	0	0	0	0	0	60.01
		RESPIRATORY THERAPY	0	0	1, 438	0	49, 675	1
		PHYSI CAL THERAPY CARDI AC REHAB	0	0	1, 932 194	0	195, 700 97, 963	1
		ELECTROCARDI OLOGY	0	0	98	0	3, 156	1
		ELECTROENCEPHALOGRAPHY	o	Ö	271	ő	1, 358	
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PAT	47, 508	0	2, 840	О	65, 185	1
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	O	7, 920	72.00
		DRUGS CHARGED TO PATIENTS	0	46, 349	2, 175	0	75, 803	73.00
		TIENT SERVICE COST CENTERS						
		CLINIC	0	0		0	1, 707	90.00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT	0	0	5, 869	0	313, 925	91. 00 92. 00
		REIMBURSABLE COST CENTERS						92.00
		AMBULANCE SERVICES	0	0	0	ol	52, 147	95.00
99. 10	09910	CORF	0	0	0	o		99. 10
		HOME HEALTH AGENCY	0	0	0	0	27, 082	101.00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113.00
		HOSPI CE	0	0		0		116.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	47, 508	46, 349	47, 336	7, 152	3, 377, 617]118.00
		GIFT FLOWER COFFEE SHOP & CAN	0	0	0	O	0	190. 00
		RESEARCH	o	Ö		Ö		191.00
		PHYSICIANS PRIVATE OFFICES	O	0	0	Ö		192.00
192. 01	19201	DEKALB MEDICAL SERVICES	0	0	4, 696	o	983, 294	192. 01
		PHARMACARE	0	0	1, 317	0	63, 597	192. 02
		OUTSOURCED DIETICIAN	0	0	0	0		192. 03
		BUSI NESS HEALTH	0	0	0	0		192.04
		NONPALD WORKERS	0	0		0		193.00
		OTHER NONREIMBURSABLE COST CENT ADULT DAY CARE		0		0		194. 00 194. 01
		FOUNDATION	0	0		0		194.01
200.00		Cross Foot Adjustments				٩		200.00
201.00		Negative Cost Centers	О	O	О	o	0	201.00
202. 00		TOTAL (sum lines 118 through 201)	47, 508	46, 349	53, 349	7, 152	4, 428, 781	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS DEKALB MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2018 Part II
To 09/30/2019 Date/Time Prepared: 2/25/2020 11:43 am Provider CCN: 15-0045

					2/25/2020 11:43 am
	Cost Center Description	Intern &	Total		7 207 2020 111 10 diii
	·	Resi dents			
		Cost & Post			
		Stepdown			
		Adj ustments	27, 00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
	00100 CAP REL COSTS-BLDG & FIXT				1.00
	00101 MOB WEST				1. 01
	00102 NORTH ANNEX				1. 02
	00103 GARRETT CLINIC				1. 03
1.04	00104 BUTLER				1.04
	00105 MOB EAST				1. 05
	00107 MEDICAL ARTS				1. 07
	00108 SMALTZ WAY				1.08
	00200 CAP REL COSTS-MVBLE EQUIP				2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
	DO500 ADMINISTRATIVE & GENERAL DO700 OPERATION OF PLANT				5. 00 7. 00
	00800 LAUNDRY & LINEN SERVICE				8.00
	00900 HOUSEKEEPI NG				9. 00
	01000 DI ETARY				10.00
	01001 SNACK BAR				10. 01
11.00	D1100 CAFETERI A				11.00
	01300 NURSING ADMINISTRATION				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	D1500 PHARMACY				15. 00
	01600 MEDICAL RECORDS & LIBRARY				16.00
	D1700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS				17. 00
	03000 ADULTS & PEDIATRICS	0	497, 031		30.00
	03100 INTENSIVE CARE UNIT	0	210, 084	•	31.00
	04300 NURSERY	0	35, 440	•	43.00
P	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0	667, 807		50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	488, 472	•	52. 00
	D5400 RADI OLOGY-DI AGNOSTI C	0	369, 582	•	54.00
	06000 LABORATORY	0	202, 637	1	60.00
4	06001 BL00D LABORATORY 06500 RESPIRATORY THERAPY	0	0 49, 675	1	60. 01 65. 00
	06600 PHYSI CAL THERAPY	0	195, 700	•	66.00
	06601 CARDI AC REHAB	0	97, 963	•	66. 01
	06900 ELECTROCARDI OLOGY	0	3, 156	•	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	1, 358	•	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	65, 185		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	7, 920	•	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	75, 803		73.00
	OUTPATIENT SERVICE COST CENTERS		4 707	I	00.00
	D9000 CLINIC D9100 EMERGENCY	0	1, 707 313, 925	1	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT	0	313, 923		92.00
	OTHER REIMBURSABLE COST CENTERS				72.00
	09500 AMBULANCE SERVICES	0	52, 147		95. 00
	09910 CORF	0	0		99. 10
	10100 HOME HEALTH AGENCY	0	27, 082		101.00
	SPECIAL PURPOSE COST CENTERS	T		I	
	11300 INTEREST EXPENSE		14 042		113.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	14, 943 3, 377, 617		116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	0	3, 377, 017		110.00
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
	19100 RESEARCH	0	0	•	191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0		192.00
192. 01 1	19201 DEKALB MEDICAL SERVICES	0	983, 294		192. 01
	19202 PHARMACARE	0	63, 597	•	192. 02
	19203 OUTSOURCED DI ETI CI AN	0	344	•	192. 03
	19204 BUSI NESS HEALTH	0	2, 314	•	192.04
	19300 NONPALD WORKERS 07950 OTHER NONRELMBURSABLE COST CENT	0	0	1	193. 00 194. 00
	07950 OTHER NONRETMBURSABLE COST CENT	0	0	1	194.00
	07951 ADOLT DAT CARE	0	1, 615	1	194.01
200.00	Cross Foot Adjustments	l 0	0	•	200.00
201.00	Negative Cost Centers	0	Ö	•	201. 00
202.00	TOTAL (sum lines 118 through 201)	0	4, 428, 781		202. 00

Peri od: From 10/01/2018 To 09/30/2019 Date/Ti me Prepared: 2/25/2020 11: 43 am

				CAP	TAL RELATED CO)STS	2/25/2020 TI:	43 alli
				CAI	TIAL KLLATED CO	313		
		Cost Center Description	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT	BUTLER	
		·	(SQUARE FEET)	(SQUARE FEET)		CLI NI C	(SQUARE FEET)	
						(SQUARE FEET)		
			1. 00	1. 01	1. 02	1. 03	1. 04	
4 00		AL SERVICE COST CENTERS	100 100	ı	1			
1.00		CAP REL COSTS-BLDG & FLXT	199, 123	17 224				1.00
1. 01 1. 02	1	MOB WEST NORTH ANNEX	0	16, 334 0				1. 01 1. 02
1. 02	1	GARRETT CLINIC	0		0	3, 750		1.02
1. 04		BUTLER	0		o o	3, 730	4, 977	1.03
1. 05		MOB EAST	0	Ö	o	0	0	ı
1.07		MEDICAL ARTS	0	0	0	0	0	1.07
1.08	00108	SMALTZ WAY	0	0	0	0	0	1. 08
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	1	ADMINISTRATIVE & GENERAL	20, 887	0		0	0	5.00
7.00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	80, 191	2, 931		0	0	7. 00 8. 00
8. 00 9. 00		HOUSEKEEPING	1, 194 1, 909		· -	0	0	•
10. 00	1	DI ETARY	1, 002		1	0	0	10.00
10. 01	1	SNACK BAR	0		o o	0	ő	10.01
11. 00		CAFETERI A	3, 092	O	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1, 060	0	0	0	0	13.00
14.00		CENTRAL SERVICES & SUPPLY	1, 259	0	0	0	0	14.00
15. 00	1	PHARMACY	1, 158		0	0	0	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	1, 298			0	0	16.00
17. 00		SOCIAL SERVICE	164	0	0	0	0	17. 00
30. 00		ADULTS & PEDIATRICS	11, 726	0	0	0	0	30.00
31. 00		INTENSIVE CARE UNIT	4, 979		•	0	0	31.00
43. 00		NURSERY	892	ĺ		0	0	43.00
		LARY SERVICE COST CENTERS				-		
50.00	05000	OPERATING ROOM	17, 741	0	0	0	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	13, 796	0	0	0	0	52.00
54.00		RADI OLOGY-DI AGNOSTI C	9, 315	0		0	0	
60.00	1	LABORATORY	4, 189	l .	· -	784	352	1
60. 01		BLOOD LABORATORY	0	0	0	0	0	•
65.00		RESPIRATORY THERAPY	1, 092			0	0	65.00
66. 00 66. 01		PHYSI CAL THERAPY CARDI AC REHAB	5, 216 2, 745			0	0	66. 00 66. 01
69. 00		ELECTROCARDI OLOGY	2, 743			0	0	69.00
70.00		ELECTROENCEPHALOGRAPHY	0		o o	0	Ö	70.00
71.00		MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	0			0	0	90.00
91.00		EMERGENCY	7, 696	0	0	0	0	91.00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT REIMBURSABLE COST CENTERS						92.00
95. 00		AMBULANCE SERVICES	821	0	0	0	0	95.00
99. 10			0		•	0		99. 10
		HOME HEALTH AGENCY	300			0		101.00
		AL PURPOSE COST CENTERS						
	1	INTEREST EXPENSE						113.00
		HOSPI CE	300			0		116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194, 022	2, 931	0	784	352	118. 00
100.00		IMBURSABLE COST CENTERS GIFT FLOWER COFFEE SHOP & CAN		1 0	1	0	0	100 00
	1	RESEARCH	0	0		0		190. 00 191. 00
		PHYSICIANS PRIVATE OFFICES	0			0		192.00
		DEKALB MEDICAL SERVICES	5, 101	13, 403	1, 824	2, 966		192.01
		PHARMACARE	0	0	0	0		192. 02
192.03	19203	OUTSOURCED DIETICIAN	0	0	0	0	0	192. 03
	1	BUSINESS HEALTH	0	0	0	0		192. 04
		NONPALD WORKERS	0	0	0	0		193. 00
		OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194. 00
		ADULT DAY CARE	0	0	0	0		194. 01
		FOUNDATION	0		' O	O	0	194. 02
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00		Cost to be allocated (per Wkst. B,	4, 348, 909		0	0	2 214	201.00
202.00	1	Part I)	7, 570, 707			O	0,010	_52.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21. 840315	0. 000000	0. 000000	0. 000000	1. 771348	203.00
		· · · · · · · · · · · · · · · · · · ·			,			

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Li	eu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der	CCN: 15-0045 Peri od: From 10/01/201	Worksheet B-1
		To 09/30/201	9 Date/Time Prepared:

						2/25/2020 11:	43 am	
			CAPITAL RELATED COSTS					
	Cost Center Description	BLDG & FLXT	MOB WEST	NORTH ANNEX	GARRETT	BUTLER		
	cost denter bescription	(SQUARE FEET)			CLINIC	(SQUARE FEET)		
		,	,		(SQUARE FEET)	,		
		1. 00	1. 01	1. 02	1. 03	1. 04		
204.00	Cost to be allocated (per Wkst. B,						204.00	
205. 00	Part II) Unit cost multiplier (Wkst. B, Part						205. 00	
206.00	NAHE adjustment amount to be allocated						206. 00	
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-0045

				Т	o 09/30/2019	Date/Time Pre 2/25/2020 11:	
			CAPI TAL REI	_ATED COSTS		27 207 2020 111	
	Cost Center Description	MOB EAST (SQUARE FEET)	MEDICAL ARTS (SQUARE FEET)	SMALTZ WAY (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	
		1. 05	1. 07	1. 08	2. 00	4. 00	
1. 00 1. 01 1. 02	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT O0101 MOB WEST O0102 NORTH ANNEX						1. 00 1. 01 1. 02
1. 03 1. 04 1. 05 1. 07	O0103 GARRETT CLINIC O0104 BUTLER O0105 MOB EAST O0107 MEDICAL ARTS	37, 481 0	7, 225				1. 03 1. 04 1. 05 1. 07
1. 08 2. 00 4. 00 5. 00	00108 SMALTZ WAY 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 0 5, 019	0 0	3, 168 0	199, 123 0	28, 385, 255 4, 129, 630	1. 08 2. 00 4. 00 5. 00
7. 00 8. 00 9. 00 10. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	11, 140 0 76 204	680 0	0 0	80, 191 1, 194 1, 909	613, 519 29, 999 859, 120 110, 850	7. 00 8. 00 9. 00
10. 01 11. 00 13. 00	01001 SNACK BAR 01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 0 0	0	0	0 3, 092 1, 060	0 355, 353 505, 591	10. 01 11. 00 13. 00
14. 00 15. 00 16. 00 17. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 0 284 0	0		1, 158 1, 298	102, 560 591, 122 215, 593 73, 384	15. 00 16. 00
30. 00 31. 00 43. 00	03100 INTENSIVE CARE UNIT	0 0 0	0	0	4, 979	1, 940, 215 1, 003, 425 177, 282	
50. 00 52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM	0 0	0	000000000000000000000000000000000000000	13, 796	1, 686, 601 463, 291 1, 769, 774	50.00 52.00 54.00
60. 00 60. 01 65. 00 66. 00	06000 LABORATORY 06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 0 0	0	0 0	4, 189 0 1, 092	1, 189, 354 0 611, 602 297, 908	60. 00 60. 01 65. 00
66. 01 69. 00 70. 00	06601 CARDI AC REHAB 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0 0	0	0		165, 152 139, 662 35, 396	66. 01 69. 00 70. 00
71. 00 72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0 0 0	0	0 0	0 0	0 0 0	71.00 72.00 73.00
90. 00 91. 00 92. 00		0	0	0			90. 00 91. 00 92. 00
99. 10	09500 AMBULANCE SERVICES 09910 CORF 010100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0 0	0		0	1, 221, 686 0 694, 164	99. 10
	0 11300 INTEREST EXPENSE 0 11600 HOSPI CE	0 16, 723				127, 312 20, 627, 387	
191. 0 192. 0	0 19000 GIFT FLOWER COFFEE SHOP & CAN 0 19100 RESEARCH 0 19200 PHYSICIANS PRIVATE OFFICES	0 0 750	Ō	000000000000000000000000000000000000000	0 0	0	190. 00 191. 00 192. 00
192. 0 192. 0 192. 0	1 19201 DEKALB MEDICAL SERVICES 2 19202 PHARMACARE 3 19203 OUTSOURCED DIETICIAN 4 19204 BUSINESS HEALTH	20, 758 0 0 0	0	3, 168 0 0	5, 101 0 0 0	6, 699, 805 816, 038 31, 855 143, 726	192. 02 192. 03 192. 04
194. 0 194. 0 194. 0 200. 0		0 0 0	0 0 0	0 0	0 0	0	193. 00 194. 00 194. 01 194. 02 200. 00
201. 0		0	66, 060	4, 996	0	7, 029, 538	201. 00 202. 00

Heal th Finar	ncial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od: From 10/01/2018	Worksheet B-1	
					To 09/30/2019		
			CAPITAL REI	LATED COSTS			
	Cost Center Description	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	EMPLOYEE	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	BENEFI TS	
						DEPARTMENT	
						(UNADJUSTED	
						SALARY)	
		1. 05	1. 07	1. 08	2. 00	4. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	9. 143253	1. 57702	0. 000000	0. 247648	203. 00
204.00	Cost to be allocated (per Wkst. B,					0	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part					0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0045 Peri od: Worksheet B-1 From 10/01/2018 To 09/30/2019 Date/Time Prepared:

				1	0 07/30/2017	Date/lime Pre 2/25/2020 11:	
	Cost Center Description	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A	5. 00	7. 00	8. 00	9. 00	
4 00	GENERAL SERVICE COST CENTERS			Г			
1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 07 1. 08 2. 00 4. 00 5. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB WEST 00102 NORTH ANNEX 00103 GARRETT CLINIC 00104 BUTLER 00105 MOB EAST 00107 MEDICAL ARTS 00108 SMALTZ WAY 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	-9, 196, 471	55, 903, 259				1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 07 1. 08 2. 00 4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	0	4, 282, 410				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	63, 505	1, 194	148, 942		8.00
9.00	00900 HOUSEKEEPI NG	0	1, 519, 775		6, 192	146, 687	
	01000 DI ETARY 01001 SNACK BAR	0	249, 527 0	1, 206 0	1, 040 0	1, 206 0	
	01100 CAFETERI A		566, 197	3, 092	0	3, 092	
	01300 NURSI NG ADMI NI STRATI ON	0	725, 581	1, 060	0	1, 060	1
	01400 CENTRAL SERVICES & SUPPLY	0	281, 362	1, 259	0	1, 259	14.00
	01500 PHARMACY	0	806, 227	1, 158	0	1, 158	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	349, 576 100, 762		0	1, 582 164	1
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		100, 702	104	U	104	17.00
30.00	03000 ADULTS & PEDI ATRI CS	0	3, 118, 525	11, 726	30, 143	11, 726	30.00
	03100 INTENSIVE CARE UNIT	0	1, 694, 348		12, 909		
43. 00	04300 NURSERY	0	269, 556	892	2, 119	892	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	3, 011, 788	17, 741	26, 573	17, 741	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	954, 825		5, 778	13, 796	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 087, 644	9, 315	17, 418	9, 315	54.00
	06000 LABORATORY	0	3, 366, 897	5, 325	90	5, 325	1
	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY	0	0	0 1, 092	0	1 003	
	06600 PHYSI CAL THERAPY		894, 604 1, 461, 152	1	3, 012	1, 092 5, 216	
	06601 CARDI AC REHAB	0	274, 323		845	2, 745	
	06900 ELECTROCARDI OLOGY	0	185, 171	0	0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	66, 143		1, 111	0 0	
	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 553, 673 970, 613		0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	3, 343, 035		0	0	1
	OUTPATIENT SERVICE COST CENTERS						1
	09000 CLI NI C	0	104, 606		1, 175	0	
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT	0	2, 198, 172	7, 696	32, 568	7, 696	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	0	1, 626, 645	821	5, 360	821	
	09910 CORF	0	0	0	0	0	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	1, 012, 795	300	0	300	101. 00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	465, 367	300	117	300	116. 00
118. 00		-9, 196, 471	38, 604, 804	94, 644	146, 450	91, 465	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
	19100 RESEARCH		0	· ·	0		191.00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
	19201 DEKALB MEDICAL SERVICES	0	9, 632, 587		1, 827		192. 01
	19202 PHARMACARE 19203 OUTSOURCED DI ETI CI AN	0	7, 200, 593		0		192.02
	19203 OUTSOURCED DIETICIAN 19204 BUSINESS HEALTH		42, 170 261, 132		665		192. 03 192. 04
	19300 NONPAI D WORKERS	0	0	0	0		193.00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194. 00
	07951 ADULT DAY CARE	0	0	0	0		194. 01
194. 02 200. 00	07952 FOUNDATION Cross Foot Adjustments		161, 973	0	0	0	194. 02 200. 00
200.00							201.00
202.00	3		9, 196, 471	4, 986, 896	113, 683		
	Part I)			00 0====			
202 2-							
203. 00 204. 00			0. 164507 456, 179		0. 763270 40, 877		204.00

Heal th Finar	ncial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Period: From 10/01/2018	Worksheet B-1	
					o 09/30/2019		pared: 43 am_
	Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		n	E & GENERAL	PLANT	LINEN SERVICE	(SQUARE FEET)	
			(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF		
					LAUNDRY)		
		5A	5. 00	7. 00	8. 00	9. 00	
205.00	Unit cost multiplier (Wkst. B, Part		0. 008160	11. 961059	0. 274449	0. 542216	205.00
	[11]						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
ı	1 ,	1	ı	1	1	ı	'

	nanciai systems	DEKALB MEMORIA		45 0045 5		J OF FORM CMS-2	
COST ALL	OCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 10/01/2018 To 09/30/2019	Worksheet B-1 Date/Time Pre 2/25/2020 11:	pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	
					(DI RECT NRS I NG)	(COSTED REQUIS.)	
		10. 00	10. 01	11. 00	13. 00	14. 00	
	ENERAL SERVICE COST CENTERS D100 CAP REL COSTS-BLDG & FIXT						1.00
	D101 MOB WEST						1.00
1.02 00	0102 NORTH ANNEX						1. 02
	0103 GARRETT CLINIC						1.03
	0104 BUTLER 0105 MOB_EAST						1. 04 1. 05
1. 07 00	0107 MEDICAL ARTS						1. 07
	0108 SMALTZ WAY						1.08
1	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
1	D500 ADMINI STRATI VE & GENERAL						5. 00
	0700 OPERATION OF PLANT						7.00
	D800 LAUNDRY & LINEN SERVICE D900 HOUSEKEEPING						8. 00 9. 00
1	1000 DI ETARY	28, 324					10.00
1	1001 SNACK BAR	0	О				10. 01
	1100 CAFETERI A	0	0	32, 495	1		11.00
	1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY	0	0	653 283		100	13.00
	1500 PHARMACY	o	Ö	C	1	0	1
	1600 MEDICAL RECORDS & LIBRARY	0	0	694		0	
	1700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	0	0	100	2, 080	0	17.00
	3000 ADULTS & PEDIATRICS	21, 126	0	3, 035	63, 121	0	30.00
	3100 INTENSIVE CARE UNIT	7, 198	o	1, 472		0	
	4300 NURSERY NCILLARY SERVICE COST CENTERS	0	0	248	5, 163	0	43.00
	5000 OPERATING ROOM	O	ol	2, 489	51, 774	0	50.00
	5200 DELIVERY ROOM & LABOR ROOM	0	o	649		0	
	5400 RADI OLOGY-DI AGNOSTI C	0	0	2, 908		0	
	6000 LABORATORY 6001 BLOOD LABORATORY	0	0	2, 331 0		0	60. 00 60. 01
65.00 0	6500 RESPIRATORY THERAPY	O	ō	1, 007	Ö	0	65.00
	6600 PHYSI CAL THERAPY	0	0	552		0	66.00
	6601 CARDI AC REHAB 6900 ELECTROCARDI OLOGY	0	0	301 222		0	66. 01 69. 00
70. 00 0	7000 ELECTROENCEPHALOGRAPHY	0	O	71		0	
	7100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	633		100	
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	0	0	C	1	0	
Ol	JTPATIENT SERVICE COST CENTERS	<u> </u>					
	9000 CLINIC	0	0	63		0	
	9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT	0	0	2, 420	50, 341	0	91. 00 92. 00
	THER REIMBURSABLE COST CENTERS						72.00
	9500 AMBULANCE SERVICES	0	0	2, 700		0	
	9910 CORF D100 HOME HEALTH AGENCY	0	0	1, 221		0	99. 10 101. 00
	PECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	1, 221	23, 403]101.00
	1300 INTEREST EXPENSE	_	_				113.00
116. 00 1° 118. 00	1600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 28, 324	0	112 24, 164			116. 00 118. 00
	ONREI MBURSABLE COST CENTERS	20, 324		24, 104	200, 146	100	1118.00
190. 00 19	9000 GIFT FLOWER COFFEE SHOP & CAN	0	0	C			190.00
	9100 RESEARCH 9200 PHYSICIANS PRIVATE OFFICES	0	0	C			191.00
	9200 PHYSICIANS PRIVATE OFFICES 9201 DEKALB MEDICAL SERVICES	0	0	7, 212	1		192. 00 192. 01
	9202 PHARMACARE	o	ō	1, 033			192. 02
	9203 OUTSOURCED DI ETI CI AN	0	0	C			192.03
	9204 BUSINESS HEALTH 9300 NONPAID WORKERS	0	0	C			192. 04 193. 00
	7950 OTHER NONREIMBURSABLE COST CENT	o o	Ö	C			194.00
	7951 ADULT DAY CARE	0	0	C	-1		194. 01
194. 02 0 200. 00	7952 FOUNDATION Cross Foot Adjustments	0	O	86	9	0	194. 02 200. 00
200.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	346, 632	О	801, 025	909, 613	412, 896	
203 00	Part I) Unit cost multiplier (West R Part I)	12 220102	0 000000	2/ 450715	3 404521	A 128 060000	203 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 238102	0. 000000	24. 650715	3. 496521	4, 128. 960000	µ∠U3. UU

3	DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 15-0045			Worksheet B-1	
Descri pti on	DI ETARY	SNACK BAR	CAFETERI A	NURSI NG	CENTRAL	
	,	(MEALS	(FTES)	ADMI NI STRATI O		
	SERVED)	SERVED)		N	SUPPLY	
				(DI RECT NRS	(COSTED	
				I NG)	REQUIS.)	
	10. 00	10. 01	11. 00	13.00	14. 00	
allocated (per Wkst. B,	39, 284	0	110, 81	1 44, 553	47, 508	204. 00
ultiplier (Wkst. B, Part	1. 386951	0. 000000	3. 41009	4 0. 171260	475. 080000	205. 00
						206. 00
						207. 00
	STICAL BASIS Description allocated (per Wkst. B, multiplier (Wkst. B, Part ment amount to be allocated B-2) ost multiplier (Wkst. D, mnd IV)	DIETARY (MEALS SERVED) 10.00 allocated (per Wkst. B, 39,284 aultiplier (Wkst. B, Part 1.386951 ment amount to be allocated B-2) cost multiplier (Wkst. D,	DIETARY (MEALS SERVED) DIETARY (MEALS SERVED) 10.00 10.01 allocated (per Wkst. B, 39,284 oultiplier (Wkst. B, Part 1.386951 0.000000 ment amount to be allocated B-2) cost multiplier (Wkst. D,	District District	Provider CCN: 15-0045 Period: From 10/01/2018	Provider CCN: 15-0045 Period: From 10/01/2018 To 09/30/2019 Date/Time Pre 2/25/2020 11: Description

Cost Center Description Planking Planking SCOLAR Scolar Sco				'	o 09/30/2019 Date/lime Pro 2/25/2020 11:	
SARRAMAL SERVICE CORST CENTRESS 15.00 16.00 17.00	Cost Center Description	(COSTED	RECORDS & LI BRARY	SERVI CE		
CHERNEL SERVICE COST CENTERS 1.00			NUE)	.=		
1.00 100000 100000 100000 100000 100000 100000	GENERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00		
1.01 OOTO MOR WEST 1.02 OOTO MORTH AMPEX 1.03 OOTO MORTH AMPEX 1.04 OOTO MORTH AMPEX 1.05 OOTO MORTH AMPEX 1.06 OOTO MORTH AMPEX 1.07 OOTO MORTH AMPEX 1.08 OOTO MORTH AMPEX 1.09 OOTO MORTH AMPEX 1.09 OOTO MORTH AMPEX 1.09 OOTO MORTH AMPEX 1.09 OOTO MORTH AMPEX 1.00 OOTO MORTH AMPEX 1.0						1.00
1.03 00103 CARRETT CLINI C						1.01
1.04 DOTO-10 HINTER 1.00						1.02
1.05 00106 MOB EAST						
1.0.7 00107] MEDICAL ARTS 1.0						
1.08 001008 SMALTZ WAY						1. 07
4.00						1. 08
5.00						2.00
0.0000 OPERATION OF PLANT						
8.00 00800 LANIBRY & LINEN SERVICE 9.00 00900 DISTARY 10.00 10.00 DISTARY						7.00
10.00 1000 DETARY						8.00
10.00 10.001 (SMACK BAR 11.00 11.00 (AFFTERIA 11.00 (AFFTERIA 11.0						9.00
11.00 01000 (AFETERIA 11.00 13.00 01300 (MIRS) MIRS MAX MIRS TRATION 13.00 13.00 01300 (MIRS) MIRS MAX M						10.00
13.00 01300 MURSING ADMINISTRATION 14.00 01400 (CENTRAL SERVICES & SUPPLY 10.00 10.00 01500 PHARMACY 10.00 10.00 01500 PHARMACY 10.00 10.00 01500 PHARMACY 10.00 10.00 01.00 01.00 11.00						•
14.00						
15.00 01500 PHARMACY 100 152.583,957 16.00 17.00						14.00
17. 00 01700 SOCIAL SERVICE 0 0 0 100 17. 00 17.		100				15.00
INPART ENT ROUTINE SERVICE COST CENTERS						16.00
30.00		0	0	100		17. 00
31.00 03100 INTENSIVE CARE UNIT 0 5.041, 350 0 31.04			10 217 727	100		20.00
43. 00 04300 NURSERY 0 1.004.680 0 43. 00						
50.00		l .				43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 2, 625, 532 0 52.00 54.00 5						
54.00 05400 RADIOLOGY-DI AGNOSTIC 0 33, 368, 812 0 60.00		1				50.00
60.00 06000 LABORATORY						
60.00				-		60.00
66.00 06600 PHYSI CAL THERAPY 0 6.6.17,684 0 666.00		o	0	-		60. 01
66.01 06601 06601 06601 06601 066000 066000 066000 066000 066000 066000 066000 06600		O	4, 923, 836	C		65.00
69, 00 06900 ELECTROCARDI OLOGY 0 337, 145 0 69, 00 70, 00 7000 ELECTROENCEPHALOCRAPHY 0 92, 279 0 70, 00 70, 00 7000 ELECTROENCEPHALOCRAPHY 0 97, 277, 045 0 71, 00 71, 00 71, 00 71, 00 72, 00 72, 00 72, 00 72, 00 72, 00 72, 00 72, 00 72, 00 72, 00 73, 00 7		=		-		66.00
70. 00 07000 CANON CALCETROENCEPHALOGRAPHY 0 9.727, 045 0 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 73. 00 7		ĭ		_		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 9,727,045 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 100 7,448,759 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 100 7,448,759 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 100 7,448,759 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 100 0 7,448,759 0 9. 00 07300 DRUGS CHARGED TO PATIENTS 100 0 0 311,361 0 90. 00 0900 CLI NI C 90. 00 09000 CLI NI C 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 9 0 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT 91. 00 09100 EMERGENCY 91. 00 0990 COMPRISED COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 99. 10 0910 CORP 0 0 0 99. 11 09910 CORP 0 0 0 0 99. 11 09910 CORP 0 0 0 0 99. 11 09910 CORP 0 0 0 0 99. 11 09910 CORP 0 0 0 0 99. 11 09910 CORP 100 0910 CORP 100 0 0 0 99. 11 09910 CORP 100 0910 CORP 100 0910 CORP 100 0 0 10 0 10 0 10 0 10 0 10 0 10 0		-		-		1
73.00 07300 DRUGS CHARGED TO PATIENTS 100 7, 448,759 0 73.00		_		_		71.00
OUTPATIENT SERVICE COST CENTERS O		O	0	C		72.00
90. 00		100	7, 448, 759	C		73.00
91.00 09100 EMERGENCY 09200 09SERVATI ON BEDS (NON-DI STI NCT 92.00 09500 09SERVATI ON BEDS (NON-DI STI NCT 92.00 09500 09			044 074		I	
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT OTHER REI MBURSABLE COST CENTERS 95. 00 90 0 0 0 95. 00 99. 10 09910 CORF 0 0 0 0 0 99. 10 00910 CORF 0 0 0 0 0 0 99. 10 00 0 0 0 0 10 10 10						•
OTHER REIMBURSABLE COST CENTERS 0 0 0 0 95.00		Ĭ	20, 077, 302			92.00
99. 10 09910 CORF 101.00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 113. 00 11300 I INTEREST EXPENSE 116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 100 161,990,629 100 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CAN 0 0 0 0 1910 RESEARCH 191. 00 19100 RESEARCH 0 0 0 0 0 192. 0						1
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00			0	_		95.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE		l .				
113. 00 11300 INTEREST EXPENSE 0 98,795 0 116. 00 116.00 118.00		<u> </u>	U	L.		101.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 100 161, 990, 629 100 118. 00 118. 00 190. 00 190. 00 190. 00 190. 00 191. 00 191. 00 191. 00 191. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 01 192. 01 192. 01 192. 01 192. 02 192. 02 192. 02 192. 02 192. 02 192. 02 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 04 192. 04 192. 04 192. 04 192. 04 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 194. 00 0 0 0 0 194. 00 194. 00 194. 01 07951 ADULT DAY CARE 0 0 0 0 0 194. 00 194. 00 194. 00 00 00 00 194. 00 194. 00 00 00 00 194. 00 194. 00 00 00 00 194. 00 194. 00 194. 00 00 00 00 194. 00 194. 00 00 00 00 194. 00 194. 00 00 00 00 194. 00 00 00 00 194. 00 00 00 00 00 00 194. 00 00 00 00 00 00 00 00						113.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 0 191.00 191.00 191.00 191.00 192.00	116. 00 11600 H0SPI CE	o	98, 795	C		116.00
190. 00		100	161, 990, 629	100		118. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 192. 00 192. 01 19201 DEKALB MEDICAL SERVICES 0 16, 083, 142 0 19202 PHARMACARE 192. 02 19202 PHARMACARE 0 4, 510, 186 0 192. 00 192. 04 192. 04 19204 BUSINESS HEALTH 0 0 0 0 0 19300 NONPAID WORKERS 0 0 0 0 0 0 19300 NONPAID WORKERS 0 0 0 0 0 0 193. 00 194. 00 07950 OTHER NONREI MBURSABLE COST CENT 0 0 0 0 0 0 194. 00 194. 01 107951 ADULT DAY CARE 0 0 0 0 0 0 194. 00 194. 02 07952 FOUNDATION 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, P91, 920 496, 684 134, 591		ا	ما		ıl	100.00
192.00			0			
192. 01 19201 DEKALB MEDI CAL SERVI CES 192. 02 19202 PHARMACARE 192. 03 19203 OUTSOURCED DI ETI CI AN 192. 04 19204 BUSI NESS HEALTH 193. 00 19300 NONPAI D WORKERS 194. 00 07950 OTHER NONREI MBURSABLE COST CENT 194. 01 07951 ADULT DAY CARE 194. 02 07952 FOUNDATI ON 194. 02 07952 FOUNDATI ON 194. 02 07952 Cost to be allocated (per Wkst. B, P91, 920 A96, 684 Part I) 197. 04 19204 BUSI NESS HEALTH 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Ö	Ö	-		192.00
192. 03 19203 OUTSOURCED DIETICIAN 0 0 0 192. 04 19204 BUSINESS HEALTH 0 0 0 0 193. 00 194. 00		o	16, 083, 142	C		192. 01
192.04 19204 BUSI NESS HEALTH 0 0 0 0 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 19500 OTHER NONREI MBURSABLE COST CENT 0 0 0 0 194.00 197951 ADULT DAY CARE 0 0 0 0 194.00 194.00 197952 FOUNDATI ON 0 0 0 194.00 194.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 200.00 Cost to be allocated (per Wkst. B, Part I) 991,920 496,684 134,591 202.00		0	4, 510, 186	C		192. 02
193.00 19300 NONPAID WORKERS 194.00 07950 OTHER NONREIMBURSABLE COST CENT 194.01 07951 ADULT DAY CARE 194.02 07952 FOUNDATION 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 193.00 0 0 0 0 0 194.00 194.00 194.01 195.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	C		192.03
194. 00 07950 OTHER NONREIMBURSABLE COST CENT 0 0 0 194. 00 194. 01 07951 ADULT DAY CARE 0 0 0 0 194. 02 07952 FOUNDATION 0 0 0 194. 02 07952 FOUNDATION 0 0 0 194. 02 07952 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 496, 684 134, 591 202. 00			0			
194. 01 07951 ADULT DAY CARE 0 0 0 0 194. 02 194. 02 194. 02 1955 FOUNDATION 0 0 0 194. 02 200. 00 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 991, 920 496, 684 134, 591 202. 00			0	ď		194.00
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 991,920 496,684 134,591 202.00 202.0		o	0	C		194. 01
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 991,920 496,684 134,591 202.00 202		o	0	C		194. 02
202.00 Cost to be allocated (per Wkst. B, 991,920 496,684 134,591 202.00						200.00
Part I)		001 020	104 401	12/ EO1		•
		771, 720	470, 004	134, 391		202.00
		9, 919. 200000	0. 002720	1, 345. 910000		203.00
	· · · · · · · · · · · · · · · · · · ·					

Health Financial Systems DEKALB I			AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co	CN: 15-0045	Peri od: From 10/01/2018 To 09/30/2019	Worksheet B-1 Date/Time Pre	pared:
						2/25/2020 11:	43 am
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL			
		(COSTED	RECORDS &	SERVI CE			
		REQUIS.)	LI BRARY	(TIME SPENT)			
			(GROSS REVE				
			NUE)				
		15. 00	16. 00	17. 00			
204. 00	Cost to be allocated (per Wkst. B, Part II)	46, 349	53, 349	7, 15	52		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	463. 490000	0. 000292	71. 52000	00		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C	
				From 10/01/2018		
				To 09/30/2019	Date/Time Pre	pared:
					2/25/2020 11:	43 am_
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1 00	2.00	2 00	4 00	E 00	

			7,7,111	nospi tui	113	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 908, 318		4, 908, 318		4, 916, 037	
31.00 03100 INTENSIVE CARE UNIT	2, 456, 228		2, 456, 228		2, 463, 947	
43. 00 04300 NURSERY	383, 290		383, 290	0	383, 290	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 669, 443		4, 669, 443		4, 889, 096	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 818, 806		1, 818, 806		1, 818, 806	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 198, 224	l e	4, 198, 224		4, 198, 224	
60. 00 06000 LABORATORY	4, 309, 061		4, 309, 061	0	4, 309, 061	
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	1, 130, 028	0	1, 130, 028	0	1, 130, 028	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 974, 442	0	1, 974, 442	0	1, 974, 442	
66. 01 06601 CARDI AC REHAB	455, 108	0	455, 108	0	455, 108	66. 01
69. 00 06900 ELECTROCARDI OLOGY	238, 158		238, 158	0	238, 158	69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY	82, 150		82, 150	0	82, 150	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	2, 264, 221		2, 264, 221	0	2, 264, 221	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 130, 286		1, 130, 286	0	1, 130, 286	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 905, 169		4, 905, 169	0	4, 905, 169	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	129, 709		129, 709	0	129, 709	90.00
91. 00 09100 EMERGENCY	3, 227, 645		3, 227, 645	0	3, 227, 645	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	2, 052, 285		2, 052, 285		2, 052, 285	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 002, 508		2, 002, 508	0	2, 002, 508	95.00
99. 10 09910 CORF	0		0		0	99. 10
101.00 10100 HOME HEALTH AGENCY	1, 312, 075		1, 312, 075		1, 312, 075	101.00
SPECIAL PURPOSE COST CENTERS	·					
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	566, 957		566, 957		566, 957	116.00
200.00 Subtotal (see instructions)	44, 214, 111	0	44, 214, 111	235, 091	44, 449, 202	200.00
201.00 Less Observation Beds	2, 052, 285		2, 052, 285		2, 052, 285	201.00
202.00 Total (see instructions)	42, 161, 826	0	42, 161, 826	235, 091	42, 396, 917	202. 00

CMS-2552-10
et C ne Prepared:

				-		То	09/30/2019	Date/Time Pre 2/25/2020 11:	
			Title XVIII				Hospi tal	PPS	
				Charges					
		Cost Center Description	Inpatient	Outpati ent	Total (col. (6 Cc		TEFRA	
					+ col. 7)		Ratio	I npati ent	
								Ratio	
	I		6. 00	7. 00	8. 00		9. 00	10. 00	
		IENT ROUTINE SERVICE COST CENTERS							
		ADULTS & PEDIATRICS	10, 128, 160		10, 128, 16				30.00
		INTENSIVE CARE UNIT	5, 003, 850		5, 003, 85				31.00
43.00		NURSERY	1, 006, 387		1, 006, 38	7			43.00
		LARY SERVICE COST CENTERS	7 070 07/	0.4.000.000			0.440700		
		OPERATING ROOM	7, 379, 976	24, 003, 008			0. 148789	0. 000000	
		DELIVERY ROOM & LABOR ROOM	2, 496, 761	111, 544			0. 697313	0. 000000	
		RADI OLOGY-DI AGNOSTI C	3, 600, 932	29, 257, 048			0. 127769	0. 000000	54.00
		LABORATORY	3, 862, 866	22, 482, 901			0. 163558	0. 000000	60.00
		BLOOD LABORATORY	0	0		0	0. 000000	0. 000000	
		RESPI RATORY THERAPY	3, 259, 740	1, 617, 028			0. 231717	0. 000000	
		PHYSI CAL THERAPY	674, 373	5, 841, 590			0. 303016	0. 000000	
		CARDI AC REHAB	9, 513	643, 977			0. 696427	0. 000000	
		ELECTROCARDI OLOGY	45, 213	287, 432			0. 715952	0. 000000	69. 00
		ELECTROENCEPHALOGRAPHY	1, 000	913, 012			0. 089878	0. 000000	
		MEDICAL SUPPLIES CHARGED TO PAT	1, 261, 266	3, 552, 618			0. 470352	0. 000000	
		IMPL. DEV. CHARGED TO PATIENTS	2, 543, 782	2, 279, 210			0. 234354	0. 000000	
73. 00		DRUGS CHARGED TO PATIENTS	1, 346, 628	5, 993, 732	7, 340, 36	0	0. 668246	0. 000000	73.00
		TIENT SERVICE COST CENTERS							
		CLINIC	1, 532	304, 720			0. 423537	0. 000000	
		EMERGENCY	2, 304, 828	17, 488, 249			0. 163069	0. 000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT	15, 000	3, 977, 851	3, 992, 85	1	0. 513990	0. 000000	92.00
		REIMBURSABLE COST CENTERS	,						
		AMBULANCE SERVICES	247	7, 042, 139			0. 284351	0. 000000	
99. 10			0	0		0			99. 10
101.00		HOME HEALTH AGENCY	0	1, 543, 216	1, 543, 21	6			101. 00
		AL PURPOSE COST CENTERS							
		INTEREST EXPENSE							113.00
	1	HOSPI CE	98, 795	0					116. 00
200.00	1	Subtotal (see instructions)	45, 040, 849	127, 339, 275	172, 380, 12	4			200. 00
201.00	1	Less Observation Beds							201. 00
202.00)	Total (see instructions)	45, 040, 849	127, 339, 275	172, 380, 12	4			202. 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: 15-0045	Peri od: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Prepared: 2/25/2020 11:43 am

Title XVIII Hospital PPS					2/25/2020 11:43 am	
NPATI ENT ROUTINE SERVICE COST CENTERS 11.00			Title XVIII	Hospi tal	PPS	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 031.00 03100 INTENSI VE CARE UNIT 31.00 03400 INTENSI VE CARE UNIT 31.00 03500 DELI VERY ROOM & LABOR ROOM 0.697313 52.00 05400 RADI OLOGY-DI AGROSTI C 0.127769 54.00 06.00 06000 LABORATORY 0.163558 06.00 06.00 06000 LABORATORY 0.000000 06.01 06001 06001 06001 06000 03600 RESPI RATORY THERAPY 0.231717 06.01 06.00 06000 04800 CARDIA TORY THERAPY 0.303016 06.00 06000 04800 CARDIA CREHAB 0.696427 06.00 06000 0480000 0480000 0480000 04800000 048000000 0480000000 04800000000 0480000000000	Cost Center Description	PPS Inpatient				
NPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 30.00 300 ADULTS & PEDI ATRI CS 31.00 31.00 31.00 31.00 INTENSI VE CARE UNIT 31.00 43.00		Ratio				
30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 03100 INTENSIVE CARE UNIT 31. 00 ANGILLARY SERVICE COST CENTERS 43. 00 ANGILLARY SERVICE COST CENTERS 50. 00 50.00		11. 00				
31.00 03100 INTENSI VE CARE UNIT 31.00 04300 NURSERY 43.00 050000 050000 050000 050000 050000 050000 050000 050000 0500000 0500000 0500000 050						
43. 00						
ANCILLARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT				31.00	0
50. 00 05000 DERATI NG ROOM 0.155788 50. 00					43.00	0
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 697313 0. 167305 0. 127769 0. 16000 0. 00 0. 0000 LABORATORY 0. 163558 0. 00 0. 0000 DELI VERY ROOM & LABORATORY 0. 0000000 0. 00000 DELI ORDATORY 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 127769 0. 163558 0. 00 06000 LABORATORY 0. 163558 0. 00 06000 LABORATORY 0. 0000000 0. 06000 0. 06000 0. 06000 0. 06000 0. 06000 0. 06500 RESPI RATORY THERAPY 0. 231717 0. 06500 RESPI RATORY THERAPY 0. 303016 0. 000000 0. 06000 0. 06000 PHYSI CAL THERAPY 0. 303016 0. 000000 0. 060000 0. 060000 0. 060000 0. 060000 0. 060000 0. 060000 0. 0600000 0. 0600000000 0. 060000000000		0. 155788				
60. 00 06000 LABORATORY 0. 163558 60. 00 60. 01 6001 BLOOD LABORATORY 0. 000000 60. 01 60500 RESPI RATORY THERAPY 0. 303016 66. 00 66. 00 66. 00 66. 00 66. 01 66. 00 66. 01	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 697313			52.00	0
60. 01 06001 BLOOD LABORATORY 0.000000 65. 00 65. 00 665. 00 665. 00 665. 00 666. 00 06600 PHYSI CAL THERAPY 0.303016 66. 00 06600 PHYSI CAL THERAPY 0.303016 66. 00 06600 CARDI AC REHAB 0.696427 66. 01 69. 00 06900 ELECTROCARDI OLOGY 0.715952 69. 00 70. 00 7000 ELECTROCARDI OLOGY 0.715952 70. 00 7000 ELECTROCHALOGRAPHY 0.089878 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0.470352 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.234354 72. 00 73. 00 DRUGS CHARGED TO PATI ENTS 0.668246 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.668246 73. 00 09000 CLI NI C 0.423537 90. 00 91. 00 09100 EMERGENCY 0.163069 91. 00 92. 00 09SERVATION BEDS (NON-DISTINCT 0.513990 07HER REI MBURSABLE COST CENTERS 95. 00 09910 CORF 09910 CORF 99. 10 00910 CORF 99. 10 00910 LORF 101. 00 10100 HOME HEALTH AGENCY 99. 10 101. 00 10100 HOME HEALTH AGENCY 99. 10 101. 00 10100 HOME HEALTH AGENCY 99. 10 101. 00 1000 HOME HEALTH AGENCY 99. 10 100. 00 0.500 0.	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 127769			54.00	0
65. 00 06500 RESPIRATORY THERAPY 0. 231717 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 303016 66. 00 66. 01 06601 CARDI AC REHAB 0. 696427 66. 01 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 69. 00 70. 00 07000 ELECTROCREPHALOGRAPHY 0. 889878 70. 00 71. 00 07000 ELECTROCREPHALOGRAPHY 0. 470352 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 234354 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 73. 00 00TPATIENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 423537 90. 00 99. 00 09000 DRUGS CHARGED TO PATI NOT 0. 513990 92. 00 00TPATIENT SERVI CE COST CENTERS 95. 00 09200 DRUGS CHARGED TO PATI NOT 0. 513990 92. 00 00TPATIENT SERVI CE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 284351 95. 00 99. 10 09910 CORF 99. 10 101. 00 10100 HOME HEALTH AGENCY 99. 10 101. 00 10100 HOME HEALTH AGENCY 113. 00 116. 00 11300 I NTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	60. 00 06000 LABORATORY	0. 163558			60.00	0
66. 00	60. 01 06001 BLOOD LABORATORY	0. 000000			60.0	1
66. 01 06601 CARDI AC REHAB 0. 696427 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 69. 00 07000 ELECTROCARDI OLOGY 0. 715952 69. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0. 470352 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 234354 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 668246 73. 00 000 09000 CLI NI C 0. 468246 91. 00 09100 EMERGENCY 0. 163069 91. 00 09100 EMERGENCY 0. 163069 91. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT 0. 513990 071HER REI MBURSABLE COST CENTERS 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 09910 CORF 99. 10 101. 00 10100 HOME HEALTH AGENCY 99. 10 101. 00 10100 HOME HEALTH AGENCY 101. 00 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 00 201. 00 Less Observation Beds	65. 00 06500 RESPIRATORY THERAPY	0. 231717			65.00	0
69. 00 06900 ELECTROCARDI OLOGY 0. 715952 69. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0. 470352 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 234354 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 73. 00 07100 EMERGENCY 0. 163069 91. 00 09100 EMERGENCY 0. 163069 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 0. 513990 92. 00 0710R REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 284351 95. 00 99. 10 101. 00 10100 HOME HEALTH AGENCY 99. 10 101. 00 10100 HOME HEALTH AGENCY 101. 00 10100 HOME HEALTH AGENCY 101. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00	66. 00 06600 PHYSI CAL THERAPY	0. 303016			66.00	0
70. 00	66. 01 06601 CARDI AC REHAB	0. 696427			66. O	1
71. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 715952			69.00	0
72. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 089878			70.00	0
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 668246 73. 00 00 00 00 00 00 00 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 470352			71. 00	0
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.423537 90.00 91.00 09100 EMERGENCY 0.163069 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 0.513990 92.00 O9500 AMBULANCE SERVICES 0.284351 95.00 99.10 09910 CORF 99.10 10100 HOME HEALTH AGENCY 99.10 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11600 HOSPICE 116.00 1000 HOSPICE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234354			72.00	0
90. 00 09000 CLINIC 0. 423537 90. 00 91. 00 09100 EMERGENCY 0. 163069 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT 0. 513990 071HER REIMBURSABLE COST CENTERS 0. 284351 95. 00 09910 CORF 99. 10 09910 CORF 99. 10 10100 HOME HEALTH AGENCY 99. 10 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 116.00 HOSPICE 116. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 668246			73.00	0
91. 00 09100 EMERGENCY 0. 163069 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 0. 513990 92. 00 00	OUTPATIENT SERVICE COST CENTERS					
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT 0. 513990 0. 513990 0. 513990 0. 513990 0. 513990 0. 284351 0.	90. 00 09000 CLINIC	0. 423537			90.00	0
OTHER REI MBURSABLE COST CENTERS 95.00 995.00 AMBULANCE SERVI CES 0.284351 95.00 99.10 09910 CORF 99.10 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 116.00 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91. 00 09100 EMERGENCY	0. 163069			91.00	0
95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 513990			92.00	0
99. 10 09910 CORF 99. 10 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 116.00 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	OTHER REIMBURSABLE COST CENTERS					
101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	95. 00 09500 AMBULANCE SERVICES	0. 284351			95.00	0
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11600	99. 10 09910 CORF				99. 10	0
113. 00	101.00 10100 HOME HEALTH AGENCY				101. 00	0
116. 00 116.00 200. 00 Subtotal (see instructions) 201. 00 Less Observation Beds	SPECIAL PURPOSE COST CENTERS					
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	113. 00 11300 I NTEREST EXPENSE				113. 00	0
201.00 Less Observation Beds 201.00	116. 00 11600 HOSPI CE				116. 00	0
201.00 Less Observation Beds 201.00	200.00 Subtotal (see instructions)				200. 00	0
					201. 00	0
	202.00 Total (see instructions)				202. 00	0

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Pre 2/25/2020 11:	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Li mi t Adj .	Total Costs	RCE Di sal I owance	Total Costs	

-						2/23/2020 11.	75 am
	,		Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
I NE	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 030	000 ADULTS & PEDIATRICS	4, 908, 318		4, 908, 318	7, 719	4, 916, 037	30.00
31. 00 03	100 INTENSIVE CARE UNIT	2, 456, 228		2, 456, 228	7, 719	2, 463, 947	31.00
43.00 043	300 NURSERY	383, 290		383, 290	0	383, 290	43.00
ANG	CILLARY SERVICE COST CENTERS						1
	OOO OPERATING ROOM	4, 669, 443		4, 669, 443	219, 653	4, 889, 096	50.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM	1, 818, 806		1, 818, 806	0	1, 818, 806	52.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	4, 198, 224		4, 198, 224	0	4, 198, 224	54.00
60.00 060	000 LABORATORY	4, 309, 061		4, 309, 061	0	4, 309, 061	60.00
	001 BLOOD LABORATORY	0		(0	0	1
65. 00 06!	500 RESPI RATORY THERAPY	1, 130, 028	0	1, 130, 028	0	1, 130, 028	65.00
66.00 066	600 PHYSI CAL THERAPY	1, 974, 442		1, 974, 442		1, 974, 442	66.00
66, 01 066	601 CARDI AC REHAB	455, 108	ł	455, 108		455, 108	66. 01
69. 00 069	900 ELECTROCARDI OLOGY	238, 158		238, 158		238, 158	69.00
	000 ELECTROENCEPHALOGRAPHY	82, 150		82, 150		82, 150	
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PAT	2, 264, 221		2, 264, 221		2, 264, 221	
	200 IMPL. DEV. CHARGED TO PATIENTS	1, 130, 286		1, 130, 286		1, 130, 286	1
	300 DRUGS CHARGED TO PATIENTS	4, 905, 169		4, 905, 169		4, 905, 169	
	TPATIENT SERVICE COST CENTERS						
	DOO CLINIC	129, 709		129, 709	0	129, 709	90.00
91.00 09	100 EMERGENCY	3, 227, 645	l .	3, 227, 645			
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT	2, 052, 285	l .	2, 052, 285		2, 052, 285	1
	HER REIMBURSABLE COST CENTERS					, , , , , , ,	
	500 AMBULANCE SERVICES	2, 002, 508		2, 002, 508	0	2, 002, 508	95.00
99. 10 099		0				0	1
	100 HOME HEALTH AGENCY	1, 312, 075		1, 312, 075		1, 312, 075	1
	ECIAL PURPOSE COST CENTERS	., .,		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		.,, = . = , =	1
	300 INTEREST EXPENSE						113.00
	600 HOSPI CE	566, 957		566, 957	,	566, 957	
200.00	Subtotal (see instructions)	44, 214, 111					
201.00	Less Observation Beds	2, 052, 285	l e	2, 052, 285		2, 052, 285	
202.00	Total (see instructions)	42, 161, 826					
_02.00	1	.2, .3., 020		1 .2, .5., 626	200,071	1 .2,0,0,717	

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0045	Peri od: Worksheet C From 10/01/2018 Part I To 09/30/2019 Date/Time Prepared:

					Го 09/30/2019	Date/Time Pre 2/25/2020 11:	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
		/ 00	7.00	0.00	0.00	Rati o	
	INDATION DOUTING CODY CO COCT CONTEDC	6. 00	7. 00	8. 00	9. 00	10.00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	10 100 1/0		10 100 144	\		30.00
		10, 128, 160		10, 128, 160			
	03100 NTENSIVE CARE UNIT	5, 003, 850		5, 003, 850			31.00 43.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 006, 387		1, 006, 38	/		43.00
FO 00	05000 OPERATING ROOM	7 270 07/	24 002 000	21 202 00	0 140700	0.000000	-0.00
50.00		7, 379, 976	24, 003, 008			0. 000000 0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 496, 761	111, 544				
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 600, 932	29, 257, 048			0.000000	
60.00	06000 LABORATORY	3, 862, 866	22, 482, 901			0.000000	
60. 01	06001 BLOOD LABORATORY	0	1 (17 020			0.000000	
	06500 RESPIRATORY THERAPY	3, 259, 740	1, 617, 028			0.000000	
66.00	06600 PHYSI CAL THERAPY	674, 373	5, 841, 590			0.000000	
66. 01	06601 CARDI AC REHAB	9, 513	643, 977			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	45, 213	287, 432			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	1, 000	913, 012			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 261, 266	3, 552, 618			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 543, 782	2, 279, 210			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 346, 628	5, 993, 732	7, 340, 360	0. 668246	0. 000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	1, 532	304, 720			0. 000000	
	09100 EMERGENCY	2, 304, 828	17, 488, 249			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	15, 000	3, 977, 851	3, 992, 85	0. 513990	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	,		r	, ,		
95.00	09500 AMBULANCE SERVICES	247	7, 042, 139			0. 000000	95.00
	09910 CORF	0	0		1		99. 10
101.00	10100 HOME HEALTH AGENCY	0	1, 543, 216	1, 543, 21	5		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	98, 795	0	98, 79			116. 00
200.00		45, 040, 849	127, 339, 275	172, 380, 12	1		200. 00
201.00							201.00
202.00	Total (see instructions)	45, 040, 849	127, 339, 275	172, 380, 12	1		202. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAI	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	DETAILED MEMORITY	Provi der CCN: 15-0045	Peri od: From 10/01/2018	Worksheet C Part I Date/Time Pre	pared:
		Title XIX	Hospi tal	2/25/2020 11: Cost	43 alli
Cost Center Description	PPS Inpatient Ratio				

		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					1
30.00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					1
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
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. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLI NI C	0. 000000				90.00
91. 00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					1
95. 00 09500 AMBULANCE SERVI CES	0. 000000				95.00
99. 10 09910 CORF					99. 10
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					1
113.00 11300 I NTEREST EXPENSE					113. 00
116. 00 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 Co		Peri od:	Worksheet D	
				From 10/01/2018 Fo 09/30/2019		narod:
				10 077 307 2017	2/25/2020 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	497, 031	0	497, 03		89. 86	
31.00 INTENSIVE CARE UNIT	210, 084		210, 08			
43. 00 NURSERY	35, 440		35, 44		52. 66	
200.00 Total (lines 30 through 199)	742, 555		742, 55	7, 326		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, 106				l	30.00
31.00 INTENSIVE CARE UNIT	282	·	1		l	31.00
43. 00 NURSERY	0	0			ļ	43.00
200.00 Total (lines 30 through 199)	1, 388	152, 187				200. 00

Health Financial Systems	DEKALB MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2018 To 09/30/2019		narod:
				10 07/30/2017	2/25/2020 11:	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	667, 807		•		36, 801	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	488, 472		•		71	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	369, 582				19, 123	54.00
60. 00 06000 LABORATORY	202, 637	26, 345, 767			10, 201	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.0000		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	49, 675				8, 972	65.00
66. 00 06600 PHYSI CAL THERAPY	195, 700				8, 506	66.00
66. 01 06601 CARDI AC REHAB	97, 963	653, 490	0. 14990	7 2, 892	434	66. 01
69. 00 06900 ELECTROCARDI OLOGY	3, 156	332, 645	0. 00948	8 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 358	914, 012	0. 00148	674	1	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	65, 185	4, 813, 884	0. 01354	1 589, 319	7, 980	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	7, 920	4, 822, 992	0. 00164	2 704, 290	1, 156	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	75, 803	7, 340, 360	0. 01032	414, 877	4, 284	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 707	306, 252	0. 00557	4 967	5	90.00
91. 00 09100 EMERGENCY	313, 925	19, 793, 077	0. 01586	0 1, 039, 145	16, 481	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	207, 494	3, 992, 851	0. 05196	6 14, 344	745	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 748, 384	147, 557, 330		8, 686, 829	114, 760	200 00

Nursing School Nurs	Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments School Post-Stepdown Adjustments Nursing School Post-Stepdown Ad	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			From 10/01/2018	Part III Date/Time Pre	epared: 43 am
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2A 2.00 3.00			Title	e XVIII	Hospi tal	PPS	
NPATIENT ROUTINE SERVICE COST CENTERS Adjustments Adjustments Adjustments Adjustments 1	Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
INPATIENT ROUTINE SERVICE COST CENTERS Adjustments 1.00 2A 2.00 3.0		School	School	Post-Stepdowr	Cost	Medi cal	
INPATIENT ROUTINE SERVICE COST CENTERS		Post-Stepdown		Adjustments		Educati on	
INPATIENT ROUTINE SERVICE COST CENTERS 1						Cost	
1			1.00	2A	2. 00	3. 00	
1	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		•	•		
A3.00 Q4300 NURSERY O O O O O O O O O	30. 00 03000 ADULTS & PEDIATRICS	0	C		0 0	0	30.00
Total (lines 30 through 199)	31.00 03100 INTENSIVE CARE UNIT	0	l		0	0	31.00
Note Cost Center Description Swing-Bed Adjustment Amount (see instructions) Inpatient Inpa	43. 00 04300 NURSERY	0		ol	0 0	0	43.00
Cost Center Description	200.00 Total (lines 30 through 199)	0		ol	0	0	200.00
Amount (see instructions) 1 through 3, minus col. 4)	Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	Inpatient	
INPATIENT ROUTINE SERVICE COST CENTERS		Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS		Amount (see	1 through 3,		col. 6)		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 0 5, 531 0. 00 1, 106 30. 00 31. 00 03000 ADULTS & PEDI ATRI CS 0 0 1, 122 0. 00 282 31. 00 04300 NURSERY 0 673 0. 00 0 43. 00 04300 NURSERY 0 7, 326 0 1, 388 200. 00 0 0 0 0 0 0 0 0		instructions)	minus col. 4)				
30. 00		4. 00	5. 00	6. 00	7. 00	8. 00	
31. 00	INPATIENT ROUTINE SERVICE COST CENTERS						
43. 00	30. 00 03000 ADULTS & PEDIATRICS	0	C	5, 53	0.00	1, 106	30.00
Total (lines 30 through 199) 0 7,326 1,388 200.00	31.00 03100 INTENSIVE CARE UNIT		C	1, 12	0.00	282	31.00
Cost Center Description	43. 00 04300 NURSERY		C	67	0.00	0	43.00
Program Pass-Through Cost (col. 7 x col. 8) 9.00	200.00 Total (lines 30 through 199)		C	7, 32	6	1, 388	200.00
Pass-Through Cost (col . 7 x col . 8) 9.00	Cost Center Description	I npati ent					
Cost (col . 7 x col . 8) 9.00		Program					
X COİ . 8) 9.00		Pass-Through					
9.00 I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 0 31.00 31.00 03100 INTENSI VE CARE UNI T 0 31.00 43.00 04300 NURSERY 0 43.00		Cost (col. 7					
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 0 31.00 31.00 INTENSIVE CARE UNIT 0 31.00 43.00 NURSERY 0 43.00		x col. 8)					
30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 00 31. 00 03100 INTENSI VE CARE UNI T 0 31. 00 04300 NURSERY 0 43. 00		9. 00					
31. 00 03100 INTENSIVE CARE UNIT 0 31. 00 43. 00 04300 NURSERY 0 43. 00							
43. 00 04300 NURSERY 0 43. 00		0					
		0					
200.00 Total (lines 30 through 199) 0 200.00		0					43.00
	200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0045	From 10/01/2018	Worksheet D Part IV Date/Time Prepared: 2/25/2020 11:43 am
		T' 11 . \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11	20

				'		2/25/2020 11:	43 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
66. 01	06601 CARDI AC REHAB	0	0	C	0	0	66. 01
69.00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	C	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0		(0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200.00

Health Financial Systems	DEKALB MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0045	Peri od: From 10/01/2018 To 09/30/2019	Worksheet D Part IV Date/Time Prepared: 2/25/2020 11:43 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	All Other	Total Cost Total	Total Charges	Ratio of Cost

			'	0 077 007 2017	2/25/2020 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		1		04 000 004		
50. 00 05000 OPERATING ROOM	0	0		31, 382, 984		1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		2, 608, 305		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		32, 857, 980		1
60. 00 06000 LABORATORY	0	0		26, 345, 767		
60. 01 06001 BLOOD LABORATORY	0	0		0	0.000000	1
65. 00 06500 RESPIRATORY THERAPY	0	0		4, 876, 768		
66. 00 06600 PHYSI CAL THERAPY	0	0		6, 515, 963		1
66. 01 06601 CARDI AC REHAB	0	0		653, 490		
69. 00 06900 ELECTROCARDI OLOGY	0	0		332, 645		1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		914, 012		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		4, 813, 884		1
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENTS	0	0		4, 822, 992		l
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0		7, 340, 360	0. 000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	306, 252		
91. 00 09100 EMERGENCY	0	0	C	19, 793, 077		1
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT	0	0	C	3, 992, 851	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	[C	147, 557, 330		200. 00

Health Financial Systems	DEKALB MEMORIA	AL HOSPLTAL		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS				Period: From 10/01/2018 To 09/30/2019	Worksheet D Part IV	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)	10.00	x col . 10)	10.00	x col . 12)	
ANOULLARY OFFICE OCCUPANTED	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000	1 700 110				
50. 00 05000 OPERATI NG ROOM	0. 000000	1, 729, 448		5, 286, 226		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	377	(0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 700, 121	(5, 749, 386		54.00
60. 00 06000 LABORATORY	0. 000000	1, 326, 378	(1, 856, 916	1	60.00
60. 01 06001 BL00D LABORATORY	0. 000000	0	(0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 000000	880, 799		179, 537		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	283, 198		37, 908		66. 00
66. 01 06601 CARDI AC REHAB	0. 000000	2, 892		222, 470		66. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		114, 015		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	674		205, 428	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	589, 319		560, 875	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	704, 290		573, 997	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000	414, 877	(2, 069, 706	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	967	(74, 815	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 039, 145		2, 572, 483	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	14, 344		544, 908	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		8, 686, 829		20, 048, 670	0	200. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
				From 10/01/2018		
				To 09/30/2019		
		T: 11	V0/11.1		2/25/2020 11:	43 am_
		litie	XVIII	Hospi tal	PPS	
		550	Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Servi ces (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						1
50.00 05000 OPERATING ROOM	0. 148789			0	786, 532	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 697313			0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 127769	5, 749, 386		0	734, 593	54.00
60. 00 06000 LABORATORY	0. 163558	1, 856, 916		0	303, 713	60.00
60. 01 06001 BL00D LABORATORY	0. 000000	0		0 0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0. 231717	179, 537		0 0	41, 602	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 303016	37, 908		0	11, 487	66.00
66. 01 06601 CARDI AC REHAB	0. 696427	222, 470		0	154, 934	66. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 715952	114, 015		0	81, 629	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 089878	205, 428		0	18, 463	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 470352	560, 875		0	263, 809	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234354	573, 997		0	134, 518	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 668246	2, 069, 706		0 9, 226	1, 383, 073	73.00
OUTPATIENT SERVICE COST CENTERS				-		1
90. 00 09000 CLI NI C	0. 423537	74, 815		0 0	31, 687	90.00
91. 00 09100 EMERGENCY	0. 163069	2, 572, 483		0	419, 492	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 513990	544, 908		0 0	280, 077	92.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		1
95. 00 09500 AMBULANCE SERVI CES	0. 284351			0		95.00
200.00 Subtotal (see instructions)		20, 048, 670		0 9, 226	4, 645, 609	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		20, 048, 670		0 9, 226	4, 645, 609	202.00
, ,	1		•			

Health Financial Systems	DEKALB MEMORI.	AL HOSPITAL		In Lieu	of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0045	Peri od: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Pre 2/25/2020 11:	pared: 43 am
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To				

		Cos	sts	
	Cost Center Description	Cost	Cost	
		Rei mbursed	Rei mbursed	
		Servi ces	Services Not	
		Subject To	Subject To	
		Ded. & Coins.		
		(see inst.)	(see inst.)	
		6. 00	7. 00	
	ANCILLARY SERVICE COST CENTERS			4
50.00	05000 OPERATING ROOM	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	66.00
66. 01	06601 CARDI AC REHAB	0	0	66. 01
69. 00	06900 ELECTROCARDI OLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 165	73.00
	OUTPATIENT SERVICE COST CENTERS			1
90.00	09000 CLI NI C	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	0	6, 165	200.00
201.00		0		201.00
	Only Charges			
202.00		0	6, 165	202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0045	From 10/01/2018	Date/Time Prepared:
			2/25/2020 11:43 am
	Title XVIII	Hospi tal	PPS

			10 077 007 2017	2/25/2020 11:	43 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	F			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	I NPATI ENT DAYS			F F21	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 531	1. 00 2. 00
	Private room days (excluding swing-bed and observation bed da	sivata room days	5, 531 0		
3. 00	do not complete this line.	ys). IT you have only pr	ivate room days,	Ü	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	3, 222	4.00		
5. 00	Total swing-bed SNF type inpatient days (including private ro	3, 222	5.00		
3.00	reporting period	U	3.00		
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days, arts. becomber	0. 0. 1 0001	Ü	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excludinç	g swing-bed and	1, 106	9. 00
10.00	newborn days)	-1 (!1!!!		0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private)	coom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12. 00
.2.00	through December 31 of the cost reporting period	7. o y (1.1.o. da. 1.1g p. 1. va	lo room dayo,	Ü	.2.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lin	ne)		
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	
16. 00	Nursery days (title V or XIX only)	0	16. 00		
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	0.00	18. 00		
10.00	reporting period	es al tel December 31 01	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
	reporting period	g			
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instruction			4, 916, 037	•
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ting period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	ng period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 21 of the cost reporti	ng poriod (line	0	24. 00
24.00	7 x line 19)	1 31 01 the cost reporti	ng perrou (Trie	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25. 00
20.00	x line 20)	or or the oper reperting	, por rou (11110 0	Ü	20.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 916, 037	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	•
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	•
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	stions)	0. 00 0. 00		
35.00	Average per diem private room cost differential (line 34 x li	0.00			
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
57.00	27 minus line 36)	p	5. 5.161 (11116	1, 710, 037	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see			888. 82	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			983, 035	39. 00
40.00	Medically necessary private room cost applicable to the Progr	,		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		983, 035	41.00

Heal th	Financial Systems DEKALB MEMORIAL HOSPITAL In Li	eu of Form CMS-2	2552-10				
	FATION OF INPATIENT OPERATING COST Provider CCN: 15-0045 Period:	Worksheet D-1					
	From 10/01/201 To 09/30/201	9 Date/Time Pre					
	Title XVIII Hospital	2/25/2020 11: PPS	43 am_				
	Cost Center Description Total Total Average Per Program Days	-					
	Inpatient Inpatient Diem (col. 1	(col . 3 x					
	Cost Days ÷ col . 2) 1.00 2.00 3.00 4.00	col . 4) 5.00					
42.00			42.00				
42.00	Intensive Care Type Inpatient Hospital Units	2 (10.200	42.00				
43. 00 44. 00	INTENSIVE CARE UNIT 2, 463, 947 1, 122 2, 196. 03 28 CORONARY CARE UNIT	2 619, 280	43. 00 44. 00				
	BURN INTENSIVE CARE UNIT		45. 00				
46.00			46.00				
47.00	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)	1, 892, 553 3, 494, 868					
47.00	PASS THROUGH COST ADJUSTMENTS	3, 474, 000	49.00				
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I ar	nd 152, 187	50. 00				
51. 00	III Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	114, 760	51.00				
31.00	and IV)	114, 700	31.00				
52.00	Total Program excludable cost (sum of lines 50 and 51)	266, 947					
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3, 227, 921	53.00				
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
54. 00 55. 00	Program di scharges Target amount per di scharge	0.00					
56. 00		0.00	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	0.00	58. 00 59. 00				
37.00	market basket	0.00	37.00				
60.00		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 the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	0	61.00				
	amount (line 56), otherwise enter zero (see instructions)						
62.00							
03.00	3.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	9 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)		00.00				
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		0	67. 00				
	(line 12 x line 19)						
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	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	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	1	75. 00				
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00				
77.00	, ,		77.00				
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00				
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	1	79. 00 80. 00				
81.00			81.00				
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00 83. 00				
84.00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)		84.00				
85.00	Utilization review - physician compensation (see instructions)		85. 00				
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	1	86. 00				
87. 00	Total observation bed days (see instructions)	2, 309	87. 00				
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	888. 82					
υ 9 . UU	Observation bed cost (line 87 x line 88) (see instructions)	2, 052, 285	U7. UU				

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2018 To 09/30/2019		pared: 43 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	497, 031	4, 916, 037	0. 10110	4 2, 052, 285	207, 494	90.00
91.00 Nursing School cost	0	4, 916, 037	0.00000	0 2, 052, 285	0	91.00
92.00 Allied health cost	0	4, 916, 037	0.00000	0 2, 052, 285	0	92.00
93.00 All other Medical Education	0	4, 916, 037	0. 00000	0 2, 052, 285	0	93.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0045	Peri od: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/25/2020 11:43 am
	Title XIX	Hospi tal	Cost

		Title XIX	Hospi tal	2/25/2020 11: Cost	43 am_
	Cost Center Description	I II II E XIX	110Spi tai	Cost	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		5, 531	1.00
2. 00	Inpatient days (including private room days, excluding swing-			5, 531	2.00
3. 00	Private room days (excluding swing-bed and observation bed days)	0	3.00		
4 00	do not complete this line.	and days)		3, 222	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room between type inpatient days).		r 31 of the cost		4. 00 5. 00
5.00	reporting period	om days) trii odgir becembe		O	3.00
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	R1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	daye, a.te. becombe. t		Ü	0.00
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	158	9.00
10.00	newborn days)			0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom davs) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e	enter O on this line)	,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12.00
12 00	through December 31 of the cost reporting period	V anly (including privat	-a raam daya)	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			U	13. 00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)	, 3	,	673	15.00
16. 00				0	16.00
17.00	SWI NG BED ADJUSTMENT	and the second Department 21	-E	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 d	or the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0. 00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	os after December 21 of t	ho cost	0. 00	20. 00
20.00	reporting period	s arter becember 31 or 1	.ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction			4, 908, 318	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22.00
22.00	5 x line 17)	. 21 -6 +6+			22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	ng period (iine o	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)	•	`		
25. 00		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	, ,	(line 21 minus line 26)		4, 908, 318	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(**************************************		.,	
28. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· Lino 29)		0. 000000	30. 00 31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	÷ 1111e 20)		0. 000000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (line	0 4 000 210	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerential (IINe	4, 908, 318	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00				887. 42	
39.00		,		140, 212	
40.00	Medically necessary private room cost applicable to the Programator Total Program general inpatient routine service cost (line 39)	•		0 140, 212	
50	1.1.1.1 1.1.1		ı	110, 212	00

	Financial Systems	DEKALB MEMORIA		ON 45 00:5		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	F	Period: From 10/01/2018		
				Т	o 09/30/2019	Date/Time Pre 2/25/2020 11:	
	Cost Center Description	Total		e XIX Average Per	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpatient	Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 383, 290	2.00	3. 00 569. 52	4.00	5. 00	42.00
40.00	Intensive Care Type Inpatient Hospital Units	0.457.000	4 400	0.400.45			40.00
43. 00 44. 00	INTENSIVE CARE UNIT	2, 456, 228	1, 122	2, 189. 15	0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
40.00	December 1 and 1 a	-+ D 21 2	1 1: 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		98, 669 238, 881	
	PASS THROUGH COST ADJUSTMENTS	9 7 9		,			
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	0	51.00
E2 00	and IV)	EO and E1)				0	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated, non-ph	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line				·		
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	urgot amount (lino 56 minus	lino 52)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	irget amount (Title 50 IIITius	11 He 33)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of		0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	ŕ				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıcti ons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
4F 00	instructions)(title XVIII only)	to often Decemb	on 21 of the	ooot ronorting	norted (Coo		45.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts arter beceilib	er 31 of the	cost reporting	perrou (see	0	65. 00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	portina period	0	67.00
	(line 12 x line 19)	o .			. 0.	-	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c	,					71.00
72.00	Program routine service cost (line 9 x line	,	. (1: 14)	: 25)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient	•		•	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	76)					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi der recor	de)			78. 00 79. 00
80.00	Total Program routine service costs for comp	, ,		,	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi		,				81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
55. 60	PART IV - COMPUTATION OF OBSERVATION BED PAS:		Jugir 00)				33.00
87.00	Total observation bed days (see instructions	•	Line 2)			2, 309	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				887. 42 2, 049, 053	1
		,					•

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2018 To 09/30/2019		pared: 43 am_
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	497, 031	4, 908, 318	0. 10126	2, 049, 053	207, 493	90.00
91.00 Nursing School cost	0	4, 908, 318	0.00000	2, 049, 053	0	91.00
92.00 Allied health cost	0	4, 908, 318	0.00000	2, 049, 053	0	92.00
93.00 All other Medical Education	0	4, 908, 318	0. 00000	2, 049, 053	0	93. 00

Health Financial Systems DEKALB MEMORIAL HOSPITAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN:	I: 15 0045 E	<u>In Lieu</u> Period:	u of Form CMS-2 Worksheet D-3	
TIVEATTENT ANGIELANT SERVICE COST AFFORTIONWENT		rom 10/01/2018		
	Т	o 09/30/2019		
Title X	XVI I I	Hospi tal	2/25/2020 11: PPS	43 am_
	Ratio of Cost		Inpatient	
	To Charges		Program Costs	
	_	Charges	(col. 1 x	
			col. 2)	
	1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		2, 826, 167		30.00
31. 00 03100 INTENSIVE CARE UNIT		1, 118, 077		31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS 50, 00 05000 OPERATING ROOM	0.155700	1 700 440	2/0 427	50.00
50. 00 05000 0PERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 155788 0. 697313		269, 427 263	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 697313		217, 223	54.00
60, 00 06000 LABORATORY	0. 163558		217, 223	
60. 01 06001 BLOOD LABORATORY	0. 000000		210, 940	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 231717		204, 096	
66. 00 06600 PHYSI CAL THERAPY	0. 303016		85, 814	
66. 01 06601 CARDI AC REHAB	0. 696427		2, 014	1
69. 00 06900 ELECTROCARDI OLOGY	0. 715952		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 089878		61	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 470352	589, 319	277, 187	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234354	704, 290	165, 053	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 668246	414, 877	277, 240	73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 423537		410	
91. 00 09100 EMERGENCY	0. 163069		169, 452	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 513990	14, 344	7, 373	92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES		0 (0) 000	4 000 550	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		8, 686, 829	1, 892, 553	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0 404 020		201.00
202.00 Net charges (line 200 minus line 201)		8, 686, 829		202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Health Financial Systems DEKALB MEMOR	RIAL HOSPITAL		In lia	u of Form CMS-:	2552_10
Title XIX			F	Period: From 10/01/2018	Worksheet D-3	3
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.		T: ±1	- VIV	11: 4-1		43 am
To Charges Program Costs (col . 1 x col . 2) 1.00 2.00 3.00	Cost Contor Doscription	11 (1				
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3	cost center bescription			10.000		
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00			To onal ges			
1.00 2.00 3.00				onal goo		
30. 00 03000 ADULTS & PEDIATRICS 449, 182 30. 31. 00 03100 INTENSIVE CARE UNIT 96, 545 31. 43. 00 04300 NURSERY 0 43. ANCILLARY SERVICE COST CENTERS			1.00	2.00		
31. 00 03100 INTENSI VE CARE UNI T 96, 545 43. 43. 00 04300 NURSERY 0 0 43. ANCILLARY SERVI CE COST CENTERS	INPATIENT ROUTINE SERVICE COST CENTERS		•			
43. 00 04300 NURSERY NURSERY SERVICE COST CENTERS So. 00 05000 OPERATI NG ROOM So. 148789 So. 988 So. 628 So. 52. 00 05200 DELI VERY ROOM & LABOR ROOM Co. 697313 Ood Ood So. 127769 Co. 975 So. 988 So. 628 So. 52. 00 Ood Co. 127769 Co. 975 So. 988 So. 628 So. 989 Co. 127769 Co. 989 Co. 127769 Co. 989 Co. 127769 Co. 989 Co. 127769 Co. 989 Co. 127769 Co. 989	30. 00 03000 ADULTS & PEDI ATRI CS			449, 182		30.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 55. 00 05400 RADIOLOGY-DIAGNOSTIC 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 60. 01 06001 BLOOD LABORATORY 60. 01 06001 BLOOD LABORATORY 60. 01 06001 BLOOD LABORATORY 60. 01 06000 PHYSI CAL THERAPY 60. 01 06600 PHYSI CAL THERAPY 60. 01 06601 CARDIAC REHAB 60. 01 06601 CARDIAC REHAB 60. 01 06601 CARDIAC REHAB 60. 01 06601 CARDIAC REHAB 60. 01 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 60. 00 07300 DRUGS CHARGED TO PATIENTS 60. 00 07500 DELECTRO NO PATIENTS 60. 00 07500 DELECTRO NO PATIENTS 60. 00 07500 DRUGS CHARGED TO PATIEN	31.00 03100 INTENSIVE CARE UNIT			96, 545		31.00
50. 00 05000 0FERATI NG ROOM 0. 148789 57, 988 8, 628 50. 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 697313 0 0 52. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 127769 26, 975 3, 447 54. 60. 00 06000 LABORATORY 0. 163558 120, 287 19, 674 60. 60. 01 06001 BLOOD LABORATORY 0. 000000 0 0 0 60. 65. 00 06500 RESPI RATORY THERAPY 0. 231717 63, 757 14, 774 65. 66. 01 06601 CARDI AC REHAB 0. 303016 5, 711 1, 731 66. 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 3, 597 2, 575 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0. 470352 12, 249 5, 761 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 234354 32, 664 7, 655 72. </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>43.00</td>				0		43.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 697313 0 0 52. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 127769 26, 975 3, 447 54. 60. 00 06000 LABORATORY 0. 163558 120, 287 19, 674 60. 60. 01 06001 BLOOD LABORATORY 0. 000000 0 0 60. 65. 00 06500 RESPI RATORY THERAPY 0. 231717 63, 757 14, 774 65. 66. 01 06601 CARDI AC REHAB 0. 690427 180 125 66. 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 3, 597 2, 575 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 0 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0. 470352 12, 249 5, 761 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 668246 40, 921 27, 345 73.						1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 127769 26, 975 3, 447 54. 60. 00 06000 LABORATORY 0. 163558 120, 287 19, 674 60. 60. 01 06001 BLOOD LABORATORY 0. 000000 0 0 60. 65. 00 06500 RESPI RATORY THERAPY 0. 231717 63, 757 14, 774 65. 66. 00 06600 PHYSI CAL THERAPY 0. 303016 5, 711 1,731 66. 66. 01 06601 CARDI AC REHAB 0. 69427 180 125 66. 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 3, 597 2, 575 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 0 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0. 470352 12, 249 5, 761 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 40, 921 27, 345 73.						1
60. 00 06000 LABORATORY 0. 163558 120, 287 19, 674 60. 60. 01 06001 BLOOD LABORATORY 0. 000000 0 0 60. 65. 00 06500 RESPI RATORY THERAPY 0. 231717 63, 757 14, 774 65. 66. 00 06600 PHYSI CAL THERAPY 0. 303016 5, 711 1, 731 66. 66. 01 06601 CARDI AC REHAB 0. 696427 180 125 66. 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 3, 597 2, 575 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 0 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0. 470352 12, 249 5, 761 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 40, 921 27, 345 73.			1			02.00
60. 01 06001 BL00D LABORATORY 0.000000 0 0 60. 60. 65. 00 06500 RESPI RATORY THERAPY 0.231717 63, 757 14, 774 65. 66. 00 06600 PHYSI CAL THERAPY 0.303016 5, 711 1, 731 66. 66. 01 06601 CARDI AC REHAB 0.696427 180 125 66. 69. 00 06900 ELECTROCARDI OLOGY 0.715952 3, 597 2, 575 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.089878 0 0 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0.470352 12, 249 5, 761 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.668246 40, 921 27, 345 73.						
65. 00 06500 RESPIRATORY THERAPY 0. 231717 63, 757 14, 774 65. 66. 00 06600 PHYSI CAL THERAPY 0. 303016 5, 711 1, 731 66. 66. 01 06601 CARDI AC REHAB 0. 696427 180 125 66. 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 3, 597 2, 575 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 0 0 70 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0. 470352 12, 249 5, 761 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 40, 921 27, 345 73.						
66. 00 06600 PHYSI CAL THERAPY 0. 303016 5, 711 1, 731 66. 66. 01 06601 CARDI AC REHAB 0. 696427 180 125 66. 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 3, 597 2, 575 69. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 0 0 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 668246 40, 921 27, 345 73.			1		_	
66. 01 06601 CARDI AC REHAB 0. 696427 180 125 66. 66. 69. 00 06900 ELECTROCARDI OLOGY 0. 715952 3, 597 2, 575 69. 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 0 0 70. 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0. 470352 12, 249 5, 761 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 40, 921 27, 345 73.			1			1
69. 00 06900 ELECTROCARDI OLOGY 0. 715952 3, 597 2, 575 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 089878 0 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0. 470352 12, 249 5, 761 71. 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 40, 921 27, 345 73.						
70. 00 07000 ELECTROENCEPHALOGRAPHY 0.089878 0 0 70. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0.470352 12, 249 5, 761 71. 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.668246 40, 921 27, 345 73.						
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0. 470352 12, 249 5, 761 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 668246 40, 921 27, 345 73.			•			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 234354 32, 664 7, 655 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 668246 40, 921 27, 345 73.						
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 668246 40, 921 27, 345 73.						
					,	
	OUTPATIENT SERVICE COST CENTERS		0.000240	70, 721	21, 343	73.00
			0. 423537	7 0	0	90.00
					6. 954	
	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		0. 513990		0	1
OTHER REI MBURSABLE COST CENTERS						
						95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 406,975 98,669 200.	200.00 Total (sum of lines 50 through 94 and 96 through 98)		406, 975	98, 669	200.00
				0		201.00
202.00 Net charges (line 200 minus line 201) 406,975 202.	202.00 Net charges (line 200 minus line 201)			406, 975		202.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0045	Period: Worksheet E From 10/01/2018 Part A To 09/30/2019 Date/Time Prepared: 2/25/2020 11:43 am

		T: +1 - W// L1	11	2/25/2020 11:	43 am		
		Title XVIII	Hospi tal	PPS			
				1. 00			
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00		
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	prior to October 1 (see	0	1. 00 1. 01		
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)						
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)						
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)						
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01		
2. 01	Outlier payment for discharges for Model 4 BPCI (see instructions	s)		0	2.01		
2. 03	Outlier payments for discharges occurring prior to October 1 (see	•		0	2.03		
2.04	Outlier payments for discharges occurring on or after October 1			4, 324	2.04		
3.00	Managed Care Simulated Payments			0	3.00		
4. 00	Bed days available divided by number of days in the cost reportion Indirect Medical Education Adjustment	ng period (see instru	ctions)	30. 67	4.00		
5. 00	FTE count for allopathic and osteopathic programs for the most roor before 12/31/1996. (see instructions)	ecent cost reporting	period ending on	0. 00	5.00		
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	criteria for an add-o	n to the cap for	0. 00	6. 00		
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified undo ACA \S 5503 reduction amount to the IME cap as specified under 42			0. 00 0. 00	7. 00 7. 01		
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)	c and osteopathic pro c)(2)(iv), 64 FR 2634	grams for O (May 12,	0. 00	8. 00		
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots report straddles July 1, 2011, see instructions.	under § 5503 of the	ACA. If the cost	0.00	8. 01		
8. 02	The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions)	from a closed teachi	ng hospi tal	0. 00	8. 02		
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (see	0. 00	9. 00		
10.00	FTE count for allopathic and osteopathic programs in the current	year from your recor	ds	0.00	10.00		
11. 00	FTE count for residents in dental and podiatric programs.				11.00		
12.00	Current year allowable FTE (see instructions)			0.00			
13.00	Total allowable FTE count for the prior year.		1	0.00			
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or atter sep	tember 30, 1997,	0. 00	14.00		
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15.00		
16.00	Adjustment for residents in initial years of the program			0.00	16.00		
17.00	Adjustment for residents displaced by program or hospital closure	е		0.00	17. 00		
18. 00	Adjusted rolling average FTE count			0. 00			
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000			
20.00	Prior year resident to bed ratio (see instructions)			0.000000			
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0.000000	21. 00 22. 00		
22. 00				0			
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 of	f the MMA			22.01		
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$.		FR 412. 105	0.00	23. 00		
24.00	IME FTE Resident Count Over Cap (see instructions)			0. 00	1		
25. 00	If the amount on line 24 is greater than -0-, then enter the low instructions)	er of line 23 or line	24 (see	0. 00	25. 00		
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00		
27.00	IME payments adjustment factor. (see instructions)			0. 000000	1		
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00		
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01		
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01		
20.00	Disproportionate Share Adjustment		+!>		20.00		
30.00	Percentage of SSI recipient patient days to Medicare Part A patie	ent days (see instruc	ti ons)	5. 10	1		
31.00	Percentage of Medicaid patient days (see instructions)			21. 12	1		
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			26. 22 10. 85	1		
	Disproportionate share adjustment (see instructions)				34.00		
00	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		ı	. 2, 200	,		

	Financial Systems DEKALB MEMORIA			eu of Form CMS-2	2552-1		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0045	Period: From 10/01/2018 To 09/30/2019				
		Title XVIII	Hospi tal	PPS	10 dill		
				On/After 10/1			
	Uncompensated Care Adjustment		1.00	2. 00			
	Total uncompensated care amount (see instructions)		0	8, 272, 872, 447	35.00		
35. 01	Factor 3 (see instructions)		0. 000000000				
35. 02							
35 03	instructions) Pro rata share of the hospital uncompensated care payment a	amount (see instructions)	0	490, 151	35. 0		
	Total uncompensated care (sum of columns 1 and 2 on line 35		490, 151		36.00		
	Additional payment for high percentage of ESRD beneficiary			T			
40.00	Total Medicare discharges on Worksheet S-3, Part I excludin 652, 682, 683, 684 and 685 (see instructions)	ng discharges for MS-DRGs	0		40.00		
	032, 002, 003, 004 and 003 (See Tristructions)		Before 1/1	On/After 1/1			
			1. 00	1. 01			
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0	0	41.00		
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding M	IS-DRGs 652 682 683 68	34 0	0	41. 0°		
	an 685. (see instructions)	5 302, 302, 300, 3.					
	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00	l	42.0		
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)	682, 683, 684 an 685. (se	ee 0		43.00		
44. 00	Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	7 0.000000		44.0		
	days)						
	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line		0.00	0.00	45. 0 46. 0		
47. 00	Subtotal (see instructions)	41.01)	3, 230, 710		47.0		
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48.00		
	only. (see instructions)			Amount			
				Amount 1.00			
	Total payment for inpatient operating costs (see instruction			3, 230, 710			
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, P			214, 123	50. 00 51. 00		
	Direct graduate medical education payment (from Wkst. E-4,			0	52.0		
	Nursing and Allied Health Managed Care payment			0	53.0		
	Special add-on payments for new technologies			0	54.0		
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	40)		0	54. 0 55. 0		
56. 00	Cost of physicians' services in a teaching hospital (see in			Ö	56.0		
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.0		
	Ancillary service other pass through costs from Wkst. D, Pt Total (sum of amounts on lines 49 through 58)	. IV, col. 11 line 200)		0 3, 444, 833	58. 0 59. 0		
	Primary payer payments			3, 444, 633			
	Total amount payable for program beneficiaries (line 59 min	nus line 60)		3, 440, 875			
	Deductibles billed to program beneficiaries			479, 188			
	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			0 8, 453			
	Adjusted reimbursable bad debts (see instructions)			5, 494	65.0		
66. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		8, 453	66.0		
	Subtotal (line 61 plus line 65 minus lines 62 and 63)	MC PRO	(2, 967, 181	67.0		
68. 00 69. 00	Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96	• •	,	0	68. 0 69. 0		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	77. (101 301 300 111311 4011	5113)	0	70.0		
70. 00	Rural Community Hospital Demonstration Project (§410A Demon	, ,	e instructions)	0	70. 5		
70. 50	Demonstration payment adjustment amount before sequestration			0	70. 8 70. 8		
70. 50 70. 87	SCH or MDH volume decrease adjustment (contractor use only)			0	70.8		
70. 50 70. 87 70. 88	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in	ISTRUCTI ONS)					
70. 50 70. 87 70. 88 70. 89	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)	*		0	70.9		
70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	*		0	70. 9		
70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	*		0	70. 9 70. 9		
70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	*		0			

	Financial Systems DEKALB MEMORIAL				u of Form CMS-2	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider Co	CN: 15-0045	Peri od: From 10/01/2018	Worksheet E Part A	
				To 09/30/2019		pared:
		Title	: XVIII	Hospi tal	PPS	45 4111
				(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		2019	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			2019	484, 102	70. 97
70. 98	Low Volume Payment-3	,			0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			3, 390, 659	71.00
71.01	Sequestration adjustment (see instructions)				67, 813	71.01
71. 02	Demonstration payment adjustment amount after sequestration				0	71.02
	Interim payments				3, 124, 433	
	Tentative settlement (for contractor use only)				0	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	2, 72, and			198, 413	74.00
75. 00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	nce with			72, 849	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					İ
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.00
	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instructions)				0.00	
	Time value of money for operating expenses (see instructions)	40110110)			0.00	
	Time value of money for capital related expenses (see instruc	tions)			Ō	96.00
			'	Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)				0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)				0. 0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	s)			0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)				0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions				0	104. 00
200 0	Rural Community Hospital Demonstration Project (§410A Demonst					200 00
200.00	Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	rioa unaer	the ZIST			200. 00
	Cost Reimbursement					1
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin	e 49)				201. 00
	Madiana dia banasa (ana imperiora)	C 77)				201.00

Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration

202. 00 203. 00

204. 00 205. 00

206. 00

207.00

208.00

209. 00 210. 00

211. 00

212. 00 213. 00

218. 00

202.00 Medicare discharges (see instructions)

peri od)
204.00 Medi care target amount

210.00 Reserved for future use

203.00 Case-mix adjustment factor (see instructions)

205.00 Case-mix adjusted target amount (line 203 times line 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205)

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

Adjustment to Medicare Part A Inpatient Reimbursement

211.00 Total adjustment to Medicare IPPS payments (see instructions)

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

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

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

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

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 10/01/2018 Part A Exhi bit 4 To 09/30/2019 Date/Time Prepared: Provider CCN: 15-0045

					Ic	09/30/2019	2/25/2020 11:	
		W (0 E D) A			XVIII	Hospi tal	PPS	
		W/S E, Part A line	E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	0	0	0		0	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 663, 975	0		2, 663, 975	2, 663, 975	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	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	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	0	0	0		0	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	4, 324	0		4, 324	0	2. 03
3. 00	instructions) Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5. 00	Indirect Medical Education Adjunction Adjunction Morksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions)							
7 00	Indirect Medical Education Adju					0.000000		7 00
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0.000000	0. 000000	0. 000000	0	7.00
8. 00	IME adjustment (see instructions)	28. 00	0	U	0	0	0	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Disproportionate Share Adjustm	ent						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1085	0. 1085	0. 1085	0. 1085		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	72, 260	0	0	72, 260	72, 260	11. 00
11. 01	Uncompensated care payments	36. 00	490, 151	0	0	490, 151	490, 151	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	rcentage of ESI 46.00	אט beneficiary	di scharges 0	0	O	0	12.00
	(see instructions)		2 220 710		_			
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	3, 230, 710 0	0	0	3, 230, 710 0	3, 230, 710 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	3, 230, 710	0	0	3, 230, 710	3, 230, 710	15. 00

capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for 54.00 0 0 0 new technologies 17.01 Net organ aquisition cost	Hospi tal Peri od On/After 10/01 4.00 214,123		
Tine E, Part A) Entitlement to 10/01	0n/After 10/01 4.00 0 214,123	through 4) 5.00 214, 123	
0	10/01 4.00 214,123	5. 00	
16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost	4. 00 214, 123	214, 123	
16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost	214, 123	214, 123	
capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for 54.00 0 0 new technologies 17.01 Net organ aquisition cost	0		
17.00 Special add-on payments for 54.00 0 0 new technologies 17.01 Net organ aquisition cost		0	17. 00
			1
17 02 Credits received from 68 00 0	0		17. 01
		ol o	17. 02
manufacturers for replaced devices for applicable MS-DRGs			
18.00 Capital outlier reconciliation 93.00 0 0 adjustment amount (see	0	0	18.00
i nstructi ons)			
171 00 008101712	3, 444, 833	3, 444, 833	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 1.00 213,789 0 (213, 789	213, 789	20.00
20.01 Model 4 BPCI Capital DRG other 1.01 0 0 than outlier	0	0	20. 01
21.00 Capital DRG outlier payments 2.00 334 0	334	334	21.00
21.01 Model 4 BPCI Capital DRG 2.01 0 0	0	0	21. 01
outlier payments			
22.00 Indirect medical education 5.00 0.0000 0.0000 0.0000 0.0000	0.0000		22. 00
adj ustment (see instructions)	0	0	
24. 00 Allowable disproportionate 10. 00 0. 0000 0. 0000 0. 0000 0. 0000 10. 0000 0. 0	0.0000		24. 00
25.00 Disproportionate share 11.00 0 0 (0	0	25.00
	214, 123	214, 123	26. 00
W/S E, Part A (Amounts to			
line E, Part A)			
0 1.00 2.00 3.00	4. 00	5. 00	
27.00 Low volume adjustment factor 0.000000	0. 140530)	27.00
28.00 Low volume adjustment 70.96 (transfer amount to Wkst. E, Pt. A, line)		0	28. 00
29.00 Low volume adjustment 70.97 (transfer amount to Wkst. E,	484, 102	484, 102	29.00
Pt. A, line) 100.00 Transfer low volume adjustments to Wkst. E, Pt. A.			100. 00

Wisst. E. Pt. Art. From Period to arter 10/01 Period 10/01 Period to arter 10/01 Period to arter 10/01 Period to						To 09/30/2019	Date/Time Pre 2/25/2020 11:	pared:
A.				Title	XVIII	Hospi tal		45 aiii
1.00 BRG amounts other than outlier payments for 1.00 0 0 0 0 0 0 0 0 0				Wkst. E, Pt.				
1.00 BRG amounts other than outlife payments for 1.01 0 0 0 0 0 0 0 0 0			0		2.00	3. 00	4. 00	
discharges occurring prior to October 1 1.02 2,663,975 2,663,975 1.02 2,663,975 1.02 2,663,975 1.02 2,663,975 1.02 3.03 3.00 3.0	1.00	DRG amounts other than outlier payments				2, 22		1.00
DRC amounts other than outli ler payments for discharges occurring on or after October 1 1.03 0 0 0 0 0 0 1.03	1. 01		1. 01	0		0	0	1. 01
1.03	1. 02	DRG amounts other than outlier payments for	1. 02	2, 663, 975		2, 663, 975	2, 663, 975	1. 02
1	1. 03	DRG for Federal specific operating payment	1. 03	O		0	0	1. 03
2.00	1. 04	1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	O		0	0	1. 04
2.01 OutFlee payments for discharges for Model 4 2.02 0 0 0 0 0 2.01	2. 00	Outlier payments for discharges (see	2. 00					2. 00
Drior to October 1 (see instructions) 2.03 Outle payments for discharges occurring on 2.04 4,324 0 0 0 3.00 0 0 0 0 0 0 0 0 0	2. 01	Outlier payments for discharges for Model 4	2. 02	0		0	0	2. 01
0	2. 02		2. 03	O	4, 32	4	0	2. 02
A.00 Managed care simulated payments 3.00 0 0 0 0 0 4.00	2. 03		2. 04	4, 324		0	0	2. 03
Indirect Medical Education Adjustment				١				
See instructions Comparison	5. 00	Indirect Medical Education Adjustment	21.00	0. 000000	0, 00000	0.00000		5. 00
IME payment adjustment for managed care (see 22.01 0 0 0 0 0 0 0 0 0		(see instructions)						
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA IME payment adjustment factor (see 27.00 0.00000 0.000000 0.00000000		IME payment adjustment for managed care (see		0		-		
Instructions 1			e Add-on for Se	ection 422 of t	the MMA			
No. IME payment adjustment add on for managed 28.01 0 0 0 0 0 0 0 0 0	7. 00		27. 00	0. 000000	0. 00000	0. 000000		7. 00
Care (see instructions) Care (see instructions) Care (see instructions) Care (see instructions) Care (see instructions) Care (see instructions) Care (see instructions) Care instructions) Care instructions C				0		-		
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 0 0 0 0 0 0 0 0 0	9 00		29 00	0			0	9 00
Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1085 0.1085 0.1085 0.1085 10.00				Ö				
10.00 Allowable disproportionate share percentage (see instructions) 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 72,260 0 72,260 72,260 11.00		lines 6.01 and 8.01)						
11.00 Disproportionate share adjustment (see 34.00 72,260 0 72,260 72,260 11.00 12.00 12.00 12.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 15.00 15.00 15.00 16.00 17.0	40.00		22.00	0.4005	0.400	0.4005		10.00
11.00 Disproportionate share adjustment (see 34.00 72,260 0 72,260 72,260 11.00 instructions) Uncompensated care payments 36.00 490,151 0 490,151 490,151 11.01 Additional payment for high percentage of ESRD beneficiary discharges	10.00		33.00	0. 1085	0.108	0. 1085		10.00
11. 01 Uncompensated care payments 36. 00 490, 151 0 490, 151 490, 151 11. 01	11. 00	Disproportionate share adjustment (see	34. 00	72, 260		72, 260	72, 260	11. 00
12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 13.00 Subtotal (see instructions) 47.00 3,230,710 4,324 3,226,386 3,230,710 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGS 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 18.00 18.00 17.00 18.00 12.00 0 0 0 0 0 0 0 0 0	11. 01		36. 00	490, 151		0 490, 151	490, 151	11. 01
13.00 Subtotal (see instructions) 47.00 3,230,710 4,324 3,226,386 3,230,710 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 49.00 3,230,710 4,324 3,226,386 3,230,710 15.00 16.00 Payment for inpatient program capital (from wkst. L, Pt. I, if applicable) 50.00 214,123 0 214,123 214,123 16.00 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 18.00 18.00 18.00 19.00				di scharges				
13.00 Subtotal (see instructions) 47.00 3,230,710 4,324 3,226,386 3,230,710 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48.00 0 0 0 0 14.00 15.00 Total payment for inpatient operating costs (see instructions) 49.00 3,230,710 4,324 3,226,386 3,230,710 15.00 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50.00 214,123 0 214,123 214,123 16.00 17.01 Net organ acquisition cost 68.00 0 0 0 0 0 0 17.01 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 0 18.00	12. 00	1 3 `	46. 00	0	'	0	0	12. 00
Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies of the organ acquisition cost	13.00		47. 00	3, 230, 710	4, 32	4 3, 226, 386	3, 230, 710	13. 00
instructions) Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 17.00 17.01 Net organ acquisition cost 0 0 0 0 0 0 0 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions)		Hospital specific payments (completed by SCH			1			
16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 0 0 0 0 0 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions)	15. 00	instructions) Total payment for inpatient operating costs	49. 00	3, 230, 710	4, 32	3, 226, 386	3, 230, 710	15. 00
17.00 Special add-on payments for new technologies 54.00 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 18.00	16. 00	Payment for inpatient program capital (from	50. 00	214, 123		0 214, 123	214, 123	16. 00
17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 68.00 0 0 17.02 0 0 0 0 0 18.00		Special add-on payments for new technologies	54. 00	О		0 0	0	
18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 18.00 amount (see instructions)		Credits received from manufacturers for	68. 00	0		0 0	0	
	18. 00	Capital outlier reconciliation adjustment	93. 00	o		0 0	0	18. 00
	19. 00				4, 32	3, 440, 509	3, 444, 833	19. 00

Heal th	Financial Systems	DEKALB MEMORI	ΔΙ ΗΛΟΡΙΤΔΙ		In lie	u of Form CMS-2	2552_10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA				Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Exhibi Date/Time Pre 2/25/2020 11:	t 5 pared:
				XVIII	Hospi tal	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	213, 789	(213, 789	213, 789	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	334	(334	334	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	'	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 000	0.0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	'	0	0	25.00
26. 00	Total prospective capital payments (see instructions)	12. 00	214, 123	(214, 123	214, 123	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		o	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	484, 102		484, 102	484, 102	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	5, 443		5, 443	5, 443	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-66, 067		-66, 067	-66, 067	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(0	0	1
	•					(Am+ +o	

0 70. 99

1.00

Ν

2.00

0

3.00

0

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

32.00

100.00

32.00 HAC Reduction Program adjustment (see

instructions)

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

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN		Worksheet E Part B Date/Time Prepared: 2/25/2020 11:43 am
•	T1 1 1	 	DDO

PART R . MODICAL AND OTHER HEATTH SERVICES 1.00				077 007 2017	2/25/2020 11:	
New Teach and other services (see instructions)			Title XVIII	Hospi tal		
New Teach and other services (see instructions)						
					1.00	
Medical and other services reinhursed under OPPS (see Instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES				
0.00 0.00 1.00 0.00 1.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000 0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0	1.00	Medical and other services (see instructions)			6, 165	1.00
0.00 1.00	2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		4, 645, 609	2.00
0	3.00	OPPS payments			3, 770, 621	3.00
Enter the hospital specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)			16, 644	4.00
Line 2 times line 5	4. 01	Outlier reconciliation amount (see instructions)			ol	4. 01
	5.00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	5.00
Transitional corridor payment (see instructions) 0 0 0 0 0 0 0 0 0	6.00	Line 2 times line 5			ol	6.00
Ancil lary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200 0, 9, 00	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
0.00 0 0 0 0 0 0 0 0	8.00	Transitional corridor payment (see instructions)			0	8. 00
1.00 Total cost (sum of lines 1 and 10) (see instructions) 6, 165 11.00	9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9. 00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Reasonable Reasona	10.00	Organ acquisitions			0	10.00
COMPUTATION OF LESSER OF COST OR CHARCES Reasonable charges Reasonable charges Reasonable charges Page	11.00	Total cost (sum of lines 1 and 10) (see instructions)			6, 165	11.00
12.00 Ancil lary service charges 9,226 12,00 13,00 10 10 10 10 11 12 12						
12.00 Ancil lary service charges 9,226 12,00 13,00 10 10 10 10 11 12 12		Reasonable charges				
13.00 organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69) 0 13.00	12.00				9, 226	12.00
14.00 Total reasonable charges (sum of lines 12 and 13) 15.00	13.00		ine 69)		0	13.00
Customary charges	14.00		ŕ		9, 226	14.00
15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00						
had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 17.00 17.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00	15.00		payment for services on	a charge basis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)	16.00	, ,		9	ا 0	16.00
17. 00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17. 00 0.000000 17. 00 17. 00 17. 00 18. 00 Total customary charges (see instructions) 9.26 18. 00				3		
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 3.061 19. 00 19	17.00				0. 000000	17. 00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 3.061 19. 00 19	18.00	Total customary charges (see instructions)			9, 226	18. 00
Instructions	19.00		ly if line 18 exceeds li	ine 11) (see	3, 061	19.00
Instructions				, ,		
Instructions	20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ine 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 23.00		instructions)				
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 3, 30 3, 00 3, 30 3, 00 24. 00 COMPUTATION OF REIMBURSEMENT SETILEMENT	21.00	Lesser of cost or charges (see instructions)			6, 165	21.00
Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) 3, 787, 265 24, 00	22.00	Interns and residents (see instructions)			ol	22.00
COMPUTATION OF RELIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 0 0 0 0 0 0 0 0 0	23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		ol	23.00
25.00 Deductible sand coin surance amounts (for CAH, see instructions) 758, 998 26.00	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			3, 787, 265	24.00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 758,998 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 3,034,432 27.00 27.00 28.						
26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 758, 998 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 3,034,432 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 3,034,432 30.00 32.00 Subtotal (line 30 minus line 31) 3,027,316 32.00 ALOWABLE BAD DEBTS (FCKLUBE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 8,693 34.00 34.00 Allowable bad debts (see instructions) 86,983 34.00 35.00 Allowable bad debts for dual elligible beneficiaries (see instructions) 86,983 36.00 38.00 MSP-LCC reconciliation amount from PS& 3,083,865 39.00 39.90 Pioneer ACO demonstration payment adjustment (see instructions) 9,90 39.97 Pemonstration payment adjustment amount before sequestration	25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		0	25. 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 1,00 1,0	26.00	Deductibles and Coinsurance amounts relating to amount on lin	e 24 (for CAH, see inst	ructions)	758, 998	26.00
28. 00	27.00				3, 034, 432	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 3.00			•	- `		
30.00 Subtotal (sum of lines 27 through 29) 3, 034, 432 30.00 Primary payer payments 3, 034, 432 30.00 Primary payer payments 3, 027, 316 31.00 32.00 Subtotal (line 30 minus line 31) 3, 027, 316 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Adjusted reimbursable bad debts (see instructions) 86, 983 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 86, 983 36.00 Adjusted reimbursable bad debts (see instructions) 86, 983 36.00 37.00 Subtotal (see instructions) 86, 983 36.00 37.00 Subtotal (see instructions) 87.00 38.00 38.00 MSP-LCC reconciliation amount from PS&R 49 38.00 39.00 3	28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		ol	28. 00
31.00 Primary payer payments 7, 116 31.00 32.00 Subtotal (line 30 minus line 31) 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 56, 539 35.00 35.00 Adjusted reimbursable bad debts (see instructions) 86, 983 36.00 37.00 Subtotal (see instructions) 88, 983 36.00 37.00 Subtotal (see instructions) 88, 983 36.00 37.00 Subtotal (see instructions) 88, 983 36.00 37.00 Subtotal (see instructions) 88, 983 36.00 37.00 Subtotal (see instructions) 88, 983 36.00 38.00 MSP-LCC reconciliation amount from PS&R 49 38.00 MSP-LCC reconciliation amount from PS&R 49 38.00 MSP-LCC reconciliation payment adjustment (see instructions) 99, 90 90, 90 9	29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			ol	29.00
32.00 Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 32.00	30.00	Subtotal (sum of lines 27 through 29)			3, 034, 432	30.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line I1) 0 33.00 34.00 All lowable bad debts (see instructions) 86, 983 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 86, 983 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 86, 983 36.00 37.00 Subtotal (see instructions) 3, 083, 855 37.00 38.00 MSP-LCC reconciliation amount from PS&R 49 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.95 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 3, 083, 806 40.00 40.01 Sequestration adjustment (see instructions) 61,676 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 2, 965, 518 41.00 42.00 Tentative settlement (for contractors use only) 56,612 43.00 44.00 Protested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 94.00 50.00 Original outlier amount (see instructions) 0 90.00 90.00 Original outlier amount (see instructions) 0 91.00 90.00 Ottlier reconciliation adjustment amount (see instructions) 0 92.00 90.00 Time Value of Money (see instructions) 0 92.00 90.00 Time Value of Money (see instructions) 0 93.00	31.00	Pri mary payer payments			7, 116	31.00
33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 86, 983 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 56, 539 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 86, 983 36.00 37.00 Subtotal (see instructions) 3,083, 855 37.00 38.00 MSP-LCC reconciliation amount from PS&R 49 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 97.50 99.97	32.00				3, 027, 316	32.00
34.00 Allowable bad debts (see instructions) 86,983 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 56,539 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 86,983 36.00 37.00 Subtotal (see instructions) 3,083,855 37.00 38.00 MSP-LCC reconciliation amount from PS&R 49 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9,000 0.00		,	CES)			
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36.00	34.00	Allowable bad debts (see instructions)			86, 983	34.00
37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 49 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Demonstration payment adjustment (see instructions) 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.97 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Fig. 15-12. To BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 70.00 Outlier reconciliation adjustment amount (see instructions) 71.00 Outlier reconciliation adjustment amount (see instructions) 72.00 The rate used to calculate the Time Value of Money 73.00 Time Value of Money (see instructions) 74.00 Oppose the formulation of the payment amount (see instructions) 75.00 Oppose the payment and payment amount (see instructions) 76.00 Oppose the payment and payment amount (see instructions) 77.00 Oppose the payment and payment amount (see instructions) 78.00 Oppose the payment and payment amount (see instructions) 79.00 Oppose the payment and payment amount (see instructions) 79.00 Oppose the payment and payment amount (see instructions) 79.00 Oppose the payment and payment amount (see instructions) 79.00 Oppose the payment and payment amount (see instructions) 79.00 Oppose the payment and payment amount (see instructions) 79.00 Oppose the payment and payment amount (see instructions) 79.00 Oppose the payment and payment amount (see instructions) 79.00 Oppose the payment and payment amount and payment amount and payment amount and payment amount and payment amount and payment amount and payment amount and payme						
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Pi oneer ACO demonstration payment adjustment (see instructions) 39. 50 39. 97 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 30. 99 40. 00 Subtotal (see instructions) 30. 88, 806 40. 00 40. 01 Demonstration adjustment (see instructions) 30. 88, 806 40. 00 40. 01 Demonstration payment adjustment amount after sequestration 40. 02 Interim payments 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Grig inal outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 10. 00 93. 00 Time Value of Money (see instructions) 93. 95 39. 97 39. 97 39. 98 39. 90 39. 97 39. 98 39. 90 39. 99 30. 30 39. 97 30. 39. 98 30. 39. 90 39. 99 30. 39. 99 30. 30 30. 30. 30. 30. 30. 30. 30. 30. 30. 30.		MSP-LCC reconciliation amount from PS&R			49	38. 00
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50 40. 01 Sequestration adjustment (see instructions) 61, 676 40. 02 Hinterim payments 62. 00 43. 00 44. 00 Fortested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 91. 00 91. 00 92. 00 93. 99 79. 99 79. 99. 00 71 ime Value of Money (see instructions) 70 79. 99. 00 79. 00					0	
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40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{2}\$ TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 One of Money (see instructions) 95.00 One of Money (see instructions) 96.00 One of Money (see instructions) 97.00 One of Money (see instructions) 98.00 One of Money (see instructions) 99.00 One of Money (see instructions) 99.00 One of Money (see instructions) 99.00 One of Money (see instructions) 99.00 One of Money (see instructions) 99.00 One of Money (see instructions) 99.00 One of Money (see instructions) 99.00 One of Money (see instructions)			ced devices (see instru	ctions)	0	
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{5115.2}}{\text{10 BE COMPLETED BY CONTRACTOR}} 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 40.00 94.00 40.00 94.00 95.00 Og 40.00 96.00 Og 40.00 97.00 Og 40.00 97.00 Og 40.00 97.00 Og 97.00 97.00 Og 97.00 97.00 Og 97.00						
40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments Tentative settlement (for contractors use only) 42.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5115.2}{10 BE COMPLETED BY CONTRACTOR} 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 40.00 40.00	40. 00	· · · · · · · · · · · · · · · · · · ·				
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42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 56, 612 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Outlier of Money (see instructions) 0 Outlier of Money (see instructions) 0 Outlier of Money (see instructions)						
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93.00 Time Value of Money (see instructions) 0 93.00		· · · · · · · · · · · · · · · · · · ·				
					1	1
94.00 Total (sum of lines 91 and 93) 0 94.00		,				
	94.00	Tiotal (Sum of lines 91 and 93)		l	0)	94.00

Health Financial Systems DEKA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2018 | Part | To 09/30/2019 | Date/Time Prepared: 2/25/2020 11:43 am Provi der CCN: 15-0045

					2/25/2020 11: 2	43 am_
			XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 124, 43	3	2, 965, 518	1.00
2.00	Interim payments payable on individual bills, either			O	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER		1			2 01
3. 01	ADJUSTMENTS TO PROVIDER			0	0 0	3. 01
3. 02 3. 03						3. 02 3. 03
3. 03						3. 03
3. 04						3. 04
3.05	Provider to Program			J	U	3.05
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ADJUST MENTS TO TROOKAW					3. 51
3. 52				o O	l ő	3. 52
3. 53				o o	0	3. 53
3. 54				Ö	l ő	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)		3, 124, 43	3	2, 965, 518	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		1	_	_	
5. 01	TENTATI VE TO PROVI DER			O O	0	5. 01
5. 02)	0	5. 02
5. 03	Dravi dan ta Dragnam			0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			0	0	5. 50
5. 51	TENTATIVE TO PROGRAW			0		5. 51
5. 51				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			5		5. 99
3. 77	5. 50-5. 98)					5. //
6. 00	Determined net settlement amount (balance due) based on					6. 00
00	the cost report. (1)					00
6. 01	SETTLEMENT TO PROVIDER		198, 41	3	56, 612	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 322, 84	5	3, 022, 130	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0045 From 10/01/2018 To 09/30/2019 Title XVIII Hospital Title XVIII Hospital Provider CCN: 15-0045 From 10/01/2018 To 09/30/2019 Title XVIII Hospital PPS 1.00 TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 4.00 Total inpatient days from S-3, Pt. I, col. 6. line 2 4.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 20 Total hospital charges from Wkst. C, Pt. I, col. 8 line 20 Total hospital charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 Total hospital charity care charges from Wkst. S-2, Pt. I Total hospital charity care charges from Wkst. S-2, Pt. I Total hospital charity care charges from Wkst. S-3, Pt. I col. 8 line 20 Total hospital charity care charges from Wkst. S-2, Pt. I Total hospital charity care charges from Wkst. S-3, Pt. I col. 8 line 20 Total hospital charity care charges from Wkst. S-3, Pt. I col. 8 line 20 Total hospi	Heal th	Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
To 09/30/2019 Date/Time Prepared: 2/25/2020 11: 43 am Title XVIII Hospital PPS TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from Wkst. C, Pt. I, col. 8 line 20 5.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 31.00	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0045			1
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31.00 Other Adjustment (specify) 31.00	30.00						30.00
			s line 30 and l	ine 31) (see instruction	ns)		32.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0045	Peri od: Worksheet E-3 From 10/01/2018 Part VII To 09/30/2019 Date/Time Prepared: 2/25/2020 11: 43 am

		7	To 09/30/2019	Date/Time Pre 2/25/2020 11:	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		238, 881		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		238, 881	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		238, 881	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		545, 727		8. 00
9. 00	Ancillary service charges		406, 975	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	,		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		952, 702	0	12.00
	CUSTOMARY CHARGES	 	_		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
14 00	basis			0	14 00
14. 00	Amounts that would have been realized from patients liable for		0	0	14.00
15. 00	a charge basis had such payment been made in accordance with 4 Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		952, 702	0.000000	
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	713, 821	0	1
17.00	line 4) (see instructions)	y 11 1111c 10 exceeds	713,021	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
	16) (see instructions)	,			
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	16)	238, 881	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		238, 881	0	29. 00
30. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	30.00
	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		238, 881	0	
32.00	Deductibles		230, 001	0	
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0	O	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	238, 881	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 00)	0	0	
	Subtotal (line 36 ± line 37)		238, 881	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		238, 881	0	
41.00	Interim payments		520, 692	0	1
42.00	Balance due provider/program (line 40 minus line 41)		-281, 811	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems

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

Provi der CCN: 15-0045

Peri od: Worksheet G From 10/01/2018 To 09/30/2019 Date/Time Prepared: 2/25/2020 11:43 am

oni y)				077 007 2017	2/25/2020 11:	43 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	838, 052	1	0	0	
2. 00 3. 00	Temporary investments Notes receivable	0	0	0	0	
4. 00	Accounts receivable	24, 356, 507	_	0	0	
5. 00	Other recei vable	79, 373	1	0	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	-15, 562, 779	0	0	0	
7. 00	Inventory	1, 642, 647		0	0	
8. 00	Prepai d expenses	504, 683	1	0	0	1
9. 00 10. 00	Other current assets Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10)	11, 858, 483	- 1	0	-	
11.00	FIXED ASSETS	11,000,100	9			11.00
12.00	Land	347, 792	0	0	0	12.00
13. 00	Land improvements	1, 857, 914	1	0	0	
14.00	Accumulated depreciation	-1, 852, 386	1	0	_	1
15.00	Buildings	61, 359, 416	1	0	0	
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-36, 098, 138 2, 735, 818	1	0	0	
18. 00	Accumulated depreciation	-50, 677	1	0	0	
19. 00	Fi xed equipment	0	Ö	0	Ö	
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	
22. 00	Accumulated depreciation	0	0	0	0	
23. 00	Maj or movable equipment	26, 001, 251	0	0	0	1
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-22, 131, 936	0	0	0	
26. 00	Accumulated depreciation			0	0	
27. 00	HIT designated Assets	0	Ö	0	Ö	
28. 00	Accumulated depreciation	0	0	0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29)	32, 169, 054	0	0	0	30.00
31. 00	OTHER ASSETS Investments	18, 802, 730	l ol	0	0	31.00
32.00	Deposits on Leases	10, 602, 730		0	0	
33. 00	Due from owners/officers	0	0	0	0	
34. 00	Other assets	28, 141	0	0	0	
35.00	Total other assets (sum of lines 31-34)	18, 830, 871	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	62, 858, 408	0	0	0	36.00
27 00	CURRENT LI ABI LI TI ES	2 125 210		0		27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	2, 125, 310 3, 063, 587	1	0	0	
39. 00	Payrol I taxes payable	3,003,307		0	0	
40. 00	Notes and Loans payable (short term)	615, 148	_	0	Ö	
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	
44.00	Other current liabilities	165, 944		0	Ĭ	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	5, 969, 989	0	0	0	45.00
46. 00	Mortgage payable	1 0	0	0	0	46.00
47. 00	Notes payable	10, 630, 611	_	0		
48. 00	Unsecured Loans	0	Ō	0	0	
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10, 630, 611		0		1
51. 00	Total liabilities (sum of lines 45 and 50)	16, 600, 600	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	46, 257, 808				52.00
53. 00	Specific purpose fund	40, 237, 808				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	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	46, 257, 808	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	62, 858, 408	1	0	0	
	[59]			J		
		•	. '		•	•

Provider CCN: 15-0045

| Peri od: | Worksheet G-1 | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared:

					To 09/30/2019	Date/Time Pre 2/25/2020 11:	
		Genera	l Fund	Speci al F	Purpose Fund	Endowment Fund	
		1.00	2.00	2.00	4.00	F 00	
1. 00	Fund balances at beginning of period	1. 00	2. 00 46, 634, 753	3. 00	4.00	5. 00	1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		-376, 945				2.00
3.00	Total (sum of line 1 and line 2)		46, 257, 808		0		3.00
4. 00	Additions (credit adjustments) (specify)	0	,,		0	0	
5.00		0			0	0	5.00
6.00		0			0	0	6.00
7.00		0			0	0	
8. 00		0			0	0	
9. 00	T-1-1	0	•		0	0	1
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		46, 257, 808		0		10.00
12.00	Deductions (debit adjustments) (specify)	0	40, 257, 808	1	0	0	
13. 00	beductions (debit adjustiments) (specify)	0			0		1
14. 00		Ö			0		
15. 00		0			0	Ö	
16.00		0			0	0	16.00
17.00		0			0	0	
18.00	Total deductions (sum of lines 12-17)		0	1	0		18. 00
19. 00	Fund balance at end of period per balance		46, 257, 808		0		19. 00
	sheet (line 11 minus line 18)	Endowment	DI ant	E Fund			
		Fund	FIAIIL	. Tuliu			
		1 0110					
		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)				0		2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	٥	0		0		3. 00 4. 00
5. 00	Additions (credit adjustments) (specify)		0				5.00
6. 00			0				6.00
7. 00			0	,			7.00
8.00			0				8. 00
9.00			0)			9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14. 00 15. 00			0				14. 00 15. 00
16. 00			0				16.00
17. 00			0				17.00
18. 00	Total deductions (sum of lines 12-17)	o	O		0		18.00
19.00	Fund balance at end of period per balance	o			0		19.00
	sheet (line 11 minus line 18)						

Health Financial Systems

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0045

		-	Го 09/30/2019	Date/Time Pre 2/25/2020 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	45 (111)
	3337 331731 23337 977 377	1. 00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	11, 134, 54	7	11, 134, 547	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF			0	5.00
6. 00	Swing bed - NF			0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	11 104 54	,	11 104 547	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	11, 134, 54	/	11, 134, 547	10. 00
11. 00	INTENSIVE CARE UNIT	5, 003, 850		5, 003, 850	11. 00
12. 00	CORONARY CARE UNIT	3,003,030	1	3, 003, 030	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL I NTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	5, 003, 850		5, 003, 850	16.00
	11-15)	.,,		., ,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16, 138, 39	7	16, 138, 397	17.00
18.00	Ancillary services	21, 329, 37	85, 158, 540	106, 487, 914	18.00
19.00	Outpatient services	7, 457, 03	33, 612, 381	41, 069, 417	19.00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	21.00
22. 00	HOME HEALTH AGENCY		1, 543, 216	1, 543, 216	22.00
23. 00	AMBULANCE SERVICES	-1, 75	7, 044, 139	7, 042, 386	23.00
24. 00	CMHC				24.00
24. 10	CORF		이	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPI CE	170, 350		98, 795	26.00
27. 00	DEKALB MEDI CAL SERVI CES	•	16, 083, 142	16, 083, 142	27.00
27. 01	OTHER INCOME		13, 401	13, 401	27. 01 27. 02
27. 02 27. 03	SELF INSURANCE PHARMACARE		2, 286, 303 6, 324, 033	2, 286, 303 6, 324, 033	27. 02
27. 03	OTHER INCOME	70, 93		118, 537	27. 03
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.			197, 205, 541	28.00
20.00	G-3, line 1)	45, 104, 340	132, 041, 201	197, 200, 541	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		71, 909, 451		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00					33.00
34.00					34.00
35.00					35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)				37.00
38. 00			-		38.00
39. 00					39. 00
40.00					40.00
41.00	Table 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	(41.00
42.00	Total deductions (sum of lines 37-41)	For	71 000 451		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	rer	71, 909, 451		43. 00
	to Wkst. G-3, line 4)	I	1		1

	<u> </u>	MEMORIAL			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0045	Peri od: From 10/01/2018	Worksheet G-3	
				To 09/30/2019	Date/Time Pre	pared:
					2/25/2020 11:	
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, col				197, 205, 541	
2. 00	Less contractual allowances and discounts on patien	ts' accoun	ts		128, 769, 623	
3.00	Net patient revenues (line 1 minus line 2)				68, 435, 918	
4.00	Less total operating expenses (from Wkst. G-2, Part		43)		71, 909, 451	
5.00	Net income from service to patients (line 3 minus l	ine 4)			-3, 473, 533	5.00
	OTHER I NCOME					
6. 00	Contributions, donations, bequests, etc				0	
7. 00	Income from investments				0	
8. 00	Revenues from telephone and other miscellaneous com	muni cati on	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	
	Parking Lot receipts				0	
13.00	Revenue from Laundry and Linen service				0	
	Revenue from meals sold to employees and guests				0	
	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical supplies	to other t	han patients		0	
17.00	Revenue from sale of drugs to other than patients				0	1
					0	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and cant	een			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	MI SC I NCOME				2, 884, 780	24.00
24.01	INVESTMENT RETURN				597, 285	24. 01
24.02	LOSS ON DISPOSAL				-41, 471	24. 02
24.03	CONTRIBUTION TO THE COMMUNITY				-549, 116	24. 03
24.04	EXCESS OF ASSETS ACQUIRED OVER LIABI				205, 110	24.04
25.00	Total other income (sum of lines 6-24)				3, 096, 588	25.00
26.00	Total (line 5 plus line 25)				-376, 945	26.00
27. 00	OTHER EXPENSES (SPECIFY)				0	27.00

27.00 0

0 28.00 -376, 945 29.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 00 OTHER EXPENSES (SPECIFY)

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

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834, 507

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-172

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0

0

834, 335

20.00

21.00

22.00

23.00

23.50

24.00

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

Home Delivered Meals Program

20.00

21.00

22.00

23.00

23.50

CUSI F	Financial Systems ALLOCATION - HHA GENERAL SERVICE	COST	DENALD WEWORTAL	L HOSPITAL Provi der Co	ON: 15 0045	Period:	u of Form CMS-2 Worksheet H-1	
	ALLOCATION - HHA GENERAL SERVICE	2 COST		HHA CCN:	15-7157	From 10/01/2018 To 09/30/2019	Part I	pared:
						Home Health	PPS	10 4111
			Capital Rela	ted Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	
		0	1. 00	2. 00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	ol	o				0	1.00
1.00	Fixtures		٩				O	1.00
2. 00	Capital Related - Movable	O		0			0	2.00
3. 00	Equipment Plant Operation & Maintenance		0	0		0	0	3.00
4. 00	Transportation	0	o	0		0 0	O	4.00
5. 00	Administrative and General	293, 594	0	0		0 0	293, 594	
,	HHA REIMBURSABLE SERVICES				<u> </u>	ما ما	227.244	
6. 00 7. 00	Skilled Nursing Care Physical Therapy	297, 946 123, 558	0	0		0 0	297, 946 123, 558	
7. 00 8. 00	Occupati onal Therapy	36, 206	0	0		0 0	36, 206	
9. 00	Speech Pathology	2, 719	ő	0		0 0	2, 719	
10.00	Medical Social Services	29, 136	0	0		0 0	29, 136	
11. 00 12. 00	Home Health Aide Supplies (see instructions)	51, 176 0	0	0		0 0	51, 176 0	
13. 00	Drugs	0	o	0	•	0	0	l
14.00	DME	0	Ö	0		0 0	0	ı
	HHA NONREI MBURSABLE SERVI CES							
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0	0	
17. 00	Pri vate Duty Nursing	0	0	0		0 0	0	l
18. 00	Clinic	0	Ö	0		0 0	0	
19. 00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	
22. 00	Homemaker Service	0	0	0			0	
23. 00	All Others (specify)	Ö	Ö	0		0 0	0	
23. 50	Tel emedi ci ne	0	0	0		0 0	0	
24. 00	Total (sum of lines 1-23)	834, 335 Admi ni strati v	Total (cols.	0		0 0	834, 335	24.00
		e & General	4A + 5)					
	1	5. 00	6. 00					
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							 1.00
00	Fixtures							
2. 00	Capital Related - Movable							2.00
	Equi pment							
3. 00	TPLANT ODELATION & Maintenance							3.0
	Plant Operation & Maintenance Transportation							1
4. 00	Transportation Administrative and General	293, 594						4.0
4. 00 5. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES		A50 715					4. 00 5. 00
4. 00 5. 00 6. 00	Transportation Administrative and General	161, 769	459, 715 190, 644					4. 0 5. 0
4. 00 5. 00 6. 00 7. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care		459, 715 190, 644 55, 864					4. 0 5. 0 6. 0 7. 0
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	161, 769 67, 086 19, 658 1, 476	190, 644 55, 864 4, 195					4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	161, 769 67, 086 19, 658 1, 476 15, 819	190, 644 55, 864 4, 195 44, 955					4. 0 5. 0 6. 0 7. 0 8. 0 9. 0
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	161, 769 67, 086 19, 658 1, 476	190, 644 55, 864 4, 195					4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786	190, 644 55, 864 4, 195 44, 955 78, 962					4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786	190, 644 55, 864 4, 195 44, 955 78, 962 0					4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786 0	190, 644 55, 864 4, 195 44, 955 78, 962 0 0					4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786 0	190, 644 55, 864 4, 195 44, 955 78, 962 0					4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 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	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786 0 0	190, 644 55, 864 4, 195 44, 955 78, 962 0 0					4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 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	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786 0 0 0	190, 644 55, 864 4, 195 44, 955 78, 962 0 0 0					4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0
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 19. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786 0 0 0	190, 644 55, 864 4, 195 44, 955 78, 962 0 0 0					4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 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 19. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786 0 0 0	190, 644 55, 864 4, 195 44, 955 78, 962 0 0 0					4. 0 5. 0 7. 0 8. 0 9. 0 11. 0 12. 0 13. 0 14. 0 15. 0 17. 0 18. 0 19. 0 20. 0
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786 0 0 0	190, 644 55, 864 4, 195 44, 955 78, 962 0 0 0					4. 0 5. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 19. 0 20. 0 21. 0
22. 00 23. 00	Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	161, 769 67, 086 19, 658 1, 476 15, 819 27, 786 0 0 0	190, 644 55, 864 4, 195 44, 955 78, 962 0 0 0					3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 2

Health Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HHA STATISTICAL BA	SIS		Provi der C		Peri od:	Worksheet H-1	
			HHA CCN:		From 10/01/2018 To 09/30/2019		
					Home Health Agency I	PPS	
	Capital Rel	ated Costs					
	BI dgs &	Movabl e	PI ant	Transportation	Reconciliatio	Admi ni strati v	
	Fixtures (SQUARE FEET)	Equi pment (DOLLAR VALUE)	Operation & Maintenance (SQUARE FEET)	n (MI LEAGE)	n	e & General (ACCUM. COST)	
	1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
GENERAL SERVICE COST CENTERS							

		Capitai kei	ateu costs					
		BI das &	Movabl e	Plant	Transportatio	Reconciliatio	Administrativ	
		Fixtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Maintenance	II (WILLEAGE)	11	(ACCUM. COST)	
		(SQUARE FEET)	VALUE)	(SQUARE FEET)			(ACCOM. COST)	
		1. 00	2. 00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	JA. 00	3.00	
1. 00	Capital Related - Bldg. &	0				0		1.00
1.00	Fixtures							1.00
2.00	Capital Related - Movable		0			0		2.00
2.00	Equipment		ŭ					1
3.00	Plant Operation & Maintenance	o	0	0	i	0		3.00
4.00	Transportation (see	0	0	0				4.00
	instructions)							
5.00	Administrative and General	0	0	0	d	-293, 594	540, 741	5.00
	HHA REIMBURSABLE SERVICES				•			
6.00	Skilled Nursing Care	0	0	0	C	0	297, 946	6.00
7.00	Physical Therapy	o	0	0	o c	0	123, 558	7. 00
8.00	Occupational Therapy	0	0	0	o	0	36, 206	8. 00
9.00	Speech Pathology	0	0	0	o	0	2, 719	9. 00
10.00	Medical Social Services	O	0	0	o c	0	29, 136	10.00
11.00	Home Health Aide	0	0	0	o c	0	51, 176	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	C	0	0	15.00
16.00	Respiratory Therapy	0	0	0	C	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17. 00
18. 00	Clinic	0	0	0	C	0	0	18. 00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Tel emedi ci ne	0	0	0	0	0	0	23. 50
24.00	Total (sum of lines 1-23)	0	0	0	0	-293, 594	540, 741	24.00
25.00	Cost To Be Allocated (per	0	0	0	0		293, 594	25. 00
	Worksheet H-1, Part I)							ı
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000		0. 542948	26. 00

Peri od: Worksheet H-2
From 10/01/2018 Part I
To 09/30/2019 Date/Time Prepared: 2/25/2020 11: 43 am
Home Heal th PPS Provider CCN: 15-0045 HHA CCN: 15-7157

						Home Health Agency I	PPS	
			CAPI TAL RELATED COSTS					
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT CLI NI C	BUTLER	
		0	1. 00	1. 01	1. 02	1. 03	1. 04	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	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) Telemedicine Total (sum of lines 1-19) (2)	0 459, 715 190, 644 55, 864 4, 195 44, 955 78, 962 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 552 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000				1. 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 17. 00 18. 00 19. 50 20. 00 21. 00
	prace:		CAPI TAL REL	ATED COSTS				
	Cost Center Description	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
1.00		1. 05	1. 07	1. 08	2.00	4.00	4A	4 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0		0 0	178, 460 459, 715 190, 644 55, 864 4, 195 44, 955 78, 962 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00

⁽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 DEKA ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: | Worksheet H-2 From 10/01/2018 | Part | Part | Date/Time Prepared: 2/25/2020 11: 43 am | PPS | Provider CCN: 15-0045 HHA CCN: 15-7157

						Home Health	PPS	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	Agency I DI ETARY	SNACK BAR	
	2001 COCO. 2000. Pt. O	E & GENERAL	PLANT	LINEN SERVICE	11000EREEL THO	5.2.7	Olivion Brin	
		5. 00	7. 00	8. 00	9. 00	10. 00	10. 01	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Administrative and General 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) Telemedicine	29, 358 75, 627 31, 362 9, 190 690 7, 395 12, 990 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9, 983 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 764 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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 19. 50
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 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	166, 612	9, 983 NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	3, 764 PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	20.00
		11. 00	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 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 21. 00	Administrative and General 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) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	30, 099 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	88, 822 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

⁽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 DEKA ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 2/25/2020 11: 43 am Provider CCN: 15-0045 Peri od: From 10/01/2018 To 09/30/2019 HHA CCN: 15-7157 Home Health PPS

						Agency I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA		
			Resi dents		A&G (see Part	Costs		
			Cost & Post		11)			
			Stepdown					
			Adjustments					
		24. 00	25. 00	26. 00	27. 00	28. 00		
1.00	Administrative and General	340, 486	0	340, 486				1.00
2.00	Skilled Nursing Care	535, 342	0	535, 342		722, 948		2.00
3.00	Physi cal Therapy	222, 006	0	222, 006		299, 806		3.00
4.00	Occupational Therapy	65, 054	0	65, 054		87, 852		4.00
5.00	Speech Pathology	4, 885	0	4, 885		6, 597		5.00
6.00	Medical Social Services	52, 350	0	52, 350		70, 696		6.00
7.00	Home Health Aide	91, 952	0	91, 952	32, 224	124, 176		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0	1	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	1	11.00
12.00	Respiratory Therapy	0	0	0	0	0	1	12.00
13.00	Private Duty Nursing	0	0	0	0	0	1	13.00
14.00	Clinic	0	0	0	0	0	1	14.00
15.00	Health Promotion Activities	0	0	0	0	0	1	15.00
16.00	Day Care Program	0	0	0	0	0	1	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	1	17.00
18.00	Homemaker Service	0	0	0	0	0	1	18.00
19.00	All Others (specify)	0	0	0	0	0	1	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	1	19. 50
20.00	Total (sum of lines 1-19) (2)	1, 312, 075	o	1, 312, 075	340, 486	1, 312, 075	2	20.00
21.00	Unit Cost Multiplier: column				0. 350442		2	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.

Home Health PPS

						Agency I	PPS	
		CAPI TAL				, Agency i		
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT	BUTLER	MOB EAST	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	CLINIC	(SQUARE FEET)	(SQUARE FEET)	
		1.00	1 01	1.00	(SQUARE FEET)	1.04	1.05	
1. 00	Administrative and General	1.00	1. 01	1. 02 0	1.03	1.04	1.05	1.00
2. 00	Skilled Nursing Care	0		0			0	
3. 00	Physical Therapy	0	_	0	1	_	ő	3.00
4. 00	Occupational Therapy	0	0	Ö	-	Ō	o	4. 00
5. 00	Speech Pathology	0	0	0	d	0	0	5.00
6.00	Medical Social Services	0	0	0	o	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	C	0	0	8.00
9.00	Drugs	0	0	0	1	_	0	9.00
10.00	DME	0	0	0			0	10.00
11.00	Home Dialysis Aide Services	0	0	0	1	_	0	11.00
12.00	Respiratory Therapy	0	0	0	-			12.00
13. 00 14. 00	Private Duty Nursing	0	0	0	1	_	0	13. 00 14. 00
15. 00	Health Promotion Activities			0	1	_	0	15.00
	Day Care Program	0	0	0		0	o o	16.00
17. 00	Home Delivered Meals Program	0	0	Ö		Ö	ő	17. 00
18.00	ı	0	0	0	o c	0	О	18.00
19.00	All Others (specify)	0	0	0	o c	0	0	19.00
19. 50		0	0	0	o c	0	0	19. 50
	Total (sum of lines 1-19)	300		0	O	0	0	20.00
21. 00	Total cost to be allocated	6, 552		0	0	0	0	21.00
22. 00	Unit cost multiplier	21. 840000		0.000000	0.000000	0. 000000	0. 000000	22. 00
		CAPI	TAL RELATED CO	1313				
	Cost Center Description	MEDICAL ARTS	SMALTZ WAY	MVBLE FOULP	FMPLOYEE	Reconciliatio	ADMI NI STRATI V	
	Cost Center Description	MEDICAL ARTS (SQUARE FEET)	SMALTZ WAY (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconciliatio n		
	Cost Center Description	MEDICAL ARTS (SQUARE FEET)	SMALTZ WAY (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			ADMINISTRATIV E & GENERAL (ACCUM. COST)	
	Cost Center Description				BENEFI TS		E & GENERAL	
	Cost Center Description	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT (UNADJUSTED SALARY)	n	E & GENERAL (ACCUM. COST)	
1.00		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET) 2.00	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00	n 5A	E & GENERAL (ACCUM. COST)	1.00
1.00	Administrative and General	(SQUARE FEET) 1.07	(SQUARE FEET) 1.08	2.00 300	BENEFI TS DEPARTMENT (UNADJUSTED SALARY) 4. 00 694, 164	5A 0	E & GENERAL (ACCUM. COST) 5.00 178,460	1.00
2.00	Administrative and General Skilled Nursing Care	(SQUARE FEET)	(SQUARE FEET) 1.08 0 0	2.00 300 0	BENEFI TS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164	5A 0	E & GENERAL (ACCUM. COST) 5.00 178,460 459,715	2.00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	(SQUARE FEET) 1.07	(SQUARE FEET) 1.08	2.00 300	BENEFI TS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164	5A 0	E & GENERAL (ACCUM. COST) 5.00 178, 460 459, 715 190, 644	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	(SQUARE FEET) 1.07	(SQUARE FEET) 1.08 0 0	2.00 300 0	BENEFI TS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164	5A 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5.00 178, 460 459, 715 190, 644 55, 864	2. 00 3. 00 4. 00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	(SQUARE FEET) 1.07	1.08 0 0 0	2.00 300 0 0	BENEFI TS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164	5A 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5.00 178, 460 459, 715 190, 644	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	(SQUARE FEET) 1.07	1.08 0 0 0 0	2.00 300 0 0	BENEFI TS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00 178, 460 459, 715 190, 644 55, 864 4, 195	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	(SQUARE FEET) 1.07	1.08 0 0 0 0	2.00 300 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 178,460 459,715 190,644 55,864 4,195	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 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	(SQUARE FEET) 1.07	1.08 0 0 0 0 0 0	2.00 300 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 44, 955 78, 962	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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	(SQUARE FEET) 1.07	1. 08 0 0 0 0 0 0 0	2.00 300 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 44, 955 78, 962 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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	(SQUARE FEET) 1.07	1.08 0 0 0 0 0 0	2.00 300 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 78, 962 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	Administrative and General 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	(SQUARE FEET) 1.07	1. 08 1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 300 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 78, 962 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	Administrative and General 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	(SQUARE FEET) 1.07	1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 300 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 44, 955 78, 962 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	Administrative and General 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	(SQUARE FEET) 1.07	1. 08 1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 300 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 78, 962 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	Administrative and General 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	(SQUARE FEET) 1.07	1. 08 1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 300 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 78, 962 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	Administrative and General 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	(SQUARE FEET) 1.07	1.08 1.08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 300 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 44, 955 78, 962 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
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	Administrative and General 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	(SQUARE FEET) 1.07	1. 08 1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 300 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 78, 962 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
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	Administrative and General 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	(SQUARE FEET) 1.07	1. 08 1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 300 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 44, 955 78, 962 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 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 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General 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) Telemedicine	(SQUARE FEET) 1.07	1. 08 1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 300 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFITS DEPARTMENT (UNADJUSTED SALARY) 4.00 694,164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 44, 955 78, 962 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 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 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00	Administrative and General 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) Telemedicine Total (sum of lines 1-19)	(SQUARE FEET) 1.07	1. 08 1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 300 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (UNADJUSTED SALARY) 4. 00 694, 164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 78, 962 0 0 0 0 0 0 0 0 1, 012, 795	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 19.50 20.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General 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) Telemedicine	(SQUARE FEET) 1.07	1. 08 1. 08 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 300 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	BENEFI TS DEPARTMENT (UNADJUSTED SALARY) 4.00 694, 164 00 00 00 00 00 00 00 00 00 00 00 00 00	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL (ACCUM. COST) 5. 00 178, 460 459, 715 190, 644 55, 864 4, 195 78, 962 0 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 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00 21.00

Peri od: Worksheet H-2
From 10/01/2018 Part II
To 09/30/2019 Date/Time Prepared: 2/25/2020 11: 43 am

Home Health PPS BASIS HHA CCN: 15-7157

						Home Health	PPS	
	Cost Contar Deceriation	ODEDATION OF	I ALINDDY 0	HOUSEKEEDING	DIETADY	Agency I	CAFETEDIA	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS	(MEALS	(FTES)	
		(SQUARE FEET)	(POUNDS OF		SERVED)	SERVED)		
		7. 00	LAUNDRY) 8. 00	9. 00	10.00	10. 01	11. 00	
1. 00	Administrative and General	300	0.00		0	0	1, 221	1. 00
2. 00	Skilled Nursing Care	0		0	0	o	1, 221	2. 00
3. 00	Physi cal Therapy	0	0	o	0	o	0	3. 00
4. 00	Occupational Therapy	0	0	ا	0	o	0	4. 00
5. 00	Speech Pathology	0	0	0	0	o	0	5. 00
6. 00	Medical Social Services	0			0	0	0	6. 00
7. 00	Home Heal th Ai de	0		Ö	0	0	0	7. 00
8. 00	Supplies (see instructions)	0	0	o	0	o	0	8. 00
9. 00	Drugs	0	0	ol	0	o	0	9. 00
10.00	DME	0	0	ا	0	o	0	10.00
11. 00	Home Dialysis Aide Services	0	0	o	0	o	0	11. 00
12. 00	Respiratory Therapy	0	0	o	0	0	0	12.00
13. 00	Pri vate Duty Nursing	0	0	o	0	0	0	13.00
14. 00	Clinic	0	0	o	0	0	0	14.00
15. 00	Health Promotion Activities	0	0	ol	0	0	0	15. 00
16. 00	Day Care Program	0	0	ol	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	ol	0	o	0	17. 00
18. 00	Homemaker Service	0	0	ol	0	o	0	18. 00
19. 00	All Others (specify)	0	0	ol	0	o	0	19. 00
19. 50	Tel emedi ci ne	0	0	o	0	0	0	19. 50
20.00	Total (sum of lines 1-19)	300	0	300	0	0	1, 221	20.00
21.00	Total cost to be allocated	9, 983	0	3, 764	0	0	30, 099	21.00
22.00	Unit cost multiplier	33. 276667	0. 000000	12. 546667	0. 000000	0. 000000	24. 651106	22.00
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL		
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE		
		N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)		
		(DI RECT_NRS	(COSTED		(GROSS REVE			
		I NG)	REQUIS.)	45.00	NUE)	47.00		
1. 00	Administrative and General	13. 00 25, 403	14. 00	15. 00 0	16. 00 0	17. 00 0		1.00
2. 00	Skilled Nursing Care	25, 403		0	0	0		2.00
3. 00	Physical Therapy	0		0	0	0		3.00
4. 00	Occupational Therapy	0		0	0	0		4. 00
5. 00	Speech Pathology	0		0	0	0		5. 00
6. 00	Medical Social Services	0			0	0		6. 00
7. 00	Home Heal th Ai de	0			0	0		7. 00
8. 00	Supplies (see instructions)	0			0	0		8. 00
9. 00	Drugs	0			0	o		9. 00
10.00	DME	0		Ö	0	o o		10.00
11. 00	Home Dialysis Aide Services	0		l o	0	o		11.00
12. 00	Respiratory Therapy	0		l o	0	o		12.00
13. 00	Pri vate Duty Nursing	0	0	o	0	o		13.00
14. 00	Clinic	0		l o	0	o		14. 00
15. 00	Health Promotion Activities	0			0	o		15.00
16. 00	Day Care Program	0			0	o		16.00
17. 00	Home Delivered Meals Program	0	0	ا	0	o		17. 00
18. 00	Homemaker Service	0	0	o	0	o		18. 00
19. 00	All Others (specify)	o o		Ö	0	o		19.00
19. 50	Tel emedi ci ne	0	l 0	l ol	o.	o		19. 50
20. 00	Total (sum of lines 1-19)	25, 403	l	l ol	0	o		20.00
21. 00	Total cost to be allocated	88, 822	0	ol	0	o		21. 00
22. 00	Unit cost multiplier	3. 496516	0. 000000	0. 000000	0. 000000	0. 000000		22.00
	1							

Heal th	Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COS	TS		Provi der C	CN: 15-0045	Peri od:	Worksheet H-3	
				HHA CCN:	15-7157	From 10/01/2018 To 09/30/2019		
				Ti tl e	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
		0	Part I)	Part II)	2.00	4.00	col . 4)	
	PART I - COMPUTATION OF LESSER		1.00	2.00	3.00	4.00	5.00	
	COST LIMITATION Cost Per Visit Computation	OF AUGREGATE	PROGRAM COST, I	AGGREGATE OF T	ne Prograw Li	WITATION COST, C	JR DENEFICIARY	
1. 00	Skilled Nursing Care	2.00	722, 948		722, 94	48 3, 201	225. 85	1.00
2. 00	Physical Therapy	3.00					237. 19	
3. 00	Occupational Therapy	4.00					173. 62	
4. 00	Speech Pathology	5. 00		l .			173. 61	4.00
5. 00	Medical Social Services	6. 00	,	l e	70, 69		744. 17	ı
6. 00	Home Heal th Aide	7.00		l e	124, 13		95. 59	l
7. 00	Total (sum of lines 1-6)		1, 312, 075	l			, , , ,	7.00
7.00			170127070		Program Visi			71.00
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deductibles		
					Deductibles			
		0	1. 00	2. 00	Coi nsurance 3. 00	4.00	5. 00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8. 00	Skilled Nursing Care		34620	C		22		8.00
8. 01	Skilled Nursing Care		99915	l c				8. 01
9. 00	Physi cal Therapy		34620			11		9.00
9. 01	Physi cal Therapy		99915	l c	42	20		9. 01
10.00	Occupational Therapy		34620	l c)	10		10.00
10.01	Occupational Therapy		99915	l c	10	67		10.01
11.00	Speech Pathology		34620	l c		0		11.00
11.01	Speech Pathology		99915	C) ·	12		11. 01
12.00	Medical Social Services		34620	C		1		12.00
12.01	Medical Social Services		99915	C) ;	39		12.01
13.00	Home Health Aide		34620	C)	15		13.00
13.01	Home Health Aide		99915	C	40	05		13. 01
14.00	Total (sum of lines 8-13)			C				14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.		÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)		
		_	Part I)	Part II)				
	Supplies and Drugs Cost Comput	ations	1. 00	2. 00	3.00	4. 00	5. 00	
15. 00	Cost of Medical Supplies	8.00	0	l c		0 0	0. 000000	15.00
	Cost of Drugs	9. 00				0 0	0. 000000	
	,		Program Visits		Cost of			
			J		Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
	DART I COMPUTATION OF LECCED	6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF I	HE PROGRAM LI	MITATION COST, C	JK BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1, 129			0 254, 985		1.00
2. 00	Physical Therapy	0	431			0 102, 229		2.00
3.00	Occupational Therapy	0	177			0 30, 731		3.00
4. 00	Speech Pathology	0	12			0 2, 083		4.00
5. 00	Medical Social Services	0	40			0 29, 767		5.00
6. 00	Home Health Aide	0	420			0 40, 148		6.00
7. 00	Total (sum of lines 1-6)	0	2, 209			0 459, 943		7.00
	•	•			•			

Health Financial Systems		DEKALB MEMORI				u of Form CMS-	
APPORTIONMENT OF PATIENT SERVICE COS	ΓS		Provi der CO	CN: 15-0045	Peri od: From 10/01/2018	Worksheet H-3 Part I	3
			HHA CCN:	15-7157	To 09/30/2019	Date/Time Pro 2/25/2020 11:	
			Title	XVIII	Home Health Agency I	PPS	45 diii
Cost Center Description	(00	7.00	0.00	0.00		44.00	
Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10. 00	11.00	
8.00 Skilled Nursing Care 8.01 Skilled Nursing Care 9.00 Physical Therapy							8. 00 8. 0° 9. 00
9.01 Physical Therapy 10.00 Occupational Therapy 10.01 Occupational Therapy							9. 0° 10. 0° 10. 0°
11.00 Speech Pathology 11.01 Speech Pathology 12.00 Medical Social Services							11. 00 11. 0 12. 00
12.01 Medical Social Services 13.00 Home Health Aide 13.01 Home Health Aide							12. 0° 13. 0° 13. 0°
14.00 Total (sum of lines 8-13)	Donor			C+ -£			14.00
	Progi	ram Covered Cha	arges	Cost of Services			
		Par	t B		Part B		
Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	
		Coi nsurance	corristrance		Coi nsurance	corrisar ance	
	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
Supplies and Drugs Cost Comput 15.00 Cost of Medical Supplies	atrons	15, 937	0		ol ol	(15.00
16.00 Cost of Drugs		0			0		16.00
Cost Center Description	Total Program Cost (sum of cols. 9-10)						
DADT I COMPUTATION OF LEGGED	12.00	DDOODAM OOST	100DE04TE 0E TI	IE DDOODAM I	IMITATION OOCT O	D. DENEEL OL ADV	
PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	OF AGGREGATE	PRUGRAM CUSI, A	AGGREGATE OF IF	HE PROGRAM L	IMITATION COST, O	R RENEFICIARY	
1.00 Skilled Nursing Care	254, 985						1.00
2.00 Physical Therapy							2.00
	102, 229						1
3.00 Occupational Therapy	30, 731						3.0
3.00 Occupational Therapy 4.00 Speech Pathology	30, 731 2, 083						3. 0 4. 0
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services	30, 731						3. 00 4. 00 5. 00
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6)	30, 731 2, 083 29, 767						3. 00 4. 00 5. 00 6. 00 7. 00
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide	30, 731 2, 083 29, 767 40, 148 459, 943						3. 00 4. 00 5. 00 6. 00
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6)	30, 731 2, 083 29, 767 40, 148						3. 00 4. 00 5. 00 6. 00
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 5.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	30, 731 2, 083 29, 767 40, 148 459, 943						3. 0' 4. 0' 5. 0' 6. 0' 7. 0'
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 5.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	30, 731 2, 083 29, 767 40, 148 459, 943						3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 8. 0
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 5.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 3.00 Skilled Nursing Care 9.00 Physical Therapy	30, 731 2, 083 29, 767 40, 148 459, 943						3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 8. 0 9. 0
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 3.00 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 10.00 Occupational Therapy	30, 731 2, 083 29, 767 40, 148 459, 943						3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 8. 0 9. 0 9. 0 10. 0
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 3.00 Skilled Nursing Care 8.01 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 10.00 Occupational Therapy 10.01 Occupational Therapy	30, 731 2, 083 29, 767 40, 148 459, 943						3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 8. 0 9. 0 9. 0 10. 0
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 8.00 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 10.00 Occupational Therapy 11.00 Speech Pathology	30, 731 2, 083 29, 767 40, 148 459, 943						3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 8. 0 9. 0 10. 0 11. 0
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 8.00 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 10.00 Occupational Therapy 10.01 Occupational Therapy 10.01 Speech Pathology 11.01 Speech Pathology 12.02 Pathology 13.02 Speech Pathology	30, 731 2, 083 29, 767 40, 148 459, 943						3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 9. 0 10. 0 11. 0 11. 0
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 8.00 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 10.00 Occupational Therapy 10.01 Occupational Therapy 11.00 Speech Pathology 11.01 Speech Pathology 12.00 Medical Social Services	30, 731 2, 083 29, 767 40, 148 459, 943						3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 12. 00
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 8.00 Skilled Nursing Care 8.01 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 9.01 Occupational Therapy 10.00 Occupational Therapy 11.00 Speech Pathology 11.01 Speech Pathology 12.00 Medical Social Services 12.01 Medical Social Services 13.00 Home Health Aide	30, 731 2, 083 29, 767 40, 148 459, 943						3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 12. 00 13. 00
3.00 Occupational Therapy 4.00 Speech Pathology 5.00 Medical Social Services 6.00 Home Health Aide 7.00 Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation 8.00 Skilled Nursing Care 9.00 Physical Therapy 9.01 Physical Therapy 10.00 Occupational Therapy 10.01 Occupational Therapy 11.00 Speech Pathology 11.01 Speech Pathology 12.00 Medical Social Services	30, 731 2, 083 29, 767 40, 148 459, 943						3. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 9. 0 10. 0 11. 0 11. 0 12. 0 12. 0

Heal th	Financial Systems		DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 15-0045	Peri od:	Worksheet H-3	
						From 10/01/2018		
				HHA CCN:	15-7157	To 09/30/2019		
					\0.41.1.1		2/25/2020 11:	43 am
				litle	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	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 SERVI	CES FURNISHED E	BY SHARED HOSPI	ITAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 303016	0		0 col. 2, line 2	. 00	1.00
1.01	Physical Therapy 1	66. 01	0. 696427	0		0 col. 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. 470352	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 668246	0		0 col. 2, line 1	6. 00	5.00

		ORIAL HOSPITAL	ON 45 0015		u of Form CMS-2	
ALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der C	UN: 15-0045	Peri od: From 10/01/2018	Worksheet H-4 Part I-II	
		HHA CCN:	15-7157	To 09/30/2019	Date/Time Pre 2/25/2020 11:	
		Title	XVIII	Home Health	PPS	45 4111
				Agency I	t B	
			Part A	Not Subject	Subject to	
				to	Deductibles &	
				Deductibles & Coinsurance	Coi nsurance	
			1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR	CUSTOMARY CHARG	ES			
. 00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1. (
. 00	Total charges			0 0	0	1
	Customary Charges					1
3. 00	Amount actually collected from patients liable for payme	nt for services		0 0	0	3.0
1. 00	on a charge basis (from your records) Amount that would have been realized from patients liable	e for pavment		0 0	0	4.0
00	for services on a charge basis had such payment been mad with 42 CFR §413.13(b)				Ŭ	
5. 00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000		0.000000	•
5. 00 7. 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable	cost (complete		0 0	0	
. 00	only if line 6 exceeds line 1)	cost (comprete			U	/. \
3. 00	Excess of reasonable cost over customary charges (comple	te only if line		0 0	0	8.0
0. 00	1 exceeds line 6) Primary payer amounts			0 0	0	9. (
. 00	Trimury payer amounts			Part A	Part B	7. (
				Servi ces 1.00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)			0	0	
11. 00 12. 00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0	244, 583 56, 519	
13. 00	Total PPS Reimbursement - LUPA Episodes			0	5, 589	
4.00	Total PPS Reimbursement - PEP Episodes	1.5		0	2, 493	
5. 00 6. 00	Total PPS Outlier Reimbursement - Full Episodes with Out Total PPS Outlier Reimbursement - PEP Episodes	liers		0	7, 042 159	
7. 00	Total Other Payments			0	0	1
8. 00	DME Payments			0	0	
9.00	Oxygen Payments			0	0	
0.00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude	coi nsurance)		0	0	
2. 00		corrisar arice)		0	316, 385	1
3. 00				0	0	
4. 00	,			0	316, 385	1
25. 00 26. 00	Coinsurance billed to program patients (from your record Net cost (line 24 minus line 25)	S)		0	0 316, 385	
	Reimbursable bad debts (from your records)				310, 303	27.
8. 00	Reimbursable bad debts for dual eligible beneficiaries ()			28.
9.00	Total costs - current cost reporting period (line 26 plu	s line 27)		0	316, 385	
0. 00 0. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instru	ctions)		0	0	1
0. 99	Demonstration payment adjustment amount before sequestra			0	0	1
1. 00	Subtotal (see instructions)			0	316, 385	1
1. 01	Sequestration adjustment (see instructions)	ion		0	6, 328	
31. 02 32. 00	Demonstration payment adjustment amount after sequestrat Interim payments (see instructions)	1 011		0	0 310, 057	
, <u>, , , , , , , , , , , , , , , , , , </u>	Tentative settlement (for contractor use only)			0	0	1
33.00						
	Balance due provider/program (line 31 minus lines 31.01,			0	0	1

Health Financial Systems DEKALB MEMORIA
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Peri od: From 10/01/2018 To 09/30/2019 Date/Time Prepared: 2/25/2020 11: 43 am PPS Provider CCN: 15-0045 TO PROGRAM BENEFICIARIES HHA CCN: 15-7157

				Home Health	PPS	
		I nno+i on	+ Dorst A	Agency I	t B	
				ГВ		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		(310, 057	1.00
2. 00	Interim payments payable on individual bills, either		()	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01			(0	3. 01
3. 02			(0	3. 02
3. 03			(0	3. 03
3. 04			(0	3.04
3. 05	Dravi dan ta Dragnam)	0	3. 05
3. 50	Provider to Program			1	0	3. 50
3. 51						3. 51
3. 52					0	3. 52
3. 53					l ol	3. 53
3.54			C		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		(310, 057	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01			(0	5. 01
5.02			(0	5.02
5. 03			()	0	5. 03
F F0	Provi der to Program	l		\	0	F F0
5. 50 5. 51						5. 50 5. 51
5. 51						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
0. , ,	5. 50-5. 98)				Ĭ	0. 77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		(0	6. 01
6. 02	SETTLEMENT TO PROGRAM		(0	6. 02
7. 00	Total Medicare program liability (see instructions)			1	310, 057	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 55	1 2. 35 45.6.	ı		1	1 1	5. 55

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0 69.00

0 70.00

0 71.00 427, 384 100.00

OTHER PHYSICIAN SERVICES*

TELEHEALTH/TELEMONI TORI NG*

71.00 OTHER NONREIMBURSABLE (SPECIFY)*

NURSING FACILITY ROOM & BOARD*

RESIDENTIAL CARE*

ADVERTI SI NG*

THRIFT STORE*

65.00

66.00

67 00

68.00

69 00

70.00

100.00 TOTAL

^{*} Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.

^{**} See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)	-	
		6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS			ı	1.00
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	•	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	1	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	9, 340		3.00
4. 00	ADMI NI STRATI VE & GENERAL*	-98	278, 755	1	4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0	0	•	5.00
6. 00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPI NG*	0	0		7.00
8. 00	DI ETARY*	0	0	1	8.00
9.00	NURSI NG ADMI NI STRATI ON*	0	0	•	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	11 070	1	11.00
12.00	STAFF TRANSPORTATION*	0	11, 879	1	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	1	13.00
14.00	PHARMACY*	0	0	1	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0)	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
25 00	DI RECT PATIENT CARE SERVI CE COST CENTERS			J	25.00
25. 00	I NPATI ENT CARE-CONTRACTED**	0	0	1	25.00
26. 00	PHYSI CI AN SERVI CES**	0	0		26.00
27. 00	NURSE PRACTITIONER**	0	03.004	1	27.00
28. 00 29. 00	REGI STERED NURSE**	0	93, 094	1	28.00
	LPN/LVN**	0	0		29.00
30.00	PHYSI CAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	10 550		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	13, 558		33.00
34.00	SPIRITUAL COUNSELING**	0	20, 660	1	34.00
35.00	DI ETARY COUNSELI NG**	0	0	•	35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0		37.00
38.00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	I MAGING SERVI CES**	0	0	•	40.00
41.00	LABS & DI AGNOSTI CS**	0	0	•	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	•	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE CHEMOTHERAPY**	0	0	1	44.00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0	•	45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	<u>/</u>	46. 00
(0.00	NONREI MBURSABLE COST CENTERS			I	(0.00
60.00	BEREAVEMENT PROGRAM *	0	0	1	60.00
61.00	VOLUNTEER PROGRAM *	0	0	1	61.00
62.00	FUNDRAL SI NG*	0	0	1	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	1	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	1	64.00
65. 00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESI DENTI AL CARE*	0	0	1	66.00
67.00	ADVERTI SI NG*	0	0	•	67.00
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0	•	68.00
69.00	THRIFT STORE*	0	0	•	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	7	71.00
100.00	JI TUTAL	-98	427, 286		100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

					Hospi ce I		
	·	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED						25.00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26.00
	NURSE PRACTITIONER	0	0	0	0	0	
	REGI STERED NURSE	91, 597	0	91, 597	0	91, 597	28. 00
	LPN/LVN	0	0	0	0	0	
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
	SPI RI TUAL COUNSELI NG	20, 327	0	20, 327	0	20, 327	34.00
	DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100. 00 TOTAL *		111, 924	0	111, 924	0	111, 924	100.00
* Tran	* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.						

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5			
			± col . 6)			
		6. 00	7. 00			
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED				25.00	
26.00	PHYSI CI AN SERVI CES	0	0		26.00	
27.00	NURSE PRACTITIONER	0	0		27.00	
28.00	REGI STERED NURSE	0	91, 597		28. 00	
29. 00	LPN/LVN	0	0		29. 00	
30.00	PHYSI CAL THERAPY	0	0		30.00	
31.00	OCCUPATI ONAL THERAPY	0	0		31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00	
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00	
34.00	SPI RI TUAL COUNSELI NG	0	20, 327		34.00	
35.00	DI ETARY COUNSELI NG	0	0		35.00	
36.00	COUNSELING - OTHER	0	0		36.00	
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00	
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00	
39. 00	PATI ENT TRANSPORTATION	0	0		39.00	
40.00	I MAGI NG SERVI CES	0	0		40.00	
41. 00	LABS & DI AGNOSTI CS	0	0		41.00	
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00	
42. 50	DRUGS CHARGED TO PATIENTS	0	0		42. 50	
43.00	OUTPATIENT SERVICES	0	0		43.00	
44. 00	PALLIATIVE RADIATION THERAPY	0	0		44.00	
45. 00	PALLIATIVE CHEMOTHERAPY	0	0		45. 00	
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46. 00	
100.00	TOTAL *	0	111, 924		100.00	

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE INPATIENT	Provi der CCN	N: 15-0045	Peri od:	Worksheet 0-3	
RESPI T	E CARE		Hospi ce CCN:	15-1559	From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 11:	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	T	_1			_	
25. 00	I NPATI ENT CARE-CONTRACTED		0		0	0	20.00
	PHYSI CI AN SERVI CES	0	0		0	0	26.00
	NURSE PRACTITIONER	0	0		0 0	0	1 = 7 00
	REGI STERED NURSE	1, 079	0	1, 0	79 0	1, 079	
29. 00	LPN/LVN	0	0		0	0	29.00
	PHYSI CAL THERAPY	0	0		0	0	30.00
	OCCUPATIONAL THERAPY	0	0		0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
	MEDICAL SOCIAL SERVICES	240	O O	2	10	0	33.00
	SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG	240	0	24	40 0	240	1
	COUNSELING - OTHER	0	0		0	0	36.00
			U O		0	0	37.00
	HOSPICE AIDE & HOMEMAKER SERVICES DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0	0	38.00
39. 00	PATIENT TRANSPORTATION	0	0		0	0	39.00
40. 00	I MAGING SERVICES		0		0	0	40.00
41. 00	LABS & DIAGNOSTICS		0		0	0	41.00
	MEDICAL SUPPLIES-NON-ROUTINE		0			0	42.00
	DRUGS CHARGED TO PATIENTS		0		0 0	0	42.50
	OUTPATIENT SERVICES		0		0 0	0	43.00
	PALLIATIVE RADIATION THERAPY		0			n	44.00
	PALLI ATI VE CHEMOTHERAPY		0			0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)		ol o		0 0	0	1
10.00	(or coll)	1	٩			· ·	10.00

1, 319 100. 00

100.00 TOTAL * * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	·	ADJUSTMENTS	TOTAL (col. 5		
		ADSOSTMENTS	± col. 6)		
		6, 00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00		
25.00	I NPATI ENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	o		26.00
27.00	NURSE PRACTITIONER	0	l ol		27.00
28.00	REGI STERED NURSE	0	1, 079		28.00
29.00	LPN/LVN	0	o		29.00
30.00	PHYSI CAL THERAPY	0	o		30.00
31.00	OCCUPATI ONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	240		34.00
35.00	DI ETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39. 00	PATI ENT TRANSPORTATION	0	0		39.00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
	PALLIATIVE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1, 319	1	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	Financial Systems	DEKALB MEMORIAL				u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE GENERAL	Provi der CC	CN: 15-0045	Peri od:	Worksheet 0-4	
I NPATI	ENT CARE		Hospi ce CCN	N: 15-1559	From 10/01/2018 To 09/30/2019		pared: 43 am
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
		1. 00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0		0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	0		0	0	26.00
	NURSE PRACTITIONER	0	0		0	0	27. 00
	REGI STERED NURSE	418	0	4	18 0	418	
29. 00	LPN/LVN	0	0		0	0	29. 00
	PHYSI CAL THERAPY	0	0		0	0	30. 00
	OCCUPATI ONAL THERAPY	0	0		0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
	MEDICAL SOCIAL SERVICES	13, 558	0	13, 5!		13, 558	33. 00
	SPIRITUAL COUNSELING	93	0	•	93 0	93	34.00
	DI ETARY COUNSELI NG	0	0		0	0	35. 00
	COUNSELING - OTHER	0	0		0	0	36.00
	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0		0	0	39.00
40.00	I MAGING SERVICES	0	0		0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0		0	0	41.00
42 OO	MEDICAL SUDDILES NON DOUTINE	I 0				Λ .	12 00

0 0 0

14, 069

42.00

42.50

46.00

0 43.00

0 44.00

0 45.00

14, 069 100. 00

MEDICAL SUPPLIES-NON-ROUTINE

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

DRUGS CHARGED TO PATIENTS

44.00 PALLIATIVE RADIATION THERAPY

45.00 PALLIATIVE CHEMOTHERAPY

43.00 OUTPATIENT SERVICES

42.50

	ADJUSTMENTS	TOTAL (col. 5	
		± col. 6)	
	6. 00	7. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00 I NPATI ENT CARE-CONTRACTED	C	0	25. 0
26. 00 PHYSI CI AN SERVI CES	C	0	26.0
27. 00 NURSE PRACTITIONER	C	0	27.0
28. 00 REGI STERED NURSE	C	418	28.0
29. 00 LPN/LVN	C	0	29.0
30. 00 PHYSI CAL THERAPY	C	0	30.0
31. 00 OCCUPATIONAL THERAPY	C	0	31.0
32.00 SPEECH/LANGUAGE PATHOLOGY	C	0	32.0
33. 00 MEDICAL SOCIAL SERVICES	C	13, 558	33.0
34. 00 SPIRITUAL COUNSELING	C	93	34.0
35. 00 DI ETARY COUNSELING	C	0	35.0
36. 00 COUNSELING - OTHER	C	0	36.0
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	C	0	37.0
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	C	0	38.0
39. 00 PATIENT TRANSPORTATION	C	0	39.0
40.00 I MAGING SERVICES	C	0	40.0
41. 00 LABS & DI AGNOSTI CS	C	0	41.0
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	C	0	42.0
42.50 DRUGS CHARGED TO PATIENTS	C	0	42.5
43. 00 OUTPATIENT SERVICES	C	0	43.0
44.00 PALLIATIVE RADIATION THERAPY	C	0	44.0
45. 00 PALLIATIVE CHEMOTHERAPY	C	0	45.0
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	이	46.0
100. 00 TOTAL *	C	14, 069	100.0

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

^{100.00} TOTAL * * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAI		Inlie	u of Form CMS-2)552 <u>-</u> 1
COST ALLOCATION - DETERMINATION OF HOSP EXPENSES FOR ALLOCATION		Provi der C		Period: From 10/01/2018	Worksheet 0-5	
EXPENSES FOR ALLSGATION		Hospi ce CCI	N: 15-1559	To 09/30/2019	Date/Time Prep 2/25/2020 11:4	
				Hospi ce I		
Descriptions			HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
			ĺ	(see	, i	
				instructions)		
			1.00	2.00	3. 00	
GENERAL SERVICE COST CENTERS						
1 OO CAD DEL COSTS BLDG & ELVT				0 6 552	6 552	1

		DI RECT	SERVI CE	EXPENSES (sum	
		EXPENSES (see	EXPENSES FROM	of cols. 1 +	
		instructions)	WKST B PART I	2)	
			(see		
			instructions)		
		1. 00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS				
1. 00	CAP REL COSTS-BLDG & FIXT	0	6, 552	6, 552	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	9, 340			3.00
4. 00	ADMINISTRATIVE & GENERAL	278, 755			4.00
5. 00	PLANT OPERATION & MAINTENANCE	0	9, 983		5.00
6. 00	LAUNDRY & LINEN SERVICE	0	89	l e	6. 00
7. 00	HOUSEKEEPING	0	3, 764		7. 00
8. 00	DIETARY	0	0	0	8. 00
9. 00	NURSI NG ADMI NI STRATI ON	0	8, 168	l ' .	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11. 00	MEDI CAL RECORDS	0	269		11.00
	STAFF TRANSPORTATION	11, 879		11, 879	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
	PHARMACY	0	0	0	14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
	OTHER GENERAL SERVICE	0	0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17. 00
	LEVEL OF CARE	T		г	
	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
	HOSPI CE ROUTI NE HOME CARE	111, 924		111, 924	51.00
	HOSPICE INPATIENT RESPITE CARE	1, 319		1, 319	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	14, 069		14, 069	53.00
	NONREI MBURSABLE COST CENTERS	_			
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
	FUNDRAL SI NG	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
	PALLI ATI VE CARE PROGRAM	0		0	64.00
	OTHER PHYSI CI AN SERVI CES	0		0	65.00
66.00	RESI DENTI AL CARE	0		0	66.00
	ADVERTI SI NG	0		0	67.00
	TELEHEALTH/TELEMONI TORI NG	0		0	68.00
	THRIFT STORE	0		0	69.00
	NURSING FACILITY ROOM & BOARD	0		0	70.00
	OTHER NONREI MBURSABLE (SPECI FY)	0		0	71.00
	NEGATI VE COST CENTER	0		0	99. 00
100.00	TOTAL	427, 286	139, 671	566, 957	100. 00

Health FinancialSystemsDEKALB MEMOCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS

			nospi ce coi	N. 13-1337 1	0 07/30/2017	2/25/2020 11:	
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6, 552	6, 552				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o		l c	i i		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	40, 869	0	l c	40, 869		3.00
4.00	ADMINISTRATIVE & GENERAL	358, 072	0	l c	o	358, 072	4.00
5.00	PLANT OPERATION & MAINTENANCE	9, 983	0	l c	o	9, 983	5.00
6.00	LAUNDRY & LINEN SERVICE	89	0	l c	o	89	6.00
7.00	HOUSEKEEPI NG	3, 764	0		ol	3, 764	7.00
8.00	DI ETARY	o	0		ol	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	8, 168	0		ol	8, 168	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	o	0		ol	0	10.00
11.00	MEDI CAL RECORDS	269	0		ol	269	11. 00
12.00	STAFF TRANSPORTATION	11, 879	0		ol	11, 879	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	ď	o	0	13.00
14. 00	PHARMACY	o	0	1	ol	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	ام	0		أم	0	15. 00
16. 00	OTHER GENERAL SERVICE	ام	0		أم	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0	ĺ		0	17. 00
	LEVEL OF CARE	l l	-			-	
50.00	HOSPICE CONTINUOUS HOME CARE	0			O	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	111, 924			40, 212	152, 136	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 319	4, 717		474	6, 510	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	14, 069	1, 835			16, 087	53.00
	NONREI MBURSABLE COST CENTERS	,	•	<u> </u>			
60.00	BEREAVEMENT PROGRAM	0	0	C	0	0	60.00
61.00	VOLUNTEER PROGRAM	o	0	(o	0	61.00
62.00	FUNDRAI SI NG	o	0	(o	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0	(o	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	0	l c	o	0	64.00
65.00	OTHER PHYSICIAN SERVICES	o	0	l c	o	0	65.00
66.00	RESI DENTI AL CARE	o	0	l c	o	0	66.00
67.00	ADVERTI SI NG	o	0	l c	o	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	o	0	l c	o	0	68.00
69.00	THRI FT STORE	o	0	(o	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	o				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o	0	C	ol	0	71.00
99.00	NEGATI VE COST CENTER	o	0		ol		99. 00
100.00	TOTAL	566, 957	6, 552	C	40, 869	566, 957	100.00
	•	. '		•	. '	'	

Health FinancialSystemsDEKALB MEMOCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS Provider CCN: 15-0045 | Period: | Worksheet 0-6 | From 10/01/2018 | Part | Hospice CCN: 15-1559 | To 09/30/2019 | Date/Time Prepared: Provi der CCN: 15-0045

			nospi ce coi	10 1007	10 077 007 2017	2/25/2020 11:	
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	OPERATION &	LINEN SERVIC			
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	358, 072					4.00
5.00	PLANT OPERATION & MAINTENANCE	17, 113	27, 096				5.00
6.00	LAUNDRY & LINEN SERVICE	153	0	24	2		6. 00
7.00	HOUSEKEEPI NG	6, 452	0		10, 216		7. 00
8.00	DI ETARY	0	0		0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	14, 002	0		0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDI CAL RECORDS	461	0)	0		11.00
12.00	STAFF TRANSPORTATION	20, 363	0	1	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	o	0	1	0		13.00
14.00	PHARMACY	o	0	1	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0	1	0		15.00
16.00	OTHER GENERAL SERVICE	o	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	o	0	1	0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	260, 793					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	11, 159	19, 509	17	4 7, 356	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	27, 576	7, 587	6	8 2, 860	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	1	0		60.00
61.00	VOLUNTEER PROGRAM	0	0	1	0		61.00
62.00	FUNDRAI SI NG	0	0	1	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	1	0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	1	0		64. 00
65.00	OTHER PHYSICIAN SERVICES	0	0	1	0		65.00
66.00	RESI DENTI AL CARE	0	0	1	0 0	0	66.00
67. 00	ADVERTI SI NG	0	0	1	0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0	1	0		68. 00
69. 00	THRI FT STORE	0	0	1	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	
99. 00	NEGATI VE COST CENTER	0	0	1	이	0	1
100.00	TOTAL	358, 072	27, 096	24	2 10, 216	0	100.00

near tii	Financiai systems	DENALD WEWORTAL	L HUSPITAL		III LI E	u OI FOIIII CW3	2332-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der CO	CN: 15-0045	Peri od:	Worksheet 0-6	
				V 1F 1FF0	From 10/01/2018		
			Hospi ce CCN	N: 15-1559	To 09/30/2019	Date/Time Pre 2/25/2020 11:	parea:
					Hospi ce I	2/23/2020 11.	45 alli
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	besci i pti ons	ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATIO	SERVI CE	
		N N	SUPPLI ES	RECORDS	N	COORDI NATI ON	
		9. 00	10. 00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
1. 00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-BEDG & TTXT						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
	4						1
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9. 00	NURSI NG ADMI NI STRATI ON	22, 170					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDI CAL RECORDS	0		7:	30		11.00
12.00	STAFF TRANSPORTATION	0			32, 242		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	o			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o			0	0	15.00
16. 00	OTHER GENERAL SERVICE	0			0	0	16.00
	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
.,, 00	LEVEL OF CARE						177.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	21, 814	0		19 32, 242	Ō	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	257	0		8 0	o o	52.00
	HOSPICE GENERAL INPATIENT CARE	99	0		3 0	, o	53.00
33.00	NONREI MBURSABLE COST CENTERS	77	J		3 0	0	33.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM				0	0	61.00
62. 00	FUNDRAI SI NG				0	0	62.00
					0	_	1
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0			0	0	66.00
67. 00	ADVERTI SI NG	0			0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69. 00	THRI FT STORE	0			0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	
	NEGATI VE COST CENTER	0	0		0 0	0	99. 00
100.00	TOTAL	22, 170	0	7.	30 32, 242	0	100.00
		•					

Health FinancialSystemsDEKALB MEMOCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS

			nospi ce co	10. 13-1337 1	0 07/30/2017	2/25/2020 11:	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES		CARE SERVICES		
		14. 00	15. 00	16. 00	17. 00	18.00	
<u> </u>	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12. 00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13.00
14. 00	PHARMACY	ا					14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		0				15.00
16. 00	OTHER GENERAL SERVICE		O	1 0	1		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	ď			0		17.00
17.00	LEVEL OF CARE			l			17.00
50.00	HOSPICE CONTINUOUS HOME CARE	O	0	C		0	50.00
51.00	HOSPICE ROUTINE HOME CARE		0			467, 704	
52. 00	HOSPICE INPATIENT RESPITE CARE		0			44, 973	ł
53.00	HOSPICE GENERAL INPATIENT CARE		0	1		54, 280	1
00.00	NONREI MBURSABLE COST CENTERS	<u> </u>		1	,	01,200	00.00
60.00	BEREAVEMENT PROGRAM	0)	0	60.00
61. 00	VOLUNTEER PROGRAM	أما				Ō	
62. 00	FUNDRAI SI NG	ا		1		Ö	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	ا		1		0	63.00
64. 00	PALLIATIVE CARE PROGRAM	ا		1		0	64.00
65. 00	OTHER PHYSICIAN SERVICES	ا		1		0	65.00
66.00	RESI DENTI AL CARE	ا	0	,	0	0	66.00
67. 00	ADVERTI SI NG	ا	· ·	1		0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	ا		1		Ö	68.00
69. 00	THRI FT STORE	ا				0	69.00
70.00	NURSING FACILITY ROOM & BOARD	l \mathbb{I}				Ö	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	١	0	۱ ،	0	Ö	71.00
99.00	NEGATI VE COST CENTER	ا	0			0	99.00
	TOTAL		0	-	-	566, 957	
100.00	1101/12	١	O	1	1	300, 737	1.50.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	. In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC	E GENERAL SERVICE COSTS Provide	r CCN: 15-0045 Peri od: From 10/01/2018	Worksheet 0-6 Part II
STATISTICAL BASIS	Hospi ce	CCN: 15-1559 To 09/30/2019	Date/Time Prepared:

			Hospi ce CC	N: 15-1559	Го 09/30/2019	Date/Time Pre 2/25/2020 11:	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE			ADMI NI STRATI V	
		& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
		1. 00	2.00	SALARI ES) 3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	47	4.00	
1.00	CAP REL COSTS-BLDG & FLXT	300					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	127, 312	2		3.00
4.00	ADMINISTRATIVE & GENERAL	0	0) (-358, 072	208, 885	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0	9, 983	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0) (0	89	6.00
7.00	HOUSEKEEPI NG	0	0		0	3, 764	7.00
8.00	DI ETARY	0	0		0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0) (0	8, 168	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0)	0	0	10.00
11.00	MEDI CAL RECORDS	0	0) (0	269	11.00
12.00	STAFF TRANSPORTATION	0	0) (0	11, 879	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0) (0	0	13.00
14.00	PHARMACY	0	0) (0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0)	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0) (0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE				-	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			125, 26		1,	
52.00	HOSPICE INPATIENT RESPITE CARE	216	l .			-,	
53.00	HOSPICE GENERAL INPATIENT CARE	84	0	57	1 0	16, 087	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	_		-		
61. 00	VOLUNTEER PROGRAM	0	0)	0	ı	
62. 00	FUNDRAI SI NG	0	0)	0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0)	0	0	
64. 00	PALLIATIVE CARE PROGRAM	0	0		0	0	
65. 00	OTHER PHYSI CI AN SERVI CES	0	0		0	0	
66. 00	RESI DENTI AL CARE	0	0		0	0	
67.00	ADVERTI SI NG	0	0		0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	
69. 00	THRI FT STORE	0)	0	0	
70.00	NURSING FACILITY ROOM & BOARD	_			0	_	70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	'l 0	ή (0	0	
99.00	NEGATI VE COST CENTER	, 550		10.00		250 070	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			40, 869		358, 072	
101.00	UNIT COST MULTIPLIER	21. 840000	0. 000000	0. 32101	기	1. 714206	1101.00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPI	ICE GENERAL SERVICE COSTS	Provider CCN: 15-0045		Worksheet 0-6
STATISTICAL BASIS			From 10/01/2018	Part II

Hospi ce CCN: 15-1559 To 09/30/2019 Date/Time Prepared: 2/25/2020 11:43 am Hospi ce I Cost Center Descriptions PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (IN-FACILITY OPERATION & (SQUARE FEET) ADMI NI STRATI O (IN-FACILITY MAI NTENANCE DAYS) (DI RECT NURS. (SQUARE FEET) DAYS) HRS.) 5. 00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 300 5.00 6.00 LAUNDRY & LINEN SERVICE 0000000 43 6.00 7.00 HOUSEKEEPI NG 300 7.00 8.00 DI FTARY 8.00 \cap 43 NURSING ADMINISTRATION 9.00 0 22, 988 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 11.00 MEDICAL RECORDS 0 11.00 0 STAFF TRANSPORTATION 0 12.00 12.00 0 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 0 0 14.00 **PHARMACY** 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 0 16.00 OTHER GENERAL SERVICE 0 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 0 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 51.00 HOSPICE ROUTINE HOME CARE 22,618 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 216 31 216 31 267 52.00 53 00 HOSPICE GENERAL INPATIENT CARE 84 12 103 53.00 84 12 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 00000000 0 61.00 0 62 00 FUNDRAI SI NG 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0 0 64.00 OTHER PHYSICIAN SERVICES 0 65.00 0 65.00 0 66.00 RESIDENTIAL CARE Ω 0 66.00 0 0 67.00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99. 00 NEGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 22, 170 100. 00 27.096 10, 216 242

90. 320000

5.627907

34. 053333

0.000000

0. 964416 101. 00

101.00 UNIT COST MULTIPLIER

Health Financial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S STATISTICAL BASIS	ERVICE COSTS	Provider C Hospice CC		Period: From 10/01/2018 To 09/30/2019	Worksheet 0-6 Part II Date/Time Pre	
				Hospi ce I	2/25/2020 11:	
Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATION N (MI LEAGE)	VOLUNTEER	PHARMACY (CHARGES)	
	10.00	11. 00	12. 00	13. 00	14.00	

	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATIO	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)			SERVICE)		
	OFNERAL OFRILLOS COOT OFNERO	10. 00	11. 00	12.00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS	1		I			1 00
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7. 00 8. 00	HOUSEKEEPI NG						7.00
	DI ETARY						8.00
9. 00 10. 00	NURSI NG ADMI NI STRATI ON						9.00
11. 00	ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS	0	2, 674				10.00 11.00
	STAFF TRANSPORTATION		2, 6/4	100			12.00
12.00				100			1
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE				0	0	15.00
				0	U		16. 00 17. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE						17.00
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	2, 631	1	_	Ö	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	31	1		ő	1
53. 00	HOSPICE GENERAL INPATIENT CARE	0	12		· · · · · · · · · · · · · · · · · · ·		1
00.00	NONREI MBURSABLE COST CENTERS			· · · · · · · · ·	<u> </u>	<u> </u>	00.00
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			l 0	0	0	61.00
62.00	FUNDRAI SI NG			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESI DENTI AL CARE			0	0	0	66.00
67.00	ADVERTI SI NG			0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	0	68.00
69.00	THRI FT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	1
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		730				100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 272999	322. 420000	0. 000000	0.000000	101.00

Health Financial Systems

DEKALB MEMORIAL HOSPITAL

OST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

DEKALB MEMORIAL HOSPITAL

HOSPITAL

Provider CCN: 15-045
Hospice CCN: 15-1559
Hospice CCN: 15-1559

Hospice CCN: 15-1559

Hospice CCN: 15-1559

DEKALB MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Worksheet 0-6
Part II
Date/Time Prepared:

				nospi ce cci	V. 13-1337	10	07/30/2017	2/25/2020 11:	
							Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTI	HER GENERAL	PATI ENT/		<u>'</u>		
	, , , , , , , , , , , , , , , , , , ,	ADMI NI STRATI V		SERVI CE	RESI DENTI AL				
		E SERVICES		(SPECI FY	CARE SERVICE				
		(PATI ENT		BASIS)	(IN-FACILIT	-			
		DAYS)		5,10.0)	DAYS)				
		15. 00		16. 00	17. 00				
	GENERAL SERVICE COST CENTERS	10.00		10.00	17.00				
1. 00			Т			Т			1.00
2. 00									2.00
3.00									3.00
4. 00	1		ŀ						4.00
5. 00									5.00
6.00									6.00
7. 00									7.00
8. 00									8.00
9. 00									9. 00
10. C									10.00
11. C									11. 00
12. C									12.00
13. C	O VOLUNTEER SERVICE COORDINATION								13.00
14. C	O PHARMACY								14.00
15. C	O PHYSICIAN ADMINISTRATIVE SERVICES	C							15.00
16. C	O OTHER GENERAL SERVICE			0					16.00
17. C	O PATIENT/RESIDENTIAL CARE SERVICES					0			17.00
	LEVEL OF CARE		•		<u> </u>				
50. C	O HOSPICE CONTINUOUS HOME CARE	C		0					50.00
51. C		C		0					51.00
52.0	1			0		0			52.00
53. C	1			0		0			53.00
55. 0	NONREI MBURSABLE COST CENTERS		′1	<u> </u>		<u> </u>			33.00
60. C			Т	0					60.00
61. 0				0					61.00
62. 0	1			0					62.00
63.0				0					63.00
64. C				0					1
				0					64.00
65. C				0					65.00
66. C		C	ή	0		0			66.00
67. C				0					67.00
68.0				0					68.00
69. C				0					69. 00
70. C									70.00
71. C	` ′	0)	0		0			71.00
99. C									99.00
	00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			0		0			100.00
101.	00 UNIT COST MULTIPLIER	0. 000000)	0. 000000	0. 00000	00			101.00

Health Financial Systems	DEKALB MEMORIAI	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SH LEVEL OF CARE	ARED SERVICE COSTS BY	Provi der CC	N: 15-0045	Peri od: From 10/01/2018	Worksheet 0-7	
LEVEL OF CARE		Hospi ce CCN	: 15-1559	To 09/30/2019		
				Hospi ce I		
			Charges by	/ LOC (from Provi	der Records)	

		nospi ce cci	N. 15-1559 1	0 09/30/2019	2/25/2020 11:	
				Hospi ce I		
			Charges by I	LOC (from Provi	der Records)	
			orial ges by i	200 (11011111011	der Records)	
Cost Center Descriptions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
cost center bescriptions			пспс	пкпс	ni kc	
	Part I, Col.	Charge Ratio				
	9 line	4 00	0.00	0.00	4 00	
	0	1.00	2. 00	3. 00	4. 00	
ANCILLARY SERVICE COST CENTERS			1		1	
1.00 PHYSI CAL THERAPY	66.00					
1. 01 CARDI AC REHAB	66. 01	0. 696427	[C	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. 668246	l c	0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6. 00 LABORATORY	60.00		l	0	0	
6. 01 BLOOD LABORATORY	60.01	0. 000000			0	
7. 00 MEDICAL SUPPLIES CHARGED TO PAT	71. 00				0	
8. 00 OTHER OUTPATIENT SERVICE COST CENTER	93.00			,	1	1
						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 1-11)						11. 00
	Charges by		Shared Servic	e Costs by LOC		
	LOC (from					
	Provi der					
	Records)					
Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
		x col. 2)	x col. 3)	x col. 4)	x col. 5)	
	5. 00	6.00	7.00	8.00	9. 00	
ANCILLARY SERVICE COST CENTERS				•		
1. 00 PHYSI CAL THERAPY	0	0	C) 0	0	1.00
1. 01 CARDI AC REHAB	0		ĺ	0	0	1
2. 00 OCCUPATI ONAL THERAPY		Ŭ				2.00
3. 00 SPEECH PATHOLOGY						3.00
		_	_			
4. 00 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
5. 00 DURABLE MEDI CAL EQUI P-RENTED						5.00
6. 00 LABORATORY	0	0	1	1		
6. 01 BLOOD LABORATORY	0	0		_	0	
7.00 MEDICAL SUPPLIES CHARGED TO PAT	0	0	C	0	0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER						8. 00
9. 00 RADI OLOGY-THERAPEUTI C						9.00
10.00 OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00 Totals (sum of lines 1-11)		0		0	0	
	1	,	'	'	,	

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER	DIEM COST	Provi der CCN: 15-0045		Worksheet 0-8
		U CON 15 1550	From 10/01/2018	D-+- /T: D

Date/Time Prepared: 2/25/2020 11:43 am Hospi ce CCN: 15-1559 To 09/30/2019 Hospi ce I TITLE XVIII TITLE XIX TOTAL MEDI CARE MEDI CAI D 1.00 2.00 3.00 HOSPICE CONTINUOUS HOME CARE Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, 1.00 1.00 line 11) 2 00 Total unduplicated days (Wkst. S-9, col. 4, line 10) 2 00 0 3.00 Total average cost per diem (line 1 divided by line 2) 0.00 3.00 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10) 4.00 4.00 5.00 Program cost (line 3 times line 4) 0 5.00 HOSPICE ROUTINE HOME CARE 6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, 467, 704 6.00 line 11) 7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 2,631 7.00 8.00 Total average cost per diem (line 6 divided by line 7) 177.77 8.00 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 2,607 0 9.00 10.00 Program cost (line 8 times line 9) 463, 446 10.00 HOSPICE INPATIENT RESPITE CARE Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, 44, 973 11.00 11.00 line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 12.00 Total average cost per diem (line 11 divided by line 12) 13.00 1, 450. 74 13.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 14.00 31 0 14.00 15.00 Program cost (line 13 times line 14) 44, 973 0 15.00 HOSPICE GENERAL INPATIENT CARE Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, 54, 280 16.00 16, 00 line 11) Total unduplicated days (Wkst. S-9, col. 4, line 13) 17.00 12 17.00 18.00 Total average cost per diem (line 16 divided by line 17) 4, 523. 33 18.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 10 0 19.00 Program cost (line 18 times line 19)
TOTAL HOSPICE CARE 20.00 45, 233 20.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 566, 957 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 2,674 22.00 23.00 Average cost per diem (line 21 divided by line 22) 212. 03 23. 00

Heal th	Financial Systems DEKALB MEMORIAL	HOSPI TAI	Inlie	u of Form CMS-2	2552_10	
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0045	Peri od: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III	pared:	
		Title XVIII	Hospi tal	PPS		
	<u> </u>					
				1. 00		
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
1. 00	Capital DRG other than outlier			213, 789		
1. 01	Model 4 BPCI Capital DRG other than outlier			0		
2. 00	Capital DRG outlier payments			334		
2. 01	Model 4 BPCI Capital DRG outlier payments			0		
3. 00	Total inpatient days divided by number of days in the cost r	eporting period (see ins	tructi ons)	12. 14		
4.00	Number of interns & residents (see instructions)			0.00		
5.00	Indirect medical education percentage (see instructions)			0. 00		
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01)(see instructions)			0	6.00	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	0. 00	7. 00	
8.00	Percentage of Medicaid patient days to total days (see instr	uctions)		0.00	8.00	
9.00	Sum of lines 7 and 8			0.00		
10.00	Allowable disproportionate share percentage (see instruction	s)		0. 00	10.00 11.00	
11. 00	00 Disproportionate share adjustment (see instructions)					
12.00	Total prospective capital payments (see instructions)			214, 123	12.00	
				1. 00		
4 00	PART II - PAYMENT UNDER REASONABLE COST			0	1 00	
1.00	Program inpatient routine capital cost (see instructions)			0		
2. 00 3. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0		
4. 00	Capital cost payment factor (see instructions)			0		
5.00	Total inpatient program capital cost (line 3 x line 4)			0		
3.00	Total impatrent program capital cost (Time 3 x Time 4)			U	3.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00		
1. 00	Program inpatient capital costs (see instructions)			0	1.00	
2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan	cos (soo instructions)		0		
3.00	Net program inpatient capital costs for extraordinary circumstant	ces (see Histi uctions)		0		
4. 00	Applicable exception percentage (see instructions)			0.00		
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00		
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00		
7. 00	Adjustment to capital minimum payment level for extraordinar	•	x line 6)	0.00		
8. 00	Capital minimum payment level (line 5 plus line 7)	y erroumstances (Trie 2	X 11116 0)	0		
9. 00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0		
10.00	Current year comparison of capital minimum payment level to	,	less line 9)	0		
11. 00	Carryover of accumulated capital minimum payment level over			0		
	Worksheet L, Part III, line 14)	sapi tai payiisiit (ii sii pi	. o. you.	· ·		
12.00	Net comparison of capital minimum payment level to capital p	ayments (line 10 plus li	ne 11)	0	12.00	
13. 00	Current year exception payment (if line 12 is positive, ente			0		
14. 00	Carryover of accumulated capital minimum payment level over			0		
· · ·	(if line 12 is negative, enter the amount on this line)	1 123 2 2 2 2	3 1			
15.00	Current year allowable operating and capital payment (see in	structions)		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	
				'	•	