Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of					u of Form CMS-2552-10
•	, ,	395g; 42 CFR 413.20(b)). Failu cost reporting period being o	'		FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150045 Period: From 10/01 To 09/30 PART I - COST REPORT STATUS					
PART I - COST	REPORT STATUS				
Provi der use only	1. [X] Electronically fil 2. [] Manually submitted			Date: 2/25/20	015 Time: 12:39 pm
use om y	3. [0] If this is an amen	ded report enter the number o on. Enter "F" for full or "L"	f times the provide for low.	er resubmitted this c	ost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Aud (3) Settled with Audit (4) Reopened		this Provider CCN		

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEKALB MEMORIAL HOSPITAL (150045) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-9, 650	71, 185	-35, 556	-369, 002	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	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	-1		0	9. 00
200.00	Total	0	-9, 650	71, 184	-35, 556	-369, 002	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-MEDI CARE.

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150045 Peri od: Worksheet S-2 From 10/01/2013 To 09/30/2014 Part I Date/Time Prepared: 2/25/2015 12:25 pm 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, O, or N)
V XVIII XIX Certi fi ed Number Number Туре 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 DEKALB MEMORIAL 150045 99915 07/01/1966 3.00 HOSPI TAL Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF 7 00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA DEKALB HOME HEALTH 157157 99915 07/09/1985 Ρ Ν 12.00 AGENCY Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce DEKALB HOSPICE 151559 99915 11/06/1996 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 Hospi tal -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) 10/01/2013 09/30/2014 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 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) 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 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 metho

	method of identifying the days in this cost reporting	g period di	fferent fro	m the metho	od			
	used in the prior cost reporting period? In column 2	2, enter "Y	for yes c	r "N" for r	10.			
		In-State	In-State	Out-of	Out-of	Medi cai d	Other	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
24. 00	If this provider is an IPPS hospital, enter the	461	384	0	25	775	0	24. 00
	in-state Medicaid paid days in col. 1, in-state							
	Medicaid eligible unpaid days in col. 2,							
	out-of-state Medicaid paid days in col. 3,							
	out-of-state Medicaid eligible unpaid days in col.							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25. 00	If this provider is an IRF, enter the in-state	0	0	0	0	0		25. 00
	Medicaid paid days in col. 1, the in-state Medicaid							
	eligible unpaid days in col. 2, out-of-state							
	Medicaid days in col. 3, out-of-state Medicaid							
	eligible unpaid days in col. 4, Medicaid HMO paid							
	and eligible but unpaid days in col. 5, and other							
	Medicaid days in col. 6.							
'		'		'	'	'		'

used for cap relief and/or FTEs that are nonprimary

care or general surgery. (see instructions)

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150045 Peri od: Worksheet S-2 From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/25/2015 12:25 pm Unwei ghted Program Name Program Code Unweighted IME Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Non-Provider Settings 63.00 Has your facility trained residents in non-provider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of

unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in

column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	AL HOSPITAL Provi der		eri od:		Workshe		2552-10
			rom 10/01/2 o 09/30/2		Part I Date/Ti 2/25/20		
			V 1. 00		XI X	X	25 piii
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yeapplicable column.	s or "N" for no	o in the	N N		N N		96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appropriate and the second sec	plicable column	٦.		0. 00		0. 00	97. 00
105.00 Does this hospital qualify as a Critical Access Hospital (C. 106.00 of this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		nod of payment	N N				105. 00 106. 00
107.00 Column 1: If this facility qualifies as a CAH, is it eliging for I &R training programs? Enter "Y" for yes or "N" for not instructions) If yes, the GME elimination would not be on What 25 and the program would be cost reimbursed. If yes completed Column 2: If this facility is a CAH, do I&Rs in an approve	o in column 1. orksheet B, Par e Worksheet D-2	(see rt I, column 2, Part II.	N				107. 00
train in the CAH's excluded IPF and/or IRF unit? Enter "Y column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the	•		N				108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	1	Respi ra	atory	
100 coll 6 this bassidal small 6 as a CAU as a sant again language	1.00	2.00	3.00		4. C	00	100.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109. 00
				1. 00	2. 00	3. 00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o enter the method used (A, B, or E only) in column 2. If colleither "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital provider: 15-1, §2208.1.	umn 2 is "E", ∈ for long term	enter in colum care (include	n 3 s	N		0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			"N" for	N Y			116. 00 117. 00
no. 118. 00 Is the mal practice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy	is	1			118. 00
		Premi ums	Losses	5	Insura	ance	
		1.00	2.00		3. 0	00	
118.01 List amounts of malpractice premiums and paid losses:		281, 39		2, 000	0.0		118. 01
			22	2, 000			
ata ada			1.00	2,000	2. 0	00	
Administrative and General? If yes, submit supporting sche and amounts contained therein.				2,000	2.0	00	
Administrative and General? If yes, submit supporting schedand amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies the Hold Harmless provision in ACA §3121 and applicable amendments.	dule listing co d Harmless prov n column 1 "Y" ualifies for th	vision in ACA for yes or ne Outpatient	1.00	2,000	2. 0 Y		119. 00
Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hole §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendmenter in column 2 "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.	dule listing co d Harmless prov n column 1 "Y" ualifies for th nts? (see instr	vision in ACA for yes or ne Outpatient ructions)	1. 00 N	2,000			119. 00 120. 00
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IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150045		: 0/01/2013 9/30/2014	Worksheet Part I Date/Time 2/25/2015	Prepared
	<u>'</u>		'	1. 00	2.00	
All Providers				1.00	2.00	
40.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number	f yes, and home	office cost	s	N		140. 0
1.00 2.0	00			3. 00		
If this facility is part of a chain organization, enter on home office and enter the home office contractor name and o			name and	d address	of the	
41.00 Name: Contractor's Name:		Contrac	tor's Nu	ımber:		141. 0
42.00 Street: PO Box:		7. 0.1				142. 0
43. 00 Ci ty: State:		Zi p Cod	e:			143. 0
					1.00	
44.00 Are provider based physicians' costs included in Worksheet	A?				Y	144. 0
45.00 If costs for renal services are claimed on Worksheet A, lin services only? Enter "Y" for yes or "N" for no.		costs for i	npati ent	Ī	N	145. 0
				1 00	2.00	
46.00 Has the cost allocation methodology changed from the previo	nusty filed cost	report?		1. 00 N	2.00	146. 0
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. enter the approval date (mm/dd/yyyy) in column 2.			ı	IV.		140.0
47.00 Was there a change in the statistical basis? Enter "Y" for				N		147. 0
48.00 Was there a change in the order of allocation? Enter "Y" fo				N		148. 0
49.00 Was there a change to the simplified cost finding method? E no.	inter "Y" for ye	s or "N" fo	r	N		149. 0
no.	Part A 1.00	Part B 2.00	Т	itle V 3.00	Title XI 4.00	Х
Does this facility contain a provider that qualifies for an	n exemption from	the applic		f the lowe	r of costs	
or charges? Enter "Y" for yes or "N" for no for each compor 55.00 Hospi tal	N N	N	(366.4)	2 CFR 9413 N	N	155. 0
56.00 Subprovi der - IPF	N	N		N	N	156. 0
57.00 Subprovider - IRF	N	N		N	N	157. (
58. 00 SUBPROVI DER						158. (
59.00 SNF 60.00 HOME HEALTH AGENCY	N N	N N		N N	N N	159. (160. (
61. 00 CMHC	IN IN	N		N	N N	161. 0
61. 10 CORF		N		N	N	161. 1
			<u>'</u>		1.00	
Mul ti campus						
65.00 s this hospital part of a Multicampus hospital that has on Enter "Y" for yes or "N" for no.	ne or more campu	ses in diff	erent CE	BSAs?	N	165. 0
Name	County		ip Code	CBSA	FTE/Camp	us
0	1. 00	2. 00	3. 00	4. 00	5. 00	0.004//
66.00 ffline 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0. 00 166. 0
1					1.05	
Health Information Technology (HIT) incentive in the Americ	can Decovery and	l Dainyastma	nt Act		1.00	
67.00 s this provider a meaningful user under Section §1886(n)? 68.00 f this provider is a CAH (line 105 is "Y") and is a meanin	Enter "Y" for	yes or "N"	for no.	the	Y	167. 0 0168. 0
reasonable cost incurred for the HIT assets (see instructions, 59.00 f this provider is a meaningful user (line 167 is "Y") and	ons)					0. 50169. 0
transition factor. (see instructions)			Be	gi nni ng	Endi ng	
				1. 00	2.00	

the other adjustments:

				j	To 09/30/2014		
				Par	rt A	2/25/2015 12: Part B	25 PIII
		Descr	i pti on	Y/N	Date	Y/N	
			0	1.00	2. 00	3. 00	
1. 00	Was the cost report prepared only using the provider's records? If yes, see			N	21.00	N	21. 0
	instructions.						
						1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost						
2. 00	Have assets been relifed for Medicare purpose					N	22. 0
3. 00	Have changes occurred in the Medicare depreci	ation expense	due to apprais	als made durir	ng the cost	N	23.0
	reporting period? If yes, see instructions.						
4. 00	Were new leases and/or amendments to existing	ງ Leases enter	ed into during	this cost repo	orting period?	N	24.0
	If yes, see instructions				6		
5. 00	Have there been new capitalized leases entere	ed into during	, the cost repor	ting period? I	f yes, see	N	25.0
, 00	instructions.					N.	1
6. 00	Were assets subject to Sec. 2314 of DEFRA acqu	irea auring t	ne cost reporti	ng period? if	yes, see	N	26.0
7. 00	instructions. Has the provider's capitalization policy char	ngod during th	no cost roportin	a portod2 lf v	voc cubmit	N	27. 0
7.00	copy.	iged during th	ie cost reportin	g perrous ir y	res, subilli t	IN	27. (
	Interest Expense						
8. 00	Were new Loans, mortgage agreements or Letter	cs of credit e	entered into dur	ing the cost r	eportina	Y	28. (
3. 00	period? If yes, see instructions.	0 0. 0. ou. t 0	mitor ou i mito uu.	g : 0001 .	opo. cg	•	20.
9. 00	Did the provider have a funded depreciation a	account and/or	bond funds (De	bt Service Res	serve Fund)	N	29.
	treated as a funded depreciation account? If				,		
0. 00	Has existing debt been replaced prior to its	schedul ed mat	urity with new	debt? If yes,	see	N	30.
	instructions.						
1.00	Has debt been recalled before scheduled matur	rity without i	ssuance of new	debt? If yes,	see	N	31.
	instructions.						
	Purchased Services						
2. 00	Have changes or new agreements occurred in pa			d through cont	ractual	N	32.
	arrangements with suppliers of services? If y						
3. 00	If line 32 is yes, were the requirements of S	sec. 2135.2 ap	plied pertainin	g to competiti	ve bidding? If		33.
	no, see instructions.						-
4 00	Provider-Based Physicians Are services furnished at the provider facili	ity under en e	rrangoment with	providor baca	nd physicians?	Y	24
4. 00	If yes, see instructions.	ty under an a	ırrangement with	provider-base	eu physicians?	Y	34.
5. 00	If line 34 is yes, were there new agreements	or amended ev	istina aaraaman	ts with the nr	rovi der-hased	N	35.
3. 00	physicians during the cost reporting period?		0 0	ts with the pi	ovi dei -based	IV	33.
	priyar crana darring the coat reporting perrous	11 ycs, scc 1	nstructions.		Y/N	Date	
					1. 00	2. 00	
	Home Office Costs				00	2.00	
5. 00	Were home office costs claimed on the cost re	eport?			N		36.
7. 00	If line 36 is yes, has a home office cost sta	•	repared by the	home office?			37.
	If yes, see instructions.		.,				
3. 00	If line 36 is yes, was the fiscal year end of	of the home of	fice different	from that of			38.
	the provider? If yes, enter in column 2 the f						
9. 00	If line 36 is yes, did the provider render se	ervices to oth	er chain compon	ents? If yes,			39.
	see instructions.						
0. 00	If line 36 is yes, did the provider render se	ervices to the	home office?	If yes, see			40.
	i nstructi ons.						_
					_		-
			1.	00	2.	00	-
	Cost Report Preparer Contact Information	4 111	hu ou e				
. 00	Enter the first name, last name and the title		MI CHAEL		ALESSANDRI NI		41.
	held by the cost report preparer in columns 1	i, 2, and 3,					
			1				II
	respectively.	nort	DLUE AND CO	110			11 11 1
2. 00	Enter the employer/company name of the cost r	report	BLUE AND CO.,	LLC			42.
2.00	Enter the employer/company name of the cost r preparer.	•		LLC	MALESSANDDI NI A	RLUEANDOO COM	42.
2. 00	Enter the employer/company name of the cost r	of the cost	BLUE AND CO., 317-713-7959	LLC	MALESSANDRI NI @	BLUEANDCO. COM	42.

Health Financial Systems	DEKALB MEMORI.	AL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der CCN: 150045	Peri od: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part II Date/Time Prepared: 2/25/2015 12:25 pm
	Dort D			

				From 10/01/2013 To 09/30/2014	Part II Date/Time Prep	
		5 . 5			2/25/2015 12:	25 pm
		Part B				
		Date				
		4. 00				
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,	12/10/2014				16. 00
	enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
17. 00	instructions) Was the cost report prepared using the PS&R					17. 00
17.00	Report for totals and the provider's records for allocation? If either column 1 or 3 is					17.00
	yes, enter the paid-through date in columns					
	2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments					18. 00
	made to PS&R Report data for additional					
	claims that have been billed but are not					
	included on the PS&R Report used to file					
	this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments					19. 00
	made to PS&R Report data for corrections of					
	other PS&R Report information? If yes, see					
	instructions.					
20. 00	J					20. 00
	made to PS&R Report data for Other? Describe					
21 00	the other adjustments:					21 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see					21. 00
	instructions.					
	THISTI UCTIONS.					
			3.00			
	Cost Report Preparer Contact Information		0. 00			
41. 00	Enter the first name, last name and the title	e/position	SENI OR MANAGER			41. 00
11. 00	held by the cost report preparer in columns 1		JETT OF MANAGER			. 1. 00
	respectively.	, _, a 0,				
42.00	Enter the employer/company name of the cost r	report				42. 00
	preparer.	-1				
43.00	Enter the telephone number and email address	of the cost				43.00
· · · · · ·	report preparer in columns 1 and 2, respective					
	,	-				'

 Heal th Financial
 Systems
 DEKALB

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 150045

					Τ̈́	09/30/2014	Date/Time Pre 2/25/2015 12:	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No. o	f Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		41	14, 965	0.00	0	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)							0.00
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider						0	4. 00 5. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF		•				0	
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		•	41	14, 965	0.00	0	1
7.00	beds) (see instructions)			41	14, 900	0.00	U	7.00
8.00	INTENSIVE CARE UNIT	31. 00		6	2, 190	0.00	0	8.00
9. 00	CORONARY CARE UNIT	31.00		ď	2, 170	0.00		9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	1
14. 00	Total (see instructions)	10.00	•	47	17, 155	0.00	Ö	
15. 00	CAH visits				,		0	1
16.00	SUBPROVIDER - IPF							16. 00
17.00	SUBPROVIDER - IRF							17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	116. 00		0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
25. 10	CMHC - CORF	99. 10					0	
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			47				27. 00
28. 00	Observation Bed Days						0	1
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. 01	Labor & delivery days (see instructions)			0	0			32. 00 32. 01
32. UI	Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33 00	LTCH non-covered days							33. 00
33.00	21011 Horr covered days		I	ı			I	1 33.00

Provi der CCN: 150045

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 10/01/2013 | Part | To 09/30/2014 | Date/Time Prepared: 2/25/2015 12: 25 pm

		I/P Days	/ O/P Visits	/ Trips	Full Time I	23 piii	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	1, 535	450	4, 519		10.00	1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	867	1, 110				2. 00
3.00	HMO IPF Subprovider	007	1, 110				3. 00
4. 00	HMO IRF Subprovider		0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	o o	0	0			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	1, 535	450	4, 519			7. 00
	beds) (see instructions)	.,		.,			
8.00	INTENSIVE CARE UNIT	474	0	1, 286			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	996			13.00
14.00	Total (see instructions)	2, 009	450	6, 801	0.00	435. 36	14.00
15. 00	CAH visits	0	0	0			15.00
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE		_				21. 00
22. 00	HOME HEALTH AGENCY	4, 835	0	9, 106	0.00	2. 50	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		0.040	0.504	0.00	40.00	23. 00
24. 00	HOSPI CE	0	3, 312	3, 504	0.00	18. 38	
24. 10	HOSPICE (non-distinct part)	o o	0	0			24. 10
25. 00 25. 10	CMHC - CMHC CMHC - CORF		0	0	0.00	0.00	25. 00 25. 10
26. 00	RURAL HEALTH CLINIC	١	U	U	0.00	0. 00	26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	456. 24	27. 00
28. 00	Observation Bed Days		124	715		450. 24	28. 00
29. 00	Ambul ance Trips	1, 115	124	713			29. 00
30. 00	Employee discount days (see instruction)	1, 113		120			30. 00
31. 00	Employee discount days (see l'instruction)			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	85	155			32. 00
32. 00	Total ancillary labor & delivery room		0.5	0			32. 00
32. 01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	О					33. 00

Provider CCN: 150045

Full Time Discharges					10	09/30/2014	2/25/2015 12:	
Component			Full Time	<u> </u>	Di scha	arges		
Note								
1.00		Component		Title V	Title XVIII	Title XIX		
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 HM and other (see instructions) 3 00 3 00 HM IPF Subprovider 4 00 5 00 Hospi tal Adul ts & Peds. Swing Bed SNF 6 00 6 00 Hospi tal Adul ts & Peds. Swing Bed SNF 7 00 Total Adul ts & Peds. Swing Bed SNF 8 00 Hospi tal Adul ts & Peds. Swing Bed SNF 8 00 Hospi tal Adul ts & Peds. Swing Bed SNF 9 00 COROMARY CARE UNIT 9 00 COROMARY CARE UNIT 10 00 ORGANIA (SARE UNIT) 11 00 SURGICAL INTENSIVE CARE UNIT 11 00 00 SURGICAL INTENSIVE CARE UNIT 12 00 OTHER SPECIAL CARE (SPECIFY) 13 00 NURSERY 10 10 00 ORGANIA (SARE UNIT) 15 00 CAH visits 16 00 CAH visits 17 00 CAH visits 18 00 CAH visits 19 00 ON URSING FACILITY 19 00 OTHER LONG TERM CARE 19 00 OTHER LONG TERM CARE 20 00 ON URSING FACILITY 21 00 OTHER LONG TERM CARE 22 00 ON AMBULATORY SURGICAL CENTER (D.P.) 23 00 AMBULATORY SURGICAL CENTER (D.P.) 24 10 HOSPICE (non-distinct part) 25 00 CAH C - CORF 27 00 Total (see instruction) 31 00 Employee discount days (see instruction) 31 00 Employee discount days (see instructions) 32 01 Total ancillary labor & delivery room outpatient and so control and so control and so control and outpatient days (see instructions) 32 01 Total ancillary labor & delivery room outpatient days (see instructions)			11. 00					
Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 3.00 MMO IPF Subprovider 4.00 4.00 HMO IPF Subprovider 4.00 5.00 Hospital Adulits & Peds. Swing Bed SNF 6.00 Hospital Adulits & Peds. Swing Bed NF 6.00 Total Adulits and Peds. (exclude observation beds) (see instructions) 8.00 INTERNSIVE CARE UNIT 8.00 INTERNSIVE CARE UNIT 9.00 0.0	1.00			0	579	102	2, 050	1. 00
For the portion of LDP room avail able beds) 2.00								
2 00 HM0 and other (see instructions)								
3.00 4MO I PF Subprovider 4.00 4.00 Mol IRF Subprovider 6.00 Hospi tal Adult ts & Peds. Swing Bed SNF 6.00 For all Adults & Peds. Swing Bed SNF 7.00 For all Adults & Peds. Swing Bed SNF 8.00 For all Adults & Peds. Swing Bed SNF 8.00 For all Adults & Peds. Swing Bed SNF 9.00 For all	0.00				0.40	000		0.00
4. 00 HMO RF Subprovider 5. 00 Hospi tal Adults & Peds. Swing Bed SNF 5. 00 Hospi tal Adults & Peds. Swing Bed NF 6. 00 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 8. 00 10. 00 BURN INTENSIVE CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 00 10. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 00 10. 00 1		,			242	283		
5.00		1						
6.00 Hospital Adults & Peds. Swing Bed NF								
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 1NTENSIVE CARE UNIT 9. 00 10.								
BedS) (see instructions) 8								
8. 00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 11. 00 BURN INTENSIVE CARE UNIT 11. 00 11. 00 BURN INTENSIVE CARE UNIT 11. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 11. 00 OTHER SPECIAL CARE (SPECIFY) 11. 00 11. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 OURSERY 13. 00 OURSERY 13. 00 OCAH visits 15. 00 CAH visits 15. 00 CAH visits 15. 00 CAH visits 15. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 17. 00 SUBPROVIDER - IRF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER INTENSIVE CARE UNITY 20. 00 OURSING FACILITY	7.00	· ·						7.00
9. 00 CORONARY CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 NURSERY 12. 00 14. 00 Total (see instructions) 0. 00 0 579 102 2. 050 14. 00 15. 00 CAH visits 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 16. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 18. 00 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 20. 00 C2. 00 HOME HEALTH AGENCY 20. 00 C3. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPICE (non-class tinct part) 24. 10 C3. 00 C4. 10 HOSPICE (non-class tinct part) 25. 00 C4. 00 C4. 00 C5. 00 C4. 00 C5. 00 C4. 00 C5. 00 C4. 00 C5. 00 C	0 00							9 00
10. 00 BURN INTENSIVE CARE UNIT								
11. 00 SURGICAL INTENSIVE CARE (UNIT 11. 00 12. 00 13. 00 14. 00 Total (see instructions) 0. 00 0 579 102 2. 050 14. 00 13. 00 14. 00 Total (see instructions) 0. 00 0 579 102 2. 050 14. 00 15. 00 CAH visits 15. 00								
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 HOME HEALTH ACENCY 22. 00 HOME HEALTH ACENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 CMHC - CORF 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 31. 00 Other and the see instructions outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
13. 00 14. 00 17 total (see instructions) 18. 00 19								
14.00 Total (see instructions) 0.00 0 579 102 2,050 14.00 15.00 CAH visits 0.00 CAH visits 0.00 SUBPROVIDER - IPF 0.00 SUBPROVIDER - IRF 0.00 SUBPROVIDER - IRF 0.00 SUBPROVIDER - IRF 0.00 SKILLED NURSING FACILITY 0.00 OTHER LONG TERM CARE 0.00 OTHER LONG TERM CARE 0.00 HOME HEALTH AGENCY 0.00 HOSPICE 0.00 CHOSPICE 0.00 CHOSPICE 0.00 CMHC - CMHC 0.00 CMHC - CMHC 0.00 CMC - CMF 0.00 CMC - CMC - CMC - CMC 0.00 CMC - CMC - CMC - CMC 0.00 CMC - CMC								
15. 00 16. 00 18. 00 19. 00 18. 00 19			0.00	0	E70	102	2 050	
16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 SKI LLED NURSI NG FACI LI TY 19. 00 20. 00 NURSI NG FACI LI TY 20. 00 NURSI NG FACI LI TY 20. 00 THER LONG TERM CARE 21. 00 22. 00 23. 00 HOME HEALTH AGENCY 21. 00 22. 00 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 24. 00 HOSPI CE 0. 00 24. 10 25. 00 24. 10 25. 00 25. 10 CMHC - CMHC 25. 10 26. 00 25. 10 CMHC - CORF 26. 25 25. 10 26. 25 EDEPRALLY QUALIFIED HEALTH CENTER 26. 00 26. 25 27. 00 28. 00 Observation Bed Days 28. 00 29. 00 Ambul ance Trips 30. 00 Employee di scount days - I RF 31. 00 32. 00 Total ancil lary labor & delivery room 32. 01 Total ancil lary labor & delivery room 0 uutpatient days (see instructions) 32. 01 0 utpatient days (see instructions) 32. 01 32. 01 33. 00 34. 00			0.00	U	3/9	102	2, 030	
17. 00 SUBPROVIDER - IRF 17. 00 18. 00 SUBPROVIDER 18. 00 SUBPROVIDER 18. 00						+		
18.00 19.00 SUBPROVIDER 9.01 SKILLED NURSING FACILITY 19.00 ON NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 41.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 32.01 32.01 33.01 Total ancillary labor & delivery room outpatient days (see instructions) 37.00 ON CONTROL TO CONTROL								
19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 25.00 CMHC - CMHC 25.00 CMHC - CMHC 25.10 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01								
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 40.00 HOSPICE 40.00 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.00 CMHC - CORF 26.00 RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days Ambulance Trips 30.00 Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)								
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 33. 00 24. 00 25. 10 26. 00 27. 00 28. 00 29. 00 20. 00								
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 23. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 24. 10 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20. 00 20. 00 21. 00 22. 01 23. 00 24. 00 25. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20.			0.00					
24. 00 HOSPICE			0.00					
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			0.00					
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			0.00					
25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days Observation Bed Days Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			0.00					
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			0.00					
27. 00 Total (sum of lines 14-26) 0.00 27. 00 28. 00 0bservation Bed Days 28. 00 29. 00								
28. 00 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01			0.00					
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0.00					
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)						1		
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 32.00		· ·						
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.00								
32.01 Total ancillary labor & delivery room outpatient days (see instructions)		1 ' 3						
outpatient days (see instructions)						1		
	SE. 51							32.01
	33.00							33. 00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150045 Peri od: From 10/01/2013 Part II

09/30/2014 Date/Time Prepared: 2/25/2015 12:25 pm Adj usted Worksheet A Amount Recl assi fi cati Paid Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Salaries in col. 5) Worksheet A-6) 3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 24, 854, 436 1.00 Total salaries (see 200. 00 24, 854, 436 960, 822. 00 25. 87 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -146, 331 1, 117. 00 131.00 146, 331 4.00 Admi ni strati ve Physicians - Part A - Teaching 4.01 0 0 0.00 0.00 4.01 5.00 Physician-Part B 0 0 0.00 0.00 5.00 6.00 Non-physician-Part B 0 0 0.00 0.00 6.00 0 Interns & residents (in an 21 00 O 7.00 0.00 0.00 7.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office personnel 0.00 0.00 8.00 SNF 44 00 0.00 9 00 0 00 9 00 10.00 Excluded area salaries (see 8, 401, 070 -149, 905 8, 251, 165 280, 455. 00 29. 42 10.00 instructions) OTHER WAGES & RELATED COSTS 913, 215 913, 215 11, 673. 00 78. 23 11.00 Contract labor: Direct Patient 11.00 Care 12.00 Contract Labor: Top Level 0 \mathcal{C} 0 0.00 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 1, 929. 00 207, 217 0 207, 217 107. 42 13.00 A - Administrative 14.00 Home office salaries & C 0 0.00 0.00 14.00 0 wage-related costs Home office: Physician Part A 15.00 0 0.00 0.00 15.00 - Administrative 16.00 Home office and Contract 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS Wage-related costs (core) (see 4, 962, 223 0 4, 962, 223 17.00 17.00 instructions) Wage-related costs (other) 18.00 18.00 0 0 (see instructions) 19.00 19 00 Excluded areas 2, 135, 387 2, 135, 387 20.00 Non-physician anesthetist Part 20.00 21.00 21.00 Non-physician anesthetist Part 0 0 22.00 Physician Part A -15, 245 15, 245 22.00 Administrative 22.01 Physician Part A - Teaching 0 22.01 0 23.00 Physician Part B 0 0 23.00 24.00 Wage-related costs (RHC/FQHC) 0 O 24 00 25.00 Interns & residents (in an 0 25.00 approved program) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 26.00 4. 00 194, 292 -3, 652 190, 640 5, 380. 00 35. 43 26.00 Administrative & General 133, 967. 00 27.00 2, 836, 612 405, 853 3, 242, 465 24. 20 27.00 5.00 28.00 Administrative & General under 500, 163 500, 163 2, 573.00 194.39 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 C Operation of Plant 571, 672 560, 927 21, 652. 00 -10, 745 25. 91 30.00 30.00 7 00 31.00 Laundry & Linen Service 8.00 74, 473 -1, 400 73,073 5, 390. 00 13. 56 31.00 32.00 Housekeepi ng 9.00 577,008 -10, 846 566, 162 46, 135. 00 12. 27 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 211, 912 9, 178. 00 23.09 34 00 34.00 Di etarv 10.00 561, 649 -349, 737 Di etary under contract (see 53. 34 35.00 8,534 8,534 160.00 35.00 instructions) 36.00 Cafeteri a 11.00 339, 179 339, 179 21, 989. 00 15. 42 36.00 0 12.00 37 00 Maintenance of Personnel 0.00 37 00 0 00 38.00 Nursing Administration 13.00 682, 450 -12,828 669, 622 16, 897. 00 39. 63 38.00 8, 152. 00 Central Services and Supply 15. 13 39.00 39.00 14.00 125, 675 -2, 362 123, 313 40.00 Pharmacy 15.00 509, 876 -9, 584 500, 292 11, 997. 00 41. 70 40. 00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 150045 Period: From 10/01/2013 Part II Date/Time Prepare 2/25/2015 12: 25 p	
To 09/30/2014 Date/Time Prepare 2/25/2015 12: 25 p	
	m_
Worksheet A Amount Reclassificati Adjusted Paid Hours Average Hourly	
Line Number Reported on of Salaries Salaries Related to Wage (col. 4 ÷	
(from (col.2 ± col. Salaries in col.5)	
Worksheet A-6) 3) col. 4	
1.00 2.00 3.00 4.00 5.00 6.00	
41.00 Medical Records & Medical 16.00 546,050 -10,264 535,786 30,611.00 17.50 41.	00
Records Library	
42. 00 Social Service 17. 00 64, 200 -1, 207 62, 993 2, 085. 00 30. 21 42.	00
43.00 Other General Service 18.00 0 0 0 0.00 43.	00

| Peri od: | Worksheet S-3 | From 10/01/2013 | Part III | To 09/30/2014 | Date/Time Prepared: Provider CCN: 150045

					''	0 09/30/2014	2/25/2015 12: 3	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		25, 363, 133	0	25, 363, 133	963, 555. 00	26. 32	1.00
	instructions)							
2.00	Excluded area salaries (see		8, 401, 070	-149, 905	8, 251, 165	280, 455. 00	29. 42	2.00
	instructions)							
3.00	Subtotal salaries (line 1		16, 962, 063	149, 905	17, 111, 968	683, 100. 00	25. 05	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 120, 432	0	1, 120, 432	13, 602. 00	82. 37	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		4, 977, 468	0	4, 977, 468	0.00	29. 09	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		23, 059, 963	149, 905	23, 209, 868	696, 702. 00	33. 31	6. 00
7.00	Total overhead cost (see		7, 252, 654	332, 407	7, 585, 061	316, 166. 00	23. 99	7.00
	instructions)							

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150045	Peri od: Worksheet S-3 From 10/01/2013 Part IV
		To 09/30/2014 Date/Time Prepared:

	To 09/30/2014	Date/Time Prep 2/25/2015 12:2	
		Amount Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 037, 469	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	2, 200	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)	3, 681, 711	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11. 00	3/	48, 465	
12.00		0	12. 00
	Disability Insurance (If employee is owner or beneficiary)	0	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	116	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	1, 726, 958	
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	18, 936	
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		22. 00
	Tuition Reimbursement	44, 265	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	6, 560, 120	24. 00
	Part B - Other than Core Related Cost		
25. 00	UNI FORMS	11, 389	25.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150045	From 10/01/2013	Worksheet S-3 Part V Date/Time Prepared: 2/25/2015 12:25 pm
0 1 0 1 5 11		0 1 1 1	D C: 1 O 1

		''	0 09/30/2014	2/25/2015 12:	
	Cost Center Description	·	Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1.00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - I PF				3. 00
4.00	Subprovi der - I RF				4. 00
5. 00	Subprovider - (Other)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF				8. 00
9. 00	Hospi tal -Based NF				9. 00
10. 00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	
12.00	Separately Certified ASC				12.00
13. 00	Hospi tal -Based Hospi ce		0	0	
14. 00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15. 00
16. 00	Hospi tal -Based-CMHC				16.00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17. 00	Renal Dialysis				17.00
18. 00	Other Other		0	0	18. 00

Heal th	Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOME F	IEALTH AGENCY STATISTICAL DATA			CCN: 150045 t CCN: 157157	Peri od: From 10/01/2013 To 09/30/2014	Worksheet S-4 Date/Time Pre 2/25/2015 12:	pared:
					Home Health	PPS	25 piii
					Agency I		
						00	
0.00	County	T: +1 o V	Title XVIII	T: +1 0 VIV	DEKALB	Total	0.00
		Title V 1.00	2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA			1			
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00		1	0 00 0.00		
					ployees (Full Ti		
		Enter the numb your normal	er of hours in work week	Staff	Contract	Total	
		()	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0. 00	0.0	0.00	0.00	3.00
4. 00	Director(s) and Assistant Director(s)		0.00	0.0	0.00	0.00	4. 00
5.00	Other Administrative Personnel			0.0		l .	
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			0.0		l	
8. 00	Physical Therapy Service			0.0		l	
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0.0		l	
11. 00	Occupational Therapy Supervisor			0.0		l	
12.00	Speech Pathology Service			0.0		l	
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.0		1	
15. 00	Medical Social Service Supervisor			0.0	0.00	0.00	15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0.0		1	
18. 00	Other (specify)			0.0		1	1
40.00	HOME HEALTH AGENCY CBSA CODES				-		
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				1		19. 00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
			oisodes With Outliers	LUPA Episode	es PEP Only	Total (cols.	
		Outliers		·	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1. 00	2. 00	3.00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	2, 317			61 91	2, 676	
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	385, 140 873			90 14, 924 23 7	444, 290 964	1
24. 00	Physical Therapy Visit Charges	154, 685		1		l e	
25. 00	Occupational Therapy Visits	0		1	0 0		25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	0 50		I	0 0	0 62	26. 00 27. 00
28. 00	Speech Pathology Visit Charges	9, 675	2, 322		0 0	11, 997	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	22 6, 067	l e	51	2 1 54 277	27 7, 452	29. 00 30. 00
31. 00	Home Health Aide Visits	943	l e	1	2 38	1	
32.00	Home Health Aide Visit Charges	100, 050	1	1	17 4, 005		
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4, 205	405	1	137	4, 835	33.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 655, 617	63, 121	12, 0:	0 23 20, 466	0 751, 227	
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	222		:	22 9	253	36. 00
37. 00	•	47.040	10	1	1	11	1
38.00	Total Non-Routine Medical Supply Charges	17, 263	836	il 3:	51 324	18, /74	38.00

Health Financial Systems		DEKALB MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL IDENTIFICATION DATA			Provider CCN: 150045	Peri od: From 10/01/2013	Worksheet S-9	
			Component CCN: 151559			
				Hospi ce I		
	Unduplicated					

						ноѕргсе т		
		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							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	3, 253	71	1, 176	0	153	3, 477	2.00
3.00	Inpatient Respite Care	31	2	o	0	0	33	3.00
4.00	General Inpatient Care	28	0	o	0	1	29	4.00
5.00	Total Hospice Days	3, 312	73	1, 176	0	154	3, 539	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	95	3	25	0	11	109	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0. 00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	34. 86	24. 33	47. 04	0.00	14. 00	32. 47	8. 00
	5/line 6)							
9.00	Unduplicated Census Count	95	0	o	0	0	95	9.00

1000/		I AL HOSPITAL	0011 4500:5		u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150045	Peri od: From 10/01/2013	Worksheet S-10	0
				To 09/30/2014	Date/Time Pre	pared:
					2/25/2015 12:	
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column	3 divided by li	ne 202 colum	n 8)	0. 350070	1.0
	Medicaid (see instructions for each line)					
2. 00	Net revenue from Medicaid				3, 082, 438	
3. 00	Did you receive DSH or supplemental payments from Medicaid				N	3.0
1.00	If line 3 is "yes", does line 2 include all DSH or supplem		from Medicai	d?		4.0
. 00	If line 4 is "no", then enter DSH or supplemental payments	from Medicaid			0	
. 00	Medicaid charges				11, 172, 869	
7. 00 3. 00	Medicaid cost (line 1 times line 6)	rom (lino 7 min	us sum of Li	noc 2 and E. if	3, 911, 286	
3. 00	Difference between net revenue and costs for Medicaid prog < zero then enter zero)			nes 2 and 5; 11	828, 848	8.0
	State Children's Health Insurance Program (SCHIP) (see ins	tructions for ea	ach line)			
. 00	Net revenue from stand-alone SCHIP				0	
0.00	3				0	
1.00	Stand-alone SCHIP cost (line 1 times line 10)				0	
2. 00	Difference between net revenue and costs for stand-alone S enter zero)	CHIP (line 11 m	inus line 9;	if < zero then	0	12. (
	Other state or local government indigent care program (see	instructions fo	or each line)		
3. 00	Net revenue from state or local indigent care program (Not	included on li	nes 2, 5 or	9)	0	13.
4. 00	Charges for patients covered under state or local indigent	care program (Not included	in lines 6 or	0	14. (
	10)					
5. 00	State or local indigent care program cost (line 1 times li				0	
6. 00	Difference between net revenue and costs for state or loca	l indigent care	program (li	ne 15 minus line	0	16. 0
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)					
7. 00	Private grants, donations, or endowment income restricted	to funding char	ity care		0	17. (
8. 00					0	
9. 00	9 . 11 1	' '		ms (sum of lines	828, 848	19. (
	8, 12 and 16)		. 3	`	·	
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
0 00	T-1-1 : -: 1:	(-+ 6:11	1.00	2. 00	3.00	20. (
0. 00	Total initial obligation of patients approved for charity charges excluding non-reimbursable cost centers) for the e		1, 144, 1	58 0	1, 144, 158	20. (
1. 00	Cost of initial obligation of patients approved for charit		400, 5	35 0	400, 535	21 (
1. 00	times line 20)	y care (iiile i	400, 3	55	400, 555	~ ' ' '
2. 00	Partial payment by patients approved for charity care			0 0	0	22. (
3. 00	1 1 3 1 1 1 1		400, 5	35 0	400, 535	23. (
					4 00	
4. 00	Does the amount in line 20 column 2 include charges for pa	tient days beyon	nd a Length (of stay limit	1. 00 N	24. (
55	imposed on patients covered by Medicaid or other indigent		a rongtii i	o. otay iiiii t	"	- ' ' \
25. 00	If line 24 is "yes," charges for patient days beyond an i		ogram's Leng	th of stay limit	0	25. (
6. 00				,	4, 891, 623	
7. 00	Medicare bad debts for the entire hospital complex (see in				87, 920	
8. 00	Non-Medicare and non-reimbursable Medicare bad debt expens				4, 803, 703	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad deb			e 28)	1, 681, 632	29. (
	10 1 6 1 1 (1: 00 1 0 1 1: 00)				2, 082, 167	30. C
30. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 pl				2, 911, 015	

Heal th	Financial Systems	DEKALB MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 10/01/2013 To 09/30/2014	Date/Time Pre	narodi
					10 09/30/2014	2/25/2015 12:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	Б р
	·			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
	OFFICE OFFICE OFFICE	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVI CE COST CENTERS		4 744 000	4 744 00		4 744 000	1 00
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FIXT OO101 MAC WEST - NEW		4, 744, 822	1		4, 744, 822	
1. 01	00101 MAC WEST - NEW		25, 115 3, 966			25, 115 3, 966	
1. 02	00103 GARRETT CLINIC - NEW		19, 781	1			
1. 03	00104 BUTLER - NEW		11, 914			11, 914	
1. 05	00105 MAC EAST - NEW		152, 791	1			
1.06	00106 GARRETT LAB - NEW		102,771	1	0 0	0	1
1. 07	00107 MEDI CAL ARTS - NEW		57, 252	57, 25	2 0	57, 252	
1. 08	00108 DAY SPRING - NEW		0		0	0	1. 08
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		0	0	2. 00
3.00	00300 OTHER CAP REL COSTS		0		0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	194, 292	2, 620, 669	2, 814, 96	1 -3, 652	2, 811, 309	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 836, 612	6, 539, 751	9, 376, 36	390, 257	9, 766, 620	5. 00
7.00	00700 OPERATION OF PLANT	571, 672	1, 329, 405				
8.00	00800 LAUNDRY & LINEN SERVICE	74, 473	160, 338		· ·		
9.00	00900 HOUSEKEEPI NG	577, 008	373, 437	1			
10.00	01000 DI ETARY	535, 234	509, 846	1			
10. 01	01001 SNACK BAR	26, 415	38, 222				
	01100 CAFETERI A	0	121 705		0 681, 793		
13.00	01300 NURSI NG ADMI NI STRATI ON	682, 450	131, 785	1		'	
14. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	125, 675	142, 059	1			
15. 00 16. 00	01600 MEDI CAL RECORDS & LI BRARY	509, 876 546, 050	102, 766	1,			
	01700 SOCIAL SERVICE	64, 200	7, 954				1
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	04, 200	7, 734	12, 13	-1, 207	70, 747	17.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 462, 627	530, 614	2, 993, 24	1 -840, 877	2, 152, 364	30.00
31.00	03100 INTENSIVE CARE UNIT	912, 885	166, 232				
43.00	04300 NURSERY	0	1, 226	1, 22	6 259, 924	261, 150	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	1, 595, 686	1, 536, 038				
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	299	1			
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 605, 683	1, 217, 557 1, 878, 550				
60. 00	06001 BL00D LABORATORY	1, 345, 133	1, 676, 330	3, 223, 00	3 -25, 284	3, 190, 399 	60.00
65. 00	06500 RESPI RATORY THERAPY		507, 438	507, 43	8 0	507, 438	
66. 00	06600 PHYSI CAL THERAPY	346, 831	762, 709	1			
66. 01	06601 CARDI AC REHAB	96, 686	19, 797	1			
69.00	06900 ELECTROCARDI OLOGY	61, 142	14, 728	75, 87	0 21, 285	97, 155	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	224, 832				1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1, 618, 582	1		1, 618, 582	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	625, 452			625, 452	
/3.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 879, 443	1, 879, 44	3 0	1, 879, 443	/3.00
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	66, 005	20, 478	86, 48	3 -1, 241	85, 242	90.00
	09100 EMERGENCY	1, 216, 731	711, 430	1			
	09200 OBSERVATION BEDS (NON-DISTINCT	1,210,731	711, 430	1, 720, 10	22,070	1, 703, 271	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	1, 149, 556	865, 641	2, 015, 19	7 -21, 608	1, 993, 589	95. 00
99. 10	09910 CORF	0	0	1	0	0	99. 10
101.00	10100 HOME HEALTH AGENCY	894, 290	358, 661	1, 252, 95	1 -2, 737	1, 250, 214	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	444 000	4/4 000)	0		113. 00
	11600 HOSPI CE	111, 229	161, 822				
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	18, 608, 441	30, 073, 402	48, 681, 84	3 109, 396	48, 791, 239	1118.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		0 0	0	190. 00
	19100 RESEARCH		0	1	0 0		191.00
	19200 PHYSICIANS PRIVATE OFFICES	106, 105	143, 889	249, 99	4 -1, 994		
	19201 DEKALB MEDICAL SERVICES	5, 742, 553	2, 207, 746				
	19202 PHARMACARE	394, 931	3, 637, 008	1		4, 031, 939	192. 02
	19300 NONPALD WORKERS		0		0	0	193. 00
	07950 OTHER NONREIMBURSABLE COST CENT		0		0		194. 00
	07951 ADULT DAY CARE	0	0] _	0		194. 01
	07952 FOUNDATION	2, 406	5, 373	1			194. 02
200.00	TOTAL (SUM OF LINES 118-199)	24, 854, 436	36, 067, 418	60, 921, 85	4 0	60, 921, 854	1200.00

Provider CCN: 150045

				2/25/2015	5 12: 25 pm
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-132, 931	4, 611, 891	•	1. 00
1.01	00101 MAC WEST - NEW	0	25, 115		1. 01
1.02	00102 NORTH ANNEX - NEW	0	3, 966		1. 02
1.03	00103 GARRETT CLINIC - NEW	0	19, 781		1. 03
1.04	00104 BUTLER - NEW	0	11, 914		1. 04
1.05	00105 MAC EAST - NEW	0	152, 791		1. 05
1.06	00106 GARRETT LAB - NEW	0	0		1. 06
1.07	00107 MEDICAL ARTS - NEW	0	57, 252		1. 07
1.08	00108 DAY SPRING - NEW	0	0		1. 08
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	0		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-545, 846	2, 265, 463		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 571, 522	7, 195, 098		5. 00
7.00	00700 OPERATION OF PLANT	-11, 188	1, 879, 144		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-1, 429	231, 982		8. 00
9.00	00900 HOUSEKEEPI NG	-3, 614	935, 985		9. 00
10.00	01000 DI ETARY	-5, 839	347, 387	'	10. 00
10. 01	01001 SNACK BAR	-64, 140	0		10. 01
11. 00	01100 CAFETERI A	-254, 472	427, 321		11. 00
13.00	01300 NURSING ADMINISTRATION	0	801, 407		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	265, 372		14. 00
15.00	01500 PHARMACY	0	500, 292		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-906	637, 646		16. 00
17.00	01700 SOCIAL SERVICE	0	70, 947		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-5, 040	2, 147, 324		30. 00
31.00	03100 INTENSIVE CARE UNIT	-60, 400	1, 001, 558		31. 00
43.00	04300 NURSERY	0	261, 150		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-1, 097, 287	2, 004, 444		50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	534, 963		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-21, 293	2, 749, 332		54.00
60.00	06000 LABORATORY	-22, 338	3, 176, 061		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
65.00	06500 RESPIRATORY THERAPY	0	507, 438		65. 00
66.00	06600 PHYSI CAL THERAPY	-23, 122	1, 032, 398		66. 00
66. 01	06601 CARDI AC REHAB	-15, 665	146, 502		66. 01
69.00	06900 ELECTROCARDI OLOGY	-11, 300	85, 855		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	224, 832		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	O	1, 618, 582		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	625, 452		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-10, 332	1, 869, 111		73. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	85, 242		90. 00
91.00	09100 EMERGENCY	-529, 514	1, 375, 777		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT				92. 00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-44, 350	1, 949, 239		95. 00
99. 10	09910 CORF	0	0		99. 10
101.00	10100 HOME HEALTH AGENCY	-52, 159	1, 198, 055		101. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	0	0		113. 00
116.00	11600 H0SPI CE	-81	272, 402		116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5, 484, 768	43, 306, 471		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	o	248, 000		192. 00
192.01	1 19201 DEKALB MEDICAL SERVICES	0	7, 842, 940		192. 01
192. 02	19202 PHARMACARE	o	4, 031, 939		192. 02
193.00	19300 NONPALD WORKERS	ol	0		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	o	0		194. 00
	1 07951 ADULT DAY CARE	0	0		194. 01
	2 07952 FOUNDATI ON	0	7, 736		194. 02
200.00	1	-5, 484, 768		l e e e e e e e e e e e e e e e e e e e	200. 00
				•	•

| Peri od: | Worksheet A-6 | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared:

					10	09/30/2014 Date	5/2015 12:25 pm
		Increases				2720	77 2010 12. 20 pm
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4.00	5. 00			
	A - CAFETERIA RECLASS						
1.00	CAFETERI A	11.00	339, 179	342, 614			1. 00
	0 — — — — —		339, 179	342, 614			
	C - LABOR DELIVERY NURSERY	· · · · · · · · · · · · · · · · · · ·					
1.00	NURSERY	43.00	205, 488	54, 436			1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	422, 688	111, 976			2. 00
	0		628, 176	166, 412			
	E - NORTH ANNEX RECLASS	I					
1.00	HOME HEALTH AGENCY	101.00	0	14, 073			1. 00
2. 00	HOSPI CE	116.00	Ö	1, 523			2. 00
	0			15, 596			
	F - REHABILITATION OFFICE REC	CLASS		,			
1.00	CARDI AC REHAB	66. 01	46, 199	1, 302			1.00
	0		46, 199	1, 302			
	G - RADIOLOGY ADMIN RECLASS			.,,			
1.00	ELECTROCARDI OLOGY	69.00	12, 344	10, 090			1.00
	0	— — — +	12, 344	10, 090			
	H - BONUS ACCRUAL RECLASS		1=1 = 1.1	,			
1.00	ADMI NI STRATI VE & GENERAL	5, 00	405, 853	0			1. 00
2.00		0.00	0	0			2. 00
3. 00		0.00	Ö	0			3. 00
4.00		0.00	O	0			4. 00
5. 00		0.00	o	0			5. 00
6. 00		0.00	Ö	Ö			6. 00
7. 00		0.00	Ö	o			7. 00
8. 00		0.00	Ö	o			8. 00
9. 00		0.00	Ö	o			9. 00
10.00		0.00	Ö	o			10.00
11. 00		0.00	Ö	o			11. 00
12. 00		0.00	Ö	o			12. 00
13. 00		0.00	Ö	o			13. 00
14. 00		0.00	o	o			14. 00
15. 00		0.00	Ö	Ö			15. 00
16. 00		0.00	o	0			16. 00
17. 00		0.00	o	0			17. 00
18. 00		0.00	o	0			18. 00
19. 00		0.00	Ö	o			19. 00
20. 00		0.00	Ö	o			20. 00
21. 00		0.00	o	0			21. 00
22. 00		0.00	o	0			22. 00
23. 00		0.00	Ö	Ö			23. 00
24. 00		0.00	Ö	Ö			24. 00
25. 00		0.00	Ö	Ö			25. 00
26. 00		0.00	Ö	Ö			26. 00
27. 00		0.00	o	Ö			27. 00
		<u> </u>	405, 853	<u> </u>			
500.00	Grand Total: Increases		1, 431, 751	536, 014			500.00
	•	'		•			•

| Peri od: | Worksheet A-6 | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared:

					1	Го 09/30/2014	Date/Time Prepared: 2/25/2015 12:25 pm
		Decreases					2/20/2013 12. 23 pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	10. 00	33 <u>9, 1</u> 79	34 <u>2, 6</u> 14	0		1.00
	0		339, 179	342, 614			
	C - LABOR DELIVERY NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	628, 176	166, 412			1.00
2.00		0.00	0	0			2. 00
	0		628, 176	166, 412	2		
	E - NORTH ANNEX RECLASS					I	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	15, 596			1. 00
2.00		0.00		0	0		2. 00
	0		0	15, 596			
1 00	F - REHABILITATION OFFICE REC		47, 400	4 000		I	1.00
1. 00	PHYSICAL THERAPY		4 <u>6, 1</u> 99				1.00
	G - RADIOLOGY ADMIN RECLASS		46, 199	1, 302	[
1. 00	RADI OLOGY - DI AGNOSTI C	54.00	12, 344	10, 090	0		1. 00
1.00	n olog 1-DI AGNOS I I C		12, 344	10,090			1.00
	H - BONUS ACCRUAL RECLASS		12, 344	10, 090	,		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3, 652	C	0		1.00
2. 00	OPERATION OF PLANT	7.00	10, 745	C			2. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	1, 400	Ö			3. 00
4. 00	HOUSEKEEPI NG	9. 00	10, 846	C			4.00
5. 00	DI ETARY	10.00	10, 061	C	o		5. 00
6. 00	SNACK BAR	10. 01	497	C			6.00
7. 00	NURSING ADMINISTRATION	13. 00	12, 828	C	o		7. 00
8. 00	CENTRAL SERVICES & SUPPLY	14.00	2, 362	C			8. 00
9.00	PHARMACY	15. 00	9, 584	C	ol		9. 00
10.00	MEDICAL RECORDS & LIBRARY	16.00	10, 264	Ö	o		10.00
11.00	SOCI AL SERVI CE	17. 00	1, 207	C	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	46, 289	C	o		12. 00
13.00	INTENSIVE CARE UNIT	31.00	17, 159	C	0		13.00
14.00	OPERATING ROOM	50.00	29, 993	C	0		14. 00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	30, 181	C	0		15. 00
16. 00	LABORATORY	60.00	25, 284	C			16. 00
17. 00	PHYSI CAL THERAPY	66. 00	6, 519	C			17. 00
18. 00	CARDI AC REHAB	66. 01	1, 817	C			18. 00
19. 00	ELECTROCARDI OLOGY	69. 00	1, 149	C	1		19. 00
20. 00	CLINIC	90.00	1, 241	C			20. 00
21. 00	EMERGENCY	91.00	22, 870	C	0		21. 00
22. 00	AMBULANCE SERVICES	95.00	21, 608	C	0		22. 00
23. 00	HOME HEALTH AGENCY	101.00	16, 810	0	-		23.00
24. 00	HOSPI CE	116.00	2, 091	0	1		24. 00
25. 00	PHYSICIANS PRIVATE OFFICES	192.00	1, 994	O			25. 00
26. 00	DEKALB MEDICAL SERVICES	192. 01	107, 359	0	0		26. 00
27. 00	FOUNDATI ON	194. 02	43		 		27. 00
500.00	Grand Total: Decreases		405, 853 1, 431, 751	536, 014	,		500. 00
500.00	pi anu rotar. Decreases		1, 431, /51	JJU, U14	'l l	I	300.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 150045 Peri od: Worksheet A-7 From 10/01/2013 Part I Date/Time Prepared: 09/30/2014 2/25/2015 12:25 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 393, 118 1.00 1, 699, 339 0 2.00 Land Improvements 7,039 2.00 0 3.00 Buildings and Fixtures 52, 726, 620 872, 920 872, 920 3.00 869, 983 Building Improvements 0 4.00 0 4.00 5.00 Fixed Equipment 0 5.00 0 3, 595, 266 6.00 Movable Equipment 20, 947, 606 6, 410, 826 6, 410, 826 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 75, 766, 683 7, 283, 746 7, 283, 746 4, 472, 288 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 7, 283, 746 7, 283, 746 4, 472, 288 10.00 75, 766, 683 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 393, 118 0 1.00 2.00 Land Improvements 1, 692, 300 0 2.00 3.00 Buildings and Fixtures 52, 729, 557 0 3.00 0) 4.00 Building Improvements 4.00

23, 763, 166

78, 578, 141

78, 578, 141

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0

0

0

0

5.00

6.00

7.00

8.00

9.00

10.00

5.00

6.00

7.00

8.00

9.00

Fi xed Equipment

Movable Equipment

Reconciling Items

HIT designated Assets

10.00 Total (line 8 minus line 9)

Subtotal (sum of lines 1-7)

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS DEKALB MEMORIAL HOSPITAL

Provi der CCN: 150045

					o 09/30/2014		pared:
		_				2/25/2015 12:	
			SL	JMMARY OF CAPIT	ΓAL		
Cost	Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	'	•			instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
PART II - R	ECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMN	l 2, LINES 1 a	nd 2			
	TS-BLDG & FLXT	4, 390, 725	0	354, 097	0	0	1. 00
1.01 MAC WEST -	NEW	25, 115	0	C	0	0	1. 01
1.02 NORTH ANNEX		3, 966	0	C	0	0	1. 02
1.03 GARRETT CLI	NIC - NEW	19, 781	0	C	0	0	1. 03
1.04 BUTLER - NE	W	11, 914	0	C	0	0	1. 04
1.05 MAC EAST -	NEW	152, 791	0	C	0	0	1. 05
1.06 GARRETT LAB		0	0	C	0	0	1. 06
1.07 MEDICAL ART		57, 252	0	C	0	0	1. 07
1.08 DAY SPRING		0	0	C	0	0	1. 08
	TS-MVBLE EQUIP	0	0	C	0	0	2. 00
3.00 Total (sum	of lines 1-2)	4, 661, 544	0	354, 097	0	0	3. 00
		SUMMARY OF	CAPITAL				
Cost	Center Description		otal (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	15.00				
DADT II D	ECONCILIATION OF AMOUNTS FROM WORK	14.00	15. 00	nd 2			
	TS-BLDG & FLXT	SHEET A, CULUMN	4, 744, 822				1. 00
1. 01 MAC WEST -			25, 115	•			1.00
1. 02 NORTH ANNEX			3, 966				1. 02
1. 03 GARRETT CLI			19, 781				1. 02
1. 04 BUTLER - NE			11, 914				1. 03
1. 05 MAC EAST -			152, 791				1. 05
1. 06 GARRETT LAB			132, 771				1.06
1. 07 MEDI CAL ART			57, 252				1. 07
1. 08 DAY SPRING			07, 232	i e			1. 08
	TS-MVBLE EQUIP		0				2.00
	of lines 1-2)		5, 015, 641				3.00
1.000 (00		1	2, 3.0, 0	ı			

۷.	: 00 GAI REE COSTS WINDEL EQUIT	U	1	1	0.000000	١	2.00
3.	.00 Total (sum of lines 1-2)	0	0	0	1.000000	0	3. 00
		ALLOCA ⁻	TION OF OTHER C	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.	. OO CAP REL COSTS-BLDG & FLXT	0	0	0	4, 389, 870	0	1.00
1.	. O1 MAC WEST - NEW	0	0	0	25, 115	i ol	1. 01
1.	. 02 NORTH ANNEX - NEW	0	0	0	3, 966	i ol	1. 02
1.	.03 GARRETT CLINIC - NEW	0	0	0	19, 781	o	1.03
1.	. 04 BUTLER - NEW	0	0	0	11, 914	l ol	1. 04
1.	. 05 MAC EAST - NEW	0	0	0	152, 791	l o	1. 05
1.	. 06 GARRETT LAB - NEW	0	0	0	0	l o	1.06
1.	. 07 MEDICAL ARTS - NEW	0	0	l 0	57, 252	l ol	1. 07
	.08 DAY SPRING - NEW	0	0	0	0	l ol	1. 08
	. OO CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2. 00
	.00 Total (sum of lines 1-2)	0	0		4, 660, 689	0	3. 00
0.	100 10tal (Sam et 111105 1 2)		SI	JMMARY OF CAPIT			0.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	· ·		instructions)	instructions)	Capi tal -Relate	of cols. 9	
			,		d Costs (see	through 14)	
					instructions)	,	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.	. OO CAP REL COSTS-BLDG & FLXT	222, 021	0	0	0	4, 611, 891	1.00

1.01	MAC WEST - NEW	0	0	0	0	25, 115	1. 01
1.02	NORTH ANNEX - NEW	0	0	0	0	3, 966	1. 02
1.03	GARRETT CLINIC - NEW	0	0	0	0	19, 781	1.03
1.04	BUTLER - NEW	0	0	0	0	11, 914	1.04
1.05	MAC EAST - NEW	0	0	0	0	152, 791	1. 05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0	57, 252	1.07
1.08	DAY SPRING - NEW	0	0	0	0	0	1. 08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	222, 021	0	0	0	4, 882, 710	3. 00

| Peri od: | Worksheet A-8 | From 10/01/2013 | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150045

				'.	09/30/2014	Date/Time Prep 2/25/2015 12:2	
				Expense Classification on		2/25/2015 12. 2	25 piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 A	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 11	1. 00
1.00	COSTS-BLDG & FLXT (chapter 2)	A	-132,070	CAP REL CUSTS-BLDG & FIXT	1.00	''	1.00
1. 01	Investment income - MAC WEST -		0	MAC WEST - NEW	1. 01	0	1. 01
1. 02	NEW (chapter 2) Investment income - NORTH		0	NORTH ANNEX - NEW	1. 02	О	1. 02
1. 03	ANNEX - NEW (chapter 2) Investment income - GARRETT		0	GARRETT CLINIC - NEW	1 02	0	1. 03
1.03	CLINIC - NEW (chapter 2)		O	GARRETT CLINIC - NEW	1. 03	١	1. 03
1. 04	Investment income - BUTLER - NEW (chapter 2)		0	BUTLER - NEW	1. 04	0	1. 04
1. 05	Investment income - MAC EAST -		0	MAC EAST - NEW	1. 05	О	1. 05
1. 06	NEW (chapter 2) Investment income - GARRETT		0	GARRETT LAB - NEW	1. 06	o	1. 06
	LAB - NEW (chapter 2)					J	
1. 07	Investment income - MEDICAL ARTS - NEW (chapter 2)		0	MEDICAL ARTS - NEW	1. 07	0	1. 07
1.08	Investment income - DAY SPRING	i	0	DAY SPRING - NEW	1. 08	О	1. 08
2. 00	- NEW (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	o	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0. 00	О	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	o	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0. 00	o	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	О	9. 00
10.00	Provider-based physician adjustment	A-8-2	-1, 740, 324			O	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	О	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			o	12. 00
	transactions (chapter 10)		O			ı	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	B B		LAUNDRY & LINEN SERVICE CAFETERIA	8. 00 11. 00	0 0	13. 00 14. 00
15. 00	Rental of quarters to employee		254, 472	CAI ETENTA	0.00	o	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	o	16. 00
10.00	supplies to other than		· ·		0.00	ı	10.00
17. 00	patients Sale of drugs to other than	В	-8. 297	DRUGS CHARGED TO PATIENTS	73. 00	o	17. 00
	patients						
18. 00	Sale of medical records and abstracts	В	-906	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0. 00	o	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
	repay Medicare overpayments	'					
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
		<u> </u>			<u>'</u>		

Peri od: Worksheet A-8 From 10/01/2013 To 09/30/2014 Date/Time Prepared:

				To	09/30/2014	Date/Time Prep	
				Expense Classification on	Worksheet A	2/25/2015 12: 2	25 pm
				To/From Which the Amount is 1			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
07.01	D MAG WEGT NEW	1.00	2.00	3.00	4. 00	5. 00	04 04
26. 01 26. 02	Depreciation - MAC WEST - NEW Depreciation - NORTH ANNEX -			MAC WEST - NEW NORTH ANNEX - NEW	1. 01 1. 02	0	26. 01 26. 02
20.02	NEW NORTH ANNEX		O	NORTH ANNEX NEW	1.02	J	20.02
26. 03	Depreciation - GARRETT CLINIC		0	GARRETT CLINIC - NEW	1. 03	0	26. 03
	- NEW			DUTI ED NEW			
26. 04 26. 05	Depreciation - BUTLER - NEW Depreciation - MAC EAST - NEW			BUTLER - NEW MAC EAST - NEW	1. 04 1. 05	0	26. 04 26. 05
26. 05	Depreciation - GARRETT LAB -			GARRETT LAB - NEW	1. 06	0	26. 05
20.00	NEW STATE OF THE PROPERTY OF T		0	CARRELL END NEW	1.00	Ŭ	20.00
26. 07	Depreciation - MEDICAL ARTS -		0	MEDICAL ARTS - NEW	1. 07	0	26. 07
0, 00	NEW DAY ORDING			DAY ODDING NEW			0, 00
26. 08	Depreciation - DAY SPRING -		0	DAY SPRING - NEW	1. 08	0	26. 08
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 00 30. 00
30.00	therapy costs in excess of	A-0-3	Ü	cost center bereted	07.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions)	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
31.00	Adjustment for speech pathology costs in excess of	A-0-3	U	cost center bereted	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
22.00	Depreciation and Interest	D	210	EMPLOYEE DENEELTS DEDARTMENT	4 00	0	22.00
33. 00 33. 01	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	33. 00 33. 01
33. 05	WASTE DI SPOSAL REVENUE	В		OPERATION OF PLANT	7. 00	Ö	33. 05
33. 06	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7. 00	0	33. 06
33. 07	HOUSEKEEPING INCOME	В	·	HOUSEKEEPI NG	9. 00	0	33. 07
33. 08	OBSTETRI CS MI SCELLANEOUS	В	-40	ADULTS & PEDIATRICS	30. 00	0	33. 08
33. 09	I NCOME RADI OLOGY NON-PATIENT REVENUE	В	-5 187	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 09
33. 10	NON-PATIENT LAB REVENUE	В		LABORATORY	60.00	Ö	33. 10
33. 11	MI SCELLANEOUS I NCOME	В		CARDI AC REHAB	66. 01	0	33. 11
33. 12	MI SCELLANEOUS I NCOME	В		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 12
33. 13	AMBULANCE SERVICE REVENUE	В	·	AMBULANCE SERVICES	95. 00 10. 00	0	33. 13
33. 15 33. 16	DIABETES SERVICE MISC INCOME HOME HEALTH MISCELLANEOUS	B B		DIETARY HOME HEALTH AGENCY	101.00	0	33. 15 33. 16
00. 10	I NCOME		01,770	HOME HEXETH AGENOT	101.00	Ŭ	00.10
33. 18	LOBBYING PORTION OF IHA & AHA	A	-6, 135	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
22 10	DUES		2.2	HOSDICE	114 00	0	22 10
33. 19	LOBBYING PORTION OF LAHHC DUES - HOS	A	-33	HOSPI CE	116. 00	0	33. 19
33. 20	LOBBYING PORTION OF LAHHC DUES	А	-50	HOME HEALTH AGENCY	101.00	0	33. 20
	- HHA						
33. 23	NON-ALLOWABLE MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00 E4. 00	0	33. 23
33. 24 33. 25	NON-ALLOWABLE MARKETING NON-ALLOWABLE MARKETING	A A		RADI OLOGY-DI AGNOSTI C PHYSI CAL THERAPY	54. 00 66. 00	0	33. 24 33. 25
33. 26	NON-ALLOWABLE MARKETING	A		HOME HEALTH AGENCY	101. 00	0	33. 26
33. 27	NON-ALLOWABLE MARKETING	A	-48	HOSPI CE	116. 00	0	33. 27
33. 28	NON-ALLOWABLE MARKETING	A		CARDI AC REHAB	66. 01	0	33. 28
33. 31	LI FELI NE EXPENSES - DEPRECIATION	A	-855	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 31
33. 32	FLOWER/GIFTS	A	-6. 037	ADMINISTRATIVE & GENERAL	5. 00	0	33. 32
33. 33	SELF-INSURANCE EXPENSES	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	Ö	33. 33
33. 37	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 37
33. 38	THERAPY MI SCELLANEOUS REVENUE	A		PHYSICAL THERAPY	66.00	0	33. 38
33. 39 33. 40	HAF FEE SNACK BAR	A A		ADMINISTRATIVE & GENERAL SNACK BAR	5. 00 10. 01	0	33. 39 33. 40
33. 41	INVESTMENT MANAGEMENT FEE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 40
33. 42			0		0.00	0	33. 42
33. 43	TOTAL COURS CALL STATE		0		0. 00	0	33. 43
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-5, 484, 768				50. 00
_	column 6, line 200.)						
(1) De	scription - all chapter referen	ces in this col	umn pertain to	CMS Pub. 15-1.			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

Health Financial Systems	DEKALB MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES		Provi der CCN		Peri od:	Worksheet A-8		
					From 10/01/2013 To 09/30/2014	Date/Time Pre 2/25/2015 12:	
			Expense Classi 1	fication on	Worksheet A		
			To/From Which the	Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Cent	er	Line #	Wkst. A-7 Ref.	
cost center bescription	1.00	2.00	3.00	.01	4.00	5, 00	
	1.00	2.00	3.00		4.00	5.00	

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.

						To 09/30/2014	Date/Time Pre 2/25/2015 12:	epared: 25 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		ldenti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	35, 413	0	35, 413	177, 200	159	1. 00
2.00	31.00	INTENSIVE CARE UNIT	50, 400	50, 400	0	177, 200	0	2. 00
3.00	50.00	OPERATING ROOM	1, 094, 537	1, 094, 537	0	177, 200	0	3. 00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	99, 485	13, 918	84, 529	177, 200	1, 197	4. 00
5.00	69. 00	ELECTROCARDI OLOGY	11, 300	11, 300		177, 200	0	5. 00
6.00		EMERGENCY	529, 014			177, 200	0	6. 00
7.00		ADULTS & PEDIATRICS	5, 000	5, 000	0	177, 200	0	7. 00
8. 00		INTENSIVE CARE UNIT	10, 000			177, 200	0	8. 00
9. 00		OPERATING ROOM	2, 750			177, 200	0	9.00
10.00		EMERGENCY	500			177, 200	0	10.00
200.00			1, 838, 399				1, 356	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er			Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9.00	12. 00	13. 00	14.00	
1.00		ADMINISTRATIVE & GENERAL	13, 546	677			0	
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2. 00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	101, 975	5, 099	0	0	0	1
5.00		ELECTROCARDI OLOGY	0	0	0	0	0	5. 00
6.00	91.00	EMERGENCY	0	0	0	0	0	6. 00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7. 00
8.00		INTENSIVE CARE UNIT	0	0	0	0	0	8. 00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9. 00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			115, 521			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1/ 00	47.00	10.00		
4 00	1.00	2.00	15. 00	16. 00	17. 00	18. 00		4 00
1.00		ADMINISTRATIVE & GENERAL	0	,		21, 867		1.00
2.00		INTENSIVE CARE UNIT	0		_	50, 400		2.00
3.00		OPERATING ROOM	0			1, 094, 537		3.00
4.00		RADI OLOGY-DI AGNOSTI C	0			14, 956		4. 00
5.00		ELECTROCARDI OLOGY	0	0	0	11, 300		5. 00
6.00		EMERGENCY	0	0	0	529, 014		6.00
7.00		ADULTS & PEDIATRICS	0	0	0	5,000		7. 00
8.00		INTENSIVE CARE UNIT	0	0	0	10, 000		8. 00
9.00		OPERATING ROOM	0	· -	0	2, 750		9. 00
10.00	91.00	EMERGENCY	0	-	0	500		10.00
200.00			0	115, 521	21, 867	1, 740, 324	l	200. 00

Provider CCN: 150045

						0 09/30/2014	2/25/2015 12:	
					CAPITAL RE	LATED COSTS		,
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	
			Allocation (from Wkst A					
			col. 7) 0	1.00	1. 01	1. 02	1. 03	
	GENER	AL SERVICE COST CENTERS	U	1.00	1.01	1.02	1.03	
1.00		CAP REL COSTS-BLDG & FIXT	4, 611, 891	4, 611, 891				1. 00
1.01	00101	MAC WEST - NEW	25, 115	O	25, 115			1. 01
1.02	00102	NORTH ANNEX - NEW	3, 966	0	0	3, 966		1. 02
1.03		GARRETT CLINIC - NEW	19, 781	0	1	0	19, 781	1. 03
1. 04	1	BUTLER - NEW	11, 914	0	_	0	0	1. 04
1.05		MAC EAST - NEW	152, 791	0	0	0	0	1. 05
1. 06 1. 07	1	GARRETT LAB - NEW MEDICAL ARTS - NEW	57, 252		0	0	0 0	1. 06 1. 07
1.07		DAY SPRING - NEW	37, 232	1 0	0	0	0	1. 07
2.00		CAP REL COSTS-MVBLE EQUIP	0	Ĭ			Ĭ	2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	2, 265, 463	o	0	0	0	4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	7, 195, 098	595, 075	0	0	0	5. 00
7.00		OPERATION OF PLANT	1, 879, 144		1	0	0	7. 00
8.00		LAUNDRY & LINEN SERVICE	231, 982			0	0	8. 00
9.00		HOUSEKEEPI NG	935, 985		1	0	0	9.00
10. 00 10. 01		DI ETARY SNACK BAR	347, 387	23, 162	1	0	0 0	10. 00 10. 01
11. 00		CAFETERIA	427, 321	54, 484	_	0	0	11. 00
13. 00		NURSI NG ADMI NI STRATI ON	801, 407	24, 503	1	0	Ö	13. 00
14.00		CENTRAL SERVICES & SUPPLY	265, 372			0	0	14. 00
15. 00	01500	PHARMACY	500, 292	26, 768	0	0	0	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	637, 646			0	0	16. 00
17. 00		SOCIAL SERVICE	70, 947	3, 791	0	0	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	2, 147, 324	271, 058	0	0	0	30. 00
31. 00	1	INTENSIVE CARE UNIT	1, 001, 558		1			31. 00
43. 00		NURSERY	261, 150	1	1			43. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATI NG ROOM	2, 004, 444		1		l e	50.00
52.00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	534, 963			0	0	52. 00 54. 00
54. 00 60. 00	1	LABORATORY	2, 749, 332 3, 176, 061	215, 325 96, 833		0	4, 136	
60. 01	1	BLOOD LABORATORY	0	0	1	o o	0	60. 01
65.00		RESPI RATORY THERAPY	507, 438	25, 243	0	0	0	65.00
66. 00		PHYSI CAL THERAPY	1, 032, 398	1	1	0	0	66. 00
66. 01	1	CARDI AC REHAB	146, 502		i	0	0	66. 01
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	85, 855 224, 832		1	0	0 0	69. 00 70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PAT	1, 618, 582	1	0	0		70.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	625, 452		Ō	0	0	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	1, 869, 111	0	0	0	0	73. 00
00.00		TIENT SERVICE COST CENTERS	0F 242		1 0			00.00
90. 00 91. 00		CLI NI C EMERGENCY	85, 242 1, 375, 777			0	l e	
92. 00		OBSERVATION BEDS (NON-DISTINCT	1,0,0,,,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				92. 00
	OTHER	REIMBURSABLE COST CENTERS						
95. 00	1	AMBULANCE SERVI CES	1, 949, 239	1	1	0	0	95. 00
	09910	CORF HOME HEALTH AGENCY	1 100 055		1	2 570	0	99. 10 101. 00
101.00		AL PURPOSE COST CENTERS	1, 198, 055		<u> </u>	3, 579	0	101.00
113.00		INTEREST EXPENSE						113. 00
	1	HOSPI CE	272, 402	o	0	387		116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43, 306, 471	4, 493, 976	5, 528	3, 966	4, 136	118. 00
100.00		IMBURSABLE COST CENTERS GIFT FLOWER COFFEE SHOP & CAN				^		190. 00
		RESEARCH	0		1	0		190. 00 191. 00
		PHYSICIANS PRIVATE OFFICES	248, 000			0		191.00
	1	DEKALB MEDICAL SERVICES	7, 842, 940			0	15, 645	
192. 02	19202	PHARMACARE	4, 031, 939		0	0	0	192. 02
		NONPALD WORKERS	0	0	0	0		193. 00
		OTHER NONREIMBURSABLE COST CENT ADULT DAY CARE	0		0	0		194. 00 194. 01
		FOUNDATION	7, 736	1	0	0		194. 01 194. 02
200.00		Cross Foot Adjustments	,,,30]				200. 00
201.00	1	Negative Cost Centers		0	0	0		201. 00
202.00)	TOTAL (sum lines 118-201)	55, 437, 086	4, 611, 891	25, 115	3, 966	19, 781	202. 00

Provi der CCN: 150045

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2013 | Part | Date/Time Prepared: | 2/25/2015 12: 25 pm | COSTS |

		CAPITAL RELATED COSTS					
	Cost Center Description	RIITI ER _ NEW	MAC FAST - NEW	GARRETT LAB -	MEDICAL ARTS -	DAY SPRING -	
	cost center bescription	DOTEEN NEW I	WING EAST INEW	NEW	NEW NEW	NEW	
	THERE AS A COLUMN	1. 04	1. 05	1. 06	1. 07	1. 08	
	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT						1.00
	00101 MAC WEST - NEW						1. 00
	00102 NORTH ANNEX - NEW						1. 02
	00103 GARRETT CLINIC - NEW						1. 03
1	00104 BUTLER - NEW	11, 914					1. 04
1	00105 MAC EAST - NEW	0	152, 791				1. 05
	DO106 GARRETT LAB - NEW DO107 MEDICAL ARTS - NEW	0	0	0	57, 252		1. 06 1. 07
4	00108 DAY SPRING - NEW		0	0	57, 252	0	
	00200 CAP REL COSTS-MVBLE EQUIP	_	_			_	2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	o	0	0	0	0	
	00500 ADMINISTRATIVE & GENERAL	0	20, 460	0	0	0	5. 00
1	00700 OPERATION OF PLANT	0	45, 412 0	0	4, 540	0	7. 00 8. 00
- 1	DO800 LAUNDRY & LINEN SERVICE DO900 HOUSEKEEPING		310	0	0	0	1
	01000 DI ETARY	o	832	ő	o	0	1
	01001 SNACK BAR	o	0	0	0	0	10. 01
	01100 CAFETERI A	0	0	0	0	0	
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	0	U O	0	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY		1, 158	0	0	0	16.00
1	01700 SOCIAL SERVICE	o	0		o	0	17. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
4	03000 ADULTS & PEDIATRICS	0	0		0	0	
1	03100 INTENSIVE CARE UNIT	0	0		0	0	
	04300 NURSERY NNCILLARY SERVICE COST CENTERS	0	0	0	0	0	43.00
	05000 OPERATING ROOM	ol	0	0	0	0	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	o	0	0	0	0	52. 00
1	D5400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	
1	06000 LABORATORY	843	0	0	0	0	60.00
1	06001 BL00D_LABORATORY 06500 RESPI RATORY_THERAPY	0	0	0	U O	0	
	06600 PHYSI CAL THERAPY		0	0	0	0	66.00
	06601 CARDI AC REHAB	ō	0	Ō	Ö	0	ı
	06900 ELECTROCARDI OLOGY	o	0	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	D7100 MEDICAL SUPPLIES CHARGED TO PAT D7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
- 1	07300 DRUGS CHARGED TO PATTENTS		0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		70.00
	09000 CLI NI C	0	0		0	0	90. 00
	09100 EMERGENCY	0	0	0	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT						92. 00
	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	ام	0	0	ol	0	95. 00
	09910 CORF	ا	0		Ö	0	1
	10100 HOME HEALTH AGENCY	O	0		0	0	101.00
_	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		•				113. 00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 843	0 68, 172	0	0 4, 540		116. 00 118. 00
_	IONREI MBURSABLE COST CENTERS	043	00, 172	<u> </u>	4, 340		1110.00
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
	19100 RESEARCH	o	0	0	0		191. 00
1	19200 PHYSI CI ANS PRI VATE OFFI CES	0	52, 778	0	43, 699		192. 00
	19201 DEKALB MEDICAL SERVICES 19202 PHARMACARE	11, 071	31, 841 0	0	9, 013 0		192. 01 192. 02
	19300 NONPALD WORKERS		0	0	0		192. 02
	07950 OTHER NONREIMBURSABLE COST CENT		0	o o	o	0	194. 00
194. 01	07951 ADULT DAY CARE	o	0	0	O	0	194. 01
	07952 FOUNDATION	0	0	0	0	0	194. 02
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		0			^	200. 00 201. 00
201.00	TOTAL (sum lines 118-201)	11, 914	152, 791	0	57, 252		201.00
_ 3 00	1.1 (1 7.1.00 7.10 201)		.52, 171	١	37, 202	O	,

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

					Т	o 09/30/2014	Date/Time Pre 2/25/2015 12:	
			CAPI TAL				2/23/2013 12.	23 piii
			RELATED COSTS					
		Cost Center Description	MVBLE EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI VE		
				BENEFITS DEPARTMENT		& GENERAL	PLANT	
			2.00	4. 00	4A	5. 00	7. 00	
	GENER.	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
1.01		MAC WEST - NEW						1. 01
1. 02		NORTH ANNEX - NEW GARRETT CLINIC - NEW						1. 02
1. 03 1. 04	1	BUTLER - NEW						1. 03 1. 04
1. 05		MAC EAST - NEW						1. 05
1.06	1	GARRETT LAB - NEW						1. 06
1.07		MEDICAL ARTS - NEW						1. 07
1.08		DAY SPRING - NEW						1. 08
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP	0	2 245 442				2. 00 4. 00
5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL		2, 265, 463 297, 833		8, 108, 466		5. 00
7. 00	1	OPERATION OF PLANT	l o	51, 523			4, 496, 499	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	0	6, 712			36, 277	8. 00
9.00	1	HOUSEKEEPI NG	0	52, 004	1, 032, 427	176, 878	60, 309	9. 00
10.00	1	DIETARY	0	17, 084			36, 641	10.00
10. 01		SNACK BAR	0	2, 381			71 (12	10. 01
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	0	31, 155 61, 507			71, 612 32, 206	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY		11, 327			38, 252	14. 00
15. 00	1	PHARMACY	0	45, 954			35, 183	1
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49, 214	752, 627	128, 942	93, 548	16. 00
17. 00		SOCIAL SERVICE	0	5, 786	80, 524	13, 796	4, 983	17. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS		1/4 250	2 502 (22	442.474	25/ 2//	20.00
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	164, 250 82, 276			356, 266 151, 275	30. 00 31. 00
43. 00		NURSERY	0	18, 875			49, 098	43. 00
		LARY SERVICE COST CENTERS	-1	,	2, 222	2 1/ 21 1	,	
50.00	1	OPERATING ROOM	0	143, 815			539, 017	50. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	38, 826			149, 725	
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	0	143, 582 121, 233			283, 014 181, 961	54. 00 60. 00
60. 00		BLOOD LABORATORY	0	121, 233		382, 320	181, 401	60.00
65. 00		RESPI RATORY THERAPY	o	0		91, 261	33, 178	65. 00
66.00	06600	PHYSI CAL THERAPY	0	27, 015	1, 179, 986	202, 159	158, 475	66. 00
66. 01		CARDI AC REHAB	0	12, 958			83, 400	
69.00		ELECTROCARDI OLOGY	0	6, 644			0	69.00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PAT		0	.,		0	70. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0			0	73. 00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	0	5, 949			0	
91.00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT	0	109, 661	1, 662, 807	284, 877	233, 125	91.00
72.00		REIMBURSABLE COST CENTERS						72.00
	09500	AMBULANCE SERVICES	0	103, 607	2, 153, 585	368, 959	132, 407	95. 00
	09910		0	0		0	0	
101.00		HOME HEALTH AGENCY	0	80, 600	1, 282, 234	219, 676	84, 220	101. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE			I			113. 00
	1	HOSPI CE	0	10, 025	282, 814	48, 453	9, 115	116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1, 701, 796			2, 853, 287	
		MBURSABLE COST CENTERS			1			
		GIFT FLOWER COFFEE SHOP & CAN	0	0		0		190. 00
		RESEARCH PHYSICIANS PRIVATE OFFICES	0	9, 563		0 83, 921	0 1, 100, 610	191. 00
		DEKALB MEDICAL SERVICES	0	517, 611			542, 602	
		PHARMACARE		36, 276				192. 02
193.00	19300	NONPALD WORKERS	0	0	C	0	0	193. 00
		OTHER NONREIMBURSABLE COST CENT	0	0	C	0		194. 00
		ADULT DAY CARE	0	0	7	0		194. 01
194. 02 200. 00		FOUNDATION Cross Foot Adjustments		217	7, 953	1, 363	0	194. 02 200. 00
200.00	1	Negative Cost Centers		0	"	n	Λ	200. 00
202.00	1	TOTAL (sum lines 118-201)	0	2, 265, 463	55, 437, 086	8, 108, 466		
	•	,					•	

| Peri od: | Worksheet B | From 10/01/2013 | Part | | To 09/30/2014 | Date/Time Prepared: Provider CCN: 150045

			To	09/30/2014	Date/Time Pre 2/25/2015 12:	
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DIETARY	SNACK BAR	CAFETERI A	25 piii
	LINEN SERVICE	9. 00	10.00	10.01	11 00	
GENERAL SERVICE COST CENTERS	8. 00	9.00	10.00	10. 01	11. 00	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 MAC WEST - NEW						1. 01
1. 02 00102 NORTH ANNEX - NEW						1. 02
1. 03 00103 GARRETT CLINIC - NEW 1. 04 00104 BUTLER - NEW						1. 03 1. 04
1. 05 00104 BOTLER - NEW						1. 05
1. 06 00106 GARRETT LAB - NEW						1. 06
1.07 00107 MEDICAL ARTS - NEW						1. 07
1.08 00108 DAY SPRING - NEW						1. 08
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT 5.00 OO500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	348, 193					8.00
9. 00 00900 HOUSEKEEPI NG	20, 200	ł				9. 00
10. 00 01000 DI ETARY	0	10, 741	502, 400			10.00
10. 01 01001 SNACK BAR	0	0		2, 789		10. 01
11. 00 01100 CAFETERI A	0	20, 993	0	2, 789	696, 236	1
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	9, 441	0	0	18, 358	
15. 00 01400 CENTRAL SERVICES & SUPPLY	0	11, 213 10, 314		0	8, 863 13, 045	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0			Ö	33, 280	1
17. 00 01700 SOCI AL SERVI CE	0	, , , ,	Ō	0		1
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	130, 385	l		0	83, 607	30.00
31. 00 03100 INTENSIVE CARE UNIT	32, 000	l		0		1
43.00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	4, 465	14, 393	0	0	7, 845	43. 00
50. 00 05000 OPERATING ROOM	51, 452	158, 010	O	0	57, 833	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0 0		Ö	Ö	16, 120	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	35, 666	82, 964	0	0	58, 127	1
60. 00 06000 LABORATORY	0	53, 341	0	0	57, 924	1
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	1
65. 00 06500 RESPIRATORY THERAPY	3, 561	9, 726		0	12.027	
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 CARDI AC REHAB	6, 998 1, 176	46, 456 24, 448		0	13, 927 7, 077	1
69. 00 06900 ELECTROCARDI OLOGY	1,170	24, 440		0	3, 866	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	Ö	Ö	Ö	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	ł		0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
90.00 OUTPATIENT SERVICE COST CENTERS	2, 068			٥	2 002	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	51, 623		0	0	2, 803 45, 670	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	31,023	00, 340		J	43, 070	92.00
OTHER REIMBURSABLE COST CENTERS			<u> </u>			72.00
95. 00 09500 AMBULANCE SERVICES	4, 696	38, 815	0	0	57, 607	95. 00
99. 10 09910 CORF	0	l e		0	0	1
101. 00 10100 HOME HEALTH AGENCY	0	24, 689	0	0	41, 555	101. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE			I	1		113. 00
116. 00 11600 HOSPI CE	136	2, 672	0	0	3 753	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	344, 426			2, 789		
NONREI MBURSABLE COST CENTERS	·			·]
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0		-	0		191. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	322, 638	0	0	13, 181 111, 303	192.00
192. 01 19201 DEKALB MEDI CAL SERVI CES 192. 02 19202 PHARMACARE	3, 767	159, 061		0		192. 01
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENT	0	0	l o	o		194. 00
194. 01 07951 ADULT DAY CARE	0	0	0	O		194. 01
194. 02 07952 FOUNDATI ON	0	0	0	0	1, 085	194. 02
200. 00 Cross Foot Adjustments	_	_			_	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	0 348, 193	0 1, 289, 814	502, 400	0 2, 789		201.00
202. 00 TOTAL (SUIII TITIES TIO-201)	1 340, 193	1, 207, 014	1 502, 400	2, 109	070, 230	1202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 10/01/2013 | Part |
| To 09/30/2014 | Date/Time Prepared: | 2/25/2015 12: 25 pm Provider CCN: 150045

				09/30/2014	2/25/2015 12:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	13.00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	
GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01 00101 MAC WEST - NEW						1. 01
1.02 00102 NORTH ANNEX - NEW						1. 02
1.03 00103 GARRETT CLINIC - NEW						1. 03
1.04 00104 BUTLER - NEW						1. 04
1.05 00105 MAC EAST - NEW						1. 05
1.06 00106 GARRETT LAB - NEW						1. 06
1.07 00107 MEDICAL ARTS - NEW						1. 07
1.08 00108 DAY SPRING - NEW						1. 08
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
10. 01 01001 SNACK BAR						10. 01
11. 00 01100 CAFETERI A						11. 00
13.00 O1300 NURSING ADMINISTRATION	1, 099, 457					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	31, 118	447, 639				14. 00
15. 00 01500 PHARMACY	0	0	729, 726			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	1, 035, 820		16. 00
17. 00 01700 SOCIAL SERVICE	7, 959	0	0	0	110, 984	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	293, 644	0	0	103, 673	110, 984	30. 00
31. 00 03100 INTENSIVE CARE UNIT	130, 414	0	0	42, 250	0	31. 00
43. 00 04300 NURSERY	27, 530	0	0	10, 389	0	43. 00
ANCILLARY SERVICE COST CENTERS		_1				
50. 00 05000 OPERATI NG ROOM	203, 074	0	0	214, 576	0	50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	56, 628	0	0	21, 445	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	186, 554	0	54.00
60. 00 06000 LABORATORY	19, 735	0	0	171, 227	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPIRATORY THERAPY	0	0	0	26, 205	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	34, 033	0	66.00
66. 01 06601 CARDI AC REHAB	0	U	0	3, 866	0	66. 01
69. 00 06900 ELECTROCARDI OLOGY	0	U	0	8, 283	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	447 (20	0	11, 934	0	70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PAT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0	447, 639 0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		o	729, 726	151	0	73. 00
OUTPATIENT SERVICE COST CENTERS	UU	<u> </u>	129, 120	131	0	73.00
90. 00 09000 CLI NI C	9, 864	ol	0	3, 388	0	90. 00
91. 00 09100 EMERGENCY	160, 410	o	o	93, 911	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	100, 410	ď		73, 711	O	92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	n n	O	0	0	0	95. 00
99. 10 09910 CORF	0	Ö	Ö	Ö	0	99. 10
101.00 10100 HOME HEALTH AGENCY	145, 923	Ö	Ö	0		101. 00
SPECIAL PURPOSE COST CENTERS	1107720	٥,	5	<u> </u>		
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	13, 158	o	0	5, 986	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 099, 457	447, 639	729, 726	937, 871	110, 984	
NONREI MBURSABLE COST CENTERS	1, 21.1, 12.1	,			,	
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	o	o	0	0		191. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	o	o	0	0		192. 00
192. 01 19201 DEKALB MEDICAL SERVICES	o	o	0	97, 949		192. 01
192. 02 19202 PHARMACARE	O	o	0	0	0	192. 02
193.00 19300 NONPALD WORKERS	O	o	o	o		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENT	0	ol	o	o	0	194. 00
194.01 07951 ADULT DAY CARE	0	ol	o	o	0	194. 01
194. 02 07952 FOUNDATI ON	0	o	o	o	0	194. 02
200.00 Cross Foot Adjustments		ļ				200. 00
201.00 Negative Cost Centers	0	o	o	o	0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 099, 457	447, 639	729, 726	1, 035, 820	110, 984	202. 00
	·	·	·			

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

						To 09/30/2014 Date/Time P 2/25/2015 1	
		Cost Center Description	Subtotal	Intern &	Total	272372013 1	2. 23 piii
		·		Residents Cost			
				& Post			
				Stepdown Adjustments			
			24. 00	25. 00	26. 00		
		AL SERVICE COST CENTERS					
1.00	1	CAP REL COSTS-BLDG & FIXT					1.00
1. 01 1. 02	1	MAC WEST - NEW NORTH ANNEX - NEW					1. 01 1. 02
1. 02		GARRETT CLINIC - NEW					1. 02
1.04	1	BUTLER - NEW					1. 04
1.05	1	MAC EAST - NEW					1. 05
1.06	1	GARRETT LAB - NEW					1. 06
1.07		MEDICAL ARTS - NEW					1. 07
1. 08 2. 00	1	DAY SPRING - NEW CAP REL COSTS-MVBLE EQUIP					1. 08 2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00		ADMINISTRATIVE & GENERAL					5. 00
7.00	1	OPERATION OF PLANT					7. 00
8. 00	1	LAUNDRY & LINEN SERVICE					8. 00
9.00		HOUSEKEEPI NG					9. 00
10. 00 10. 01		DI ETARY SNACK BAR					10. 00 10. 01
11. 00	1	CAFETERI A					11. 00
13. 00	1	NURSI NG ADMI NI STRATI ON					13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY					14. 00
15. 00	1	PHARMACY					15. 00
16.00	1	MEDICAL RECORDS & LIBRARY					16.00
17. 00		SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS					17. 00
30. 00		ADULTS & PEDI ATRI CS	4, 605, 226	0	4, 605, 22	26	30.00
31.00	1	INTENSIVE CARE UNIT	1, 947, 030	l I	1, 947, 03		31.00
43.00		NURSERY	485, 474	0	485, 47	74	43. 00
FO 00		_ARY SERVICE COST CENTERS	4 220 (27		4 220 7	27	F0.00
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	4, 220, 627 1, 093, 334		4, 220, 62 1, 093, 33		50. 00 52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	4, 287, 077		4, 287, 07		54. 00
60.00	1	LABORATORY	4, 466, 835	l I	4, 466, 83		60. 00
60. 01	1	BLOOD LABORATORY	0	0		0	60. 01
65. 00		RESPIRATORY THERAPY	696, 612	l I	696, 61		65. 00
66. 00 66. 01	1	PHYSI CAL THERAPY CARDI AC REHAB	1, 642, 034 381, 070		1, 642, 03 381, 07		66. 00 66. 01
69. 00	1	ELECTROCARDI OLOGY	120, 495	l I	120, 49		69. 00
70.00		ELECTROENCEPHALOGRAPHY	275, 285		275, 28		70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PAT	2, 343, 521		2, 343, 52		71. 00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	732, 606		732, 60		72. 00
73. 00		DRUGS CHARGED TO PATIENTS FIENT SERVICE COST CENTERS	2, 919, 210	0	2, 919, 2	10	73. 00
90. 00		CLINIC	124, 937	0	124, 93	37	90.00
		EMERGENCY	2, 600, 763	0	2, 600, 76	53	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT		0			92. 00
95 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	2, 756, 069	0	2, 756, 06	sol	95. 00
	09910		2, 730, 007	o	2, 730, 00	0	99. 10
		HOME HEALTH AGENCY	1, 798, 297	1	1, 798, 29	97	101. 00
		AL PURPOSE COST CENTERS					
	1	INTEREST EXPENSE	2// 007		2// 0/	27	113.00
118.00		HOSPICE SUBTOTALS (SUM OF LINES 1-117)	366, 087 37, 862, 589	1	366, 08 37, 862, 58		116. 00 118. 00
110.00		MBURSABLE COST CENTERS	37,002,307	<u> </u>	37, 002, 30	57	110.00
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0		0	190. 00
		RESEARCH	0	0		0	191. 00
		PHYSICIANS PRIVATE OFFICES	2, 010, 190		2, 010, 19		192. 00
		DEKALB MEDICAL SERVICES PHARMACARE	10, 788, 712 4, 765, 194		10, 788, 7° 4, 765, 19		192. 01 192. 02
		NONPALD WORKERS	4, 703, 174		4, 703, 1	0	193. 00
	1	OTHER NONREIMBURSABLE COST CENT	Ö	o		0	194. 00
194. 01	07951	ADULT DAY CARE	0	O		0	194. 01
		FOUNDATION	10, 401	0	10, 40	01	194. 02
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers	0	0		U O	200. 00 201. 00
201.00	1	TOTAL (sum lines 118-201)	55, 437, 086	0	55, 437, 08) 36	201.00
	1	(1 22, 30, 300	, 9	,, 00	1	1

| Peri od: | Worksheet B | From 10/01/2013 | Part | I | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150045

					Тс		Date/Time Pre 2/25/2015 12:	
					CAPITAL REL	ATED COSTS		
		Cost Center Description	Di rectly	BLDG & FIXT	MAC WEST - NEW			
			Assigned New Capital			NEW	- NEW	
			Related Costs	1.00	1.01	1.00	4.00	
	GENER	AL SERVICE COST CENTERS	0	1.00	1.01	1. 02	1. 03	
	1	CAP REL COSTS-BLDG & FIXT						1.00
		MAC WEST - NEW NORTH ANNEX - NEW						1. 01 1. 02
1.03	00103	GARRETT CLINIC - NEW						1. 03
		BUTLER - NEW MAC EAST - NEW						1. 04 1. 05
		GARRETT LAB - NEW						1. 06
	1	MEDICAL ARTS - NEW						1.07
		DAY SPRING - NEW CAP REL COSTS-MVBLE EQUIP						1. 08 2. 00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	0	595, 075 1, 853, 695	1	0	0	
	1	LAUNDRY & LINEN SERVICE	o	27, 600	·	ő	0	
		HOUSEKEEPI NG DI ETARY	0	44, 128 23, 162		0	0	9. 00 10. 00
	1	SNACK BAR	0	23, 102		0	0	10.00
	1	CAFETERI A	0	54, 484	1	0	0	11. 00
	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	24, 503 29, 103	1	0	0	13. 00 14. 00
15. 00	01500	PHARMACY	0	26, 768	0	o	0	15. 00
	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	0	64, 609 3, 791	1	0	0	16. 00 17. 00
17.00		I ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	3, 771	0	O _I	0	17.00
	1	ADULTS & PEDIATRICS	0	271, 058		0	0	30. 00 31. 00
	1	INTENSIVE CARE UNIT NURSERY	0	115, 094 37, 355	1	0	0	1
FO 00		LARY SERVICE COST CENTERS		410, 100		ما	0	FO 00
	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	410, 100 113, 916	·	0	0	50. 00 52. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	215, 325	0	0	0	54.00
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	0	96, 833 0		0	4, 136 0	60. 00 60. 01
	1	RESPI RATORY THERAPY	Ö	25, 243		ő	0	65. 00
66. 00 66. 01	1	PHYSI CAL THERAPY CARDI AC REHAB	0	120, 573 63, 453	1	0	0	66. 00 66. 01
		ELECTROCARDI OLOGY	0	05, 455	1	0	0	69. 00
		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	1	MEDICAL SUPPLIES CHARGED TO PAT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0	0	
		TIENT SERVICE COST CENTERS CLINIC	0	0	0	O	0	90. 00
91.00	09100	EMERGENCY	0	177, 369	Ö	o	0	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT REIMBURSABLE COST CENTERS						92.00
	09500	AMBULANCE SERVICES	0	100, 739	0	0	0	
99. 10		CORF HOME HEALTH AGENCY	0	0		0 3, 579	0	99. 10 101. 00
		AL PURPOSE COST CENTERS	ı o	0	η σ _ι	3, 379	0	101.00
		INTEREST EXPENSE	0	0		207	0	113.00
118.00		HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0	0 4, 493, 976		387 3, 966		116. 00 118. 00
400.00		MBURSABLE COST CENTERS						
		GIFT FLOWER COFFEE SHOP & CAN RESEARCH	0	0	0	0		190. 00 191. 00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	117, 915		O	0	192. 00
		DEKALB MEDICAL SERVICES PHARMACARE	0	0	1, 702 0	0	15, 645 0	192. 01 192. 02
		NONPALD WORKERS	0	0		0		193. 00
		OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194.00
		ADULT DAY CARE FOUNDATION	0	0	0	0		194. 01 194. 02
200.00		Cross Foot Adjustments		-				200. 00
201. 00 202. 00		Negative Cost Centers TOTAL (sum lines 118-201)	0	0 4, 611, 891	0 25, 115	0 3, 966	0 19, 781	201. 00 202. 00
00	1		۱ ۹	.,, 5/1	_==,	3, 700	. , , , 51	

Provi der CCN: 150045

		CAP	TAL RELATED C	OSTS	2/25/2015 12:	25 pm
Cost Center Description	BUTLER - NEW N	MAC EAST - NEW	GARRETT LAB -	MEDICAL ARTS -	DAY SPRING -	
	1.04	4.05	NEW	NEW	NEW	
GENERAL SERVICE COST CENTERS	1.04	1. 05	1.06	1. 07	1. 08	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 00101 MAC WEST - NEW						1. 01
1. 02 00102 NORTH ANNEX - NEW						1. 02
1. 03 00103 GARRETT CLINIC - NEW						1. 03
1. 04 00104 BUTLER - NEW						1. 04
1. 05 00105 MAC EAST - NEW 1. 06 00106 GARRETT LAB - NEW						1. 05
1.07 00100 GARRETT LAB - NEW						1. 06 1. 07
1. 08 00107 MEDICAL ARTS = NEW						1. 08
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	o	0	0	0	0	1
5.00 00500 ADMINISTRATIVE & GENERAL	0	20, 460	0	0	0	5. 00
7.00 O0700 OPERATION OF PLANT	0	45, 412	0	4, 540	0	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	1
9. 00 00900 HOUSEKEEPI NG	0	310	0	0	0	
10. 00 01000 DI ETARY	0	832	0	0	0	1
10. 01 01001 SNACK BAR	0	0	0	0	0	1
11. 00 01100 CAFETERI A	0	0	0	0	0	
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY		0	0	0	0	
15. 00 01500 PHARMACY		0		0	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY		1, 158		0	0	1
17. 00 01700 SOCI AL SERVI CE	0	0	ĺ	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS		_		_		
50. 00 05000 OPERATING ROOM	0	0	0		0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	843	0	0	0	0	
60. 01 06001 BLOOD LABORATORY	043	0		0	0	
65. 00 06500 RESPIRATORY THERAPY		0		0	Ö	
66. 00 06600 PHYSI CAL THERAPY	0	0	Ö	0	0	
66. 01 06601 CARDI AC REHAB	o	0	0	0	0	66. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	l	0	0	0	0	90.00
91. 00 09100 EMERGENCY		0			0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		O	٥	0	0	92.00
OTHER REI MBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
99. 10 09910 CORF	0	0	O	0	0	
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	0			116. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	843	68, 172	0	4, 540	0	118. 00
NONREI MBURSABLE COST CENTERS	0	0	0		0	190. 00
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 191.00 19100 RESEARCH		0	0	0		191.00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES		52, 778		43, 699		192. 00
192. 01 19201 DEKALB MEDI CAL SERVI CES	11, 071	31, 841	Ö	9, 013		192. 01
192. 02 19202 PHARMACARE	0	0	Ö	0		192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194. 00
194. 01 07951 ADULT DAY CARE	0	0	0	0		194. 01
194. 02 07952 FOUNDATI ON	0	0	0	0	0	194. 02
200.00 Cross Foot Adjustments	[_	_	_	_	200.00
201.00 Negative Cost Centers	11 01	150 701	0	[0		201. 00
202.00 TOTAL (sum lines 118-201)	11, 914	152, 791	0	57, 252	0	202. 00

| Peri od: | Worksheet B | From 10/01/2013 | Part | I | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150045

				Т	o 09/30/2014	Date/Time Pre 2/25/2015 12:	
		CAPI TAL				2/23/2013 12.	23 piii
		RELATED COSTS					
	Cost Center Description	MVBLE EQUIP	Subtotal	EMPLOYEE	ADMI NI STRATI VE		
				BENEFITS	& GENERAL	PLANT	
		2.00	24	DEPARTMENT	F 00	7.00	
	GENERAL SERVICE COST CENTERS	2.00	2A	4. 00	5. 00	7. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 MAC WEST - NEW						1. 01
1. 02	00102 NORTH ANNEX - NEW						1. 02
1.03	00103 GARRETT CLINIC - NEW						1. 03
1.04	00104 BUTLER - NEW						1. 04
1.05	00105 MAC EAST - NEW						1. 05
1.06	00106 GARRETT LAB - NEW						1. 06
1.07	00107 MEDI CAL ARTS - NEW						1. 07
1.08	00108 DAY SPRING - NEW						1.08
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	o	0				2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL		615, 535		615, 535		5.00
7. 00	00700 OPERATION OF PLANT		1, 908, 154			1, 958, 082	1
8. 00	00800 LAUNDRY & LINEN SERVICE	o	27, 600			15, 797	1
9.00	00900 HOUSEKEEPI NG	0	44, 438			26, 263	1
10.00	01000 DI ETARY	0	23, 994	(5, 052	15, 956	10.00
10. 01	01001 SNACK BAR	0	0	C	31	0	10. 01
11. 00	01100 CAFETERI A	0	54, 484	(-,	31, 185	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	24, 503		1 1	14, 024	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	29, 103	1	-,	16, 657	1
15.00	01500 PHARMACY	0	26, 768	1		15, 321	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY	0	65, 767			40, 737	1
17.00	01700 SOCIAL SERVICE I NPATIENT ROUTINE SERVICE COST CENTERS	l d	3, 791		1, 047	2, 170	17.00
30. 00	03000 ADULTS & PEDIATRICS	0	271, 058		33, 590	155, 142	30.00
31. 00	03100 I NTENSI VE CARE UNI T	o	115, 094			65, 875	
43.00	04300 NURSERY	0	37, 355			21, 381	1
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	410, 100			234, 725	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	113, 916			65, 201	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	215, 325 102, 833			123, 243 79, 238	
60. 00	06001 BL00D LABORATORY		102, 633			74, 230	1
65. 00	06500 RESPI RATORY THERAPY		25, 243			14, 448	1
66. 00	06600 PHYSI CAL THERAPY	0	120, 573			69, 011	1
66. 01	06601 CARDI AC REHAB	0	63, 453	(2, 899	36, 318	66. 01
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	1, 203	0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	C		0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		,	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			0	1
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			24, 310		73.00
90.00	09000 CLI NI C	0	0		1, 186	0	
	09100 EMERGENCY	0	177, 369	C	21, 626	101, 519	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT		0				92.00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES		100, 739		28, 010	57, 659	95. 00
	09910 CORF	0	100, 739 N			37, 639	1
	10100 HOME HEALTH AGENCY		3, 579				101. 00
	SPECIAL PURPOSE COST CENTERS	-1				22/ 21 2	1
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	387		3, 678		116. 00
118. 00		0	4, 581, 161	(446, 533	1, 242, 514	118. 00
100.00	NONREI MBURSABLE COST CENTERS		0			0	100.00
	19000 GIFT FLOWER COFFEE SHOP & CAN 19100 RESEARCH	0	0		1		190. 00 191. 00
	19100 RESEARCH 19200 PHYSICIANS PRIVATE OFFICES		232, 277		6, 371	479, 282	
	19201 DEKALB MEDICAL SERVICES		69, 272		109, 617	236, 286	
	19202 PHARMACARE	o	0,7,2,2		52, 911		192. 02
	19300 NONPALD WORKERS		0		o o		193. 00
	07950 OTHER NONREIMBURSABLE COST CENT	0	0	(o o		194. 00
	07951 ADULT DAY CARE	0	0	(0		194. 01
	07952 FOUNDATION	0	0	(103	0	194. 02
200.00	1 1		0		, ,	^	200.00
201. 00 202. 00		0	4, 882, 710		615, 535		201.00
202.00	1.01/12 (3011 11/103 110 201)	· 9	1, 302, 710	1	, 015, 555	1, 730, 302	1202.00

| Peri od: | Worksheet B | From 10/01/2013 | Part II | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
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					To	09/30/2014	Date/Time Pre 2/25/2015 12:	
		Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	23 piii
			LINEN SERVICE 8.00	9. 00	10.00	10. 01	11. 00	
	GENER	AL SERVICE COST CENTERS	8.00	7.00	10.00	10.01	11.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
1. 01 1. 02		MAC WEST - NEW NORTH ANNEX - NEW						1. 01 1. 02
1.02		GARRETT CLINIC - NEW						1. 02
1. 04		BUTLER - NEW						1. 04
1.05	1	MAC EAST - NEW						1. 05
1.06		GARRETT LAB - NEW						1.06
1. 07 1. 08	1	MEDICAL ARTS - NEW DAY SPRING - NEW						1. 07 1. 08
2. 00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	46, 860					7. 00 8. 00
9. 00	1	HOUSEKEEPING	46, 860 2, 719	l				9. 00
10.00	1	DI ETARY	0	723	45, 725			10.00
10. 01	1	SNACK BAR	0	0	0	31		10. 01
11.00		CAFETERI A	0	1, 414	0	31	93, 786	1
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	636 755	0	0	2, 473 1, 194	1
15. 00	1	PHARMACY	0	694	0	ol	1, 757	1
16. 00	1	MEDICAL RECORDS & LIBRARY	0	1, 847	0	o	4, 483	1
17. 00		SOCIAL SERVICE	0	98	0	0	305	17. 00
20.00		ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	17, 548	7, 032	36, 144	ol	11 242	30. 00
30. 00 31. 00		INTENSIVE CARE UNIT	4, 307			o	11, 262 5, 004	1
43. 00	1	NURSERY	601	969	· ·	Ö	1, 057	1
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	6, 924			0	7, 790	1
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0 4, 800	2, 955 5, 586		0	2, 171 7, 830	1
60.00		LABORATORY	4, 000	3, 592	o o	o	7, 803	1
60. 01	06001	BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00	1	RESPI RATORY THERAPY	479		0	0	0	65.00
66. 00 66. 01		PHYSI CAL THERAPY	942 158		0	0	1, 876 953	1
69. 00		CARDI AC REHAB ELECTROCARDI OLOGY	130	1, 646	0	0	521	1
70. 00	1	ELECTROENCEPHALOGRAPHY	0	Ö	Ö	Ö	0	1
71. 00		MEDICAL SUPPLIES CHARGED TO PAT	0	0	- 1	O	0	
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	1
73. 00		DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	0	0	0	U	0	73. 00
90.00		CLINIC	278	0	0	0	378	90. 00
91. 00		EMERGENCY	6, 947	4, 602	0	o	6, 152	1
92. 00		OBSERVATION BEDS (NON-DISTINCT						92. 00
95 00		REI MBURSABLE COST CENTERS AMBULANCE SERVI CES	632	2, 614	O	ol	7 760	95. 00
99. 10			0			Ö	0	1
	10100	HOME HEALTH AGENCY	0	1, 662	0	0	5, 598	101. 00
440.00		AL PURPOSE COST CENTERS		Г		T		
		I NTEREST EXPENSE HOSPI CE	18	180	0	0	506	113. 00 116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	46, 353			31		118. 00
		MBURSABLE COST CENTERS					.,	
	1	GIFT FLOWER COFFEE SHOP & CAN	0	0	-	0		190. 00
		RESEARCH PHYSICIANS PRIVATE OFFICES	0	0 21, 725		0		191. 00 192. 00
		DEKALB MEDICAL SERVICES	507	10, 710		0		192. 00
		PHARMACARE	0	0	Ö	ō		192. 02
	1	NONPALD WORKERS	0	0	0	o		193. 00
		OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194. 00
		ADULT DAY CARE FOUNDATION	0	0	0	0		194. 01 194. 02
200.00		Cross Foot Adjustments	0			ď	140	200. 00
201.00		Negative Cost Centers	0	0	0	o		201. 00
202. 00)	TOTAL (sum lines 118-201)	46, 860	86, 848	45, 725	31	93, 786	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045

Peri od: Worksheet B From 10/01/2013 Part II To 09/30/2014 Date/Time Prepared:

2/25/2015 12:25 pm Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE RECORDS & ADMI NI STRATI ON SERVICES & **SUPPLY** LI BRARY 13.00 15.00 17.00 14.00 16,00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 MAC WEST - NEW 1.01 1.01 1.02 00102 NORTH ANNEX - NEW 1.02 1.03 00103 GARRETT CLINIC - NEW 1.03 00104 BUTLER - NEW 1.04 1.04 1.05 00105 MAC EAST - NEW 1.05 00106 GARRETT LAB - NEW 1.06 1.06 1.07 00107 MEDICAL ARTS - NEW 1.07 1.08 00108 DAY SPRING - NEW 1.08 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 10.01 01001 SNACK BAR 10.01 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 53, 178 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1,505 53, 191 14.00 01500 PHARMACY 51, 993 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 C 0 122, 623 16.00 17.00 01700 SOCIAL SERVICE 385 0 0 7,796 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 7, 796 30 00 14 202 n 12 268 30.00 03100 INTENSIVE CARE UNIT 0 31.00 6,308 0 5,000 0 31.00 43.00 04300 NURSERY 1, 332 0 1, 229 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 9, 822 50.00 0 0 25, 442 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 2,739 0 2, 538 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 22, 076 0 54.00 60 00 06000 LABORATORY 955 Ω 0 20, 262 0 60 00 06001 BLOOD LABORATORY 0 60.01 0 0 0 60.01 06500 RESPIRATORY THERAPY 0 0 0 3, 101 0 65.00 65.00 0 06600 PHYSI CAL THERAPY 66.00 0 0 4,027 0 66.00 66.01 06601 CARDI AC REHAB Ω 0 457 0 66 01 0 69.00 06900 ELECTROCARDI OLOGY C 0 980 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 1, 412 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 53, 191 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 72 00 C 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 51, 993 18 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 477 401 90.00 0 0 09100 EMERGENCY 0 91.00 91.00 7.759 C 11, 113 Ω 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 0 0 99. 10 |09910 CORF 0 99. 10 Λ Ω 0 Ω 101.00 10100 HOME HEALTH AGENCY 7,058 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 636 0 708 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 53.178 53, 191 51, 993 111,032 7, 796 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 190 00 0 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 0 0 0 0 192. 01 19201 DEKALB MEDICAL SERVICES 0 0 11, 591 0 192, 01 192. 02 19202 PHARMACARE C 0 0 192. 02 0 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194. 00 07950 OTHER NONREIMBURSABLE COST CENT 0 0 0 0 194.00 0 194. 01 07951 ADULT DAY CARE 0 0 0 194, 01 C 194. 02 07952 FOUNDATION 0 0 0 194. 02 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118-201) 7, 796 202. 00 202.00 53, 178 53, 191 51, 993 122, 623

| Peri od: | Worksheet B | From 10/01/2013 | Part II | To 09/30/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 150045

				To 09/30/2014	Date/Ti me Prepared: 2/25/2015 12: 25 pm
Cost Center Description	Subtotal	Intern &	Total		272072010 12.20 piii
		Residents Cost & Post			
		Stepdown			
	24.00	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS	24.00	23.00	20.00		
1. 00 00100 CAP REL COSTS-BLDG & FLXT					1.00
1.01 00101 MAC WEST - NEW 1.02 00102 NORTH ANNEX - NEW					1. 01
1. 03 00103 GARRETT CLINIC - NEW					1. 02
1. 04 00104 BUTLER - NEW					1. 04
1.05 00105 MAC EAST - NEW					1. 05
1. 06 00106 GARRETT LAB - NEW					1.06
1. 07 00107 MEDI CAL ARTS - NEW 1. 08 00108 DAY SPRI NG - NEW					1. 07
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8. 00 9. 00
10. 00 01000 DI ETARY					10.00
10. 01 01001 SNACK BAR					10. 01
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY					14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16.00
17. 00 01700 SOCI AL SERVI CE					17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	_				
30. 00 03000 ADULTS & PEDI ATRI CS	566, 042	l e			30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	229, 748 68, 052	l e			31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	08, 032	2 0	00, 0	002	43.00
50. 00 05000 OPERATING ROOM	738, 716	5 0	738, 7	716	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	198, 464	l e			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	419, 286	l e			54.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	258, 905	ı		905 0	60.00
65. 00 06500 RESPIRATORY THERAPY	50, 854	٥ ا	1	9	65. 00
66. 00 06600 PHYSI CAL THERAPY	214, 904	4 0	214, 9	904	66. 00
66. 01 06601 CARDI AC REHAB	105, 884	1			66. 01
69. 00 06900 ELECTROCARDI OLOGY	2, 704	1			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	4, 336 74, 242	1			70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 135	l .			72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	76, 321	1	76, 3	321	73. 00
OUTPATIENT SERVICE COST CENTERS	1				
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	2, 720	l e			90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	337, 087	7 O	1	J87	91. 00
OTHER REIMBURSABLE COST CENTERS			I.	L	72.00
95. 00 09500 AMBULANCE SERVICES	197, 414	ı		414	95. 00
99. 10 09910 CORF	74 046	0	1	0	99. 10
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	71, 249	9 0	71, 2	249	101. 00
113. 00 11300 NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE	10, 082	2 0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 635, 145	5 0	3, 635, 1	145	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN			ı		100.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 191.00 19100 RESEARCH				0	190. 00 191. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	741, 431	0	741, 4	431	192. 00
192.01 19201 DEKALB MEDICAL SERVICES	452, 974		452, 9		192. 01
192. 02 19202 PHARMACARE	52, 911	.	52, 9		192. 02
193. 00 19300 NONPALD WORKERS 194. 00 07950 OTHER NONRELMBURSABLE COST CENT		-		0	193. 00 194. 00
194.00 07950 01HER NONRETMBURSABLE COST CENT 194.01 07951 ADULT DAY CARE				0	194. 00
194. 02 07952 FOUNDATI ON	249	9 0	1	249	194. 02
200.00 Cross Foot Adjustments		l .		0	200. 00
201.00 Negative Cost Centers	(0		0	201. 00
202.00 TOTAL (sum lines 118-201)	4, 882, 710	0	4, 882, 7	/ 10	202. 00

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 150045

Peri od: Worksheet B-1 From 10/01/2013 To 09/30/2014 Date/Time Prepared:

2/25/2015 12:25 pm CAPITAL RELATED COSTS BLDG & FIXT MAC WEST - NEW NORTH ANNEX - GARRETT CLINIC BUTLER - NEW Cost Center Description (SOUARE FEET) NFW (SOUARE FEET) NEW (SQUARE FEET) (SQUARE FEET) (SQUARE FEET) 1.04 1.00 1.01 1.02 1.03 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 199, 511 1.00 00101 MAC WEST - NEW 16, 334 1.01 1.01 0 1.02 00102 NORTH ANNEX - NEW 0 3,072 1.02 00103 GARRETT CLINIC - NEW 1.03 0 0 0 0 3, 750 1.03 00104 BUTLER - NEW 4, 977 1.04 0 1.04 0 00105 MAC EAST - NEW 0 1.05 0 Ω 1.05 1.06 00106 GARRETT LAB - NEW 0 C 0 0 0 1.06 1.07 00107 MEDICAL ARTS - NEW 0 0 0 0 1.07 C o 00108 DAY SPRING - NEW 0 0 1 08 0 1 08 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 25, 743 0 0 0 5.00 00700 OPERATION OF PLANT 7 00 80 191 2 931 0 7 00 0 8.00 00800 LAUNDRY & LINEN SERVICE 1, 194 0 0 8.00 00900 HOUSEKEEPI NG 9.00 1,909 0 0 0 0 0 0 0 9.00 01000 DI ETARY 10 00 1,002 Ω 0 10 00 10.01 01001 SNACK BAR 0 10.01 01100 CAFETERI A 2, 357 11.00 11.00 0 13.00 01300 NURSING ADMINISTRATION 1,060 0 13.00 0 01400 CENTRAL SERVICES & SUPPLY 0 1, 259 14 00 Ω 0 14 00 0 15.00 01500 PHARMACY 1, 158 0 0 0 15.00 2, 795 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 164 0 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 726 0 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 4,979 0 31.00 04300 NURSERY 43.00 1.616 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 741 0 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 4, 928 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 9.315 0 0 0 54.00 0 06000 LABORATORY 0 60.00 4, 189 664 784 352 60.00 06001 BLOOD LABORATORY 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 1,092 0 0 0 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 5, 216 66.00 0 0 06601 CARDI AC REHAB 66.01 2.745 C 0 66.01 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 Λ 71.00 Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 7,673 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 4, 358 0 0 0 95.00 0 09910 CORF 0 99. 10 99. 10 C 0 0 0 101.00 10100 HOME HEALTH AGENCY 2.772 0 101.00 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 300 0 116.00 118 00 SUBTOTALS (SUM OF LINES 1-117) 194, 410 3.595 3.072 784 352 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00 0 191.00 191. 00 19100 RESEARCH 0 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 5.101 11, 632 0 0 192 00 0 0 192. 01 19201 DEKALB MEDICAL SERVICES 1, 107 2, 966 4, 625 192. 01 192. 02 19202 PHARMACARE 0 0 0 192. 02 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194.00 07950 OTHER NONREIMBURSABLE COST CENT 0 0 194 00 0 Ω 194.01 07951 ADULT DAY CARE 0 0 0 0 0 194. 01 194. 02 07952 FOUNDATI ON 0 194. 02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 11, 914 202. 00 4, 611, 891 25, 115 3, 966 19, 781 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 23. 115974 1. 537590 1. 291016 5. 274933 2. 393812 203. 00 Cost to be allocated (per Wkst. B, 204. 00 204.00 Part II)

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 10/01/2013		nonod.
				To 09/30/2014	Date/Time Pre 2/25/2015 12:	25 pm
		CAP	ITAL RELATED (COSTS		
Cost Center Description	BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX -	GARRETT CLINIC	BUTLER - NEW	
	(SQUARE FEET)		NEW	- NEW	(SQUARE FEET)	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
	1. 00	1. 01	1. 02	1. 03	1. 04	
205.00 Unit cost multiplier (Wkst. B, Part						205. 00
		l	l		l	I

Provider CCN: 150045

| Period: | Worksheet B-1 | | From 10/01/2013 | | Date/Time Prepared: | 2/25/2015 12: 25 pm | |

			CAP	TTAL RELATED CO	OSTS	2/25/2015 12:	
		MAG FACT NEW				I MUDIE FOLLIE	
	Cost Center Description	MAC EAST - NEW	NEW NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	MVBLE EQUIP (SQUARE FEET)	
		(SQUARE FEET) 1.05	(SQUARE FEET) 1.06	(SQUARE FEET) 1.07	(SQUARE FEET) 1.08	2.00	
	GENERAL SERVICE COST CENTERS	1.05	1.00	1.07	1.00	2.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT 00101 MAC WEST - NEW						1.00
1. 01 1. 02	00102 NORTH ANNEX - NEW						1. 01 1. 02
1.03	00103 GARRETT CLINIC - NEW						1. 03
1. 04 1. 05	OO104 BUTLER - NEW OO105 MAC EAST - NEW	37, 481					1. 04 1. 05
1.05	00106 GARRETT LAB - NEW	37, 461	0				1.05
1.07	00107 MEDICAL ARTS - NEW	0	0	8, 575			1. 07
1. 08 2. 00	00108 DAY SPRING - NEW 00200 CAP REL COSTS-MVBLE EQUIP	0	0	0	0	199, 511	1. 08 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	177, 511	1
5.00	00500 ADMINISTRATIVE & GENERAL	5, 019		0	_	,	1
7. 00 8. 00	OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE	11, 140	0	680 0		007.7.	
9. 00	00900 HOUSEKEEPI NG	76	Ö	Ö	_		1
10. 00	01000 DI ETARY	204		0	_	1, 002	1
10. 01 11. 00	01001 SNACK BAR 01100 CAFETERI A	0	0	0	0	0 2, 357	
	01300 NURSING ADMINISTRATION				0		1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	1, 259	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 284	0	0	0		1
	01700 SOCIAL SERVICE	0		0	_		1
	INPATIENT ROUTINE SERVICE COST CENTERS		Ī	I			1
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0					1
43. 00	04300 NURSERY	0		•			1
	ANCILLARY SERVICE COST CENTERS		I _	T -			1
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C			0			1
	06000 LABORATORY	0	0	0	_	4, 189	•
60. 01 65. 00	06001 BL00D LABORATORY 06500 RESPI RATORY THERAPY	0	0	0	0	0 1, 092	
66. 00	06600 PHYSI CAL THERAPY	0		0	0		•
66. 01	06601 CARDI AC REHAB	0	0	0	0	2, 745	•
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	Ö	0	Ö	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1	0		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
90. 00	09000 CLINIC	0	0	0	0	0	90.00
	09100 EMERGENCY	0	0	0	0	7, 673	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	4, 358	95. 00
	09910 CORF	0					
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0] 0	101. 00
113.00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0		•			116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	16, 723	0	680	0	194, 410]118.00
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190. 00
	19100 RESEARCH	12.047	0	0	_		191.00
	19200 PHYSICIANS PRIVATE OFFICES 19201 DEKALB MEDICAL SERVICES	12, 947 7, 811		6, 545 1, 350			192. 00 192. 01
192. 02	19202 PHARMACARE	0		0	0	0	192. 02
	19300 NONPALD WORKERS 07950 OTHER NONRELMBURSABLE COST CENT	0	0	0	0		193. 00 194. 00
	07951 ADULT DAY CARE				0		194. 00
194. 02	07952 FOUNDATI ON	0	0	0	0	0	194. 02
200. 00 201. 00	, ,	1					200. 00
201.00	9	152, 791	0	57, 252	0	0	201.00
	Part I)						
203. 00 204. 00		4. 076492	0. 000000	6. 676618	0. 000000	0. 000000	203. 00
201.00	Part II)						-555

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				rom 10/01/2013 o 09/30/2014		pared: 25 pm
	CAPITAL RELATED COSTS					
Cost Center Description	MAC EAST - NEW	GARRETT LAR -	MEDICAL ARTS -	DAY SPRING -	MVBLE EQUIP	
odst deliter bescription	WING EAST IVEW	NEW	NEW	NEW	(SQUARE FEET)	
	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
	1.05	1.06	1.07	1. 08	2. 00	
205.00 Unit cost multiplier (Wkst. B, Part						205. 00

Health Fina	ncial Systems	DEKALB MEMORIAL HOSPITAL In Lieu of Form					
COST ALLOCA	TION - STATISTICAL BASIS		Provi der	1	Period: From 10/01/2013 Fo 09/30/2014		pared:
	Cost Center Description	EMPLOYEE REBENEFITS DEPARTMENT (UNADJUSTED SALARY)	econciliation	ADMINISTRATIVI & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	·
		4.00	5A	5. 00	7. 00	8. 00	
1. 00 00100 1. 01 00100 1. 02 00100 1. 03 00100 1. 04 00100 1. 05 00100 1. 06 00100	RAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT MAC WEST - NEW NORTH ANNEX - NEW GARRETT CLINIC - NEW MAC EAST - NEW GARRETT LAB - NEW MEDICAL ARTS - NEW						1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07
2. 00 00200 4. 00 00400 5. 00 00500 7. 00 00700 8. 00 00800 9. 00 01000 10. 01 01000 11. 00 01100 13. 00 01300 14. 00 01400 15. 00 01500 16. 00 01600 17. 00 01700	B DAY SPRING - NEW CAP REL COSTS-MVBLE EQUIP DEMPLOYEE BENEFITS DEPARTMENT DADMINISTRATIVE & GENERAL DOPERATION OF PLANT DLAUNDRY & LINEN SERVICE DHOUSEKEEPING DIETARY I SNACK BAR DCAFETERIA DNURSING ADMINISTRATION DCENTRAL SERVICES & SUPPLY DPHARMACY DMEDICAL RECORDS & LIBRARY DSOCIAL SERVICE	24, 663, 796 3, 242, 465 560, 927 73, 073 566, 162 185, 994 25, 918 339, 179 669, 622 123, 313 500, 292 535, 786 62, 993	-8, 108, 466 0 0 0 0 0 0 0 0 0	3, 838, 82 266, 29- 1, 032, 42 388, 46 2, 38 512, 966 887, 41 305, 80 573, 01-	1 147, 996 4 1, 194 7 1, 985 5 1, 206 0 2, 357 7 1, 060 2 1, 259 4 1, 158 7 3, 079	311, 386 18, 065 0 0 0 0 0 0	9. 00 10. 00 10. 01 11. 00 13. 00 14. 00 15. 00 16. 00
30. 00 03000 31. 00 03100 43. 00 04300	D ADULTS & PEDIATRICS DINTENSIVE CARE UNIT DINURSERY	1, 788, 162 895, 726 205, 488	0 0 0	1, 198, 92	4, 979	28, 617	31.00
50. 00 05000 52. 00 05200 54. 00 05400 60. 01 06000 65. 00 06500 66. 01 06600 66. 01 06600 69. 00 07000 71. 00 07100 72. 00 07200 73. 00 07300 0UTPA	LARY SERVICE COST CENTERS DOPERATING ROOM DELIVERY ROOM & LABOR ROOM DRADIOLOGY-DIAGNOSTIC DLABORATORY BLOOD LABORATORY RESPIRATORY THERAPY PHYSICAL THERAPY CARDIAC REHAB DELECTROCARDIOLOGY DELECTROENCEPHALOGRAPHY DMEDICAL SUPPLIES CHARGED TO PAT DIMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	1, 565, 693 422, 688 1, 563, 158 1, 319, 849 0 0 294, 113 141, 068 72, 337 0 0	0 0 0 0 0 0 0 0 0	3, 108, 23' 3, 400, 12' 532, 68 1, 179, 98 222, 91: 92, 49' 224, 83: 1, 618, 58: 625, 45: 1, 869, 11'	5 4, 928 9, 315 7 5, 989 0 1 1, 092 6 5, 216 3 2, 745 9 0 2 0 2 0	0 31, 896 0 0 3, 185 6, 258 1, 052 0 0 0	52. 00 54. 00 60. 00 60. 01 65. 00 66. 01 69. 00 70. 00 71. 00 72. 00 73. 00
91. 00 09100 92. 00 09200	D CLINIC D EMERGENCY D OBSERVATION BEDS (NON-DISTINCT R REIMBURSABLE COST CENTERS	64, 764 1, 193, 861	0			1, 849 46, 166	1
95. 00 09500 99. 10 09910 101. 00 10100	O AMBULANCE SERVICES	1, 127, 948 0 877, 480	0 0 0	2, 153, 58 (1, 282, 23	0	0	95. 00 99. 10 101. 00
116. 00 11600 118. 00	INTEREST EXPENSE HOSPICE SUBTOTALS (SUM OF LINES 1-117) EIMBURSABLE COST CENTERS	109, 138 18, 527, 197	0 -8, 108, 466	282, 81, 34, 332, 78			113. 00 116. 00 118. 00
190. 00 1900 191. 00 1910 192. 00 1920 192. 01 1920 192. 02 1920 193. 00 1930 194. 00 0795 194. 01 0795	GIFT FLOWER COFFEE SHOP & CAN	0 0 104, 111 5, 635, 194 394, 931 0 0 0 2, 363	0 0 0 0 0 0 0	489, 84 8, 429, 82: 4, 068, 21! 7, 95:	3 17, 859 5 0 0 0 0 0 0 0	0 0 3, 369 0 0 0 0	190. 00 191. 00 192. 00 192. 01 192. 02 193. 00 194. 00 194. 01 194. 02 200. 00 201. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 091854 0		0. 17132: 615, 53	30. 382571	1. 118204	

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				rom 10/01/2013 o 09/30/2014		narodi
			'	0 09/30/2014	Date/Time Pre 2/25/2015 12:	
Cost Center Description	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	
	BENEFITS		& GENERAL	PLANT	LINEN SERVICE	
	DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	
	(UNADJUSTED				LAUNDRY)	
	SALARY)					
	4.00	5A	5. 00	7. 00	8. 00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000		0. 013006	13. 230641	0. 150488	205. 00

Heal th Financial Systems

DEKALB MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045
From 10/01/2013
To 09/30/2014

Date/Time Prepared: 2/25/2015 12: 25 pm

Cost Center Description

HOUSEKEEPING (SQUARE FEET) (MEALS SERVED) (MEALS SERVED) (FTES)

NURSING ADMINISTRATION (DIRECT NRS)

					10	09/30/2014	Date/lime Pre 2/25/2015 12:	
		Cost Center Description	HOUSEKEEPI NG	DIETARY	SNACK BAR	CAFETERI A	NURSI NG	
			(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	(FTES)	ADMI NI STRATI ON	
							(DI RECT NRS	
			0.00	10. 00	10.01	11 00	1 NG)	
	GENER	AL SERVICE COST CENTERS	9. 00	10.00	10. 01	11. 00	13. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1.01		MAC WEST - NEW						1. 01
1.02	1	NORTH ANNEX - NEW						1. 02
1. 03 1. 04		GARRETT CLINIC - NEW BUTLER - NEW						1. 03 1. 04
1. 05		MAC EAST - NEW						1. 05
1.06	00106	GARRETT LAB - NEW						1. 06
1.07		MEDICAL ARTS - NEW						1. 07
1. 08 2. 00	1	DAY SPRING - NEW CAP REL COSTS-MVBLE EQUIP						1. 08 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00		ADMINISTRATIVE & GENERAL						5. 00
7.00	1	OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE	144 017					8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	144, 817 1, 206	23, 381				9. 00 10. 00
10. 01	1	SNACK BAR	0	0	1			10. 01
11. 00	01100	CAFETERI A	2, 357	0	1	30, 795		11. 00
13. 00		NURSING ADMINISTRATION	1, 060		0	812	288, 028	1
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	1, 259	1	0	392 577	8, 152 0	14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	1, 158 3, 079			1, 472	0	16. 00
17. 00		SOCIAL SERVICE	164	ő		100	2, 085	•
		IENT ROUTINE SERVICE COST CENTERS	I					
30.00	1	ADULTS & PEDIATRICS	11, 726			3, 698	76, 927	1
31. 00 43. 00		INTENSIVE CARE UNIT NURSERY	4, 979 1, 616			1, 643 347	34, 165 7, 212	1
10.00		LARY SERVICE COST CENTERS	1,010	<u> </u>	o _l	017	7,212	10.00
50.00	1	OPERATING ROOM	17, 741	0		2, 558	53, 200	1
52. 00		DELIVERY ROOM & LABOR ROOM	4, 928		-	713	14, 835	1
54. 00 60. 00	1	RADI OLOGY-DI AGNOSTI C LABORATORY	9, 315 5, 989		0	2, 571 2, 562	0 5, 170	54. 00 60. 00
60. 01		BLOOD LABORATORY	0	0	o	2, 302	0,170	60. 01
65. 00		RESPI RATORY THERAPY	1, 092	0	0	0	0	65. 00
66. 00	1	PHYSI CAL THERAPY	5, 216	l	-	616	0	66. 00
66. 01 69. 00		CARDI AC REHAB ELECTROCARDI OLOGY	2, 745	0	0	313 171	0	66. 01 69. 00
70.00		ELECTROCARDI OLOGI	0	0	0	0	0	70.00
71.00	1	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71. 00
72. 00	1	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
90. 00		TIENT SERVICE COST CENTERS	0	0	0	124	2 584	90. 00
		EMERGENCY	7, 673			2, 020	42, 023	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT						92.00
05 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	4 250			2 540	0	05.00
95. 00 99. 10	09910	l control of the cont	4, 358 0	0	0	2, 548 0	0 0	95. 00 99. 10
		HOME HEALTH AGENCY	2, 772			1, 838		101.00
		AL PURPOSE COST CENTERS	I					
		I NTEREST EXPENSE HOSPI CE	300	0	0	144	2 447	113. 00 116. 00
118.00	1	SUBTOTALS (SUM OF LINES 1-117)	300 90, 733		0	166 25, 241	288, 028	
		I MBURSABLE COST CENTERS	707.00	20,001		20,211	200, 020	
		GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190. 00
		RESEARCH	0	0	0	0		191. 00
		PHYSICIANS PRIVATE OFFICES DEKALB MEDICAL SERVICES	36, 225 17, 859		0	583 4, 923		192. 00 192. 01
		PHARMACARE	0	ő	Ö	0		192. 02
		NONPALD WORKERS	0	0	0	0		193. 00
		OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194. 00
		ADULT DAY CARE FOUNDATION	0	0	0	0 48		194. 01 194. 02
200.00		Cross Foot Adjustments				40		200. 00
201.00	1	Negative Cost Centers						201. 00
202.00)	Cost to be allocated (per Wkst. B,	1, 289, 814	502, 400	2, 789	696, 236	1, 099, 457	202. 00
203.00		Part Unit cost multiplier (Wkst. B, Part	8. 906510	21. 487533	2, 789. 000000	22. 608735	3. 817188	303 00
203.00		Cost to be allocated (per Wkst. B,	86, 848			93, 786		203. 00
		Part II)				2, 130		

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 10/01/2013		
				To 09/30/2014	Date/Time Pre 2/25/2015 12:	pared: 25 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	NURSI NG	
	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED) (FTES)	ADMI NI STRATI ON	
					(DI RECT NRS	
					I NG)	
	9.00	10.00	10. 01	11. 00	13. 00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 599709	1. 955648	31. 00000	0 3. 045494	0. 184628	205. 00
11)						

COST ALLOCA	TION - STATISTICAL BASIS		Provi der		eriod: rom 10/01/2013	Worksheet B-1	
					09/30/2014	Date/Time Pre	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	2/25/2015 12:	25 pm
	'	SERVICES &	(COSTED	RECORDS &			
		SUPPLY (COSTED	REQUI S.)	LI BRARY (GROSS REVE	(TIME SPENT)		
		REQUIS.)		NUE)			
lo ENE	ALL OFFICE COOT OFFITED	14.00	15. 00	16. 00	17. 00		
	RAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
	1 MAC WEST - NEW						1. 00
	NORTH ANNEX - NEW						1. 02
l l	3 GARRETT CLINIC - NEW						1.03
1	4 BUTLER - NEW 5 MAC EAST - NEW						1. 04 1. 05
	6 GARRETT LAB - NEW						1. 06
	7 MEDICAL ARTS - NEW						1. 07
1	B DAY SPRING - NEW D CAP REL COSTS-MVBLE EQUIP						1. 08 2. 00
	DEMPLOYEE BENEFITS DEPARTMENT						4.00
1	DADMINISTRATIVE & GENERAL						5. 00
	OPERATION OF PLANT						7. 00
	D LAUNDRY & LINEN SERVICE D HOUSEKEEPING						8. 00 9. 00
	D DI ETARY						10.00
	1 SNACK BAR						10. 01
1	O CAFETERI A						11.00
	O NURSING ADMINISTRATION O CENTRAL SERVICES & SUPPLY	100					13.00
1	D PHARMACY	0	100				15. 00
1	MEDICAL RECORDS & LIBRARY	O	0	103, 617, 181			16. 00
	D SOCIAL SERVICE FIENT ROUTINE SERVICE COST CENTERS	0	0		100		17. 00
	D ADULTS & PEDIATRICS	O	0	10, 370, 365	100		30.00
	INTENSIVE CARE UNIT	O	0	4, 226, 284	0		31. 00
	D NURSERY LLARY SERVICE COST CENTERS	0	0	1, 039, 220	0		43. 00
	O OPERATING ROOM	O	0	21, 468, 206	0		50.00
52. 00 0520	DELIVERY ROOM & LABOR ROOM	O	0	2, 145, 142		i e	52. 00
1	O RADI OLOGY-DI AGNOSTI C	0	0	18, 661, 013			54.00
	D LABORATORY 1 BLOOD LABORATORY	0	0	17, 127, 841			60.00
1	RESPI RATORY THERAPY	o	0	2, 621, 276			65. 00
	PHYSI CAL THERAPY	O	0	3, 404, 275			66. 00
	1 CARDI AC REHAB D ELECTROCARDI OLOGY	0	0	386, 689 828, 581			66. 01 69. 00
	D ELECTROCARDI OLOGI D ELECTROENCEPHALOGRAPHY		0	1, 193, 725			70.00
	MEDICAL SUPPLIES CHARGED TO PAT	100	0	C			71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	0	0	C 45 444	0		72.00
	DDRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS	0	100	15, 111	0		73. 00
90.00 0900	CLI NI C	0	0	338, 920	0		90.00
	D EMERGENCY	0	0	9, 393, 913	0		91.00
	O OBSERVATION BEDS (NON-DISTINCT R REIMBURSABLE COST CENTERS						92.00
	AMBULANCE SERVICES	0	0	С	0		95. 00
99. 10 09910	CORF	0	0	C			99. 10
101. 00 10100	HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	C	0		101. 00
	INTEREST EXPENSE						113. 00
116. 00 1160		O	0				116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) EIMBURSABLE COST CENTERS	100	100	93, 819, 357	100		118. 00
	O GIFT FLOWER COFFEE SHOP & CAN	O	0	C	0		190. 00
191. 00 1910	RESEARCH	0	0	С	0		191. 00
	PHYSICIANS PRIVATE OFFICES	0	0	0.707.024	0		192.00
	1 DEKALB MEDICAL SERVICES 2 PHARMACARE	0	0	9, 797, 824 0	0		192. 01 192. 02
193. 00 1930	NONPALD WORKERS	o	0	Č	0		193. 00
	OTHER NONREIMBURSABLE COST CENT	0	0	C	0		194. 00
	1 ADULT DAY CARE 2 FOUNDATION	0	0		0		194. 01 194. 02
200. 00	Cross Foot Adjustments		U				200.00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	447, 639	729, 726	1, 035, 820	110, 984		202. 00
203. 00	Part Unit cost multiplier (Wkst. B, Part)	4, 476. 390000	7, 297. 260000	0. 009997	1, 109. 840000		203. 00
204. 00	Cost to be allocated (per Wkst. B,	53, 191	51, 993				204. 00
	Part II)						<u> </u>

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 10/01/2013 To 09/30/2014	Date/Time Pre 2/25/2015 12:	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	SERVICES &	(COSTED	RECORDS &			
	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)		
	(COSTED		(GROSS REVE			
	REQUIS.)		NUE)			
	14.00	15. 00	16.00	17. 00		
205.00 Unit cost multiplier (Wkst. B, Part	531. 910000	519. 930000	0. 00118	77. 960000		205. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	Period: Worksheet C From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:

					2/25/2015 12:	
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 605, 226		4, 605, 22	6 0	4, 605, 226	1
31.00 03100 INTENSIVE CARE UNIT	1, 947, 030		1, 947, 03	0	1, 947, 030	
43. 00 04300 NURSERY	485, 474		485, 47	4 0	485, 474	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 220, 627		4, 220, 62		., ===, ==.	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 093, 334		1, 093, 33		1, 093, 334	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 287, 077		4, 287, 07		4, 287, 077	1
60. 00 06000 LABORATORY	4, 466, 835		4, 466, 83	5 0	4, 466, 835	1
60. 01 06001 BL00D LABORATORY	0		1	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	696, 612	0	696, 61	2 0	696, 612	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 642, 034	0	1, 642, 03	4 0	1, 642, 034	66. 00
66. 01 06601 CARDI AC REHAB	381, 070	0	381, 07	0	381, 070	66. 01
69. 00 06900 ELECTROCARDI OLOGY	120, 495		120, 49	5 0	120, 495	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	275, 285		275, 28		275, 285	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	2, 343, 521		2, 343, 52		2, 343, 521	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	732, 606		732, 60	6 0	732, 606	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 919, 210		2, 919, 21	0 0	2, 919, 210	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	124, 937		124, 93	7 0	124, 937	90. 00
91. 00 09100 EMERGENCY	2, 600, 763		2, 600, 76		2, 600, 763	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	629, 107		629, 10	7	629, 107	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 756, 069		2, 756, 06	9 0	2, 756, 069	
99. 10 09910 CORF	0		1	0	0	99. 10
101.00 10100 HOME HEALTH AGENCY	1, 798, 297		1, 798, 29	7	1, 798, 297	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE					l .	113. 00
116. 00 11600 HOSPI CE	366, 087		366, 08		366, 087	1
200.00 Subtotal (see instructions)	38, 491, 696	0	38, 491, 69	6 0	1,,	
201.00 Less Observation Beds	629, 107		629, 10		629, 107	
202.00 Total (see instructions)	37, 862, 589	0	37, 862, 58	9 0	37, 862, 589	202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	Period: Worksheet C From 10/01/2013 Part I
		To 09/30/2014 Date/Time Prepared

					Го 09/30/2014	Date/Time Pre 2/25/2015 12:	pared: 25 pm
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	9, 111, 676		9, 111, 67			30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 886, 417		3, 886, 41			31. 00
43.00	04300 NURSERY	1, 024, 522		1, 024, 52	2		43. 00
	ANCILLARY SERVICE COST CENTERS						
		2, 998, 195	12, 089, 165			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 109, 626	11, 121			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 391, 810	16, 827, 159	18, 218, 96		0.000000	
60.00	06000 LABORATORY	2, 714, 099	17, 082, 167	19, 796, 26		0.000000	
60. 01	06001 BLOOD LABORATORY	0	0		0.000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	1, 578, 512	458, 300	2, 036, 81	0. 342011	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	512, 754	2, 842, 474	3, 355, 22	0. 489396	0.000000	66. 00
66. 01	06601 CARDI AC REHAB	4, 177	376, 521	380, 69	1. 000977	0.000000	66. 01
69.00	06900 ELECTROCARDI OLOGY	161, 404	655, 523	816, 92	0. 147498	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	6, 330	1, 168, 851	1, 175, 18	0. 234249	0.000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 800, 616	3, 550, 798	5, 351, 41	0. 437926	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 757, 743	1, 018, 768	2, 776, 51	0. 263858	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 933, 462	3, 532, 299	5, 465, 76	0. 534090	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	671	281, 792	282, 46	0. 442313	0.000000	90. 00
91.00	09100 EMERGENCY	1, 565, 206	7, 681, 979	9, 247, 18	0. 281249	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	O	1, 408, 120	1, 408, 12	0. 446771	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	4, 747, 624	4, 747, 62	0. 580515	0.000000	95. 00
99. 10	09910 CORF	0	0		ol l		99. 10
101.00	10100 HOME HEALTH AGENCY	0	1, 277, 596	1, 277, 59	6		101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>			·		1
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	35, 613	554, 132	589, 74	5		116. 00
200.00		32, 592, 833	75, 564, 389		1		200. 00
201.00				, . , ,			201. 00
202.00		32, 592, 833	75, 564, 389	108, 157, 22	2		202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1500	From 10/01/2013	Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm

				2/25/2015 12: 25 p)m
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					. 00
31.00 03100 INTENSIVE CARE UNIT				31.	. 00
43. 00 04300 NURSERY				43.	. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 279746			50.	. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 515542			52.	. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 235308			54.	. 00
60. 00 06000 LABORATORY	0. 225640			60.	. 00
60. 01 06001 BLOOD LABORATORY	0. 000000			60.	. 01
65. 00 06500 RESPI RATORY THERAPY	0. 342011			65.	. 00
66. 00 06600 PHYSI CAL THERAPY	0. 489396			66.	. 00
66. 01 06601 CARDI AC REHAB	1. 000977			66.	. 01
69. 00 06900 ELECTROCARDI OLOGY	0. 147498			69.	. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 234249			70.	. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 437926			71.	. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 263858			72.	. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 534090			73.	. 00
OUTPATIENT SERVICE COST CENTERS	·				
90. 00 09000 CLI NI C	0. 442313			90.	. 00
91. 00 09100 EMERGENCY	0. 281249			91.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 446771			92.	. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>				
95. 00 09500 AMBULANCE SERVI CES	0. 580515			95.	. 00
99. 10 09910 CORF				99.	. 10
101.00 10100 HOME HEALTH AGENCY				101.	. 00
SPECIAL PURPOSE COST CENTERS	·				
113. 00 11300 NTEREST EXPENSE				113.	. 00
116. 00 11600 H0SPI CE				116.	. 00
200.00 Subtotal (see instructions)				200.	. 00
201.00 Less Observation Beds				201.	. 00
202.00 Total (see instructions)				202.	
	'			1.	

Health Financial Systems	DEKALB MEMORIAL HOSPITAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der Co		Peri od: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm
•	T1 - 1	241.24		0 1

					10 09/30/2014	2/25/2015 12:	
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ATIENT ROUTINE SERVICE COST CENTERS						
30. 00 030	00 ADULTS & PEDIATRICS	4, 605, 226		4, 605, 22	6 0	4, 605, 226	30. 00
31.00 031	OO INTENSIVE CARE UNIT	1, 947, 030		1, 947, 03	0	1, 947, 030	31.00
43.00 043	00 NURSERY	485, 474		485, 47	4 0	485, 474	43.00
ANC	ILLARY SERVICE COST CENTERS						
50.00 050	OO OPERATING ROOM	4, 220, 627		4, 220, 62	7 0	4, 220, 627	50.00
52. 00 052	OO DELIVERY ROOM & LABOR ROOM	1, 093, 334		1, 093, 33	4 0	1, 093, 334	52. 00
54.00 054	OO RADI OLOGY-DI AGNOSTI C	4, 287, 077		4, 287, 07	7 0	4, 287, 077	54.00
60.00 060	00 LABORATORY	4, 466, 835		4, 466, 83	5 0	4, 466, 835	60.00
60. 01 060	01 BLOOD LABORATORY	0			0	0	60. 01
65. 00 065	00 RESPI RATORY THERAPY	696, 612	0	696, 61	2 0	696, 612	65. 00
66. 00 066	00 PHYSI CAL THERAPY	1, 642, 034	0	1, 642, 03	4 0	1, 642, 034	66. 00
66. 01 066	01 CARDI AC REHAB	381, 070	0	381, 07	0	381, 070	66. 01
69. 00 069	00 ELECTROCARDI OLOGY	120, 495		120, 49	5 0	120, 495	69. 00
70.00 070	00 ELECTROENCEPHALOGRAPHY	275, 285		275, 28	5 0	275, 285	70. 00
71.00 071	OO MEDICAL SUPPLIES CHARGED TO PAT	2, 343, 521		2, 343, 52	1 0	2, 343, 521	71. 00
72. 00 072	OO IMPL. DEV. CHARGED TO PATIENTS	732, 606		732, 60	6 0	732, 606	72. 00
73.00 073	OO DRUGS CHARGED TO PATIENTS	2, 919, 210		2, 919, 21		2, 919, 210	
	PATIENT SERVICE COST CENTERS		•		•		
90. 00 090	OO CLI NI C	124, 937		124, 93	7 0	124, 937	90. 00
91. 00 091	OO EMERGENCY	2, 600, 763		2, 600, 76	3 0	2, 600, 763	1
92. 00 092	OO OBSERVATION BEDS (NON-DISTINCT	629, 107		629, 10		629, 107	
	ER REIMBURSABLE COST CENTERS		<u> </u>				1
	OO AMBULANCE SERVICES	2, 756, 069		2, 756, 06	9 0	2, 756, 069	95. 00
99. 10 099		0			o	0	99. 10
	OO HOME HEALTH AGENCY	1, 798, 297		1, 798, 29	7	1, 798, 297	101.00
	CIAL PURPOSE COST CENTERS	.,,		.,,	- 1	.,,=	1
	00 INTEREST EXPENSE						113. 00
	00 HOSPI CE	366, 087		366, 08	7	366, 087	
200.00	Subtotal (see instructions)	38, 491, 696					
201. 00	Less Observation Beds	629, 107		629, 10		629, 107	
202. 00	Total (see instructions)	37, 862, 589					
_02.00	1.2.2. (300 1.101. 401. 51.0)	0.,002,007	1	0.,002,00	-1	0.,002,007	1-22.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	Peri od: Worksheet C From 10/01/2013 Part I To 09/30/2014 Date/Time Prepared:

				أ	To 09/30/2014	Date/Time Pre 2/25/2015 12:	pared: 25 pm
			Ti t	le XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	9, 111, 676		9, 111, 676	5		30.00
31.00	03100 INTENSIVE CARE UNIT	3, 886, 417		3, 886, 417	7		31.00
43.00	04300 NURSERY	1, 024, 522		1, 024, 522	2		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 998, 195	12, 089, 165	15, 087, 360	0. 279746	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 109, 626	11, 121	2, 120, 747	0. 515542	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 391, 810	16, 827, 159	18, 218, 969	0. 235308	0.000000	54.00
60.00	06000 LABORATORY	2, 714, 099	17, 082, 167	19, 796, 266	0. 225640	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	o	0	(0.000000	0.000000	60. 01
65. 00	06500 RESPI RATORY THERAPY	1, 578, 512	458, 300	2, 036, 812	0. 342011	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	512, 754	2, 842, 474	3, 355, 228	0. 489396	0.000000	66. 00
66. 01	06601 CARDI AC REHAB	4, 177	376, 521	380, 698	1. 000977	0.000000	66. 01
69. 00	06900 ELECTROCARDI OLOGY	161, 404	655, 523	816, 927	0. 147498	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	6, 330	1, 168, 851	1, 175, 18 ²	0. 234249	0.000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 800, 616	3, 550, 798	5, 351, 414	0. 437926	0.000000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 757, 743	1, 018, 768	2, 776, 51 ⁻	0. 263858	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 933, 462	3, 532, 299	5, 465, 76°	0. 534090	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	671	281, 792	282, 463	0. 442313	0.000000	90.00
91. 00	09100 EMERGENCY	1, 565, 206	7, 681, 979	9, 247, 185	0. 281249	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	o	1, 408, 120	1, 408, 120	0. 446771	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0	4, 747, 624	4, 747, 624	0. 580515	0. 000000	95. 00
99. 10	09910 CORF	0	0	(99. 10
101.00	10100 HOME HEALTH AGENCY	0	1, 277, 596	1, 277, 596	5		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	35, 613	554, 132	589, 745	5		116. 00
200.00	Subtotal (see instructions)	32, 592, 833	75, 564, 389	108, 157, 222	2		200.00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	32, 592, 833	75, 564, 389	108, 157, 222	2		202. 00
		·			·		

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150045	From 10/01/2013	Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm

					2/25/2015 12: 2	25 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 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 RESPI RATORY 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					
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	•				
95.00	09500 AMBULANCE SERVICES	0. 000000				95.00
99. 10	09910 CORF					99. 10
101.00	10100 HOME HEALTH AGENCY					101. 00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300 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	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 10/01/2013		
				To 09/30/2014	Date/Time Pre 2/25/2015 12:	
		Ti tl	e XVIII	Hospi tal	PPS	20 piii
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	566, 042	C	566, 04	2 5, 234	108. 15	30. 00
31.00 INTENSIVE CARE UNIT	229, 748		229, 74	8 1, 286	178. 65	31.00
43. 00 NURSERY	68, 052		68, 05	2 996	68. 33	43.00
200.00 Total (lines 30-199)	863, 842		863, 84	2 7, 516		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, 535	166, 010)			30. 00
31.00 INTENSIVE CARE UNIT	474	84, 680)			31. 00
43. 00 NURSERY	0	C)			43. 00
200.00 Total (lines 30-199)	2, 009	250, 690)			200. 00

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10								
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150045	Peri od:	Worksheet D			
				From 10/01/2013				
				To 09/30/2014	Date/Time Pre	pared:		
Cost Center Description	Capi tal	Total Charges			Capital Costs			
cost center bescription		(from Wkst. C,		Program	(column 3 x			
	(from Wkst. B.				column 4)			
	Part II, col.	8)	2)	. onar ges	COT GIIIIT 1)			
	26)							
	1.00	2.00	3.00	4. 00	5. 00			
ANCILLARY SERVICE COST CENTERS	<u> </u>		•	<u>'</u>				
50. 00 05000 OPERATING ROOM	738, 716	15, 087, 360	0. 04896	647, 078	31, 683	50.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	198, 464	2, 120, 747	0. 09358	1, 861	174	52.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	419, 286	18, 218, 969	0. 02301	913, 651	21, 027	54.00		
60. 00 06000 LABORATORY	258, 905	19, 796, 266	0. 01307	78 1, 291, 104	16, 885	60.00		
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	00	0	60. 01		
65. 00 06500 RESPIRATORY THERAPY	50, 854	2, 036, 812	0. 02496	751, 803	18, 770	65. 00		
66. 00 06600 PHYSI CAL THERAPY	214, 904	3, 355, 228	0. 06405	166, 247	10, 648	66. 00		
66. 01 06601 CARDI AC REHAB	105, 884	380, 698	0. 27813	744	207	66. 01		
69. 00 06900 ELECTROCARDI OLOGY	2, 704	816, 927	0. 00331	0 70, 392	233	69. 00		
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 336	1, 175, 181	0.00369	4, 583	17	70. 00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	74, 242	5, 351, 414	0. 01387	73 562, 349	7, 801	71. 00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 135	2, 776, 511	0. 00293	678, 094	1, 987	72. 00		
73.00 07300 DRUGS CHARGED TO PATIENTS	76, 321	5, 465, 761	0. 01396	763, 563	10, 662	73. 00		
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLI NI C	2, 720	282, 463	0.00963	30 0	0	90.00		
91. 00 09100 EMERGENCY	337, 087	9, 247, 185	0. 03645	604, 953	22, 052	91.00		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT	77, 325	1, 408, 120	0. 05491	4 0	0	92.00		
OTHER REIMBURSABLE COST CENTERS								
95. 00 09500 AMBULANCE SERVICES						95. 00		
200.00 Total (lines 50-199)	2, 569, 883	87, 519, 642		6, 456, 422	142, 146	200. 00		

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 10/01/2013 To 09/30/2014	Date/Time Pre 2/25/2015 12:	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	1	0	0	31.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
200.00 Total (lines 30-199)	0	0)	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
		ŕ		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS				·		
30. 00 03000 ADULTS & PEDI ATRI CS	5, 234	0.00	1, 53	5 0		30.00
31.00 03100 INTENSIVE CARE UNIT	1, 286	0.00	47	4 0		31.00
43. 00 04300 NURSERY	996	1	1	0 0		43.00
200.00 Total (lines 30-199)	7, 516	1	2, 00	9 0		200. 00
	•	•	•	•	•	•

llool +b	Financial Customs	DEKALB MEMORI	AL HOCDITAL		وناحا	u of Form CMC	DEED 10
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CCN: 150045	Peri od:	eu of Form CMS-: Worksheet D	2552-10
	H COSTS	VICE UINER PAS	Provider	CCN. 150045	From 10/01/2013		
THROUG	III CUSTS				To 09/30/2014		pared:
						2/25/2015 12:	25 pm
				e XVIII	Hospi tal	PPS	
	Cost Center Description		Nursing School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	9	
		1.00	0.00			4)	
	ANOULLARY CERVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			,	0 0		FO 00
		0		(0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		(0	0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	U	<u>'</u>	0	0	54.00
60.00	06000 LABORATORY	0	U	<u>'</u>	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0]	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0	<u>'</u>	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0)	0	0	66.00
66. 01	06601 CARDI AC REHAB	0	0)	0	0	66. 01
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0	0	70. 00
71. 00	07100 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	07300 DRUGS CHARGED TO PATIENTS	0	0)	0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0)	0 0	0	
91. 00	09100 EMERGENCY	0	0)	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0)	0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0)	0 0	0	200. 00

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PAS	S Provi der		Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Pre 2/25/2015 12:	pared:
Title XVIII Hospital						PPS	20 p
	Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
	·	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0				647, 078	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 120, 747	1		1, 861	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	18, 218, 969			913, 651	54.00
60.00	06000 LABORATORY	0	19, 796, 266			1, 291, 104	1
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	0. 000000	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	2, 036, 812			751, 803	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	3, 355, 228	0.00000	0. 000000	166, 247	66. 00
66. 01	06601 CARDI AC REHAB	0	380, 698			744	66. 01
69. 00	06900 ELECTROCARDI OLOGY	0	816, 927	0.00000	0. 000000	70, 392	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1, 175, 181	0.00000	0. 000000	4, 583	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	5, 351, 414	0.00000	0. 000000	562, 349	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	2, 776, 511	0.00000	0. 000000	678, 094	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5, 465, 761	0.00000	0. 000000	763, 563	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	282, 463	0.00000	0. 000000	0	90.00
91.00	09100 EMERGENCY	0	9, 247, 185	0.00000	0. 000000	604, 953	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	1, 408, 120	0.00000	0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00							95. 00
200.00	Total (lines 50-199)	0	87, 519, 642			6, 456, 422	200. 00

Health Financial Systems	DEKALB MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATI THROUGH COSTS	NT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150045	From 10/01/2013	Worksheet D Part IV Date/Time Prepared:

				'	0 077 007 2011	2/25/2015 12	: 25 pm
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	0utpat	i ent	Outpati ent			
	Program	Progr		Program			
	Pass-Through	Charg	ges	Pass-Through			
	Costs (col. 8			Costs (col. 9			
	x col . 10)		_	x col. 12)			
	11. 00	12. C	00	13. 00			
ANCI LLARY SERVI CE COST CENTERS	T				T		
50. 00 05000 OPERATI NG ROOM	0	2, 1	44, 259	C			50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0		0	C)		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		62, 962)		54.00
60. 00 06000 LABORATORY	0	1, 1	58, 590	C)		60.00
60. 01 06001 BL00D LABORATORY	0		0	C)		60. 01
65. 00 06500 RESPI RATORY THERAPY	0	10	01, 401				65. 00
66. 00 06600 PHYSI CAL THERAPY	0		762				66. 00
66. 01 06601 CARDI AC REHAB	0		43, 846				66. 01
69. 00 06900 ELECTROCARDI OLOGY	0		63, 797				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		64, 521				70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	0		93, 598				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		97, 193				72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	1, 10	09, 349				73. 00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0		67, 588				90.00
91. 00 09100 EMERGENCY	0		09, 587				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT	0	3.	24, 765				92. 00
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVI CES		40 (10.010	_			95. 00
200.00 Total (lines 50-199)	0	10, 6	42, 218	[1		200. 00

Health Financial Systems	DEKALB MEMORIAL H	IOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 150045	Peri od: From 10/01/2013	Worksheet D Part V

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 10/01/2013 To 09/30/2014		
			Ti tl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
	ANOLLI ADV. CEDVI OF COCT. CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0.27074/	2 144 250			F00, 040	FO 00
50.00		0. 279746		ı	0	599, 848	1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0. 515542 0. 235308		1	0	0 767, 801	52. 00 54. 00
60. 00	06000 LABORATORY	0. 235308			0	261, 424	
60. 00	06000 LABORATORY	0. 000000			0	201, 424	1
65. 00	06500 RESPIRATORY THERAPY	0. 342011	101, 401		0	34, 680	
66. 00	06600 PHYSI CAL THERAPY	0. 489396			0	34, 000	
66. 01	06601 CARDI AC REHAB	1. 000977	143, 846	1	0	143, 987	66. 01
69. 00	06900 ELECTROCARDI OLOGY	0. 147498			0	24, 160	
70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0. 234249		1	0 0	61, 964	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 437926			0 0	172, 367	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 263858		1	0 0	52, 031	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 534090		1	0 11, 434		1
	OUTPATIENT SERVICE COST CENTERS		.,,			, , , , , , , , , , , , , , , , , , ,	1
90.00	09000 CLI NI C	0. 442313	67, 588		0 0	29, 895	90.00
91.00	09100 EMERGENCY	0. 281249	1, 309, 587		0 0	368, 320	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 446771	324, 765		0	145, 096	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0. 580515			0		95. 00
200.00	Subtotal (see instructions)		10, 642, 218		0 11, 434	3, 254, 438	200. 00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		10, 642, 218	1	0 11, 434	3, 254, 438	202.00

Health Financial Systems	DEKALB MEMORI	AL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			CCN: 150045		Date/Time Prep 2/25/2015 12:	
			litl	e XVIII	Hospi tal	PPS	
	Cos	sts					
Cost Center Description	Cost Reimbursed Services	Serv	Cost mbursed vices Not				

		11 (1	CAVIII	1103pt tui	113	
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	C	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0				54.00
60. 00 06000 LABORATORY	C	0				60.00
60. 01 06001 BL00D LABORATORY	C	0				60. 01
65. 00 06500 RESPIRATORY THERAPY	C	0				65.00
66. 00 06600 PHYSI CAL THERAPY	C	0				66.00
66. 01 06601 CARDI AC REHAB	C	0				66. 01
69. 00 06900 ELECTROCARDI OLOGY	C	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	C	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	6, 107				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	C	0				90. 00
91. 00 09100 EMERGENCY	C	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	C	0				92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	C)				95. 00
200.00 Subtotal (see instructions)	C	6, 107				200. 00
201.00 Less PBP Clinic Lab. Services-Program	C					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	C	6, 107				202. 00

Health Financial Systems	DEKALB MEMORIAL HO	OSPI TAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 1500	45 Peri od: From 10/01/2013	Worksheet D-1
				Date/Ti me Prepared: 2/25/2015 12:25 pm
		Title XVIII	Hospi tal	PPS

		Ti +Lo VVIII	Hospi tal	2/25/2015 12:	25 pm	
	Cost Center Description	Title XVIII	Hospi tal	PPS		
				1. 00		
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		5, 234	1.00	
2. 00	Inpatient days (including private room days, excluding swing-be			5, 234	2.00	
3.00	Private room days (excluding swing-bed and observation bed days		ivate room days,	0	3. 00	
	do not complete this line.					
4.00	Semi-private room days (excluding swing-bed and observation bed			4, 519	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5. 00	
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becember	51 01 the cost	O	0.00	
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00	
	reporting period			_		
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eycluding	swing_hed and	1, 535	9. 00	
7. 00	newborn days)	the frogram (exertaining	Swifig bed and	1, 555	7. 00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00	
44.00	through December 31 of the cost reporting period (see instructi				44 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00	
	through December 31 of the cost reporting period	only (more acting provide				
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00	
14 00	after December 31 of the cost reporting period (if calendar yea			0	14 00	
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding Swing-bed	days)	0	14. 00 15. 00	
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 services	through December 31 o	f the cost	0. 00	17. 00	
10.00	reporting period	-£t Db 21 -£	*	0.00	10.00	
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18. 00	
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00	
	reporting period					
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	arter December 31 of t	ne cost	0. 00	20. 00	
21. 00	Total general inpatient routine service cost (see instructions)			4, 605, 226	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00	
	5 x line 17)					
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reportin	g period (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00	
	7 x line 19)	·				
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00	
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		4, 605, 226		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			.,		
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31. 00	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00	
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	34.00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	35. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00	
37.00	, ,				37. 00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTS				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		1	070 07	20 00	
38. 00	Adjusted general inpatient routine service cost per diem (see i	•		879.87	38.00	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	-		1, 350, 600 0	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39 +			1, 350, 600		
55	1.112g. a.m. gonor at 1.mpattone routino bot vibo bost (11116 07)		ı	., 555, 566		

<u>Heal</u> th	Financial Systems	DEKALB MEMORI	AL HOSPITAL		In_Lie	eu of Form CMS-2	<u>2552-1</u> 0
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der	CCN: 150045	Peri od: From 10/01/2013	Worksheet D-1	
					To 09/30/2014	Date/Time Pre	
			Ti t	le XVIII	Hospi tal	2/25/2015 12: 2 PPS	25 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Day		÷	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0 0.0			42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	1, 947, 030	1, 28	6 1, 514. ()2 474	717, 645	43.00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			2, 042, 119	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		4, 110, 364	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS	ationt routing	asmiless (fre	m Wka+ D aum	of Donto L and	250, 400	FO 00
30.00	Pass through costs applicable to Program inpa	atrent routine	services (110	III WKSt. D, Suii	I OI PAILS I AIIU	250, 690	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	142, 146	51.00
52. 00	and IV)	EO and E1)				392, 836	52. 00
52.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non-ph	vsician anesth	etist and	3, 717, 528	
00.00	medical education costs (line 49 minus line					0,717,020]
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	3	ng cost and ta	arget amount (line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	borting period	ending 1996,	upuateu anu co	ilipounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62.00 Relief payment (see instructions)						0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ıctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64. 00
	instructions)(title XVIII only)	· ·		•			
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	LonLy). For	0	66. 00
	CAH (see instructions)	,			3,		
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)						
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facility		•				70. 00
71. 00	Adjusted general inpatient routine service co	,		•			71. 00
72.00	,		(1)	. 05)			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.						73.00
75. 00	Capital -related cost allocated to inpatient	•		•	art II, column		75. 00
7, 00	26, line 45)	0)					7, 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
	Inpatient routine service cost (line 74 minus	•					78.00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p					79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		cost limitatio	n (line 78 mir	us line 79)		80.00
81.00	Inpatient routine service cost per drem inm Inpatient routine service cost limitation (I)				82.00
83. 00	Reasonable inpatient routine service costs (* .				83. 00
84. 00	Program inpatient ancillary services (see in		,,,,				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 66	PART IV - COMPUTATION OF OBSERVATION BED PASS] 55. 55
87. 00	Total observation bed days (see instructions))				715	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see					879. 87 629, 107	1
57.00	Topost varion bod cost (Time of A Time oo) (Set	. 111311 UCLI UIIS)				J 027, 107	1 07.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL			In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014	Date/Time Pre	pared:
					2/25/2015 12:	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	566, 042	4, 605, 226	0. 12291	3 629, 107	77, 325	90.00
91.00 Nursing School cost	0	4, 605, 226	0.00000	0 629, 107	0	91.00
92.00 Allied health cost	0	4, 605, 226	0.00000	0 629, 107	0	92.00
93.00 All other Medical Education	0	4, 605, 226	0. 00000	0 629, 107	0	93. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-255		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150045	From 10/01/2013	Worksheet D-1 Date/Time Prep 2/25/2015 12:2	
	Title XIX	Hospi tal	Cost	
0 1 0 1 1 11				

				2/25/2015 12:	25 pm
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			5, 234	1. 00
2.00	Inpatient days (including private room days, excluding swing-be			5, 234	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.			4 540	4 00
4.00	Semi-private room days (excluding swing-bed and observation bed			4, 519	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 or the cost	0	5. 00
	reporting period		21 -6	0	
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after becember	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	21 of the cost	0	7. 00
7.00	reporting period	days) till odgir becember	31 Of the cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber 5	1 of the cost	0	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	450	9. 00
,, 00	newborn days)	the regram (executaring	om ng bou and	100	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	oom davs)	0	10.00
	through December 31 of the cost reporting period (see instructi		<i>,</i>		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, ent	er O on this line)	•		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			996	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	there are December 21 -	E 111	0.00	17 00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through becember 31 o	i the cost	0.00	17. 00
18. 00		after December 31 of	the cost	0.00	18. 00
10.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				10.00
19. 00					19. 00
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			4, 605, 226	
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	1 -6 -1		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	or the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
24.00	7 x line 19)	or or the cost reporti	ing period (Title	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)	3			
26.00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		4, 605, 226	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00	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	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00					
35. 00					35. 00
36. 00					36. 00
37. 00		rrerentiai (iine	4, 605, 226	37. 00	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			879. 87	38. 00
39. 00	Program general inpatient routine service cost per diem (see 1	•		395, 942	
40. 00	Medically necessary private room cost applicable to the Program	,		0	40. 00
	Total Program general inpatient routine service cost (line 39 +	•		395, 942	
	, J.		1		

	Financial Systems	DEKALB MEMORIA		0011		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 10/01/2013		
					To 09/30/2014	Date/Time Pre 2/25/2015 12:	epared: 25 pm
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Innatient Days	Average Per	Program Days	Program Cost (col. 3 x col.	
		•		col . 2)		4)	
42 00	NURSERY (title V & XIX only)	1. 00 485, 474	2. 00 996	3. 00 487. 4	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	403, 474	770	1 407. 4	2		42.00
43. 00 44. 00		1, 947, 030	1, 286	1, 514. 0	2 0	C	
45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			anc)		459, 822	1
49.00	Total Program inpatient costs (sum of lines : PASS THROUGH COST ADJUSTMENTS	41 (111 Ough 46) (see mstructro) (S)		855, 764	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	C	50.00
51. 00		atient ancillar	v services (fr	om Wkst. D. s	um of Parts II	C	51.00
	and IV)		,				
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		lated non-nhy	veician angeth	atist and		
33.00	medical education costs (line 49 minus line		rateu, non-prij	rsi ci ali allestii	etist, and		33.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						1 54 00
	Program discharges Target amount per discharge					l	54.00
56.00	Target amount (line 54 x line 55)					l .	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)						
59. 00	9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport un	dated by the n	arkot baskot		0.00	60.00
61. 00	1				the amount by	0.00	1
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				c	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			<u> </u>	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	na period (See	С	64. 00
	instructions) (title XVIII only)	· ·		•			/= 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decemb	er 31 of the d	cost reporting	period (See	C	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	l only). For	C	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	porting period	l c	67. 00
	(line 12 x line 19)	9					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	C	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					С	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil		•				70.00
70.00	Adjusted general inpatient routine service of	•		,			71.00
72.00	,		/I: 44 I:	25)			72.00
73. 00 74. 00	Medically necessary private room cost application. 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						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	•	rovi don rocore	lc)			78. 00 79. 00
	Total Program routine service costs for comp				us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			•		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
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 65)			I	30.00
87.00	Total observation bed days (see instructions)	line 2)			l .	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		iine 2)			l	88.00
	,					/, .0/	

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014		
					2/25/2015 12:	25 pm_
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	566, 042	4, 605, 226	0. 12291	3 629, 107	77, 325	90.00
91.00 Nursing School cost	0	4, 605, 226	0.00000	0 629, 107	0	91.00
92.00 Allied health cost	0	4, 605, 226	0.00000	0 629, 107	0	92.00
93.00 All other Medical Education	0	4, 605, 226	0. 00000	0 629, 107	0	93. 00

Health Financial Systems DEKAL	LB MEMORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od: From 10/01/2013	Worksheet D-3	
			To 09/30/2014	Date/Time Pre 2/25/2015 12:	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.22	2)	
LAIDATI ENT. DOUTLAGE CEDALOE COCT. CENTEDO		1.00	2. 00	3. 00	
30.00 O3000 ADULTS & PEDIATRICS			2 057 070		20.00
			3, 057, 970		30. 00 31. 00
31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY			1, 485, 785		43.00
ANCILLARY SERVICE COST CENTERS					43.00
50. 00 O5000 OPERATI NG ROOM		0. 27974	647, 078	181, 017	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 51554		959	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23530		214, 989	
60. 00 06000 LABORATORY		0. 22564		291, 325	
60. 01 06001 BLOOD LABORATORY		0.00000			
65, 00 06500 RESPIRATORY THERAPY		0. 34201		257, 125	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 48939	166, 247	81, 361	66. 00
66. 01 06601 CARDI AC REHAB		1. 00097	744	745	66. 01
69. 00 06900 ELECTROCARDI OLOGY		0. 14749	70, 392	10, 383	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 23424	4, 583	1, 074	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 43792	26 562, 349	246, 267	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 26385			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 53409	763, 563	407, 811	73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 44231		0	
91. 00 09100 EMERGENCY		0. 28124			
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT		0. 44677	<u>'</u> 1 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES			, ,=, ,00		95. 00
200.00 Total (sum of lines 50-94 and 96-98)			6, 456, 422	2, 042, 119	
201.00 Less PBP Clinic Laboratory Services-Program of	only charges (line 61)		4 454 422		201. 00
202.00 Net Charges (line 200 minus line 201)		I	6, 456, 422	I	202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150045	Peri od:	Worksheet D-3	
			From 10/01/2013 To 09/30/2014	Date/Time Pre	nared:
			10 07/30/2014	2/25/2015 12:	
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INDATIENT DOUTINE CEDVICE COCT CENTEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS			E20 E00		30.0
31. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			520, 508 197, 016		31. 0
43. 00 03100 INTENSIVE CARE UNIT			232, 552		43.0
ANCI LLARY SERVI CE COST CENTERS			232, 332		1 43.0
50. 00 O5000 OPERATING ROOM		0. 27974	46 236, 745	66, 228	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 51554			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23530			
50. 00 06000 LABORATORY		0. 22564			
50. 01 06001 BLOOD LABORATORY		0.00000			
55. 00 06500 RESPIRATORY THERAPY		0. 3420	11 101, 392	34, 677	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 48939	96 36, 390	17, 809	66.0
66. 01 06601 CARDI AC REHAB		1. 00097	77 643	644	66. C
9. 00 06900 ELECTROCARDI OLOGY		0. 14749	3, 881	572	69. C
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 23424		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 43792		17, 037	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2638		0	1
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 5340	90 116, 533	62, 239	73.0
OUTPATIENT SERVICE COST CENTERS				,	
00. 00 09000 CLI NI C		0. 4423			1
01. 00 09100 EMERGENCY		0. 28124			
02. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT		0. 4467	71 0	0	92.0
OTHER REIMBURSABLE COST CENTERS 05.00 09500 AMBULANCE SERVICES					105.0
			1 100 21/	450.022	95.0
Total (sum of lines 50-94 and 96-98)	v charges (line (1)		1, 190, 316	1	
Less PBP Clinic Laboratory Services-Program onl	y charges (Tine 61)		1 100 214	l	201. 0 202. 0
202.00 Net Charges (line 200 minus line 201)		I	1, 190, 316	I	1202. (

CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150045	Peri od: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Pr 2/25/2015 12	
		Ti tl	e XVIII	Hospi tal	PPS	
			before 1/1	on/after 1/1		
		0	1.00	1. 01	2. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		2, 830, 58	38		1.00
1. 01	DRG amounts other than outlier payments for discharges			0		1.0
	occurring prior to October 1, 2013 (see instructions)					
. 02	DRG amounts other than outlier payments for discharges			0		1.0
	occurring on or after October 1, 2013 (see instructions)					
. 03	DRG for Federal specific operating payment for Model 4			0		1.0
	BPCI (see instructions)					
. 00	Outlier payments for discharges. (see instructions)		5, 6!	54		2.0
2. 01	Outlier reconciliation amount			0		2. 0
2. 02	Outlier payment for discharges for Model 4 BPCI (see			0		2. 0
	instructions)					
. 00	Managed Care Simulated Payments			0		3. 0
. 00	Bed days available divided by number of days in the cost		45.0	04		4.0
	reporting period (see instructions)					_
	Indirect Medical Education Adjustment			20		٠.,
. 00	FTE count for allopathic and osteopathic programs for the		0.0	00		5.0
	most recent cost reporting period ending on or before					
00	12/31/1996. (see instructions)		0.4	20		4 6
. 00	FTE count for allopathic and osteopathic programs which		0.0	50		6.0
	meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)					
. 00	MMA Section 422 reduction amount to the IME cap as		0.0	20		7.0
. 00	specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0. \			'. 0
. 01	ACA Section 5503 reduction amount to the IME cap as		0.0	20		7.0
. 0 .	specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the		0.,			1 7.0
	cost report straddles July 1, 2011 then see instructions.					
3. 00	Adjustment (increase or decrease) to the FTE count for		0.0	00		8.0
	allopathic and osteopathic programs for affiliated					
	programs in accordance with 42 CFR 413.75(b),					
	413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12,					
	1998, page 26340 and Vol. 67 Federal Register, page 50069,					
	August 1, 2002.					
3. 01	The amount of increase if the hospital was awarded FTE cap		0.0	00		8. 0
	slots under section 5503 of the ACA. If the cost report					
	straddles July 1, 2011, see instructions.					
3. 02	The amount of increase if the hospital was awarded FTE cap		0.0	00		8.0
	slots from a closed teaching hospital under section 5506					
	of ACA. (see instructions)					
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus		0.0	00		9.0
0 00	lines (8, 8,01 and 8,02) (see instructions)			20		100
10. 00	FTE count for allopathic and osteopathic programs in the		0.0	JU		10.0
1 00	current year from your records		0.0	20		11.0
1. 00	FTE count for residents in dental and podiatric programs.		•			12.0
	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.		0.0			13. 0
3.00	' '		0.0			14. 0
4. 00	Total allowable FTE count for the penultimate year if that		0.0	50		14. 0
	year ended on or after September 30, 1997, otherwise enter					
5. 00	zero. Sum of lines 12 through 14 divided by 3.		0.0	20		15. 0
6. 00	Adjustment for residents in initial years of the program		0.0			16. 0
17.00	Adjustment for residents in finitial years of the program Adjusment for residents displaced by program or hospital		0.0			17. 0
7.00	closure					''. 0
8. 00	Adjusted rolling average FTE count		0.0	00		18. 0
	Current year resident to bed ratio (line 18 divided by		0.0000			19. 0

10.00	FTE count for allopathic and osteopathic programs in the	0.00	10.00
	current year from your records		
	FTE count for residents in dental and podiatric programs.	0.00	11.00
	Current year allowable FTE (see instructions)	0.00	12.00
	Total allowable FTE count for the prior year.	0.00	13. 00
14. 00	Total allowable FTE count for the penultimate year if that	0.00	14. 00
	year ended on or after September 30, 1997, otherwise enter		
	zero.		
	Sum of lines 12 through 14 divided by 3.	0.00	15. 00
	Adjustment for residents in initial years of the program	0.00	16. 00
17. 00	Adjusment for residents displaced by program or hospital	0.00	17. 00
	cl osure		
	Adjusted rolling average FTE count	0.00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by	0. 000000	19. 00
	line 4).		
	Prior year resident to bed ratio (see instructions)	0. 000000	20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0. 000000	21.00
22. 00	IME payment adjustment (see instructions)	0	22. 00
	Indirect Medical Education Adjustment for the Add-on for Se	ction 422 of the MMA	
23.00	Number of additional allopathic and osteopathic IME FTE	0.00	23.00
	resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		
	IME ETE Dooi dont Count Over Con (occ instructions)		24.00
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
	If the amount on line 24 is greater than -0-, then enter	0.00	25. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		25. 00
25. 00	If the amount on line 24 is greater than -O-, then enter		
25. 00 26. 00 27. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)	0.00	25. 00
25. 00 26. 00 27. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)	0. 00 0. 000000	25. 00 26. 00 27. 00 28. 00
25. 00 26. 00 27. 00 28. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)	0. 00 0. 000000 0. 000000	25. 00 26. 00 27. 00
25. 00 26. 00 27. 00 28. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)	0. 00 0. 000000 0. 000000	25. 00 26. 00 27. 00 28. 00
25. 00 26. 00 27. 00 28. 00 29. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28)	0. 00 0. 000000 0. 000000	25. 00 26. 00 27. 00 28. 00
25. 00 26. 00 27. 00 28. 00 29. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28) Disproportionate Share Adjustment	0. 00 0. 000000 0. 000000 0	25. 00 26. 00 27. 00 28. 00 29. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part	0. 00 0. 000000 0. 000000 0	25. 00 26. 00 27. 00 28. 00 29. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0. 00 0. 000000 0. 000000 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days (see instructions)	0. 00 0. 000000 0. 000000 0 0 3. 74 23. 25	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions) Total IME payment (sum of lines 22 and 28) Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days (see instructions)	0. 00 0. 000000 0. 000000 0 0 3. 74 23. 25	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00

CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT				From 10/01/2013 To 09/30/2014	Part A Date/Time Pre 2/25/2015 12:	pared: 25 pm
			Ti tl	e XVIII	Hospi tal	PPS	
			0	before 1/1 1.00	on/after 1/1 1.01	2. 00	
33. 00	Allowable disproportionate share percentage (instructions)	(see		11. 4		2.00	33. 00
34. 00	Disproportionate share adjustment (see instru	ucti ons)		Prior to	8	On/After	34.00
		0		0ctober 1 1.00	1. 01	0ctober 1 2.00	
	Uncompensated Care Adjustment						
35. 00	Total uncompensated care amount (see				0	9, 046, 380, 143	35. 00
35. 01	instructions) Factor 3 (see instructions)			0. 00000000		0. 000048971	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line)			0.0000000	0	443, 010	
35. 03	(see instructions) Pro rata share of the hospital uncompensated				0	443, 010	35. 03
33. 03	care payment amount (see instructions)				Ĭ	443,010	33.00
36. 00	Total uncompensated care (sum of columns 1			443, 01	0		36.00
	and 2 on line 35.03) Additional payment for high percentage of ESR	n heneficiary disc	harnes				-
40. 00	Total Medicare discharges on Worksheet S-3,	beneficially disc	nai ges		0		40.00
	Part I excluding discharges for MS-DRGs 652,						
41 00	682, 683, 684 and 685 (see instructions)						41. 00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see						41.00
	instructions)						
41. 01	Total ESRD Medicare covered and paid				0 0		41. 01
	discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)						
42. 00	Divide line 41 by line 40 (if less than 10%,			0.0	o		42.00
	you do not qualify for adjustment)						
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7			0. 00000	0		44.00
45. 00	days) Average weekly cost for dialysis treatments			0.0	0.00		45. 00
	(see instructions)						
46. 00	Total additional payment (line 45 times line 44 times line 41.01)				0		46. 00
47. 00	Subtotal (see instructions)			3, 360, 49	o		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)				0		48. 00
49. 00	Total payment for inpatient operating costs			3, 360, 49	О		49. 00
50. 00	SCH and MDH only (see instructions) Payment for inpatient program capital (from			224, 04	4		50.00
30.00	Worksheet L, Parts I, II, as applicable)			224, 04	7		30.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)				0		51.00
52. 00	Direct graduate medical education payment (from Worksheet E-4, line 49 see				0		52. 00
53. 00	instructions). Nursing and Allied Health Managed Care				О		53. 00
54. 00	payment Special add-on payments for new technologies				o		54.00
54.00	Net organ acquisition cost (Worksheet D-4			•	0		55.00
	Part III, col. 1, line 69)						
56. 00	Cost of physicians' services in a teaching				0		56.00
57. 00	hospital (see intructions) Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30				0		57. 00
58. 00	through 35). Ancillary service other pass through costs				0		58. 00
59. 00	from Worksheet D, Part IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58)			3, 584, 53	4		59. 00
60. 00	Primary payer payments			7, 15	7		60.00
61. 00	Total amount payable for program			3, 577, 37			61.00
62.00	beneficiaries (line 59 minus line 60)			479, 64			62.00
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			15, 00			63.00
64. 00	Allowable bad debts (see instructions)			26, 03			64.00
65. 00	Adjusted reimbursable bad debts (see instructions)			16, 92	3		65. 00
		ı		1	ı		1

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150045

						2/25/2015 12:	25 pm
			Ti tl	e XVIII	Hospi tal	PPS	
				Prior to		On/After	
				October 1		October 1	
		0		1.00	1. 01	2.00	
66. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	-		8, 890			66. 00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3, 099, 644			67. 00
68. 00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see			0			68. 00
69. 00	instructions) Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see			О			69. 00
70. 00	instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0			70. 00
70. 50	RURAL DEMONSTRATION PROJECT			0			70. 50
70. 92	Bundled Model 1 discount amount			0			70. 92
70. 93	HVBP incentive payment (see instructions)			1, 516			70. 93
70. 93	Hospital readmissions reduction adjustment			0			70. 94
	(see instructions)						
70. 95	Recovery of accelerated depreciation			0			70. 95
70. 96	Low volume adjustment for federal fiscal		0	0			70. 96
	year (yyyy) (Enter in column 0 the corresponding federal year for the period						
	prior to 10/1)						
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period		2014	500, 555			70. 97
	ending on or after 10/1)						
70. 98	Low Volume Payment-3			<u> </u>			70. 98
	1			2 401 715			71. 00
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			3, 601, 715			
71. 01	Sequestration adjustment (see instructions)			72, 034			71. 01
72.00	Interim payments			3, 539, 331			72. 00
73.00	Tentative settlement (for contractor use			l 0			73.00
	only)						
74. 00	Balance due provider (Program) line 71 minus lines 71.01.72 and 73			-9, 650			74. 00
75. 00	Protested amounts (nonallowable cost report			0			75. 00
	items) in accordance with CMS Pub. 15-2, chapter 1, §115.2						
	TO BE COMPLETED BY CONTRACTOR					1	
90. 00	Operating outlier amount from Worksheet E,			0			90. 00
91. 00	Part A line 2 (see instructions) Capital outlier from Worksheet L, Part I,			О			91. 00
	line 2						
92. 00	Operating outlier reconciliation adjustment			0			92. 00
93. 00	amount (see instructions) Capital outlier reconciliation adjustment			О			93. 00
94. 00	amount (see instructions) The rate used to calculate the time value of			0.00			94. 00
	money (see instructions)						
95. 00	Time value of money for operating expenses (see instructions)			0			95. 00
96. 00	Time value of money for capital related expenses (see instructions)			0			96. 00
	· · · · · · · · · · · · · · · · · · ·			•	•	•	•

In Lieu of Form CMS-2552-10

Period:	Worksheet E
From 10/01/2013	Part A Exhibit 4
To 09/30/2014	Date/Time Prepared:
2/25/2015 12: 25 pm Provi der CCN: 150045	

Bid						'	0 07/30/2014	2/25/2015 12:	
					Ti tl	e XVIII	Hospi tal		
1.00 DRG amounts other than outlier 1.00 2.830,588 0 0 2.830,588 2.830,588 1.00 2.830,588 2.830,588 1.00 2.830,588 2.830,588 1.00 2.830,588 2.830,588 1.00 2.830,588			W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
1.00 DRS amounts other than outlier 1.00 2.830,588 0 0 2.830,588 2.830,588 1.00 payments 1.00 DRS amounts other than outlier 1.00 0 0 0 0 0 0 0 1.00 0 0 0 0 0 0 0 0 0			line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
Dayments			0	1.00	2.00	3.00	4. 00		
1.01 DRC amounts other than outlier 1.01 0 0 0 0 0 0 1.0"	1.00		1. 00	2, 830, 588	0	(2, 830, 588	2, 830, 588	1. 00
2013	1. 01	DRG amounts other than outlier	1. 01	0	0	C	0	0	1. 01
payments for discharges		2013	4.00			_			
1.03	1. 02	payments for discharges occurring on or after October	1. 02	0	0	C	0	0	1. 02
discharges (see instructions)	1. 03	DRG for Federal specific operating payment for Model 4	1. 03	0	0	C	O	0	1. 03
2.01 Outlier payments for discharges for Model 4 BPCI 3.00 Operating outlier 2.01 Operating outlier 3.00 Operating outlier 3.00 Operating outlier 3.00 Operating outlier 3.00 Operating outlier 5.00 Annunt from Worksheet F, Part 21.00 Operating 0.00000 Operating 0.000000 Operating 0.000000 Operating 0.000000 Operating 0.000000000 Operating 0.000000000 Operating 0.00000000000 Operating 0.000000	2. 00		2. 00	5, 654	0	(5, 654	5, 654	2. 00
1.00 Operating outlier 2.01 0 0 0 0 0 0 0 0 0	2. 01	Outlier payments for	2. 02	0	0	C	0	0	2. 01
A.00	3. 00	Operating outlier	2. 01	0	0	C	0	0	3. 00
Indirect Medical Education Adjustment	4. 00	Managed care simulated	3. 00	0	0	C	0	0	4. 00
5.00 Amount from Worksheet E, Part 21.00 0.0000000 0.0000000 0.0000000 0.00000000			ıstment						
ME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5.00	Amount from Worksheet E, Part		0. 000000	0. 000000	0. 000000	0. 000000		5. 00
Indirect Medical Education Adjustment For the Add-on For Section 422 of the MMA	6. 00		22. 00	0	0	(0	0	6. 00
7.00					100 6 1				
A, line 27 (see instructions) 8.00 IME adjustment (see									
8.00 IME adjustment (see 28.00 0 0 0 0 0 0 0 8.00 9.00 Total IME payment (sum of 29.00 0 0 0 0 0 0 0 10 10	7.00		27.00	0.000000	0.000000	0.000000	0.000000		7.00
9.00	8. 00	IME adjustment (see	28. 00	0	0	C	0	0	8. 00
Disproportionate Share Adjustment	9. 00	Total IME payment (sum of	29. 00	0	0	C	0	0	9. 00
10.00			ent						
11.00 Disproportionate share 34.00 81,238 0 0 81,238 81,238 11.00 adjustment (see instructions) 11.01 11.01 12.00	10. 00	Allowable disproportionate share percentage (see		0. 1148	0. 1148	0. 1148	0. 1148		10. 00
11. 01 Uncompensated care payments 36. 00 443, 010 0 0 443, 010 1443, 010 11. 07	11. 00	Di sproporti onate share	34. 00	81, 238	0	C	81, 238	81, 238	11. 00
Additional payment for high percentage of ESRD beneficiary discharges	11 01		36.00	443 010	0	(443 010	443 010	11 01
12.00 Total ESRD additional payment (see instructions) 46.00 0 0 0 0 0 12.00 13.00 Subtotal (see instructions) 47.00 3,360,490 0 0 3,360,490 3,360,490 13.00 14.00 Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions) 15.00 Total payment for inpatient operating costs SCH and MDH only (see instructions) 16.00 Payment for inpatient program capital (from Worksheet L, Parts I, as applicable) 17.00 Special add-on payments for new technologies 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 0 0 18.00	11.01				di scharges		, 443,010	443,010	11.01
13. 00 Subtotal (see instructions)	12. 00	Total ESRD additional payment		0		C	0	0	12. 00
14.00 Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions) 15.00 Total payment for inpatient operating costs SCH and MDH only (see instructions) 16.00 Payment for inpatient program capital (from Worksheet L, Parts I, as applicable) 17.00 Special add-on payments for new technologies 18.00 Capital outlier reconciliation adjustment amount (see instructions)	13 00	,	47 00	3 360 490	0	(3 360 490	3 360 490	13 00
only. (see instructions) Total payment for inpatient operating costs SCH and MDH only (see instructions) 16.00 Payment for inpatient program capital (from Worksheet L, Parts I, as applicable) 17.00 Special add-on payments for new technol ogies 18.00 Capital outlier reconciliation adjustment amount (see instructions) 49.00 3,360,490 0 0 0 3,360,490 3,360,490 15.00 224,044 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Hospital specific payments (to be completed by SCH and MDH,		0	0	C	0		14. 00
only (see instructions) 16. 00 Payment for inpatient program capital (from Worksheet L, Parts I, as applicable) 17. 00 Special add-on payments for new technologies 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 50. 00 224, 044 224, 044 224, 044 16. 00 0 0 0 0 0 0 17. 00 0 0 18. 00 0 0 0 18. 00 0 0 0 0 0 18. 00 0 0 0 0 0 0 18. 00 0 0 0 0 0 0 18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00	only. (see instructions)	49. 00	3, 360, 490	0	C	3, 360, 490	3, 360, 490	15. 00
capital (from Worksheet L, Parts I, as applicable) 17.00 Special add-on payments for 54.00 0 0 0 0 0 17.00 new technologies 18.00 Capital outlier reconciliation adjustment amount (see instructions)		operating costs SCH and MDH only (see instructions)							
17.00 Special add-on payments for new technologies 18.00 Capital outlier reconciliation adjustment amount (see instructions) 54.00 0 0 0 0 0 17.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16. 00	capital (from Worksheet L,	50. 00	224, 044	0	C	224, 044	224, 044	16. 00
18.00 Capital outlier reconciliation 93.00 0 0 0 0 18.00 adjustment amount (see instructions)	17. 00	Special add-on payments for	54. 00	0	0	C	O	0	17. 00
instructions)	18. 00	Capital outlier reconciliation adjustment amount (see	93.00	0	0	C	O	0	18. 00
19. 00 SUBTOTAL 0 0 3, 584, 534 3, 584, 534 19. 00	19. 00	instructions) SUBTOTAL			0	C	3, 584, 534	3, 584, 534	19. 00

Heal th	Financial Systems		DEKALB MEMORI.	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provi der	CCN: 150045	Peri od: From 10/01/2013 To 09/30/2014		pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		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	222, 858	0		0 222, 858	222, 858	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	1. 186	0		0 1. 186	1. 186	21.00

		w/s L, Tine	(Allounts ITolli					
		0	L) 1. 00	2.00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier		222, 858	2.00	3.00	222, 858	222, 858	20.00
20. 00	•		222, 858	0	0	222, 838	222, 838	
20. 01	Model 4 BPCI Capital DRG other	1. 01	U	Ü	0	U	0	20. 01
	than outlier	0.00	4 40/					
21. 00	Capital DRG outlier payments	2. 00	1, 186	0	0	1, 186	1, 186	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	0	0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0.0000	0.0000	0. 0000		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	0	0	0	0	0	23. 00
	adjustment (line 20 times line							
	22)							
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.0000	0.0000		24.00
	share percentage (see							
	instructions)							
25.00	Di sproporti onate share	11. 00	0	0	0	0	0	25. 00
	adjustment (line 20 times line							
	24)							
26.00	Total prospective capital	12.00	224, 044	0	0	224, 044	224, 044	26. 00
	payments (sum of lines 20-21,							
	23 and 25)							
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1. 00	2.00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.000000	0. 139643		27. 00
28.00	Low volume adjustment	70. 96			0		0	28. 00
	(transfer amount to W/S E Part							
	A line)							
29.00	Low volume adjustment	70. 97				500, 555	500, 555	29. 00
	(transfer amount to W/S E Part							
	A line)							
100.00	Transfer low volume		Υ					100. 00
	adjustments to W/S E Part A.							
	1 3					ļi.		

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	150045 Peri od: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/25/2015 12:25 pm

			10 09/30/2014	2/25/2015 12:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6, 107	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		3, 254, 438	
3.00	PPS payments			2, 426, 374	
4.00	Outlier payment (see instructions)			1, 581	
5.00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000	
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Worksheet D, Pa	rt IV column 12 line	200	0	8. 00 9. 00
10.00	Organ acquisitions	it iv, corumni is, iine	200	0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 107	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 107	11.00
	Reasonable charges				
12.00	Ancillary service charges			11, 434	12.00
13. 00	Organ acquisition charges (from Worksheet D-4, Part III, line 6	9, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			11, 434	14.00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for page 1				15.00
16. 00	Amounts that would have been realized from patients liable for	payment for services o	on a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)	if line 10 avecade li	no 11) (coo	11, 434	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds II	ne II) (See	5, 327	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	na 18) (saa	0	20. 00
20.00	instructions)	TT TITLE TT EXCECUS TT	110 10) (300	0	20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		6, 107	21. 00
22. 00	Interns and residents (see instructions)	,		0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instru-	ctions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			2, 427, 955	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			587, 529	
27. 00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the	he sum of lines 22 and	d 23} (for CAH,	1, 846, 533	27. 00
20.00	see instructions)	l: FO)		0	20.00
28. 00 29. 00	Direct graduate medical education payments (from Worksheet E-4, ESRD direct medical education costs (from Worksheet E-4, line 3			0	28. 00 29. 00
30.00	Subtotal (sum of lines 27 through 29)	6)		1, 846, 533	
31. 00	Primary payer payments			453	
32. 00	Subtotal (line 30 minus line 31)			1, 846, 080	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)		1,010,000	02.00
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	-		0	33.00
34.00	Allowable bad debts (see instructions)			109, 226	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			70, 997	35.00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		90, 179	
37. 00	Subtotal (see instructions)			1, 917, 077	
38. 00	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 98	Partial or full credits received from manufacturers for replace	a devices (see instruc	CTI ONS)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			1 017 005	39. 99
40. 00	Sequestration adjustment (see instructions)			1, 917, 095 38, 342	40. 00 40. 01
41. 00	Interim payments			1, 807, 568	
42. 00	Tentative settlement (for contractors use only)			0	
43. 00	Balance due provider/program (see instructions)			71, 185	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2		,		
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

| Peri od: | Worksheet E-1 | From 10/01/2013 | Part | To 09/30/2014 | Date/Time Prepared: | 2/25/2015 12: 25 pm Health Financial Systems DEK.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150045

					2/25/2015 12: 2	25 pm_
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 539, 331		1, 807, 568	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,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3. 02			d		0	3. 02
3.03					o	3. 03
3.04)	0	3.04
3.05)	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51			(0	3. 51
3. 52			C		0	3. 52
3.53			C		0	3. 53
3.54			(0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		3, 539, 331		1, 807, 568	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 337, 331		1, 007, 300	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03	Dravi dan ta Dragnam)	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			1	1 0	5. 50
5. 51	TENTATIVE TO PROGRAM					5. 50
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
5. , ,	5. 50-5. 98)					5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		(71, 185	6. 01
6.02	SETTLEMENT TO PROGRAM		9, 650)	0	6. 02
7.00	Total Medicare program liability (see instructions)		3, 529, 681		1, 878, 753	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor)	1. 00	2. 00	0.00
8.00	Name of Contractor					8. 00

Heal th	Financial Systems DEKALB MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150045 Period: From 10/01/2013				
			To 09/30/2014		
		Title XVIII	Hospi tal	PPS	<u> </u>
	<u> </u>				
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-	3, Part I column 15 li	ne 14	2, 050	1. 00
2.00	2.00 Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12				2. 00
3.00	3.00 Medicare HMO days from Wkst S-3, Part I, column 6. line 2				
4.00	4.00 Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12				
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			108, 157, 222	5. 00
6.00	Total hospital charity care charges from Wkst S-10, column 3 li	ne 20		1, 144, 158	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Worksheet S-2,	0	7. 00
	Part I line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			545, 813	8. 00
9.00	Sequestration adjustment amount (see instructions)			10, 916	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		534, 897	10. 00
	I NPATI ENT HOSPI TAL SERVI CES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			570, 453	30. 00
31.00	1.00 Other Adjustment (specify)				31. 00
22 00	Delenes due provider (line 0 (er line 10) minus line 20 and lin	. 21) (222 22+212+	-1	25 55/	22 00

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

570, 453 30. 00 0 31. 00 -35, 556 32. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150045	Peri od: Worksheet E-3 From 10/01/2013 Part VII To 09/30/2014 Date/Time Prepared:

PART_VII - CALCULATION OF RE UNDURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				To 09/30/2014	Date/Time Pre 2/25/2015 12:	
PART VII - CALCULATION OF RETINDURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V.O. R.XIX SERVICES			Title XLX	Hospi tal		20 p
DART VII - CALCULATION OF RETUBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Incention hospital Cysi-Visi-Visi-Visi-Vision value 1.00						
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Incention hospital Cysi-Visi-Visi-Visi-Vision value 1.00		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX	SERVI CES		
Inpati ent hospit al /SWF/NF services						İ
Medical and other services 0 2.00	1.00			855, 764		1.00
Organ acquisition (certified transplant centers only)					0	•
A.00 Subtotal (sum of lines 1, 2 and 3)				0		
Inpatient primary payer payments 0 5.0				855, 764	0	
0.00 0.00				0		
Subtotal (line 4 less sum of lines 5 and 6)					0	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges Reasonable Charges Routine service charges 1,190,316 0,90,00 0,00 Acutine service charges 1,190,316 0,90,00 0				855, 764	0	
Routine service charges		COMPUTATION OF LESSER OF COST OR CHARGES		<u>' </u>		
9,00 Ancillary service charges 1,190,316 0 9,00		Reasonabl e Charges				İ
10.00 Organ acquisition charges, net of revenue 0 10.0	8.00	Routi ne servi ce charges		950, 076		8.00
11.00	9.00	Ancillary service charges		1, 190, 316	0	9. 00
12.00 Total reasonable charges (sum of lines 8 through 11) 12.00 2,140,392 12.00 13.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 14.00 15.00 1	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOMARY CHARGES	11.00	Incentive from target amount computation		0		11. 00
13.00 Amount actually collected from patients	12.00	Total reasonable charges (sum of lines 8 through 11)		2, 140, 392	0	12.00
basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1, 284, 628 0 17.00 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 16 exceeds line 16 (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of physicians' services in a teaching hospital (see instructions) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 RROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10.00 Outlier payments 10.00 Outli		CUSTOMARY CHARGES				
14.00 Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e) 0.000000 0.000000 15.00 15.00 16.00 17.00	13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16. 00 Total customary charges (see instructions) 17. 00 Excess of customary charges (see instructions) 18. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1, 284, 628 0 17. 00 18. 00 1						
15.00	14. 00			0	0	14. 00
16. 00 Total customary charges (see instructions) 2,140,392 0 16. 00 17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1,284,628			CFR §413.13(e)			
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 1, 284, 628 0 17.00						
18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19. 00 18. 00 16) (see instructions) 19. 00 10. 0	17. 00		if line 16 exceeds	1, 284, 628	0	17.00
16) (see instructions)	40.00					40.00
19. 00 Interns and Residents (see instructions) 0 0 19. 00 20.	18.00		IT line 4 exceeds line	0	0	18.00
20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 21.00 25.00 25.764 0 21.00 27.00 27.00 28.50,764 27.00	10.00	, ,				10 00
21.00			ations)		_	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				_	_	
22.00 Other than outlier payments 0 0 22.00	21.00				U	21.00
23. 00	22 00		ompreted for PP3 provide		0	22.00
24. 00 Program capital payments 25. 00 (25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 (Customary charges (title V or XIX PPS covered services only) 29. 00 (Titles V or XIX (sum of lines 21 and 27) 29. 00 (Customary charges (title V or XIX PPS covered services only) 29. 00 (Customary charges (title V or XIX PPS covered services only) 29. 00 (Customary charges (title V or XIX PPS covered services only) 30. 00 (Subtotal (sum of lines 21 and 27) 30. 00 (Computation OF Reimburssement Settlement) 30. 00 (Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 (Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 (Deductible S) 33. 00 (Coinsurance 34. 00 (Allowable bad debts (see instructions) 35. 00 (Utilization review 36. 00 (Utilization review 37. 00 (Utilization review) 38. 00 (Utilization review) 38. 00 (Utilization review) 38. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for lines 31, 34 and 35 minus sum of lines 32 and 33) 39. 00 (Utilization for				-	_	
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 45. 00 46. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 45. 00 46. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 45. 00 46. 00 Capital exception payments (see instructions) 47. 00 Total mount payable cost report items) in accordance with CMS Pub 15-2, 48. 00 49. 00 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 49. 00					O	
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 30. 00 Coinsurance 30. 01 Allowable bad debts (see instructions) 30. 00 Allowable bad debts (see instructions) 30. 00 Utilization review 30. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 00 Direct graduate medical education payments (from Wkst. E-4) 30. 00 Bal ance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00 0 26. 00 0 27. 00 0 27. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 28. 00 0 29. 00 0 0 30. 00 0 30. 00 0 31. 00 0 855, 764 0 31. 00 0 32. 00 0 33. 00 0 34. 00 0 35. 00 0 34. 00 0 35. 00 0 36. 00 0 37. 00 0 37. 00 0 38. 00 0 39				٩		
27. 00				٩	0	
28.00 Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,				١	_	
29.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Deductibles 30.00 Coinsurance 31.00 Allowable bad debts (see instructions) 32.00 Utilization review 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 Interim payments 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 2				0		
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 855, 764 0 31.00 22.00 23.))) (855. 764		
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Coinsurance 33.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 30.00 855, 764 0 31.00 0 32.00 0 33.00 0 0 34.00 0 35.00 0 35.00 0 36.00 0 37.00 0 36.00 0 37.00 0 36.00 0 37.00 0 36.00 0 37.00 0 37.00 0 38.00 0 37.0		,				
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coi nsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 38. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Bal ance due provider/program (line 40 minus line 41) 42. 00 Bal ance due provider (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 31. 00 31. 00 32. 00 33. 00 0 32. 00 0 33. 00 0 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 39. 00 40. 00 41. 00 42. 00 43. 00 43. 00	30.00			0	0	30.00
32.00 Deductibles 0 0 32.00 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 855,764 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 855,764 0 38.00 OTHER adjustment of lines 38 and 39) 0 Direct graduate medical education payments (from Wkst. E-4) 0 0 39.00 OTOTAL amount payable to the provider (sum of lines 38 and 39) 855,764 0 40.00 41.00 Interim payments 1,224,766 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -369,002 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	31. 00	` '		855, 764	0	31.00
34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 855,764 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 855,764 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 Total amount payable to the provider (sum of lines 38 and 39) 855,764 0 40.00 Interim payments 1,224,766 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -369,002 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	32. 00			0	0	32.00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 35.00 35.00 35.00 35.00 35.00 36.00 37.00 38.55,764 0 38.00 39.00 49.00 49.00 41.00 42.00 43.00	33.00	Coinsurance		0	0	33. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 36.00 36.00 36.00 37.00 38.55,764 0 38.00 39.00 39.00 40.00 41.00 42.00 43.00	34.00	Allowable bad debts (see instructions)		0	0	34.00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 37. 00 855, 764 0 38. 00 39. 00 39. 00 40. 00 41. 224, 766 0 41. 00 42. 00 43. 00	35.00	Utilization review		0		35. 00
38.00 Subtotal (line 36 ± line 37) 855,764 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 855,764 0 40.00 41.00 Interim payments 1,224,766 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -369,002 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	855, 764	0	36.00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 40.00 41.00 41.00 42.00 43.00	37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 40.00 41.00 41.00 -369,002 0 42.00 0 43.00	38.00	Subtotal (line 36 ± line 37)		855, 764	0	38. 00
41.00 Interim payments 1,224,766 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00	39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00 43.00	40.00	Total amount payable to the provider (sum of lines 38 and 39)		855, 764	0	40. 00
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	41.00	Interim payments		1, 224, 766	0	41.00
	42.00			-369, 002	0	42. 00
chapter 1, §115.2	43.00		e with CMS Pub 15-2,	0	0	43. 00
		chapter 1, §115.2				l

Provider CDL 150005 Period Provider CDL 150005 Period	Heal th	Financial Systems DEKALB MEMORI				u of Form CMS-	2552-10
Disserver Asserts		BALANCE SHEET (If you are nonproprietary and do not maintain				Worksheet G	
Custom ASSE IS	runa t	ype accounting records, comprete the deneral runa cordinin on	' 9)				
1.00 Cash on hand in banks 1.00 2.00 3.00 4.00			General Fund	Speci fi c	Endowment Fund		25 piii
CUBRENT ASSETS 14,681			1.00		2.00	4.00	
1.00 Cash on hand In banks		CURRENT ASSETS	1.00	2.00	3.00	4.00	
Notices receivable	1.00		14, 681	(0	0	1. 00
Accounts receivable	2.00	Temporary investments	2, 937, 242	(o		
Other receivable 75.6 AB2 0 0 5.00 6.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00			0	·	1		1
A Commences for uncol lectible notes and accounts receivable -8, 494, 665 0 0 0 6, 00 7, 00 B, 00 Prepail dexpenses 477, 764 0 0 0 0 0, 00 B, 00 Determinant of the comment of t				·	1		1
1,490,596 0 0 0 7,00 0 0 0 0 0 0 0 0 0			•				1
Prepaid expenses							
10.00 Due From other Funds 0 0 0 0 10.00			1	Ċ	o o		1
1.00 Total current assets (sum of lines 1-10) 13,832,869 0 0 0 11,00	9.00		183, 905	(0		
FIXED ASSETS			0				1
12.00 Land Improvements	11. 00		13, 832, 869		0	0	11. 00
13.00 Land Improvements	12 00		303 119			0	12 00
14.00 Accumulated depreciation							1
15.00 Buildings 52,729,588 0 0 15.00		1		1			1
17.00 Leasehol d Improvements	15.00		52, 729, 558	(o	0	15. 00
18. 00 Accumulated depreciation		•	-25, 147, 402	(0		1
19.00		· ·	0	(0		1
20.00 Accumul ated depreciation			-1, 056, 557	(
21.00 Automobil es and trucks		· ' '	173 815				1
22.00 Accumulated depreciation 0 0 0 0 22.00 23.00 Major movable equipment 23,670,356 0 0 0 24.00 24.00 Accumulated depreciation -13,411,552 0 0 0 24.00 25.00 Minor equipment depreciable 0 0 0 0 25.00 26.00 Accumulated depreciation -87,018 0 0 0 26.00 27.00 HT designated Assets 0 0 0 0 0 26.00 28.00 Accumulated depreciation 0 0 0 0 0 28.00 28.00 Accumulated depreciation 0 0 0 0 28.00 29.00 Minor equipment mondepreciable 0 0 0 0 28.00 30.00 Total fixed assets (sum of lines 12-29) 37,256,607 0 0 30.00 THER ASSETS		•	173,019				1
24.00 Accumula lated depreciation -13, 411, 552 0 0 24.00			0	· ·	o o		
25.00 Minor equipment depreciable 0 0 0 25.00	23. 00	Maj or movable equipment	23, 670, 356	(o		23. 00
26.00 Accumulated depreciation -87,018 0 0 0 26.00			-13, 411, 552	1	1 1		1
27.00 HIT designated Assets 0 0 0 0 27.00 28.00 Accumulated depreciation 0 0 0 28.00 29.00 Minor equipment-nondepreciable 0 0 0 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 37,256.607 0 0 0 0 30.00 30.00 Total fixed assets (sum of lines 12-29) 37,256.607 0 0 0 31.00 31.00 Investments 18,811,389 0 0 0 31.00 32.00 Deposits on leases 92.809 0 0 0 33.00 33.00 Due from owners/officers 0 0 0 0 33.00 34.00 Other assets (sum of lines 31-34) 18,904,198 0 0 0 33.00 35.00 Total other assets (sum of lines 11, 30, and 35) 69,993,674 0 0 0 35.00 38.00 Total other assets (sum of lines 11, 30, and 35) 69,993,674 0 0 0 36.00 38.00 Salaries, wages, and fees payable 3,731,655 0 0 0 37.00 38.00 Salaries, wages, and fees payable 2,894,846 0 0 0 38.00 40.00 Notes and Loans payable (short term) 2,073,657 0 0 0 0 39.00 40.00 Accelerated payments 0 0 0 0 0 41.00 41.00 Dererred income 0 0 0 0 0 43.00 43.00 Due to other funds 0 0 0 0 0 44.00 44.00 Other current liabilities 0 0 0 0 0 0 40.00 Notes payable 0 0 0 0 0 0 0 40.00 Other current liabilities (sum of lines 37 thru 44) 9,452,132 0 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 46 thru 49 11,166,873 0 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 46 thru 49 11,166,873 0 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 40 thru 49 11,166,873 0 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 40 thru 49 11,166,873 0 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 40 thru 49 11,166,873 0 0 0 0 0 0 40.00 Other long term liabilities (sum of lines 52 thru 58) 49,374,669 0 0 0 0 0 0			0 07 010	1	0		1
28.00 Accumulated depreciation 0 0 0 0 28.00		•	-87,018				
29. 00 Minor equipment-nondepreciable 0 0 0 0 29. 00 0 0 0 0 0 0 0 0 0			0	·	1		1
30.00 Total fixed assets (sum of lines 12-29) 37,256,607 0 0 0 0 30.00		•	0	·	1		
31.00 Investments			37, 256, 607	(o		1
32.00 Deposits on leases 92,809 0 0 0 32,00 33.00 Due from owners/officers 0 0 0 0 0 33,00 34.00 Other assets 0 0 0 0 0 34,00 35.00 Total other assets (sum of lines 31-34) 18,904,98 0 0 0 35,00 CURRENT LIABILITIES							
33.00 Due from owners/officers 0 0 0 0 0 33.00 34.00 Other assets 0 0 0 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 18.904,198 0 0 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 69.993,674 0 0 0 0 35.00 CURRENT LIABILITIES							
34.00 Other assets (sum of lines 31-34)		· ·	92, 809		1 1		1
35. 00 Total other assets (sum of lines 31-34) 18, 904, 198 0 0 0 35. 00			0	1	1 1		1
36. 00 Total assets (sum of lines 11, 30, and 35) 69, 993, 674 0 0 0 36. 00			18, 904, 198	1	1 1		
37.00 Accounts payable 3,731,655 0 0 0 37.00 38.00 Salaries, wages, and fees payable 2,894,846 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 39.00 40.00 Notes and Loans payable (short term) 2,073,657 0 0 0 0 41.00 Deferred income 0 0 0 0 41.00 41.00 Deferred income 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 43.00 43.00 Due to other funds 0 0 0 0 0 0 43.00 44.00 Other current liabilities (sum of lines 37 thru 44) 9,452,132 0 0 0 0 45.00 Dong Term Liabilities (sum of lines 37 thru 44) 9,452,132 0 0 0 0 45.00 Dong taxed loans 0 0 0 0 0 0 0 0 0	36.00	Total assets (sum of lines 11, 30, and 35)	69, 993, 674	(o	0	36. 00
38.00 Sal aries, 'wages, and fees payable 2, 894, 846 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 2,073,657 0 0 0 40.00 41.00 Deferred income 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 41.00 43.00 Due to other funds 0 0 0 0 0 43.00 44.00 Other current liabilities 751,974 0 0 0 44.00 45.00 Total current liabilities 751,974 0 0 0 44.00 46.00 Mortgage payable 0 0 0 0 0 45.00 47.00 Notes payable 11,166,873 0 0 0 0 45.00 48.00 Unsecured loans 0 0 0 0 46.00 49.00 Other long term liabilities (sum of lines 46 thru 49 11,166,873 0 0 0 0 49.00 50.00 Total ling term liabilities (sum of lines 45 and 50) 20,619,005 0 0 51.00 51.00 CAPITAL ACCOUNTS 52.00 General fund bal ance 550.00 Donor created - endowment fund bal ance - unrestricted 550.00 Donor							
39.00 Payrol taxes payable 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 2,073,657 0 0 0 0 40.00 41.00 2,073,657 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 42.00 42.00 43.00 Due to other Funds 0 0 0 0 0 0 0 43.00 0 0 0 0 0 0 0 0 0							
40.00 Notes and Loan's payable (short term) 41.00 Deferred income 42.00 Accelerated payments 52.073,657 63.00 Due to other funds 64.00 Other current Liabilities 751,974 752,974 753,974 753,974 753,974 753,974 754,975 755,975 755,975 757,975			2, 894, 846	l			
41.00 Deferred income 0			2 073 657		1		
42. 00			0		ol ol		1
44.00 Other current liabilities	42.00		0				
A5.00 Total current liabilities (sum of lines 37 thru 44) 9, 452, 132 0 0 0 45.00			0				1
LONG TERM LIABILITIES			1				
46.00 Mortgage payable 0 0 0 0 0 0 46.00 47.00 Notes payable 11, 166, 873 0 0 0 0 47.00 48.00 Unsecured Loans 0 0 0 0 0 48.00 49.00 Other Long term Liabilities 0 0 0 0 0 0 0 48.00 50.00 Total Long term Liabilities (sum of Lines 46 thru 49 11, 166, 873 0 0 0 0 59.00 51.00 Total Liabilites (sum of Lines 45 and 50) 20, 619, 005 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance	45. 00		9, 452, 132	[) ()	0	45.00
47. 00 Notes payable	46 00		1 0	(0	46 00
49.00 Other long term liabilities 0 0 0 0 0 49.00 Total long term liabilities (sum of lines 46 thru 49 11, 166, 873 0 0 0 0 50.00 Total liabilites (sum of lines 45 and 50) 20, 619, 005 0 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 49,374,669 0 0 0 59.00 49,374,669 0 0 0 59.00 70.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 0 0 0 60.00			11, 166, 873				1
Total long term liabilities (sum of lines 46 thru 49 11, 166, 873 0 0 0 0 50.00	48.00	Unsecured Loans	0	(o	0	48. 00
Total liabilites (sum of lines 45 and 50) 20,619,005 0 0 0 51.00			0		0		1
CAPITAL ACCOUNTS 52.00 General fund balance 49,374,669 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - unrestricted 0 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 57.00 Plant fund balance - invested in plant 0 57.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 58.00 59.00 Total fund balances (sum of lines 52 thru 58) 49,374,669 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 0 0 0 60.00					1		
52.00 General fund balance 49,374,669 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - unrestricted 0 54.00 55.00 Bonor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 57.00 Plant fund balance - invested in plant 0 57.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 58.00 59.00 Total fund balances (sum of lines 52 thru 58) 49,374,669 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 0 0 0 0 0 0	51.00	. ,	20, 619, 005) ()	0	51.00
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 60.00 Total liabilities and fund balances (sum of lines 51 and	52 00		49 374 669				52 00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 0 0 54.00 55.00 56.00 56.00			1.7, 0, 1, 30,				
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 69, 993, 674 56.00 57.00 0 57.00 0 0 58.00 0 0 0 59.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00	1			0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 0 0 0 60.00					0		
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 0 0 0 60.00					0		
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 0 0 0 60.00		· ·					1
59.00 Total fund balances (sum of lines 52 thru 58) 49,374,669 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 0,000) 69,993,674 0 0 0 60.00	50.00						30.00
60.00 Total liabilities and fund balances (sum of lines 51 and 69,993,674 0 0 0 60.00	59. 00		49, 374, 669		ol ol	0	59. 00
[59]	60.00		69, 993, 674	(o o	0	60.00
		[59]	I	I	1		I

Peri od: Wo From 10/01/2013 Provi der CCN: 150045

					To 09/30/2014	Date/Time Prep 2/25/2015 12:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET ASSESTS RELEASED FROM RESTRICTIO CONTRIBUTIONS RECEIVED	25, 000 1, 057, 216 0	51, 139, 272 -2, 808, 642 48, 330, 630	3.00	0 0 0 0	0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Subtotal (line 3 plus line 10) NET ASSESTS RELEASED FROM RESTRICTIO	38, 177 0 0	1, 082, 216 49, 412, 846		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17)	0	38, 177 49, 374, 669		0	0	16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
1 00	Find halance at haring as a said	6.00	7. 00	8. 00	0		1.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET ASSESTS RELEASED FROM RESTRICTIO CONTRIBUTIONS RECEIVED	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Subtotal (line 3 plus line 10) NET ASSESTS RELEASED FROM RESTRICTIO Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

			To 09/30/2014	Date/Time Pre 2/25/2015 12:	
	Cost Center Description	Inpatient	Outpati ent	Total	25 piii
	p	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	10, 136, 19	99	10, 136, 199	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	10 12/ 1/	20	10 12/ 100	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	10, 136, 19	79	10, 136, 199	10.00
11. 00	INTENSIVE CARE UNIT	3, 886, 4	17	3, 886, 417	11. 00
12. 00	CORONARY CARE UNIT	3, 000, 4	17	3, 000, 417	12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	3, 886, 4	17	3, 886, 417	16.00
10.00	11-15)	0,000,1	' '	0,000,117	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	14, 022, 6	16	14, 022, 616	17. 00
18. 00	Ancillary services	16, 968, 7		76, 581, 875	18. 00
19.00	Outpatient services	1, 565, 8	77 9, 371, 891	10, 937, 768	19.00
20.00	RURAL HEALTH CLINIC		0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22.00	HOME HEALTH AGENCY		1, 277, 596	1, 277, 596	22. 00
23.00	AMBULANCE SERVICES		0 4, 747, 624	4, 747, 624	23. 00
24.00	CMHC				24. 00
24. 10	CORF		0 0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	35, 6		589, 745	
27. 00	DI ETARY		0 20, 016	20, 016	•
27. 01	DHMG PHYSI CI ANS		0 9, 797, 824	9, 797, 824	
27. 02	SELF-I NSURANCE	258, 79		1, 454, 421	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	32, 851, 63	86, 577, 861	119, 429, 485	28. 00
	G-3, line 1)				
29. 00	PART II - OPERATING EXPENSES		(0.001.0E4		29. 00
30.00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)		60, 921, 854		30.00
31. 00	ADD (SPECIFI)		0		31.00
32. 00			0		32.00
33. 00			0		33.00
34. 00			0		34.00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			o		38. 00
39. 00			o		39. 00
40. 00			0		40. 00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	60, 921, 854		43. 00
	to Wkst. G-3, line 4)				

STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 150045	Peri od:	Worksheet G-3	
JIAILI	LENT OF REVENUES AND EXITENSES	10V1 del Cell. 130043	From 10/01/2013	WOLKSHEET 0 3	
			To 09/30/2014	Date/Time Prep	
				2/25/2015 12: 2	25 pm
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28	3)		119, 429, 485	1.00
2.00	Less contractual allowances and discounts on patients' accounts			68, 509, 943	
3. 00	Net patient revenues (line 1 minus line 2)			50, 919, 542	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			60, 921, 854	
5.00	Net income from service to patients (line 3 minus line 4)			-10, 002, 312	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			1, 340, 517	
8.00	Revenues from telephone and other miscellaneous communication ser	vi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts				10.00
11. 00	Rebates and refunds of expenses				11. 00
12. 00	Parking lot receipts				12.00
13. 00	Revenue from Laundry and Linen service				13.00
14. 00	Revenue from meals sold to employees and guests				14. 00
15.00	Revenue from rental of living quarters				15. 00
	Revenue from sale of medical and surgical supplies to other than	pati ents			16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MI SCELLANEOUS I NCOME			5, 853, 153	24.00
25.00	Total other income (sum of lines 6-24)			7, 193, 670	25. 00
26.00	Total (line 5 plus line 25)			-2, 808, 642	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			-2, 808, 642	29 00

Fixtures 2.00 Capital Related - Movable 0 0 0 0	1. 00
7.00 8.00 9.00 10.00 GENERAL SERVICE COST CENTERS	
GENERAL SERVICE COST CENTERS	
1.00 Capital Related - Bldg. & 0 0 0 0 0 Fixtures 2.00 Capital Related - Movable 0 0 0 0 0	
Fixtures 2.00 Capital Related - Movable 0 0 0 0	
2.00 Capital Related - Movable 0 0 0	2. 00
	2. 00
Fault amount	
Equi pment	
3.00 Plant Operation & Maintenance 0 0 0 0 0 0	3. 00
4.00 Transportation 0 0 0 0 0	4. 00
5.00 Administrative and General -2,737 710,538 -52,159 658,379 !	5. 00
HHA REIMBURSABLE SERVICES	
6.00 Skilled Nursing Care 0 273, 271 0 273, 271	6. 00
7. 00 Physi cal Therapy 0 123, 490 0 123, 490	7. 00
8.00 0ccupati onal Therapy 0 0 0 0	8. 00
9.00 Speech Pathology 0 3,855 0 3,855	9. 00
10.00 Medical Social Services 0 27,492 0 27,492 10	0. 00
11.00 Home Health Aide 0 111,568 0 111,568 1	1. 00
	2. 00
	3. 00
	4. 00
HHA NONREI MBURSABLE SERVI CES	
15. 00 Home Dialysis Aide Services 0 0 0 0 0	5. 00
	6. 00
	7. 00
	8. 00
19.00 Health Promotion Activities 0 0 0 0	9. 00
	0. 00
	1. 00
	2. 00
	3. 00
	4. 00
2.100 [1010. (Com. 0. 1.1100 . 20)] 2,707	00

1. 00	Capital Related - Bldg. &	0	0				0	1. 00
	Fi xtures							
2.00	Capital Related - Movable	0		0			0	2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0	0		0	3. 00
4.00	Transportation	0	0	0	0	0		4. 00
5.00	Administrative and General	658, 379	0	0	0	0	658, 379	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	273, 271	0	0	0	0	273, 271	6. 00
7. 00	Physi cal Therapy	123, 490	0	0	0	0	123, 490	7. 00
8.00	Occupati onal Therapy	0	0	0	0	0	0	8. 00
9. 00	Speech Pathology	3, 855	0	0	0	0	3, 855	9. 00
10. 00	Medical Social Services	27, 492	0	0	0	0	27, 492	10. 00
11. 00	Home Health Aide	111, 568	0	0	0	0	111, 568	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	0	0	0	15.00
16.00	Respiratory Therapy	0	O	O	0	0	0	16.00
17.00	Private Duty Nursing	0	O	O	0	o	0	17.00
18.00	Clinic	o	o	o	0	o	0	18.00
19.00	Health Promotion Activities	0	O	O	0	o	0	19.00
20.00	Day Care Program	o	o	o	0	o	0	20.00
21. 00	Home Delivered Meals Program	l ol	ol	o	0	o	0	21.00
22. 00	Homemaker Service	0	0	0	o	0	0	22. 00
23. 00	All Others (specify)	0	o	o	Ö	0	0	23. 00
	Total (sum of lines 1-23)	1, 198, 055	0	o	Ö	0	1, 198, 055	
21100	Total (sam st 1111es 1 25)	Admi ni strati ve	Total (cols.	<u> </u>		J	17 1707 000	21100
		& General	4A + 5)					
		5. 00	6.00					
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. &							1. 00
1. 00	Capital Related - Bldg. & Fixtures							1. 00
	Fixtures							
1. 00 2. 00	Fixtures Capital Related - Movable							1. 00 2. 00
	Fixtures Capital Related - Movable Equipment							
2. 00 3. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance							2. 00
2. 00 3. 00 4. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	658, 379						2. 00 3. 00
2. 00 3. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General	658, 379						2. 00 3. 00 4. 00
2.00 3.00 4.00 5.00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	658, 379 333, 377	606, 648					2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care	333, 377	606, 648 274, 142					2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy		606, 648 274, 142 0					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy	333, 377 150, 652 0	274, 142 0					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	333, 377 150, 652 0 4, 703	274, 142 0 8, 558					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	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	333, 377 150, 652 0 4, 703 33, 539	274, 142 0 8, 558 61, 031					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	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	333, 377 150, 652 0 4, 703	274, 142 0 8, 558					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	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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)	333, 377 150, 652 0 4, 703 33, 539	274, 142 0 8, 558 61, 031					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	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0	274, 142 0 8, 558 61, 031					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	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539	274, 142 0 8, 558 61, 031 247, 676 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 14. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 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	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0	274, 142 0 8, 558 61, 031 247, 676 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 16. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 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
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	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 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 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 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 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 0 0					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 0 0					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 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 19. 00 20. 00 21. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 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 20. 00 21. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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 Homemaker Service	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 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 20. 00 21. 00 22. 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 19. 00 20. 00 21. 00 22. 00 23. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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 Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 0 0 0 0 0 0 0 0 0					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 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 19. 00 20. 00 21. 00 22. 00 23. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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 Homemaker Service	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 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 20. 00 21. 00 22. 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 19. 00 20. 00 21. 00 22. 00 23. 00	Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance 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 Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	333, 377 150, 652 0 4, 703 33, 539 136, 108 0 0	274, 142 0 8, 558 61, 031 247, 676 0 0 0 0 0 0 0 0 0					2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HHA STATISTICAL BASIS	Provi der CCN: 150045	Period: Worksheet H-1 From 10/01/2013 Part II
	HHA CCN: 15715	7 To 09/30/2014 Date/Time Prepared: 2/25/2015 12:25 pm
		Home Health PPS

							2/25/2015 12: 2	25 pm_
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati o	nReconciliation	Admi ni strati ve	
		Fi xtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
				(SQUARE FEET)				
		1. 00	2.00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	C		0		3.00
4.00	Transportation (see	0	0	C		0		4.00
	instructions)							
5.00	Administrative and General	0	0	C)	-658, 379	539, 676	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	C)	0 0	273, 271	6.00
7.00	Physi cal Therapy	0	0	C		0	123, 490	7. 00
8.00	Occupational Therapy	0	0	C		0	0	8. 00
9.00	Speech Pathology	0	0	C		0	3, 855	9. 00
10.00	Medical Social Services	0	0	C		0	27, 492	10.00
11. 00	Home Health Aide	0	0	C		0	111, 568	11. 00
12.00	Supplies (see instructions)	0	0	C		0	0	12.00
13.00	Drugs	0	0	C		0	0	13.00
14.00	DME	0	0	C		0	o	14.00
	HHA NONREIMBURSABLE SERVICES	<u>'</u>			1			
15. 00	Home Dialysis Aide Services	0	0	C		0 0	0	15. 00
16.00	Respiratory Therapy	0	0	C		0	0	16. 00
17. 00	Private Duty Nursing	0	0	C		0	o	17. 00
18. 00	Clinic	l 0	0	ĺ		0	o	18. 00
19. 00	Health Promotion Activities	0	0	Ċ		0	0	19. 00
20. 00	Day Care Program	0	0	Ċ		0	0	20. 00
21. 00	Home Delivered Meals Program	0	0	Ċ		0	0	21. 00
	Homemaker Service	0	0	Ċ		0	0	22. 00
	All Others (specify)	0	0	Ċ		0	0	23. 00
	Total (sum of lines 1-23)	ا م	l ő			-658, 379	539, 676	
25. 00	Cost To Be Allocated (per	ا م	l o			000,077	658, 379	
20.00	Worksheet H-1, Part I)	Ĭ			1		555, 577	_0.00
26, 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	o	1. 219952	26, 00
20.00	1	1 0.00000	0.00000		., 5. 55000	-1		

Home Health PPS

						Home Health Agency I	PPS	
			CAPI TAL					
	Cost Center Description	HHA Trial	RELATED COSTS BLDG & FLXT	MAC WEST - NI	EW NORTH ANNEX	- GARRETT CLINIC	BUTLER - NEW	
		Bal ance (1)	1. 00	1. 01	NEW 1. 02	- NEW 1. 03	1. 04	
1. 00	Administrative and General	0	0		0 3, 57		0	1. 00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	606, 648 274, 142	0	•	0	0 0	0	2. 00 3. 00
4.00	Occupational Therapy	0	0		o	0 0	0	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	8, 558 61, 031	0		0	0 0	0	5. 00 6. 00
7.00	Home Health Aide	247, 676	0		O	0 0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0		0	0 0	0	8. 00 9. 00
10.00	DME	0	0	•	o	0 0	0	10. 00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0		0	0 0	0	11. 00 12. 00
13.00	Private Duty Nursing	0	0		0	0 0	0	13. 00
14. 00 15. 00	Clinic Health Promotion Activities		0	•	0	0 0	0	14. 00 15. 00
16.00	Day Care Program	0	0		0	0 0	0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0		0	0 0	0	17. 00 18. 00
19. 00 20. 00	All Others (specify) Total (sum of lines 1-19) (2)	0 1, 198, 055	0		0 3, 57	0 0	0	19. 00 20. 00
21. 00	Unit Cost Multiplier: column	1, 178, 055			3, 37	9	0	21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.		CAP	I TAL RELATED	COSTS			
	Cost Center Description	MAC EAST - NEW	GARRETT LAB -	MEDICAL ARTS	- DAY SPRING -	MVBLE EQUIP	EMPLOYEE	
	·		NEW	NEW	NEW		BENEFITS DEPARTMENT	
		1.05	1.06	1. 07	1. 08	2. 00	4. 00	
1. 00 2. 00	Administrative and General Skilled Nursing Care	0	0	ł	0	0 0	80, 600 0	1. 00 2. 00
3.00	Physical Therapy	Ö	O		o	0 0	0	3. 00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0		0	0 0	0	4. 00 5. 00
6.00	Medical Social Services	0	0		O	0 0	0	6. 00
7. 00 8. 00	Home Health Aide Supplies (see instructions)	0	0	ł .	0	0 0	0	7. 00 8. 00
9. 00	Drugs	0	0	•	0	0 0	0	9. 00
10. 00 11. 00	DME Home Dialysis Aide Services		0		0	0 0	0	10. 00 11. 00
12.00	Respiratory Therapy	0	0		0	0 0	0	12.00
13. 00 14. 00	Private Duty Nursing Clinic	0	0		0	0 0	0	13. 00 14. 00
	Health Promotion Activities Day Care Program	0	0		0	0 0	0	15. 00 16. 00
16. 00 17. 00	Home Delivered Meals Program	0	0		0	0 0	0	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)	0	0		0	0 0	0	18. 00 19. 00
20.00	Total (sum of lines 1-19) (2)	0	0		o	0 0	80, 600	20. 00
21. 00	Unit Cost Multiplier: column							21. 00
	126. Tine i giviaea ov the sum							
	26, line 1 divided by the sum of column 26, line 20 minus							

⁽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 DEKALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: | Worksheet H-2 From 10/01/2013 | Part | Part | Date/Ti me Prepared: 2/25/2015 12: 25 pm | Home Health | PPS Provi der CCN: 150045 HHA CCN: 157157

						Home Health Agency I	PPS	
	Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			& GENERAL	PLANT	LINEN SERVICE			
		4A	5. 00	7. 00	8. 00	9. 00	10.00	
1.00	Administrative and General	84, 179	14, 422	84, 220		,	0	
2.00	Skilled Nursing Care	606, 648	103, 932	0	1		0	
3. 00 4. 00	Physical Therapy Occupational Therapy	274, 142	46, 967 0	0	1	ı "I	0	
5. 00	Speech Pathology	8, 558	1, 466	0	1		0	
6. 00	Medical Social Services	61, 031	10, 456	0	1		0	
7. 00	Home Heal th Aide	247, 676	42, 433	Ö	Ō	o	0	
8. 00	Supplies (see instructions)	0	0	0	0	o	0	8. 00
9. 00	Drugs	0	0	0	0	0	0	
10. 00	DME	0	0	0	1		0	
11. 00	Home Dialysis Aide Services	0	0	0		_	0	
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0	0	_	0	
14. 00	Clinic	0	0	0	0	_	0	1
15. 00	Health Promotion Activities	0	0	0	Ö		0	1
16. 00	Day Care Program	0	0	Ō	Ō		0	
17.00	Home Delivered Meals Program	0	0	0	0	O	0	
18. 00	Homemaker Service	0	0	0	0	0	0	
19. 00	All Others (specify)	0	0	0	0		0	
20.00	Total (sum of lines 1-19) (2)	1, 282, 234	219, 676	84, 220	0	24, 689	0	20.00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum	0. 000000						21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	SNACK BAR	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
				ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		10. 01	11. 00	13. 00	14.00	15. 00	16. 00	
1. 00	Administrative and General	0	41, 555	145, 923	0	0	0	1. 00
2.00	Skilled Nursing Care	0	0	0		-	0	
3. 00	Physi cal Therapy	0	0	0	0	-	0	
4.00	Occupational Therapy Speech Pathology	0	0	0	0	0	0	
5. 00 6. 00	Medical Social Services	0	0	0	0	0	0	
7. 00	Home Heal th Aide	0	0	0	0	Ö	0	
8. 00	Supplies (see instructions)	0	0	0	Ō	Ö	0	
9.00	Drugs	0	0	0	0	o	0	9. 00
10.00	DME	0	0	0	1		0	
11.00	Home Dialysis Aide Services	0	0	0			0	
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0	0		0	
14. 00	Clinic	0	0	0	0		0	1
15. 00	Health Promotion Activities	Ö	0	0	Ö	_	0	1
16.00	Day Care Program	0	0	0	0	o	0	1
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	
18. 00	Homemaker Service	0	0	0	0		0	
19.00	All Others (specify)	0	0	145.000	0	0	0	
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0	41, 555	145, 923	0	۷	0	20.00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							1

⁽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.

Worksheet H-2 Part I Date/Time Prepared: 2/25/2015 12:25 pm Provider CCN: 150045 Peri od: From 10/01/2013 To 09/30/2014 HHA CCN: 157157

						Home Health	PPS	•
						Agency I		
	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
				Residents Cost		A&G (see Part	Costs	
				& Post		11)		
				Stepdown				
				Adjustments				
1 00		17. 00	24. 00	25. 00	26. 00	27. 00	28. 00	1 00
1.00	Administrative and General	0	394, 988	0	394, 988			1.00
2.00	Skilled Nursing Care	0	710, 580	0	710, 580		910, 587	2. 00
3.00	Physi cal Therapy	0	321, 109	0	321, 109	90, 382	411, 491	3. 00
4.00	Occupational Therapy	0	0	0	0	0	0	4. 00
5.00	Speech Pathology	0	10, 024	0	10, 024		12, 845	5. 00
6.00	Medical Social Services	0	71, 487	0	71, 487		91, 608	
7.00	Home Health Aide	0	290, 109	0	290, 109	81, 657	371, 766	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12. 00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16.00	Day Care Program	0	0	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00	Homemaker Service	0	0	0	0	0	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
20.00	Total (sum of lines 1-19) (2)	0	1, 798, 297	0	1, 798, 297	394, 988	1, 798, 297	20. 00
21. 00	Unit Cost Multiplier: column					0. 281469		21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

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

Health Financial Systems	DEKALB MEMORIAL HO	OSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS BASIS	TO HHA COST CENTERS STATISTICAL	Provi der CCN: 150045 HHA CCN: 157157	From 10/01/2013	Worksheet H-2 Part II Date/Time Prepared: 2/25/2015 12:25 pm
			Homo Hoal th	DDC

CAPITAL RELATED COSTS BLIDG & FIXT (SQUARE FEET) (SQ
Cost Center Description SLIDG & FIXT (SOUARE FEET) (SO
1.00
1.00 Administrative and General 1.00 1.01 1.02 1.03 1.04 1.05 1.05 1.00 2.00 3.00 2.00 3.00 3.00 Physical Therapy 0 0 0 0 0 0 0 0 0
2.00 Skilled Nursing Care 0 0 0 0 0 0 0 0 0
3.00
4.00
Speech Pathology
Nome Health Aide
Supplies (see instructions)
9.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
10.00 DME
12.00 Respiratory Therapy 0 0 0 0 0 0 0 12.00
13.00
14.00 Clinic 15.00 Health Promotion Activities 0 0 0 0 0 0 0 0 14.00
15.00 Heal th Promotion Activities 0 0 0 0 0 0 0 15.00
16.00 Day Care Program
18.00 Homemaker Service
19.00
Total (sum of lines 1-19)
21.00 Total cost to be allocated 0 0 0 3,579 0 0 0 0 0 21.00
22.00 Unit cost multiplier 0.000000 0.000000 1.291126 0.000000 0.000000 0.000000 22.00
Cost Center Description GARRETT LAB - NEW (SQUARE FEET) GOUARE FEET) COUARE FEET) COUA
NEW
COUARE FEET COUARD USE FEET COUARE FEET COUARD USE FEE
1.00 Administrative and General 1.00 0 0 0 0 0 0 0 0 0
1.06 1.07 1.08 2.00 4.00 5A
1. 00 Administrative and General 0 0 0 0 877,480 0 1.00 2. 00 Skilled Nursing Care 0 0 0 0 0 0 0 0 0 2.00 3. 00 Physical Therapy 0 0 0 0 0 0 0 0 0 3.00 4. 00 Occupational Therapy 0 0 0 0 0 0 0 4.00 5. 00 Speech Pathology 0 0 0 0 0 0 0 5.00 6. 00 Medical Social Services 0
2. 00 Skilled Nursing Care 0 0 0 0 0 0 0 2.00 3. 00 Physical Therapy 0 0 0 0 0 0 0 3.00 4. 00 Occupational Therapy 0 0 0 0 0 0 0 0 4.00 5. 00 Speech Pathology 0 0 0 0 0 0 0 0 5.00 6. 00 Medical Social Services 0 0 0 0 0 0 0 0 0 0 0 7.00
3. 00 Physical Therapy 0 0 0 0 0 0 3.00 4. 00 Occupational Therapy 0 0 0 0 0 0 0 4.00 5. 00 Speech Pathology 0 0 0 0 0 0 0 0 0 5.00 6. 00 Medical Social Services 0 0 0 0 0 0 0 0 0 0 0 7.00 7. 00 Home Heal th Aide 0 0 0 0 0 0 0 0 0 0 0 0 0 0
4.00 Occupational Therapy 0 0 0 0 0 4.00 5.00 Speech Pathology 0 0 0 0 0 0 0 5.00 6.00 Medical Social Services 0 0 0 0 0 0 0 0 6.00 7.00 Home Heal th Aide 0 0 0 0 0 0 0 0 7.00
6.00 Medical Social Services 0 0 0 0 0 0 6.00 7.00 Home Health Aide 0 0 0 0 0 7.00
7.00 Home Heal th Ai de 0 0 0 0 0 7.00
9. 00 Drugs 0 0 0 0 0 9. 00
10. 00 DME 0 0 0 0 0 10. 00
11.00 Home Dialysis Aide Services 0 0 0 0 11.00
12. 00 Respiratory Therapy 0 0 0 12. 00
13.00 Private Duty Nursing 0 0 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 0 14.00
15.00 Health Promotion Activities
16.00 Day Care Program 0 0 0 0 0 16.00
17.00 Home Delivered Meals Program 0 0 0 0 0 17.00
18.00 Homemaker Service 0 0 0 0 0 18.00 19.00 All Others (specify) 0 0 0 0 0 0 19.00
20. 00 Total (sum of lines 1-19)
21. 00 Total cost to be allocated 0 0 0 80, 600 21. 00
22. 00 Unit cost multiplier 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000 0.0000000 0.0000000

Provider CCN: 150045 BASIS HHA CCN: 157157 Home Health PPS

						Home Health	PPS	
	C+ C+ Di-+i	IADMINI CTDATI VE	ODEDATION OF	I ALINIDDY 0	HOUGEKEEDING	Agency I	CNACK DAD	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	
		& GENERAL	PLANT	LI NEN SERVI CE	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)	
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF				
		5. 00	7. 00	LAUNDRY) 8. 00	9. 00	10.00	10. 01	
1. 00	Administrative and General	84, 179	2,772	0.00			10.01	1, 00
	1	1	2,772		2,112	0	0	•
2.00	Skilled Nursing Care	606, 648		_			0	2.00
3.00	Physical Therapy	274, 142		_		1	-	3.00
4.00	Occupational Therapy	0 550	· ·			0	0	4.00
5.00	Speech Pathology	8, 558	C	_		0	0	5. 00
6.00	Medical Social Services	61, 031	C	_	C		0	6.00
7.00	Home Heal th Ai de	247, 676	C		C	0	0	7. 00
8.00	Supplies (see instructions)	0	C	_		0	0	8. 00
9.00	Drugs	0	C		0	0	0	9. 00
10.00	DME	0	C	_	C	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	C	_	C	0	0	11. 00
12. 00	Respiratory Therapy	0	C	_	C		0	12. 00
13. 00	Private Duty Nursing	0	C	0	0	0	0	13. 00
14. 00	Clinic	0	C	0	0	0	0	14. 00
15. 00	Health Promotion Activities	0	C	0	C	0	0	15. 00
16. 00	Day Care Program	0	C	0	C	0	0	16. 00
17. 00	Home Delivered Meals Program	0	C	0	C	0	0	17. 00
18. 00	Homemaker Service	0	C	0	C	0	0	18. 00
19. 00	All Others (specify)	0	C	0	C	0	0	19. 00
20.00	Total (sum of lines 1-19)	1, 282, 234	2, 772	0	2, 772	. 0	0	20. 00
21. 00	Total cost to be allocated	219, 676	84, 220	0	24, 689	0	0	21. 00
22. 00	Unit cost multiplier	0. 171323	30. 382395	0.000000	8. 906566	0.00000	0. 000000	22. 00
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		(FTES)	ADMI NI STRATI ON		(COSTED	RECORDS &		
				SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
			(DI RECT NRS	(COSTED		(GROSS REVE		
		11.00	I NG)	REQUIS.)	45.00	NUE)	47.00	
4.00		11.00	13.00	14.00	15. 00	16.00	17. 00	1 00
1.00	Administrative and General	1, 838	38, 228	0	1		0	1.00
2.00	Skilled Nursing Care	0	C	0	C	_	0	2.00
3.00	Physi cal Therapy	0	C	_	C		0	3. 00
4.00	Occupational Therapy	0	C	0	C	_	0	4. 00
5.00	Speech Pathology	0	C	0	C	0	0	5. 00
6.00	Medical Social Services	0	C	_		0	0	6. 00
7. 00	Home Heal th Ai de	0	C		C	_	0	7. 00
8. 00	Supplies (see instructions)	0	C		C	0	0	8. 00
9.00	Drugs	0	C	_	0	0	0	9. 00
10.00	DME	0	C		C	_	0	10.00
11. 00	Home Dialysis Aide Services	0	C		C	_	0	11. 00
12. 00	Respiratory Therapy	0	C	_	C	0	0	12. 00
13. 00	Private Duty Nursing	0	C	_	C	0	0	13. 00
14. 00	Clinic	0	C		0	0	0	14. 00
15. 00	Health Promotion Activities	0	C	0	0	0	0	15. 00
16. 00	Day Care Program	0	C	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	C	0	0	0	0	17. 00
18. 00	Homemaker Service	0	C	0	0	0	0	18. 00
19. 00	All Others (specify)	0	C	0	0	0	0	19. 00
20.00	Total (sum of lines 1-19)	1, 838	38, 228	l .	0	0	0	20. 00
21. 00								1 24 00
	Total cost to be allocated Unit cost multiplier	41, 555 22. 608814	145, 923 3. 817176		0. 000000	0. 000000	0. 000000	21. 00 22. 00

ui tii	n Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPOR1	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der	CCN: 150045	Peri od:	Worksheet H-3	
				HHA CCN:		From 10/01/2013 To 09/30/2014	Part I Date/Time Prep 2/25/2015 12:	pared:
				Ti tl	e XVIII	Home Health Agency I	PPS	<u> </u>
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							
1.00	Skilled Nursing Care	2. 00	910, 587		910, 58	7 5, 011	181. 72	1. 00
2.00	Physi cal Therapy	3. 00		0	1			2. 00
3.00	Occupational Therapy	4. 00	0	O)	0	0. 00	3. 00
4.00	Speech Pathology	5. 00			1 .2,0		133. 80	
5.00	Medical Social Services	6. 00			91, 60		1, 832. 16	5. 00
6.00	Home Heal th Ai de	7. 00			371, 76		197. 12	6. 00
7. 00	Total (sum of lines 1-6)		1, 798, 297	О	1,798,29 Program Visits			7. 00
						rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to			
			(1)		Deductibles &			
					Coi nsurance			
	1:-:+-+:	0	1.00	2. 00	3.00	4. 00	5. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care	I	99915	198	2, 47	2		8. 00
9. 00	Physical Therapy		99915	66	1			9. 00
10.00			99915	0	l .			10. 00
11.00			99915	1	6	1		11. 00
12.00	Medical Social Services		99915	2	2!	5		12. 00
13.00	Home Health Aide		99915	48				13. 00
14.00	Total (sum of lines 8-13)			315				14. 00
	Cost Center Description		Facility Costs		Total HHA		Ratio (col. 3	
		Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (cols. + 2)	1 (from HHA Record)	÷ col. 4)	
		20, 11116	11-2, Fait 1)	Part II)	+ 2)	Record)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Comput							
	Cost of Medical Supplies	8.00				0		
16. 00	Cost of Drugs	9. 00	Program Visits		Cost of	0	0. 000000	16. 00
			riogiam visits		Servi ces			
			Par	t B	1	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &	Deductibles &	
		/ 00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
		6. 00	7.00	8.00	9. 00	10.00	11. 00	
	DART I _ COMPLITATION OF LESSED	OF ACCRECATE I			IE DRUGRAM LIMI	TALLON COST. OF		
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	NOONAW COST, A	CONCONTE OF TH	IE PROGRAM LIMI			
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	TOURAW COST, A	SORESTIE OF TH	E PROGRAM LIMI			
1. 00	BENEFICIARY COST LIMITATION	198	2, 478		E PROGRAM LIMI	1 450, 302		1. 00
1. 00 2. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation		2, 478 898			1 450, 302		2. 00
2. 00 3. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	198	2, 478 898 0		35, 98 13, 16	1 450, 302 4 179, 115 0 0		2. 00 3. 00
2.00 3.00 4.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	198	2, 478 898 0 61		35, 98 13, 16 (1 450, 302 4 179, 115 0 0 4 8, 162		2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	198 66 0 1 2	2, 478 898 0 61 25		35, 98 13, 16 13, 13, 66	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804		2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	198 66 0 1 2 48	2, 478 898 0 61 25 1, 058		35, 98 13, 16 13, 16 13, 66, 9, 46;	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553		2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	198 66 0 1 2	2, 478 898 0 61 25 1, 058		35, 98 13, 16 13, 13, 66	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553		2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	198 66 0 1 2 48	2, 478 898 0 61 25 1, 058		35, 98 13, 16 13, 16 13, 66, 9, 46;	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553		2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	198 66 0 1 2 48 315	2, 478 898 0 61 25 1, 058 4, 520		35, 98 13, 16 (13, 3, 66 9, 46 62, 40	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553 891, 936		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	198 66 0 1 2 48 315	2, 478 898 0 61 25 1, 058 4, 520		35, 98 13, 16 (13, 3, 66 9, 46 62, 40	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553 891, 936		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	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy	198 66 0 1 2 48 315	2, 478 898 0 61 25 1, 058 4, 520		35, 98 13, 16 (13, 3, 66 9, 46 62, 40	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553 891, 936		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	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	198 66 0 1 2 48 315	2, 478 898 0 61 25 1, 058 4, 520		35, 98 13, 16 (13, 3, 66 9, 46 62, 40	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553 891, 936		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	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	198 66 0 1 2 48 315	2, 478 898 0 61 25 1, 058 4, 520		35, 98 13, 16 (13, 3, 66 9, 46 62, 40	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553 891, 936		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	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	198 66 0 1 2 48 315	2, 478 898 0 61 25 1, 058 4, 520		35, 98 13, 16 (13, 3, 66 9, 46 62, 40	1 450, 302 4 179, 115 0 0 4 8, 162 4 45, 804 2 208, 553 891, 936		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

Heal th	Financial Systems		DEKALB MEMORI	AL HOSPI	TAL		In Lie	u of Form CMS-2	2552-10
APPOR1	TIONMENT OF PATIENT SERVICE COST	S			A CCN:	CCN: 150045 157157		Date/Time Pre 2/25/2015 12:	pared:
					Titl	e XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	arges		Cost of Services			
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Deducti b Coi nsur	bles & rance	Part A	Part B Not Subject to Deductibles & Coinsurance	Coi nsurance	
	Tarana and a same and a same a same a same a same a same a same a same a same a same a same a same a same a sa	6.00	7. 00	8.0	0	9. 00	10.00	11. 00	
45.00	Supplies and Drugs Cost Comput	ations	1						1
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs		С		0		0	0	15. 00 16. 00
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00							
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A	AGGREGATE	OF TH	E PROGRAM LII	MITATION COST, OF	2	
	Cost Per Visit Computation		1						
1. 00	Skilled Nursing Care	486, 283							1. 00
2.00	Physi cal Therapy	192, 279							2. 00
3.00	Occupational Therapy	0							3.00
4. 00 5. 00	Speech Pathology Medical Social Services	8, 296 49, 468							4. 00 5. 00
6. 00	Home Health Aide	218, 015							6.00
7. 00	Total (sum of lines 1-6)	954, 341							7. 00
7.00	Cost Center Description	754, 541							7.00
	0001 0011101 20001 Pt. 011	12. 00	-						
	Limitation Cost Computation								
8.00	Skilled Nursing Care								8. 00
9.00	Physi cal Therapy								9. 00
10.00	Occupational Therapy								10. 00
11. 00	Speech Pathology								11. 00
12.00	Medical Social Services								12.00
13.00	Home Heal th Ai de								13.00
14. 00	Total (sum of lines 8-13)	I	I						14. 00

Health Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150045	Peri od:	Worksheet H-3	
			HHA CCN:	157157	From 10/01/2013 To 09/30/2014	Part II Date/Time Pre 2/25/2015 12:	
	PPS						
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
	Part I, col.	Rati o	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2. 00	3. 00	4. 00		
PART II - APPORTIONMENT OF COST	T OF HHA SERVIC	ES FURNISHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66. 00	0. 489396	0		0 col. 2, line 2	. 00	1. 00
1.01 Physical Therapy 1	66. 01	1. 000977	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. 437926	0		0 col. 2, line 1	5. 00	4. 00
5.00 Cost of Drugs	73. 00	0. 534090	0		0 col. 2, line 1	6. 00	5. 00

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMAR Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions) Total charges		157157 e XVIII Part A 1.00	Home Health Agency I	Deductibles &	
Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)		Part A	Agency I Par Not Subject to Deductibles & Coinsurance	t B Subject to Deductibles &	
Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)	RY CHARGE:	1. 00	Par Not Subject to Deductibles & Coinsurance	Subject to Deductibles &	
Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)	RY CHARGE:	1. 00	Deductibles & Coinsurance	Deductibles &	-
Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)	RY CHARGE				
Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)	RY CHARGE	S		Coi nsurance 3.00	
Reasonable cost of services (see instructions)			*		
·					
u liotai charges			0 0		
Customary Charges			0 0	0	1 :
O Amount actually collected from patients liable for payment for se	ervi ces		0 0	0	1 3
on a charge basis (from your records)					
Amount that would have been realized from patients liable for pay			0	0) 4
for services on a charge basis had such payment been made in acco	ordance				
with 42 CFR 413.13(b) 0 Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 00000	0. 000000	
7 Total customary charges (see instructions)		0.0000	0.000000	0.000000	1
0 Excess of total customary charges over total reasonable cost (con	mplete		0 0	0	
only if line 6 exceeds line 1)					
Excess of reasonable cost over customary charges (complete only in 1 exceeds line 6)	it line		0 0	0	1
O Primary payer amounts			0 0	0	
			Part A Services	Part B	
			1. 00	Servi ces 2. 00	+
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					Т
Total reasonable cost (see instructions)			0	0	1
OO Total PPS Reimbursement - Full Episodes without Outliers			37, 739	456, 047	
00 Total PPS Reimbursement - Full Episodes with Outliers 00 Total PPS Reimbursement - LUPA Episodes			0	22, 530	
00 Total PPS Reimbursement - LUPA Episodes 00 Total PPS Reimbursement - PEP Episodes			0	8, 738 7, 270	
00 Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	2, 323	
00 Total PPS Outlier Reimbursement - PEP Episodes			0	366	
OO Total Other Payments			0	0	
DO DME Payments			0	0	
ON Dreathatic and Orthatic Powents			0	0	
00 Prosthetic and Orthotic Payments 00 Part B deductibles billed to Medicare patients (exclude coinsurar	nce)		0	0	
00 Subtotal (sum of lines 10 thru 20 minus line 21)	ncc)		37, 739		
00 Excess reasonable cost (from line 8)			0	0	
OO Subtotal (line 22 minus line 23)			37, 739	497, 274	
OO Coinsurance billed to program patients (from your records)			07	0	
00 Net cost (line 24 minus line 25) 00 Reimbursable bad debts (from your records)			37, 739	497, 274	
00 Reimbursable bad debts (from your records) 00 Reimbursable bad debts for dual eligible beneficiaries (see instr	ructions)				2 2
00 Total costs - current cost reporting period (line 26 plus line 27			37, 739	497, 274	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	0	1
00 Subtotal (line 29 plus/minus line 30)			37, 739	497, 274	
O1 Sequestration adjustment (see instructions)			755	9, 946	
On Interim payments (see instructions)			36, 984	487, 329	
00 Tentative settlement (for contractor use only) 00 Balance due provider/program line 31 minus lines 31.01, 32 and 33	3		0	0	
00 Balance due provider/program line 31 minus lines 31.01, 32 and 33 00 Protested amounts (nonallowable cost report items) in accordance		Pub 15_2	0	-1 0	

Heal th Financial Systems DEKALB MEMORIAL HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO Provide In Lieu of Form CMS-2552-10 Provi der CCN: 150045

PROGRAM BENEFICIARIES

HHA CCN: 157157

Peri od: From 10/01/2013 To 09/30/2014

Worksheet H-5

Home Health

Date/Time Prepared: 2/25/2015 12:25 pm PPS

				Agency I		
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		36, 984		487, 329	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment	-				3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	<u> </u>				
3. 01			0		0	3. 01
3.02			0		o	3. 02
3.03			0		0	3. 03
3.04			0		0	3.04
3.05			0		0	3. 05
	Provider to Program					
3.50			0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		36, 984		487, 329	4. 00
4.00	(transfer to Wkst. H-4, Part II, column as appropriate,		30, 704		407, 327	4.00
	line 32)					
	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			0		0	5. 01
5. 02			0		0	5. 02
5. 03	Provider to Program		0		0	5. 03
5. 50	Provider to Program		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		l ol	5. 99
0. , ,	5. 50-5. 98)		Ŭ			0. ,,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		1	6. 02
7. 00	Total Medicare program liability (see instructions)		36, 984		487, 328	7. 00
				Contractor	NPR Date	
			,	Number	(Mo/Day/Yr)	
8.00	Name of Contractor)	1. 00	2.00	8. 00
0.00	Invaline of Contractor	I			l l	0.00

			nospi ce (JON. 131339 1	0 09/30/2014	2/25/2015 12:	
					Hospi ce I	2, 20, 2010 121	20 p
		Salaries (from	Employee	Transportati or		Other	
			Benefits (from		Services (from		
			Wkst. K-2)	(() () ()	Wkst. K-3)		
		1.00	2.00	3.00	4, 00	5. 00	
	GENERAL SERVICE COST CENTERS		<u> </u>				
1.00	Capital Related Costs-Bldg and Fixt.			()	0	1.00
2.00	Capital Related Costs-Movable Equip.			1 0		0	2. 00
3.00	Plant Operation and Maintenance	0	0) (o	0	3. 00
4.00	Transportation - Staff	0	0	1 0	o	0	4. 00
5.00	Volunteer Service Coordination	0	0		o	0	5. 00
6.00	Administrative and General	2, 346		13, 121	68, 856	79, 845	6. 00
	I NPATI ENT CARE SERVI CE	, , , , , ,			,,		
7.00	Inpatient - General Care	0	0		0	0	7.00
8.00	Inpatient - Respite Care	0	0	1 0	ol	0	8. 00
	VI SI TI NG SERVI CES		<u> </u>				1
9.00	Physi ci an Servi ces	2, 217	C		0	0	9. 00
10.00	Nursi ng Care	83, 486	0	·	o	0	10. 00
11.00	Nursing Care-Continuous Home Care	0	0	·	o	0	11. 00
12.00	Physical Therapy	360	0	·	o	0	12. 00
13.00	Occupational Therapy	0	0	·	o	0	13. 00
14.00	Speech/ Language Pathology	0	0	·	o	0	14. 00
15.00	Medical Social Services	2, 189	0	·	o	0	15. 00
16.00	Spiritual Counseling	2,777	0	·	o	0	16. 00
17.00	Di etary Counseling	0	0	·	o	0	17. 00
18.00	Counseling - Other	0	0	·	o	0	18. 00
19.00	Home Health Aide and Homemaker	0	0	·	o	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	17, 854	l 0	1 0	ol	0	20. 00
21.00	Other	0	0	·	o	0	21. 00
	OTHER HOSPICE SERVICE COSTS	•					
22.00	Drugs, Biological and Infusion Therapy	0	C	(0	0	22. 00
23.00	Anal gesi cs	0	0	· C	o	0	23. 00
24.00	Sedatives / Hypnotics	0	0	(o	0	24. 00
25.00	Other - Specify	0	0	·	o	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0	·	o	0	26. 00
27.00	Pati ent Transportation	0	0	·	o	0	27. 00
28.00	I maging Services	0	0	(o	0	28. 00
29.00	Labs and Diagnostics	0	0	·	o	0	29. 00
30.00	Medical Supplies	0	0	·	o	0	30. 00
31.00	Outpatient Services (including E/R Dept.)	0	0	·	o	0	31. 00
32.00	Radi ati on Therapy	0	0	·	o	0	32. 00
33.00	Chemotherapy	0	0	·	o	0	33. 00
34.00	Other	0	0	·	o	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	•					1
35.00	Bereavement Program Costs	0	C	(0	0	35. 00
36.00	Volunteer Program Costs	0	0	· C	ol ol	0	36. 00
37.00	Fundrai si ng	0	0) (ol ol	0	37. 00
38.00	Other Program Costs	0	0) (ol ol	0	38. 00
39.00	Total (sum of lines 1 thru 38)	111, 229	0	13, 121	68, 856	79, 845	39. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150045	Period: Worksheet K From 10/01/2013

Hospi ce CCN: 151559 To 09/30/2014 Date/Ti me Prepared: 2/25/2015 12: 25 pm

			Hospi ce (CCN: 151559 To	09/30/2014	Date/Time Pre 2/25/2015 12:	
					Hospi ce I	2/25/2015 12.	20 piii
		Total (cols.	Recl assi fi cati	Subtotal (col.	Adjustments	Total (col. 8	
		1-5)	on	6 ± col. 7)	•	± col. 9)	
		6.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	C	0	0	0	1. 00
2.00	Capital Related Costs-Movable Equip.	0	C	0	0	0	2. 00
3.00	Plant Operation and Maintenance	0	C	0	0	0	3. 00
4.00	Transportation - Staff	0	C	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	C	0	0	0	5. 00
6.00	Administrative and General	164, 168	-568	163, 600	-81	163, 519	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	_		0	0	7. 00
8.00	Inpatient - Respite Care	0	C	0	0	0	8. 00
	VI SI TI NG SERVI CES						
9. 00	Physi ci an Servi ces	2, 217	C	_, _, _,	0	2, 217	9. 00
10. 00	Nursing Care	83, 486	C	1,	0	83, 486	10. 00
11. 00	Nursing Care-Continuous Home Care	0	C	0	0	0	11. 00
12. 00	Physi cal Therapy	360	C	360	0	360	12.00
13. 00	Occupational Therapy	0	C	0	0	0	13. 00
14. 00	Speech/ Language Pathology	0	C	0	0	0	14. 00
15. 00	Medical Social Services	2, 189	C	2, 189	0	2, 189	15. 00
16.00	Spiritual Counseling	2,777		2, 777	0	2, 777	16.00
17. 00	Di etary Counsel i ng	0		0	0	0	17. 00
18.00	Counseling - Other	0		0	0	0	18.00
19. 00	Home Health Aide and Homemaker	17.054		0	0	17.054	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	17, 854	C I	1,	0	17, 854	20. 00 21. 00
21. 00	Other OTHER HOSPICE SERVICE COSTS	0) U	U	0	21.00
22. 00	Drugs, Biological and Infusion Therapy	1	C	0	0	0	22. 00
23. 00	Anal gesi cs			1	0	0	23. 00
24. 00	Sedatives / Hypnotics	0			0	0	24. 00
25. 00	Other - Specify	0			0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen				0	0	26. 00
27. 00	Patient Transportation				0	0	27. 00
28. 00	Imaging Services	0			0	0	28. 00
29. 00	Labs and Diagnostics	0	Č		0	0	29. 00
30.00	Medical Supplies	0	Č		0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	Č		0	0	31. 00
32. 00	Radi ati on Therapy	0	Č	0	0	0	32.00
33. 00	Chemotherapy	0	Č	1	Ö	0	33. 00
34. 00	Other	0	Č		0	0	34. 00
00	HOSPICE NONREIMBURSABLE SERVICE				<u> </u>		1
35. 00	Bereavement Program Costs	0	C	0	0	0	35. 00
36. 00	Volunteer Program Costs	0	Ċ	o	O	0	36. 00
37.00	Fundrai si ng	0	C	o	o	0	37. 00
38.00	Other Program Costs	0	C	o	o	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	273, 051	-568	272, 483	-81	272, 402	39. 00
				•	•		

			Hospi ce CCN	l: 151559 To	09/30/2014	Date/Time Prep 2/25/2015 12:	
					Hospi ce I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	0	0	0	0	5. 00
6.00	Administrative and General	2, 346	0	0	0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0	0	0	0	9. 00
10. 00	Nursing Care	0	0	0	0	83, 486	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0	0	0	0	11. 00
12. 00	Physi cal Therapy	0	0	0	0	0	12.00
13. 00	Occupational Therapy	0	0	0	0	0	13. 00
14. 00	Speech/ Language Pathology	0	0	0	0	0	14. 00
15. 00	Medical Social Services	0	0	2, 189	0	0	15. 00
16. 00	Spiritual Counseling	0	0	0	0	0	16. 00
17. 00	Di etary Counsel i ng	0	0	0	0	0	17. 00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21. 00	Other OTHER HOSPICE SERVICE COSTS	0	U	0	U	0	21. 00
22.00	Drugs, Biological and Infusion Therapy	T					22. 00
22. 00 23. 00	Anal gesi cs						23.00
24. 00	Sedatives / Hypnotics						24.00
25. 00	Other - Specify						25.00
26. 00	Durable Medical Equipment/Oxygen						26.00
27. 00	Patient Transportation	0		0	0	0	27.00
28. 00	Imaging Services		0	0	0	0	28.00
29. 00	Labs and Diagnostics			0	0	Ö	29.00
30. 00	Medical Supplies		0	0	0	Ö	30.00
31. 00	Outpatient Services (including E/R Dept.)		o	0	0	0	31.00
32. 00	Radi ati on Therapy	o	0	0	0	0	32. 00
33. 00	Chemotherapy	l ol	Ö	0	0	0	33.00
34. 00	Other	o o	ol	0	0	0	34.00
0 11 00	HOSPI CE NONREI MBURSABLE SERVI CE	<u> </u>	<u> </u>	<u> </u>	۹۱	J	0 11 00
35. 00	Bereavement Program Costs	O	ol	0	ol	0	35. 00
36. 00	Volunteer Program Costs		ől	Ö	o	0	36. 00
37. 00	Fundrai si ng	l ol	ol	o	ol	0	37. 00
38. 00	Other Program Costs	O	o	0	o	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	2, 346	o	2, 189	0	83, 486	39.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CCN: 15	00045 Peri od: From 10/01/2013	Worksheet K-1
	Hospi ce CCN: 1		Date/Time Prepared: 2/25/2015 12:25 pm

			Hospi ce Co	JN: 151559 10	09/30/2014	Date/II me Prepared: 2/25/2015 12:25 pm
					Hospi ce I	27 237 2013 12. 23 5111
		Total Therapists	Ai des	All-Other	Total (1)	
		6.00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7, 00	
1.00	Capital Related Costs-Bldg and Fixt.					1, 00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		o	0	o	3.00
4.00	Transportation - Staff		O	0	o	4. 00
5.00	Volunteer Service Coordination		o	0	ol	5. 00
6.00	Administrative and General		o	0	2, 346	6. 00
	I NPATI ENT CARE SERVI CE	<u>'</u>			·	
7.00	Inpatient - General Care		0	0	0	7. 00
8.00	Inpatient - Respite Care		O	0	o	8.00
	VI SI TI NG SERVI CES	<u>'</u>	<u> </u>		<u> </u>	
9.00	Physi ci an Servi ces		0	2, 217	2, 217	9. 00
10.00	Nursi ng Care		O	0	83, 486	10.00
11.00	Nursing Care-Continuous Home Care		0	0	o	11.00
12.00	Physi cal Therapy	360	0	0	360	12. 00
13.00	Occupational Therapy	0	0	0	0	13. 00
14.00	Speech/ Language Pathology	0	0	0	0	14. 00
15.00	Medical Social Services		0	0	2, 189	15. 00
16.00	Spiritual Counseling		0	2, 777	2, 777	16. 00
17. 00	Di etary Counsel i ng		0	0	0	17. 00
18. 00	Counseling - Other		0	0	0	18. 00
19. 00	Home Health Aide and Homemaker		0	0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care		17, 854	0	17, 854	20.00
21.00	Other		0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS					
	Drugs, Biological and Infusion Therapy					22. 00
	Anal gesi cs					23. 00
24. 00	Sedatives / Hypnotics					24. 00
	Other - Specify					25. 00
26. 00	Durable Medical Equipment/Oxygen		_		_	26. 00
27. 00	•		0	0	0	27. 00
28. 00	I maging Services		0	0	0	28. 00
29. 00	9		0	0	0	29. 00
30.00	Medical Supplies		0	0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)		0	0	0	31. 00
32. 00	Radi ati on Therapy		0	0	0	32. 00
33. 00	Chemotherapy		0	0	0	33.00
34. 00	Other		0	0	0	34. 00
05.00	HOSPI CE NONREI MBURSABLE SERVI CE		ام			25.00
35. 00	Bereavement Program Costs		0	0	0	35. 00
36.00	9		0	0	0	36.00
37. 00 38. 00	Fundrai si ng		0	U	O O	37. 00 38. 00
	Other Program Costs Total (sum of lines 1 thru 38)	360	17, 854	4, 994	111, 229	
39.00	Tiotal (Sum Of Titles I till u 30)	300	17, 654	4, 994	111, 229	39.00

 Heal th
 Financial
 Systems
 DEKALB
 MEMORIAL
 HOSPICE

 HOSPICE
 COMPENSATION
 ANALYSIS
 CONTRACTED
 SERVICES/PURCHASED
 SERVICES
 150045 | Period: | Worksheet K-3 From 10/01/2013 151559 | To 09/30/2014 | Date/Time Prepared: 2/25/2015 12: 25 pm Provider CCN: 150045 Hospi ce CCN:

Administrator Director Social Supervisors Nurses
1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
Capital Related Costs-Bldg and Fixt. 1.00 Capital Related Costs-Bldg and Fixt. 2.00 Capital Related Costs-Movable Equip. 2.00 Capital Related Cost
1.00 Capital Related Costs-Bldg and Fixt. 2.00 Capital Related Costs-Movable Equip. 2.00 Capital Related Costs-Movable 2.0
1.00 Capital Related Costs-Bldg and Fixt. 2.00 Capital Related Costs-Movable Equip. 2.00 Capital Related Costs-Movable 2.0
3.00 Plant Operation and Maintenance 0 0 0 0 0 0 0 3.00 4.00 Transportation - Staff 0 0 0 0 0 0 0 0 4.00 5.00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 5.00 6.00 Administrative and General 0 0 0 0 0 0 0 0 0 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 0 0 0 0 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
3.00 Plant Operation and Maintenance 0 0 0 0 0 0 0 3.00 4.00 Transportation - Staff 0 0 0 0 0 0 0 0 4.00 5.00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 5.00 6.00 Administrative and General 0 0 0 0 0 0 0 0 0 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 0 0 0 0 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
4.00 Transportation - Staff
S. 00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 0
6.00 Administrative and General 0 0 0 0 0 0 0 6.00 1NPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 0 0 0 0 7.00 8.00 1npatient - Respite Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
INPATIENT CARE SERVICE
7. 00 Inpatient - General Care 0 0 0 0 0 0 0 0 8. 00
8.00 Inpatient - Respite Care 0 0 0 0 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 0 0 0 0 9.00 10.00 Nursing Care 0 0 0 0 0 0 0 10.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 0 11.00 13.00 Occupational Therapy 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 16.00
VISITING SERVICES 9.00 Physician Services 0 0 0 0 9.00 10.00 Nursing Care 0 11.00 0 0 0 0 0 11.00 13.00 0 0 0 0 0 0 0 0 0 0 0 14.00 0 0 0 0 0 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""></td<>
9.00 Physician Services 0 0 0 0 0 0 0 0 0 0 10.00 11.00 Nursing Care 0 0 0 0 0 0 0 0 10.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 11.00 11.00 11.00 Physical Therapy 0 0 0 0 0 0 12.00 12.00 Occupational Therapy 0 0 0 0 0 0 13.00 Speech/ Language Pathology 0 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 0 16.00
10.00 Nursing Care 0 0 0 0 0 10.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 11.00 12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 0 0 13.00 0 0 0 0 0 14.00 0 0 0 0 0 0 0 0 0 0 0 0 15.00 0
11. 00 Nursi ng Care-Conti nuous Home Care 0 0 0 0 0 11. 00 12. 00 Physi cal Therapy 0 0 0 0 0 12. 00 13. 00 Occupati onal Therapy 0 0 0 0 0 0 13. 00 14. 00 Speech/ Language Pathol ogy 0 0 0 0 0 0 14. 00 15. 00 Medi cal Soci al Servi ces 0 0 0 0 0 0 0 15. 00 16. 00 Spi ri tual Counsel i ng 0
12.00 Physical Therapy 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 16.00
13.00 Occupational Therapy 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 16.00
14.00 Speech/ Language Pathology 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 0 16.00
15.00 Medical Social Services 0 0 0 0 0 15.00 16.00 Spiritual Counseling 0 0 0 0 0 16.00
16.00 Spiritual Counseling 0 0 0 0 0 16.00
17.00 Di etary Counseling 0 0 0 0 17.00
18.00 Counsel i ng - Other 0 0 0 18.00
19.00 Home Heal th Ai de and Homemaker 0 0 0 0 19.00
20.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 20.00
21.00 Other 0 0 0 0 0 21.00
OTHER HOSPICE SERVICE COSTS
22. 00 Drugs, Bi ol ogi cal and Infusi on Therapy 22. 00
23. 00 Anal gesi cs 23. 00
23. 00 Analysis CS 24. 00 Sedatives / Hypnotics
25. 00 Other - Specify 25. 00
27. 00 Patient Transportation 0 0 0 0 27. 00
28. 00 Imaging Services 0 0 0 0 0 0 28. 00
29.00 Labs and Diagnostics 0 0 0 0 0 29.00
30.00 Medical Supplies 0 0 0 30.00
31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00
32.00 Radi ati on Therapy 0 0 0 0 32.00
33.00 Chemotherapy 0 0 0 0 33.00
34.00 Other 0 0 0 0 0 34.00
HOSPI CE NONREI MBURSABLE SERVI CE
35.00 Bereavement Program Costs 0 0 0 0 0 35.00
36.00 Volunteer Program Costs 0 0 0 0 36.00
37.00 Fundraising 0 0 0 0 0 37.00
38.00 Other Program Costs 0 0 0 0 38.00
39.00 Total (sum of lines 1 thru 38) 0 0 0 0 39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES Provider CCN: 150045 Peri od: Worksheet K-3 From 10/01/2013 Hospi ce CCN: 151559 09/30/2014 Date/Time Prepared: 2/25/2015 12:25 pm Hospi ce I Total Ai des All-Other Total (1) Therapi sts 7.00 8.00 9. 00 6 00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 3 00 Plant Operation and Maintenance 0 0 0 4.00 Transportation - Staff 0 0 4.00 Volunteer Service Coordination 5.00 5.00 6.00 Administrative and General 0 68, 856 68, 856 6.00 INPATIENT CARE SERVICE 7.00 Inpatient - General Care 0 0 0 7.00 8.00 Inpatient - Respite Care 0 0 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 9.00 10.00 Nursing Care 0 0 0 10.00 0 Nursing Care-Continuous Home Care 0 11.00 0 11.00 0 12.00 Physical Therapy 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 0 0 0 13.00 Speech/ Language Pathology 0 14.00 14.00 0 Medical Social Services 0 15.00 15.00 0 0 16.00 Spiritual Counseling 16.00 17.00 Dietary Counseling 0 17.00 0 0 18.00 Counseling - Other 18.00 Home Health Aide and Homemaker 0 19.00 19.00 0 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 20.00 21.00 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesi cs 23.00 Sedatives / Hypnotics 24.00 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26,00 27.00 Patient Transportation 27.00 0 28.00 Imaging Services 0 0 28.00 29 00 Labs and Diagnostics Ω 0 29 00 0 0 30.00 Medical Supplies 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 0 31.00 Radiation Therapy 0 32.00 0 0 32.00 0 0 33.00 Chemotherapy 33.00 34.00 0ther 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 O 0 35 00 Bereavement Program Costs 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00

0

68, 856

68, 856

39.00

39.00 Total (sum of lines 1 thru 38)

CAPITAL RELATED COST Hospice 1
NET EXPENSES FOR COST ALLOCATION O
FINAL SERVICE COST CENTERS FIXTURES EQUI PMENT OPERATION & MAINT.
FINAL SERVICE COST CENTERS FIXTURES EQUI PMENT OPERATION & MAINT.
ALLOCATION
ALLOCATION
CENERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00
CENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt.
1.00 Capital Related Costs-Bidg and Fixt. 0 0 0 0 2.00 2.50 2.00 2.00 2.00 2.00 2.50 2.00 2.00 2.50 2.00 2.00 2.50 2.00 2.00 2.50 2.00 2.00 2.50 2.00 2.00 2.50 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.50 2.00 2.00 2.00 2.00 2.50 2.00 2.00 2.50 2.00 2.50 2.00 2.50 2.00 2.50 2.00 2.50 2.50 2.00 2.50 2
2.00 Capital Related Costs-Movable Equip. 3.00 Plant Operation and Maintenance 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
3.00
4.00 Transportation - Staff 0 0 0 0 0 0 0 0 0
Solid
Administrative and General 163,519 0 0 0 0 0 0 0 0 0
INPATIENT CARE SERVICE
Total Tota
8.00 Inpatient - Respite Care 0 0 0 0 0 0 0 0 0
9.00 Physician Services 2,217 0 0 0 0 0 0 0 10.00
9.00 Physician Services 2,217 0 0 0 0 9.00 10.00 Nursing Care 83,486 0 0 0 0 11.00 Nursing Care-Continuous Home Care 0 0 0 0 12.00 Physical Therapy 360 0 0 0 13.00 Occupational Therapy 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 15.00 Medical Social Services 2,189 0 0 0 16.00 Spiritual Counseling 2,777 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 18.00 Counseling - Other 0 0 0 0 19.00 Haide & Homemaker 0 0 0 0 20.00 Hid de & Homemaker - Cont. Home Care 17,854 0 0 0 21.00 Other 0 0 0 0 22.00 Other 0 0 0 0 23.00 Analgesics 0 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 0 25.00 Other - Specify 0 0 0 25.00 Other - Specify 0 0 0 20.00 Other - Spec
10.00 Nursing Care 83,486 0 0 0 0 10.00 11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 12.00 Physical Therapy 360 0 0 0 0 13.00 Occupational Therapy 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 15.00 Medical Social Services 2,189 0 0 0 0 16.00 Spiritual Counseling 2,777 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 18.00 Counseling - 0 ther 0 0 0 0 19.00 Hh Aide and Homemaker 0 0 0 0 10.00 Other 0 0 0 0 10.00 Other 0 0 0 0 10.00 Other Specify 0 0 0 10.00 Other - Specify 0 0 0 10.00 Other - Specify 0 0 0 10.00 Other 0 0 0 10.00 Other 0 0 0 10.00 Other - Specify 0 0 0 10.00 Other 0 0 0 10.00 Other - Specify 0 0 0 10.00 Other 0 0 0 10.00 Other - Specify 0 0 0 10.00 Other 0 0 10.00 Other 0 0 0 10.00 Other 0 0 0 10.00 Other 0 0 10.00 Other 0 0 0 10.00 0 0 10.00 Other 0 10.00 Other 0 10.00 Other 0
11. 00 Nursi ng Care-Conti nuous Home Care 0 0 0 0 0 11. 00 12. 00 Physi cal Therapy 360 0 0 0 0 0 0 12. 00 13. 00 Occupati onal Therapy 0 0 0 0 0 0 0 0 13. 00 14. 00 Speech/ Language Pathology 0 0 0 0 0 0 0 0 0 0 0 13. 00 14. 00 Speech/ Language Pathology 0 0 0 0 0 0 0 0 0 0 0 14. 00 15. 00 Medi cal Social Services 2, 189 0 0 0 0 0 0 0 0 0 0 16. 00 0
12.00 Physical Therapy 360 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 0 15.00 Medical Social Services 2,189 0 0 0 0 16.00 Spiritual Counseling 2,777 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 19.00 Haide & Homemaker - Cont. Home Care 17,854 0 0 0 0 21.00 Other 0 0 0 0 0 22.00 Other Oth
13.00 Occupational Therapy 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 0 14.00 15.00 Medical Social Services 2,189 0 0 0 0 0 0 0 15.00 16.00 Spiritual Counseling 2,777 0 0 0 0 0 0 0 0 0 0 0 17.00 <
14. 00 Speech/ Language Pathology 0 0 0 0 0 14. 00 15. 00 Medical Social Services 2, 189 0 0 0 0 0 15. 00 16. 00 Spiritual Counseling 2,777 0 0 0 0 0 0 0 16. 00 17. 00 Dietary Counseling 0 0 0 0 0 0 0 0 0 0 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 0 0 0 0 0 0 0 18. 00 19. 00 Home Heal th Aide and Homemaker 0
15. 00 Medical Social Services 2, 189 0 0 0 0 15. 00 16. 00 Spiritual Counseling 2,777 0 0 0 0 0 16. 00 17. 00 Di etary Counseling 0 0 0 0 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 0 0 0 0 18. 00 19. 00 Home Health Aide and Homemaker 0 0 0 0 0 0 0 19. 00 20. 00 HH Aide & Homemaker - Cont. Home Care 17, 854 0 0 0 0 0 0 0 20. 00 21. 00 Other 0 0 0 0 0 0 0 0 21. 00 OTHER HOSPICE SERVICE COSTS 22. 00 Drugs, Bi ol ogical and Infusion Therapy 0 0 0 0 0 0 23. 00 24. 00 Sedatives / Hypnotics 0 0 0 0 0 0 0 24. 00 25. 00 Other - Specify 0 0 0 0 0 0 0 25. 00
16. 00 Spiritual Counseling 2,777 0 0 0 0 16. 00 17. 00 Di etary Counseling 0 0 0 0 0 0 17. 00 18. 00 Counseling - Other 0 0 0 0 0 0 0 18. 00 19. 00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 19. 00 20. 00 HH Aide & Homemaker - Cont. Home Care 17, 854 0 0 0 0 0 20. 00 21. 00 Other 0 0 0 0 0 0 21. 00 22. 00 Drugs, Bi ol ogi cal and Infusion Therapy 0 0 0 0 0 22. 00 23. 00 Anal gesi cs 0 0 0 0 0 0 24. 00 24. 00 Sedati ves / Hypnoti cs 0 0 0 0 0 0 25. 00 25. 00 Other - Speci fy 0 0 0 0 0 0 25. 00
17. 00 Di etary Counsel i ng 0 0 0 0 0 17. 00 18. 00 Counsel i ng - Other 0 0 0 0 0 0 18. 00 19. 00 Home Heal th Ai de and Homemaker 0 0 0 0 0 0 19. 00 20. 00 HH Ai de & Homemaker - Cont. Home Care 17, 854 0 0 0 0 0 20. 00 21. 00 Other 0 0 0 0 0 0 21. 00 Drugs, Bi ol ogi cal and Infusion Therapy 0 0 0 0 0 0 22. 00 23. 00 Anal gesi cs 0 0 0 0 0 0 24. 00 24. 00 Sedati ves / Hypnoti cs 0 0 0 0 0 0 25. 00 25. 00 Other - Speci fy 0 0 0 0 0 0 25. 00
18.00 Counseling - Other 0 0 0 0 0 18.00 19.00 Home Health Aide and Homemaker 0 0 0 0 0 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 17,854 0 0 0 0 0 20.00 21.00 Other 0 0 0 0 0 0 21.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 22.00 23.00 Anal gesics 0 0 0 0 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 25.00 Other - Specify 0 0 0 0 0 0
19.00 Home Health Aide and Homemaker 0 0 0 0 0 0 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 17,854 0 0 0 0 0 0 20.00 21.00 Other 0 0 0 0 0 0 0 0 0 21.00 Other OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 0 0 0 0 25.00
20. 00
21.00 Other OTHER HOSPICE SERVICE COSTS O <t< td=""></t<>
OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22.00 23.00 Anal gesics 0 0 0 0 0 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 0 25.00
22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22.00 23.00 Analgesics 0 0 0 0 0 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 0 0 25.00
23.00 Anal gesics 0 0 0 0 0 23.00 24.00 Sedatives / Hypnotics 0 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 0 0 25.00
24.00 Sedatives / Hypnotics 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 0 0 25.00
25. 00 Other - Specify 0 0 0 0 25. 00
26.00 Durable Medical Equipment/0xygen 0 0 0 0 0 26.00
27.00 Pati ent Transportati on 0 0 0 0 0 27.00
28. 00 Imagi ng Servi ces 0 0 0 0 0 0 28. 00
29.00 Labs and Diagnostics 0 0 0 0 0 29.00
30.00 Medical Supplies 0 0 0 0 0 30.00
31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 31.00
32.00 Radi ati on Therapy 0 0 0 0 32.00
33.00 Chemotherapy 0 0 0 0 33.00
34.00 Other 0 0 0 0 0 34.00
HOSPI CE NONREI MBURSABLE SERVI CE
35.00 Bereavement Program Costs 0 0 0 0 0 35.00
36.00 Volunteer Program Costs 0 0 0 0 36.00
37. 00 Fundrai si ng 0 0 0 0 0 37. 00
38.00 Other Program Costs 0 0 0 0 0 38.00
39.00 Total (sum of lines 1 thru 38) 272,402 0 0 0 39.00

			1.000.00		0 077 007 2011	2/25/2015 12: 25 pm
					Hospi ce I	
	·	VOLUNTEER	SUBTOTAL	ADMI NI STRATI VE	TOTAL (col. 5A	
		SERVI CES	(col s. 0 - 5)	& GENERAL	± col . 6)	
		COORDI NATOR				
		5. 00	5A	6. 00	7. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1. 00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance					3. 00
4.00	Transportation - Staff					4. 00
5.00	Volunteer Service Coordination	C)			5. 00
6.00	Administrative and General	C	163, 519	163, 519		6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	C	0	0	0	7. 00
8.00	Inpatient - Respite Care	C	0	0	0	8. 00
	VISITING SERVICES					
9.00	Physi ci an Servi ces	C	2, 217	3, 329	5, 546	9. 00
10.00	Nursi ng Care	C	83, 486	125, 379	208, 865	10. 00
11.00	Nursing Care-Continuous Home Care	C	0	0	0	11. 00
12.00	Physi cal Therapy	C	360	541	901	12. 00
13.00	Occupational Therapy	C	0	0	0	13. 00
14.00	Speech/ Language Pathology	C	0	0	0	14. 00
15.00	Medical Social Services	C	2, 189	3, 287	5, 476	15. 00
16.00	Spiritual Counseling	C	2, 777	4, 170	6, 947	16. 00
17.00	Di etary Counsel i ng	C	0	0	O	17. 00
18.00	Counseling - Other	C	0	0	O	18. 00
19.00	Home Health Aide and Homemaker	C	0	0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	C	17, 854	26, 813	44, 667	20. 00
21.00	Other	C	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy	C	0	0	0	22. 00
23.00	Anal gesi cs	C	0	0	0	23. 00
24.00	Sedatives / Hypnotics	C	0	0	0	24. 00
25.00	Other - Specify		0	0	o	25. 00
26.00	Durable Medical Equipment/Oxygen		0	0	o	26. 00
27.00	Patient Transportation	l c	0	0	O	27. 00
28. 00	Imaging Services		0	0	o	28. 00
29. 00	Labs and Diagnostics		0	0	o	29. 00
30.00	Medical Supplies		0	0	o	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	o	31.00
32.00	Radiation Therapy		0	0	o	32.00
33.00	Chemotherapy		0	0	o	33.00
34.00	Other		0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE					
35. 00	Bereavement Program Costs	C	0	0	0	35. 00
36.00	,		o	•		36. 00
37. 00	Fundrai si ng		0	0	o	37. 00
38. 00	Other Program Costs		ol o	l o	o	38. 00
	Total (sum of lines 1 thru 38)		272, 402	1	272, 402	39. 00
	, , , , , , , , , , , , , , , , , , , ,	'	, ,,,,	•	,	1

						2/25/2015 12:	25 pm
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON		
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
				FT.)		(HOURS)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	Capital Related Costs-Bldg and Fixt.	0					1. 00
2.00	Capital Related Costs-Movable Equip.	0	0				2. 00
3.00	Plant Operation and Maintenance	0	0	()		3. 00
4.00	Transportation - Staff	0	0	(0		4. 00
5.00	Volunteer Service Coordination	0	0	(0	0	5. 00
6.00	Administrative and General	0	0	C	0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	(0	0	7. 00
8.00	Inpatient - Respite Care	0	0	·	0	0	8. 00
	VI SI TI NG SERVI CES	'					
9.00	Physi ci an Servi ces	0	0		0	0	9.00
10.00	Nursi ng Care	0	0		0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12. 00	Physical Therapy	0	0		0	0	1
13. 00	Occupational Therapy	0	0		0	0	
14. 00	Speech/ Language Pathology	0	0	1		0	1
15. 00	Medical Social Services	0	0	1		0	1
16. 00	Spiritual Counseling	0	0	1		n o	16.00
	Di etary Counsel i ng	0	0			0	
18. 00	Counseling - Other	0	0			0	1
19. 00	Home Health Aide and Homemaker	0	0	1		0	1
20. 00	HH Ai de & Homemaker - Cont. Home Care	0	0	1		0	1
21. 00	Other	0	0	1		0	1
21.00	OTHER HOSPICE SERVICE COSTS	0	U	1) 0	U	21.00
22. 00	Drugs, Biological and Infusion Therapy	1 0	0		0	0	22. 00
		0	0	1	-	0	
24. 00	Sedatives / Hypnotics	0	0	1	_	0	1
25. 00	Other - Specify	0	0	1	_	0	
26. 00	Durable Medical Equipment/Oxygen	0	0	1		0	1
27. 00	Patient Transportation	0	0	1		0	
28. 00	•	0	0	1	-	0	1
	I maging Services	0	0				20.00
29. 00	Labs and Diagnostics	0	0		0	0	
30.00	Medical Supplies	0	0		0	0	
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	
32. 00	Radiation Therapy	0	0	1	0	0	
33. 00	Chemotherapy	0	0	1	0	0	33. 00
34. 00	Other	0	0	(0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE			1			
35. 00	Bereavement Program Costs	0	0	1		0	
36. 00	Volunteer Program Costs	0	0	(0	0	
37. 00	Fundrai si ng	0	0	·	0	0	
	Other Program Costs	0	0	·	0	0	1 00.00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	·	0	0	
40. 00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000	0. 000000	40. 00

RECONCILIATION ADMINISTRATIVE S. CENERAL SERVICE COST CENTERS CACC. COST							2/25/2015 12	:25 pm
REMERAL SERVICE COST CENTERS						Hospi ce I		
CEMERAL SERVICE COST CENTERS			RECONCI LI ATI ON					
CEMERAL SERVICE COST CENTERS								
CEMERAL SERVICE COST CENTERS								
1.00			6A	6. 00				
2.00								
1.00			0					
4.00	2.00		0					•
5.00	3.00		0					3. 00
Administrative and General	4.00	Transportation - Staff	0					4. 00
INPATIENT CARE SERVICE	5.00	Volunteer Service Coordination						5. 00
Total Paper Care	6.00	Administrative and General	-163, 519	108, 883				6. 00
B. 00 Inpatient - Respite Care 0 0 0 8. 00		I NPATI ENT CARE SERVI CE						
VISITING SERVICES	7.00	Inpatient - General Care	0	0				7. 00
9,00 Physician Services	8.00	Inpatient - Respite Care	0	0				8. 00
10.00 Nursing Care		VI SI TI NG SERVI CES						
11. 00 Nursing Care-Continuous Home Care 0 0 0 12. 00	9.00	Physi ci an Servi ces	0	2, 217				9. 00
12.00 Physical Therapy 0 360 12.00 13.00 13.00 14.00 15.00 15.00 15.00 15.00 14.00 15.00	10.00	Nursing Care	0	83, 486				10.00
13.00 0 0 0 0 0 0 0 0 0	11.00	Nursing Care-Continuous Home Care	0	0				11. 00
13.00 0 0 0 0 0 0 0 0 0			0	360				12. 00
14.00			0					13.00
15. 00 Medical Social Services 0 2,189 15. 00 16. 00 Spiritual Counseling 0 0 0 17. 00 17. 00 Dietary Counseling 0 0 0 0 18. 00 Counseling - Other 0 0 0 19. 00 Home Health Aide and Homemaker 0 0 0 19. 00 Home Health Aide and Homemaker 0 0 0 19. 00 Hill Aide & Homemaker - Cont. Home Care 0 17,854 20. 00 21. 00 Other 0 0 0 THER HOSPICE SERVICE COSTS			0	0				14. 00
16. 00 Spiritual Counseling 0 2,777 17. 00 10 etary Counseling 0 0 0 17. 00 18. 00 0 18. 00 0 18. 00 0 18. 00 0 19. 00			0	2. 189				
17. 00			0		1			
18. 00			0	1	1			
19, 00 Home Heal th Ai de and Homemaker 0 0 17, 854 20, 00	18. 00	Counseling - Other	0					
20. 00 HH Ai de & Homemaker - Cont. Home Care 0 17,854 20. 00 21. 00 0 0 0 0 0 0 0 0 0			0	1				
21.00 Other OTHER HOSPICE SERVICE COSTS O			0	17 854				
DTHER HOSPICE SERVICE COSTS					1			
22. 00 Drugs, Biological and Infusion Therapy 0 0 23. 00 23. 00 Anal gesics 0 0 23. 00 24. 00 Sedatives / Hypnotics 0 0 24. 00 25. 00 Other - Specify 0 0 0 26. 00 Durable Medical Equipment/Oxygen 0 0 26. 00 27. 00 Patient Transportation 0 0 0 27. 00 28. 00 Imaging Services 0 0 28. 00 28. 00 29. 00 Labs and Diagnostics 0 0 29. 00 30. 00 Medical Supplies 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 31. 00 32. 00 Radiation Therapy 0 0 33. 00 34. 00 Other 0 0 33. 00 34. 00 Other 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 36. 00 36. 00 37. 00 Tundraising 0 0 37. 00 <	21.00							1 21.00
23. 00	22 00		0	0				722 00
24. 00 Sedatives / Hypnotics 0 0 24. 00 25. 00 Other - Specify 0 0 0 26. 00 Durable Medical Equipment/Oxygen 0 0 26. 00 27. 00 Patient Transportation 0 0 27. 00 28. 00 Imaging Services 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 29. 00 30. 00 Medical Supplies 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 33. 00 34. 00 Other 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 36. 00 37. 00 Fundraising 0 0 36. 00 37. 00 Thoracing Costs 0 0 38. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 163, 519 39. 00			0		1			
25. 00 Other - Specify 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 27. 00 27. 00 Patient Transportation 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 29. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 33. 00 400 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		1			
26. 00 Durable Medical Equipment/Oxygen 0 0 0 27. 00 Pati ent Transportation 0 0 0 28. 00 Imaging Services 0 0 0 29. 00 Labs and Di agnostics 0 0 29. 00 30. 00 Medical Supplies 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 31. 00 32. 00 Radiation Therapy 0 0 33. 00 33. 00 Chemotherapy 0 0 33. 00 34. 00 Other 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 36. 00 37. 00 Fundraising 0 0 37. 00 38. 00 Other Program Costs 0 0 37. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 163, 519 39. 00		J .	0	1				•
27. 00 Pati ent Transportation 0 0 27. 00 28. 00 Imaging Services 0 0 0 28. 00 29. 00 Labs and Di agnostics 0 0 29. 00 30. 00 Medi cal Supplies 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 33. 00 34. 00 Other 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 8ereavement Program Costs 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 36. 00 37. 00 Fundraising 0 0 37. 00 38. 00 Other Program Costs 0 0 37. 00 38. 00 Other Program Costs 0 0 38. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 163, 519 39. 00			0					
28. 00			0		•			
29.00 Labs and Diagnostics 0 0 0 0 30.00 30.00 Medical Supplies 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 0 38.00 38.00 Other Program Costs 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519								
30.00 Medical Supplies 0 0 0 0 31.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 Other 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE					•			
31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 37.00 38.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 39.00					1			
32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 37.00 38.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 39.00			0		1			
33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 36.00 37.00 Fundrai si ng 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 37.00 38.00 Other Program Costs 0 0 0 37.00 38.00 Other Program Costs 0 0 0 37.00 38.00 Other Program Costs 0 0 0 37.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 39.00			0	· ·	1			
34.00 Other 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 35.00 36.00 37.00 Fundraising 0 0 0 0 38.00 Other Program Costs 0 0 0 38.00 Other Program Costs 0 0 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 39.00			0		1			
HOSPICE NONREIMBURSABLE SERVICE			0					
35.00 Bereavement Program Costs 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 37.00 Fundraising 0 0 0 38.00 Other Program Costs 0 0 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 39.00	34.00		0	0				34.00
36.00 Volunteer Program Costs 0 0 0 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 39.00	25 00		_	_				25 00
37.00 Fundraising 0 0 37.00 38.00 Other Program Costs 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 39.00			0					
38.00 Other Program Costs 0 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 38.00			0	· ·	1			
39.00 Cost to be Allocated (per Wkst. K-4, Part I) 163,519 39.00			0	0	1			
			0	0				•
40.00 unit cost multiplier 1.501/86 40.00		"			1			•
	40. 00	UNIT COST Multiplier	I	1. 501786	1			40.00

Provi der CCN: 150045

In Lieu of Form CMS-2552-10
Worksheet K-5
Part I
B0/2014 Date/Time Prepared:
2/25/2015 12: 25 pm Peri od: From 10/01/2013 To 09/30/2014

Hospi ce CCN: 151559

				Hospi ce I			
				CAPI TAL REI	LATED COSTS		
	Cost Center Description	Hospice Trial	BLDG & FIXT	MAC WEST - NEW			
		Bal ance (1)			NEW	- NEW	
	Tarana Sanara and American Sanara and American Sanara and American Sanara and American Sanara and American San	0	1. 00	1. 01	1. 02	1. 03	
1.00	Administrative and General		0	0	387	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	5, 546	0	0	0	0	4. 00
5.00	Nursing Care	208, 865	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7. 00	Physi cal Therapy	901	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10. 00	Medical Social Services	5, 476	0	0	0	0	10. 00
11. 00	Spiritual Counseling	6, 947	0	0	0	0	11. 00
12. 00	Dietary Counseling	0	0	0	0	0	12. 00
13. 00	Counseling - Other	0	0	0	0	0	13. 00
14. 00	Home Health Aide and Homemaker	0	0	0	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	44, 667	0	0	0	0	15. 00
16. 00	Other	0	0	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18. 00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24. 00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27.00	Radi ati on Therapy	0	0	0	0	0	27. 00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	O	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	o	0	0	0	0	32. 00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	272, 402	0	0	387	0	34.00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045 Hospi ce CCN: 151559 To

Peri od: Worksheet K-5 From 10/01/2013 | Part | To 09/30/2014 | Date/Time Prepared:

		1.0001.00		07, 00, 2011	2/25/2015 12:				
					Hospi ce I				
			CAPITAL RELATED COSTS						
	Cost Center Description	BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW			
		1. 04	1. 05	1.06	1. 07	1. 08			
1.00	Administrative and General	0	0	(0 0	0	1. 00		
2.00	Inpatient - General Care	0	0	(0	0	2. 00		
3.00	Inpatient - Respite Care	0	0		0	0	3. 00		

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

						2/25/2015 12: 2	25 pm_
					Hospi ce I		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	MVBLE EQUIP	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	
			BENEFITS		& GENERAL	PLANT	
			DEPARTMENT				
		2.00	4.00	4A	5. 00	7. 00	
1.00	Administrative and General	0	10, 025	10, 412	1, 784	9, 115	1.00
2.00	Inpatient - General Care	0	0	(0	0	2.00
3.00	Inpatient - Respite Care	0	0	(0	0	3.00
4.00	Physi ci an Servi ces	0	0	5, 540	950	0	4.00
5.00	Nursi ng Care	0	0	208, 86	35, 784	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	(0	0	6.00
7.00	Physi cal Therapy	0	0	90 ⁻	154	0	7.00
8.00	Occupational Therapy	0	0	(0	0	8.00
9.00	Speech/ Language Pathology	0	0	(0	0	9.00
10.00	Medical Social Services	0	0	5, 476	938	o	10.00
11.00	Spiritual Counseling	0	0	6, 94	1, 190	o	11.00
12.00	Di etary Counsel i ng	0	0	(0	o	12.00
13.00	Counseling - Other	0	0		0	ol	13.00
14.00	Home Health Aide and Homemaker	0	0		o	o	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	O	0	44, 66	7, 653	o	15.00
16.00	Other	O	0		0	o	16.00
17.00	Drugs, Biological and Infusion Therapy	O	0		0	ol	17.00
18.00	Anal gesi cs	o	0		o	ol	18.00
19.00	Sedatives / Hypnotics	O	0	(o	ol	19.00
20.00	Other - Specify	o	0		o	ol	20.00
21.00	Durable Medical Equipment/Oxygen	o	0	(o	ol	21.00
22. 00	Patient Transportation	o	0	(o	ol	22.00
23.00	I maging Services	o	0	(o	ol	23.00
24.00	Labs and Diagnostics	o	0	(o	ol	24.00
25.00	Medical Supplies	o	0	(o	ol	25.00
26.00	Outpatient Services (including E/R Dept.)	o	0	(o	o	26.00
27.00	Radi ati on Therapy	o	0	(o	o	27.00
28. 00	Chemotherapy	O	0	(0	ol	28.00
29. 00	Other	o	0		0	ol	29. 00
30.00	Bereavement Program Costs	o	0		o o	0	30.00
31.00	Volunteer Program Costs	o	0		o o	0	31.00
32.00	Fundrai si ng	o	0		o o	0	32.00
33. 00	Other Program Costs		0		0	o	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	o	10, 025	282, 814	48, 453	9, 115	34.00
	Unit Cost Multiplier (see instructions)			0. 000000			35.00
	·			•	•	. ,	

Health Financial Systems DEKALB !
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 150045 Hospi ce CCN: 151559

						2/23/2013 12.	25 piii
					Hospi ce I		
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	SNACK BAR	CAFETERI A	
		8. 00	9.00	10.00	10. 01	11. 00	
1.00	Administrative and General	136	2, 672	. (0	3, 753	1. 00
2.00	Inpatient - General Care	C) c) (0	0	2. 00
3.00	Inpatient - Respite Care	C) c) (0	0	3.00
4.00	Physi ci an Servi ces	C) c) (0	0	4. 00
5.00	Nursing Care	C) c) (0	0	5. 00
6.00	Nursing Care-Continuous Home Care	C) c) (0	0	6.00
7.00	Physi cal Therapy	C) c) (0	0	7. 00
8.00	Occupational Therapy	C) c) (0	0	8. 00
9.00	Speech/ Language Pathology	C) c) (0	0	9. 00
10.00	Medical Social Services	C) c) (0	0	10.00
11.00	Spiritual Counseling	C) c) (0	0	11. 00
12.00	Di etary Counseling	C	ol c		o	0	12. 00
13.00	Counseling - Other	C	ol c		o	0	13. 00
14.00	Home Health Aide and Homemaker	C	o c) (0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	C	o c) (0	0	15. 00
16.00	0ther	C) c) (0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	C) c) (0	0	17. 00
18.00	Anal gesi cs	C) C) (0	0	18. 00
19.00	Sedatives / Hypnotics	C) C) (0	0	19. 00
20.00	Other - Specify	C) C) (0	0	20.00
21.00	Durable Medical Equipment/Oxygen	C) C) (0	0	21.00
22.00	Patient Transportation	C) C) (0	0	22. 00
23.00	I maging Services	C) C) (0	0	23. 00
24.00	Labs and Diagnostics	C) C) (0	0	24. 00
25.00	Medi cal Supplies	C) C) (0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	C) C) (0	0	26. 00
27. 00	Radiation Therapy	C) C) (0	0	27. 00
28. 00	Chemotherapy	C) C) (0	0	28. 00
29. 00	Other	C) C)	0	0	29. 00
30.00	Bereavement Program Costs	C) C)	0	0	30.00
31.00	Volunteer Program Costs	C) C) (0	0	31.00
32.00	Fundrai si ng	C) C)	0	0	32. 00
33.00	Other Program Costs	C) C) (0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	136	2, 672	2 (0	3, 753	34.00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

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

					2/25/2015 12:	25 pm_	
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13.00	14.00	15. 00	16.00	17. 00	
1.00	Administrative and General	13, 158	(0 5, 986	0	1. 00
2.00	Inpatient - General Care	0	(0 0	0	2. 00
3.00	Inpatient - Respite Care	0	(0 0	0	3. 00
4.00	Physi ci an Servi ces	0	(o c	0	4. 00
5.00	Nursing Care	0	(o c	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	(o c	0	6.00
7.00	Physical Therapy	0	(o c	0	7. 00
8.00	Occupational Therapy	0	(o c	0	8. 00
9.00	Speech/ Language Pathology	0	(o c	0	9. 00
10.00	Medi cal Soci al Servi ces	0	(o c	0	10.00
11. 00	Spiritual Counseling	0	(o c	0	11. 00
12.00	Di etary Counseling	0	(o c	0	12. 00
13.00	Counseling - Other	0	(o c	0	13. 00
14.00	Home Health Aide and Homemaker	0	(o c	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	(o c	0	15. 00
16.00	0ther	0	(o c	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	(o c	0	17. 00
18.00	Anal gesi cs	0	(o c	0	18. 00
19.00	Sedatives / Hypnotics	0	(o c	0	19. 00
20.00	Other - Specify	0	(o c	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	(o c	0	21. 00
22. 00	Patient Transportation	0	(o c	0	22. 00
23.00	I maging Services	0	(o c	0	23. 00
24.00	Labs and Diagnostics	0	(o c	0	24. 00
25.00	Medical Supplies	0	(o c	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	(o c	0	26. 00
27.00	Radi ati on Therapy	0	(o c	0	27. 00
28.00	Chemotherapy	0	(o c	0	28. 00
29.00	Other	o	(ol c	0	29. 00
30.00	Bereavement Program Costs	0	(o c	0	30.00
31.00	Volunteer Program Costs	0	(o c	0	31.00
32.00	Fundrai si ng	0	(o c	0	32. 00
33.00	Other Program Costs	0	(o c	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	13, 158	(0 5, 986	0	34.00
35. 00	Unit Cost Multiplier (see instructions)						35. 00
				•			

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

						2/25/2015 12:	25 pm
					Hospi ce I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
		(col s. 4A-23)	Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
			& Post	25)	(See Part II)	26 ± 27)	
			Stepdown				
			Adjustments				
		24.00	25.00	26. 00	27. 00	28. 00	
1.00	Administrative and General	47, 016					1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physici an Services	6, 496	0	6, 496	957	7, 453	4. 00
5.00	Nursing Care	244, 649	0	244, 649	36, 050	280, 699	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	1, 055	0	1, 055	155	1, 210	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	6, 414		6, 414		7, 359	10.00
11. 00	Spiritual Counseling	8, 137	0	8, 137	1, 199	9, 336	11. 00
12.00	Di etary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	52, 320	0	52, 320	7, 710	60, 030	15.00
16.00	Other	0	0	0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18. 00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Pati ent Transportation	0	0	0	0	0	22. 00
23. 00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25. 00	Medi cal Supplies	0	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radi ati on Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30. 00	Bereavement Program Costs	0	0	0	0	0	30. 00
31. 00	Volunteer Program Costs	0	0	0	0	0	31. 00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33. 00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	366, 087	0	366, 087		366, 087	34.00
35. 00	Unit Cost Multiplier (see instructions)				0. 147353		35. 00

Health Financial Systems DEKALB MALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS DEKALB MEMORIAL HOSPITAL Provi der CCN: 150045 STATISTICAL BASIS

Hospi ce CCN: 151559

							2/23/2013 12.	23 piii
						Hospi ce I		
				CAP	ITAL RELATED C	OSTS		
			T			I		
	Cost Center Description	BLDG & FIXT	MAC WEST	- NEW		GARRETT CLINIC		
		(SQUARE FEET)			NEW	- NEW	(SQUARE FEET)	
			(SQUARE		(SQUARE FEET)	(SQUARE FEET)		
		1. 00	1.0		1. 02	1. 03	1. 04	
1.00	Administrative and General	(0	300	0	0	
2.00	Inpatient - General Care	(0	0	0	0	2. 00
3.00	Inpatient - Respite Care	(0	0	0	0	3. 00
4.00	Physician Services	C		0	0	0	0	4. 00
5.00	Nursing Care	C		0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	C		0	C	0	0	6. 00
7.00	Physi cal Therapy	C		0	C	0	0	7. 00
8.00	Occupational Therapy	C		0	C	0	0	8. 00
9.00	Speech/ Language Pathology			0	C	0	0	9. 00
10.00	Medical Social Services	C		0	C	0	0	10.00
11. 00	Spiritual Counseling			0	C	0	0	11. 00
12.00	Di etary Counsel i ng			0	C	0	0	12. 00
13.00	Counseling - Other	C		0	C	0	0	13. 00
14.00	Home Health Aide and Homemaker			0	C	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	C		0	C	0	0	15. 00
16.00	Other	C		0	C	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	(C		0	C	0	0	17. 00
18.00	Anal gesi cs			0	C	0	0	18. 00
19. 00	Sedatives / Hypnotics			0	C	0	0	19. 00
20.00	Other - Specify			0	C	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen			0	C	0	0	21. 00
22. 00	Patient Transportation			0	C	0	0	22. 00
23.00	I maging Services			0	C	0	0	23. 00
24.00	Labs and Diagnostics			0	C	0	0	24. 00
25.00	Medical Supplies			0	C	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0		0	C	0	0	26. 00
27.00	Radiation Therapy			0	C	0	0	27. 00
28. 00	Chemotherapy			0	C	0	0	28. 00
29. 00	Other			0	C	0	0	29. 00
30.00	Bereavement Program Costs			0	C	0	0	30. 00
31.00	Volunteer Program Costs	C		0	C	0	0	31.00
32.00	Fundrai si ng			0	0	0	0	32. 00
33.00	Other Program Costs			0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	[C		0	300	0	0	34.00
35.00	Total cost to be allocated	[C		0	387	0	0	35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0.	000000	1. 290000	0. 000000	0. 000000	36. 00
		•	•		-	•		•

Health Financial Systems DEKALB MALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS DEKALB MEMORIAL HOSPITAL Provi der CCN: 150045

STATISTICAL BASIS Hospi ce CCN: 151559

						27 207 2010 12.	20 pm
					Hospi ce I		
			CAP	ITAL RELATED C	0STS		
			1	1	1		
	Cost Center Description	MAC EAST - NEW			DAY SPRING -	MVBLE EQUIP	
			NEW	NEW	NEW	(SQUARE FEET)	
		(SQUARE FEET)	(SQUARE FEET)				
	1	1. 05	1. 06	1. 07	1. 08	2. 00	
1.00	Administrative and General	0	0	(0	0	
2.00	Inpatient - General Care	0	0	(0	0	2. 00
3.00	Inpatient - Respite Care	0	0	(0	0	3. 00
4.00	Physician Services	0	0	(0	0	4. 00
5.00	Nursing Care	0	0	(0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	(0	0	6. 00
7.00	Physi cal Therapy	0	0	(0	0	7. 00
8.00	Occupational Therapy	0	0	(0	0	8. 00
9.00	Speech/ Language Pathology	0	0	(0	0	9. 00
10.00	Medical Social Services	0	0	(0	0	10.00
11.00	Spiritual Counseling	0	0	(0	0	11. 00
12.00	Di etary Counsel i ng	0	0	(0	0	12.00
13.00	Counseling - Other	0	0	(0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0	(0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15. 00
16.00	Other	0	0	(0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0	(0	0	17. 00
18.00	Anal gesi cs	0	0	(0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	(0	0	19. 00
20.00	Other - Specify	0	0	(0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	(0	0	21. 00
22.00	Patient Transportation	0	0	(0	0	22. 00
23.00	I maging Services	0	0	(0	0	23. 00
24.00	Labs and Diagnostics	0	0	(0	0	24.00
25.00	Medical Supplies	0	0	(0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
27.00	Radi ati on Therapy	0	0		0	0	27. 00
28.00	Chemotherapy	0	0		0	0	28. 00
29.00	Other	0	0		0	0	29. 00
30.00	Bereavement Program Costs	0	0		0	0	30.00
31.00	Volunteer Program Costs	0	0		0	0	31.00
32.00	Fundrai si ng	0	0		0	0	32.00
33.00	Other Program Costs	0	0		0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0	0	34.00
35.00	Total cost to be allocated	0	0		0	0	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	36. 00

STATISTICAL BASIS

							2/25/2015 12: 2	25 pm
						Hospi ce I		
	Cost Center Description	EMPLOYEE	Reconci I i	ati on	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	
	·	BENEFITS			& GENERAL	PLANT	LINEN SERVICE	
		DEPARTMENT			(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	
		(UNADJUSTED			·	·	`LAUNDRY)	
		SALARY)					, , , , , , , , , , , , , , , , , , ,	
		4. 00	5A		5. 00	7. 00	8. 00	
1. 00	Administrative and General	109, 138	3	0	10, 412	300	122	1. 00
2. 00	Inpatient - General Care	0		0	0	0	0	2. 00
3. 00	Inpatient - Respite Care	i c		0	0	0	o	3. 00
4.00	Physician Services	Ċ		n	5, 546	0	Ö	4. 00
5. 00	Nursing Care		á	n	208, 865		0	5. 00
6. 00	Nursing Care-Continuous Home Care		á	n	200, 000	0	l o	6. 00
7. 00	Physical Therapy			0	901	0	l ől	7. 00
8. 00	Occupational Therapy			0	701	0	l ől	8. 00
9. 00	Speech/ Language Pathology		3	0	0	0		9. 00
10. 00	Medical Social Services		3	0	5, 476	0	0	10. 00
11. 00	Spiritual Counseling		3	0	6, 947	0		11. 00
12. 00	Di etary Counsel i ng		3	0	0, 747	0	0	12.00
13. 00	Counseling - Other		3	0	0	0		13. 00
14. 00	Home Health Aide and Homemaker			0	0	0		14. 00
				0	44 (17	0		
15.00	HH Aide & Homemaker - Cont. Home Care			0	44, 667	0		15. 00
16.00	Other			0	0	0	0	16.00
17. 00	Drugs, Biological and Infusion Therapy			0	0	0	0	17. 00
18.00	Anal gesi cs		2	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics		2	0	0	0	0	19. 00
20.00	Other - Specify		2	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	C)	0	0	0	0	21. 00
22. 00	Patient Transportation	C)	0	0	0	0	22. 00
23. 00	I maging Services	C	P	0	0	0	0	23. 00
24. 00	Labs and Diagnostics	C	P	0	0	0	0	24. 00
25. 00	Medical Supplies	C	P	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	C		0	0	0	0	26. 00
27. 00	Radi ati on Therapy	C		0	0	0	0	27. 00
28. 00	Chemotherapy	C		0	0	0	0	28. 00
29. 00	Other	C		0	0	0	0	29. 00
30.00	Bereavement Program Costs	C		0	0	0	0	30. 00
31.00	Volunteer Program Costs	C		0	0	0	0	31. 00
32. 00	Fundrai si ng	C		0	0	0	0	32. 00
33.00	Other Program Costs	C		0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	109, 138			282, 814	300	122	34.00
35. 00	Total cost to be allocated	10, 025	5		48, 453			35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 091856	5		0. 171325	30. 383333	1. 114754	36. 00

Provider CCN: 150045 STATISTICAL BASIS Hospi ce CCN:

						2/25/2015 12:	25 pm_
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	NURSI NG	
	·	(SQUARE FEET)	(MEALS SERVED	(MEALS SERVED)	(FTES)	ADMI NI STRATI ON	
		, ,			, ,		
						(DI RECT NRS	
						I NG)	
		9. 00	10.00	10. 01	11.00	13.00	
1.00	Administrative and General	300)	0 0	166	3, 447	1. 00
2.00	Inpatient - General Care			o lc	0	0	2.00
3.00	Inpatient - Respite Care			o lc	0	0	3.00
4.00	Physi ci an Servi ces			o lo	0	0	4.00
5.00	Nursing Care				0	0	5. 00
6. 00	Nursing Care-Continuous Home Care				0	Ō	6. 00
7. 00	Physical Therapy				0	ő	7. 00
8. 00	Occupational Therapy				0	ő	8. 00
9. 00	Speech/ Language Pathology				0	Ö	9.00
10. 00	Medical Social Services				0	Ö	10.00
11. 00	Spiritual Counseling				0	0	11. 00
12. 00	Di etary Counsel i ng				0	0	12.00
13. 00	Counseling - Other				0	0	13. 00
14. 00	Home Health Aide and Homemaker				0	0	14. 00
					0		ı
15.00	HH Aide & Homemaker - Cont. Home Care				U	0	15.00
16.00	Other			0	U	0	16.00
17. 00	Drugs, Biological and Infusion Therapy)) 0	Ü	0	17. 00
18.00	Anal gesi cs)	0	0	0	18.00
19. 00	Sedatives / Hypnotics	C)	0	0	0	19. 00
20.00	Other - Specify	C)	0	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	C)	0 0	0	0	21. 00
22. 00	Patient Transportation	C)	0	0	0	22. 00
23. 00	I maging Services	C)	0 0	0	0	23. 00
24. 00	Labs and Diagnostics	C)	0 0	0	0	24. 00
25. 00	Medical Supplies	C)	0 (0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	C)	0 (0	0	0	26. 00
27.00	Radiation Therapy	C)	0 (0	0	0	27. 00
28.00	Chemotherapy	C)	0 (c	0	0	28. 00
29.00	Other	C)	0 (c	0	0	29. 00
30.00	Bereavement Program Costs	C		0	0	0	30.00
31.00	Volunteer Program Costs	C		0 (c	0	0	31.00
32.00	Fundrai si ng			0 (c	0	0	32.00
33.00	Other Program Costs	l c		o lc	0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	300		ol o	166	3, 447	34.00
35. 00	Total cost to be allocated	2, 672		ol o	3, 753		
	Unit Cost Multiplier (see instructions)	8. 906667	1	0.000000			

			1.000	, , , , , , , , , , , , , , , , , , , ,	0 077 007 2011	2/25/2015 12: 25 pm
					Hospi ce I	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	·	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(COSTED	,	(GROSS REVE	`	
		REQUIS.)		NUE)		
		14. 00	15. 00	16. 00	17. 00	
1. 00	Administrative and General	0	0	598, 796		1.00
2.00	Inpatient - General Care	0	0	(ol ol	2.00
3.00	Inpatient - Respite Care	0	0		أما	3.00
4.00	Physi ci an Servi ces	0	0		أما	4.00
5. 00	Nursing Care	0	0			5.00
6. 00	Nursing Care-Continuous Home Care	0	0		ól ől	6.00
7. 00	Physical Therapy		0			7.00
8. 00	Occupational Therapy		0			8.00
9. 00	Speech/ Language Pathology		0			9.00
10.00	Medical Social Services		0			10.00
11. 00	Spiritual Counseling	0	0			11.00
12. 00	Di etary Counsel i ng		0			12.00
13. 00	Counseling - Other	0	0		d d	13.00
14. 00	Home Health Aide and Homemaker	0	0			14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		j j	15.00
		0	0			16. 00
16.00	Other	0	0			
17. 00	Drugs, Biological and Infusion Therapy	U	0			17. 00
18.00	Anal gesi cs	0	0			18.00
19.00	Sedatives / Hypnotics	0	0			19.00
20.00	Other - Specify	0	0			20.00
21. 00	Durable Medical Equipment/Oxygen	0	0			21. 00
22. 00	Pati ent Transportation	0	0			22. 00
23. 00	I maging Services	0	0	1		23. 00
24. 00	Labs and Diagnostics	0	0	1		24. 00
25. 00	Medical Supplies	0	0	1		25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	9	0	26. 00
27. 00	Radi ati on Therapy	0	0	(0	27. 00
28. 00	Chemotherapy	0	0	(0	28. 00
29. 00	Other	0	0	(0	29. 00
30. 00	Bereavement Program Costs	0	0	(이	30.00
31. 00	Volunteer Program Costs	0	0	(0	31.00
32. 00	Fundraising	0	0	(0	32.00
33. 00	Other Program Costs	0	0	(0	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	0	0	598, 796		34.00
35. 00	Total cost to be allocated	0	0	5, 986		35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.009997	0.000000	36.00

Heal th	Financial Systems	DEKALB MEMORIAL H	OSPI TAL		In Li∈	eu of Form CMS-2	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150045	Peri od:	Worksheet K-5	
					From 10/01/2013		
			Hospi ce (CCN: 151559	To 09/30/2014		
						2/25/2015 12:	25 pm_
					Hospi ce I		
	Cost Center Description			Cost to Char		Hospi ce Shared	
		1,	col . 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00	0. 4893	96 0	0	1. 00
1. 01	CARDI AC REHAB		66. 01	1.0009	77 0	0	1. 01
2.00	OCCUPATI ONAL THERAPY		67.00				2. 00
3.00	SPEECH PATHOLOGY		68.00	ol .			3. 00
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 5340	90 0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5. 00
6. 00	LABORATORY		60.00	1	40	0	6. 00
6. 01	BLOOD LABORATORY		60. 01	•		0	6. 01
7. 00	MEDICAL SUPPLIES CHARGED TO PAT		71. 00	1		0	7. 00
8. 00	OTHER OUTPATIENT SERVICE COST CENTER		93.00		20	l o	8. 00
9. 00	RADI OLOGY-THERAPEUTI C		55.00	•			9.00
				•			
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76.00	'			10.00
11. 00	Totals (sum of lines 1-10)					0	11. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPICE PER DIEM COST	Provi der CCN: 150	0045 Period: From 10/01/2013	Worksheet K-6
	Hospi ce CCN: 15		Date/Time Prepared: 2/25/2015 12:25 pm

					2/23/2013 12.2	23 PIII
				Hospi ce I		
		Title XVIII	Title XIX	0ther	Total	
		1.00	2. 00	3. 00	4. 00	
1.00	Total cost (see instructions)				366, 087	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3, 539	2.00
3.00	Average cost per diem (line 1 divided by line 2)				103. 44	3.00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line	3, 312				4.00
	5)					
5.00	Aggregate Medicare cost (line 3 time line 4)	342, 593				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line		73			6.00
	5)					
7.00	Aggregate Medicaid cost (line 3 time line 60)		7, 551			7.00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	1, 176				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	121, 645				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		C			10.00
11.00	Aggregate NF cost (line 3 times line 10)		C			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			154		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			15, 930		13.00

	n Financial Systems DEKALB MEMORIA			u of Form CMS-2	2552-10
CALCUI	LATION OF CAPITAL PAYMENT	Provider CCN: 150045	Peri od: From 10/01/2013 To 09/30/2014	Worksheet L Parts I-III Date/Time Pre 2/25/2015 12:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			222, 858	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			1, 186	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0 16. 23	2. 01
3. 00 4. 00					3. 00 4. 00
5.00	· · · · · · · · · · · · · · · · · · ·				5.00
6.00	Indirect medical education adjustment (multiply line 5 by t)	0.00	6.00	
7.00	Percentage of SSI recipient patient days to Medicare Part A	0.00	7. 00		
	30) (see instructions)		•		
8.00	Percentage of Medicaid patient days to total days (see inst	ructions)		0.00	
9. 00	Sum of lines 7 and 8			0. 00 0. 00	9.00
10.00					
11.00	Total prospective capital payments (sum of lines 1, 1.01, 2	0 224, 044	11. 00 12. 00		
12.00	Total prospective capital payments (sum of fines 1, 1.01, 2	, 2.01, 6 and 11)		224, 044	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00 4. 00					3.00
5.00					4. 00 5. 00
5.00	Total Tripatrent program capital cost (Trie 3 x Trie 4)			0	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2. 00 3. 00	Program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2)	nces (see instructions)		0	2. 00 3. 00
4.00	Applicable exception percentage (see instructions)			0. 00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5.00
6.00	Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	6.00
7. 00	Adjustment to capital minimum payment level for extraordina		(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)		,	0	8. 00
	Current year capital payments (from Part I, line 12, as app	l i cabl e)		0	9. 00
9.00				0	10.00
10.00		capital payment (from pri	or year	0	11. 00
10. 00 11. 00	Worksheet L, Part III, line 14)	1 1 3 1	no 11)	0	12 00
10. 00 11. 00 12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	payments (line 10 plus lin		0	
10. 00 11. 00 12. 00 13. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent	payments (line 10 plus liner the amount on this line	e)	0 0	13.00
10. 00 11. 00 12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ent	payments (line 10 plus liner the amount on this line	e)	0	13.00
10. 00 11. 00 12. 00 13. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, ento Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	payments (line 10 plus line er the amount on this line capital payment for the f	e)	0	13. 00 14. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see in	payments (line 10 plus line er the amount on this line capital payment for the f	e)	0	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00