modi en inidito.		
This report is	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all inte	rim FORM APPROVED
payments made	since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).	OMB NO. 0938-0050
		EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0045 Period: From 10/01/20 To 09/30/20	
PART I - COST	REPORT STATUS	
Provi der	1. [ X ] Electronically filed cost report Date: 2/27	/2019 Time: 3:17 pm
use only	2. [ ] Manually submitted cost report	
	3. [ 0 ] If this is an amended report enter the number of times the provider resubmitted thi 4. [ F ] Medicare Utilization. Enter "F" for full or "L" for low.	s cost report
Contractor use only	5. [ 1 ] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN (3) Settled with Audit 9. [ N ] Final Report for this Provider CCN (4) Reopened (5) Amended	endor Code: 4 column 1 is 4: Enter times reopened = 0-9.

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEKALB MEMORIAL HOSPITAL (15-0045) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
=	
Ti tl e	<b>)</b>
D-+-	
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	25, 729	6, 016	0	-297, 141	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	25, 729	6, 016	0	-297, 141	200.00

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

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0045 Peri od: Worksheet S-2 From 10/01/2017 Part I 09/30/2018 Date/Time Prepared: 2/27/2019 3:17 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)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal DEKALB MEMORIAL 150045 99915 07/01/1966 0 3.00 HOSPI TAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospital -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital-Based HHA DEKALB HOME HEALTH 157157 99915 07/09/1985 Ν Ρ Ν 12.00 AGENCY 13.00 Separately Certified ASC 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 Hospital -Based (CORF) I 17. 10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2017 09/30/2018 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care N Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.

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22.03

23.00

22.03 Did this hospital receive a geographic reclassification from urban to

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

yes or "N" for no.

for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

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

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58.00

59.00

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0045 Peri od: Worksheet S-2 From 10/01/2017 Part I Date/Time Prepared: 09/30/2018 2/27/2019 3:17 pm NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions 60.00 Ν (see instructions) Direct GME IME Y/N Direct GME 1.00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in 0 00 0. 00 61 00 N column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE 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. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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) 62 01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTES FTEs in Nonprovi der Hospi tal 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.

	1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider	N			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most			0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period				
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00   Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75.00
subprovi der? Enter "Y" for yes and "N" for no.				

4)). (see instructions)

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	rovider CCN: 15-0045	Period: From 10/01/20 To 09/30/20		
		10 09/30/20	2/27/2019 3	
		1.	00 2.00 3.0	00
5.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 20 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting pe	004? Enter "Y" for yes ng program in accordar lumn 3: If column 2 is	or "N" for occurrence with 42 of Y,	0	76.0
			1.00	
Long Term Care Hospital PPS  D.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and	d "N" for no		N.	80.0
1.00 Is this a Tong term care hospital (ETCH)? Enter it for yes and 1.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no.  TEFRA Providers		ng period? Ent	er N	81.0
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE 5.00 Did this facility establish a new Other subprovider (excluded unled §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			O. N	85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospital c 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	assified under section	n	N	87.0
וויסטס(מ)(ו)(ט)(עו): בווגפו ד דטו אָפּאַ טו א דטו ווט.		V	XIX	
Title V and XIX Services		1. 00	2. 00	
Does this facility have title V and/or XIX inpatient hospital so yes or "N" for no in the applicable column.			Y	90.0
I. 00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applical		N	N	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	certification)? (see		N	92.0
B.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.	title V and XIX? Enter	N	N	93.0
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.		N	N	94.0
5.00 If line 94 is "Y", enter the reduction percentage in the application.  Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		0. 00 N	0. 00 N	95. ( 96. (
7.00 If line 96 is "Y", enter the reduction percentage in the application. 3.00 Does title V or XIX follow Medicare (title XVIII) for the intersection and justments on Wkst. B, Pt. I, col. 25? Enter "Y" for a column 1 for title V, and in column 2 for title XIX.	ns and residents post	0. 00 Y	0. 00 Y	97. ( 98. (
3.01 Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y	98. (
B.02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "I for title V, and in column 2 for title XIX.		Y	Y	98. (
3.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of for title V, and in column 2 for title XIX.			N	98.0
3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rein outpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX.		N N	N	98.
B. 05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	98.
B.06 Does title V or XIX follow Medicare (title XVIII) when cost rein Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.  Rural Providers		Y	Y	98.
05.00 Does this hospital qualify as a CAH?		N		105.
06.00   If this facility qualifies as a CAH, has it elected the all-inc   for outpatient services? (see instructions)	lusive method of payme	ent N		106. (
07.00 If this facility qualifies as a CAH, is it eligible for cost re training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25	(see instructions) If			107.
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 s this a rural hospital qualifying for an exception to the CRN.	A fee schedule? See 4	.2 N		108.

Health Financial Systems HOSPLTAL AND HOSPLTAL HEALTH CARE COMPLE:		EMORI AL HOSPI TAL	r CCN: 15-0	004E D	eri od:		worksheet S-2	
HUSPITAL AND HUSPITAL HEALTH CARE COMPLE,	K IDENTIFICATION DATA	A Provide	CCN: 15-0		rom 10	0/01/2017 0/30/2018	Part I	epared:
						1. 00	2. 00	-
140.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column	1. If yes, and h	nome offic			N N	2.00	140.00
1. 00		2. 00			•	3.00		
If this facility is part of a chai office and enter the home office of				3 the na	ame and	d address	of the home	
41. 00 Name:	Contractor's Nar			ntractor	's Nur	mber:		141.00
42.00 Street:	PO Box:							142. 0
43. 00 Ci ty:	State:		Zi	p Code:				143.0
							1. 00	-
44.00 Are provider based physicians' cos	ts included in Works	heet A?					Y	144.0
45.00 If costs for renal services are cl	aimed on Wkst A li	ne 7/1 are the (	nete for			1. 00	2. 00	145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	for yes or "N" for Lude Medicare utiliz for no in column 2. y changed from the p column 1. (See CMS	no in column 1. ation for this or reviously filed	If column cost repor cost repo	ting rt?		N		146. 00
yes, enter the approval date (mm/d	d/yyyy) in column 2.							
							1. 00	1
47.00 Was there a change in the statisti							N	147.0
48.00 Was there a change in the order of				II NIII C			N	148.0
49.00 Was there a change to the simplifi	ea cost finaing meth	Part A		irt B		tle V	N Title XIX	149.0
		1.00		2. 00		3. 00	4. 00	1
Does this facility contain a provi								
or charges? Enter "Y" for yes or " 55.00Hospital	N" for no for each c	component for Pai	rt A and P	<u>'art B. (</u> N	(See 42	2 CFR §41 N	3. 13) N	  155.0
56. 00 Subprovi der - TPF		N		N		N	N N	156. 0
57.00 Subprovider - IRF		N		N		N	N	157.0
58. 00 SUBPROVI DER								158.0
59.00 SNF 50.00 HOME HEALTH AGENCY		N N		N N		N N	N N	159. C
51. OO CMHC		IV		N		N	N N	161.0
61. 10 CORF				N		N	N	161. 1
Mul ti campus							1. 00	
65.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that h	as one or more o	campuses i	n differ	ent CE	BSAs?	N	165.0
	Name	County	Sta		Code	CBSA	FTE/Campus	
66.00  fline 165 is yes, for each	0	1.00	2.0	JU 3.	00	4. 00	5. 00	166. C
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								
							1.00	
Health Information Technology (HIT	) incentive in the A	merican Recover	v and Rein	vestment	t Act		1. 00	
57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 10	under §1886(n)? En 5 is "Y") and is a m	ter "Y" for yes eaningful user (	or "N" fo	r no.		- the	Υ	167. C
reasonable cost incurred for the H 68.01 of this provider is a CAH and is n exception under §413.70(a)(6)(ii)?	ot a meaningful user	, does this prov			a hard	dshi p		168. 0
69.00  f this provider is a meaningful u transition factor. (see instruction	ser (line 167 is "Y"	) and is not a (	CAH (line	105 is "	N"), ∈	enter the	0.0	169. 0
	·					ji nni ng	Endi ng	
70 00 Enter in columns 1 and 2 the FUD b	oginning data and	ding data for th	o ropert!	na		1.00	2.00	170.0
70.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and en	uing date for th	ie reporti	ng	10/0	01/2017	12/31/2017	170. 0

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi der CCN: 15-0045	Peri od: From 10/01/2017	Worksheet S-2 Part I	!
			To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provide	er have any days for indi	viduals enrolled in	N	C	171.00
section 1876 Medicare cost plans repo	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	on				
1876 Medicare days in column 2. (see	instructions)				

OSPI .	Financial Systems DEKALB MEMORIA FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	worksheet S-2	
			F	rom 10/01/2017	Part II	
			'	o 09/30/2018	2/27/2019 3:1	
				Y/N	Date	
	0	I Committee NO		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	I for all NO re	esponses. Ente	r all dates in	the	
	COMPLETED BY ALL HOSPITALS					1
	Provider Organization and Operation					1
00	Has the provider changed ownership immediately prior to the			N		1. (
	reporting period? If yes, enter the date of the change in c	column 2. (see		5 .	\/ (I	
			1. 00	2. 00	V/I 3. 00	
00	Has the provider terminated participation in the Medicare F	Program? If	N 1.00	2.00	3.00	2. (
	yes, enter in column 2 the date of termination and in colum					
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		N			3.0
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)			_		
			1. 00	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert	ified Public	Υ	A	11/29/2018	4.0
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
00	column 3. (see instructions) If no, see instructions.		, ,			_ ,
00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reconstructions are total revenues and total revenues differences and total revenues differences.		N			5.0
	Those on the fired financial statements. If yes, submit fee	oner ration.		Y/N	Legal Oper.	
				1. 00	2.00	
	Approved Educational Activities				1	١
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is t	he provider is	N		6.0
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions		N		7.0
00	Were nursing school and/or allied health programs approved		d during the	N		8.0
	cost reporting period? If yes, see instructions.		· ·			
00	Are costs claimed for Interns and Residents in an approved		cal education	N		9.0
. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10.0
). 00	cost reporting period? If yes, see instructions.	n renewed in	the current	IN .		10.0
. 00	Are GME cost directly assigned to cost centers other than I	& R in an Ap	proved	N		11. (
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Bad Debts				1. 00	
. 00	Is the provider seeking reimbursement for bad debts? If yes	s see instruc	tions		Υ	12.0
. 00				st reporting	N N	13. (
	period? If yes, submit copy.	, ,	Ü	. 0		
4. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	fyes, see ins	tructi ons.	N	14.0
- 00	Bed Complement Did total beds available change from the prior cost reporti	na nori od2 lf	vos soo inst	ructions	Y	15 (
5. 00	The total beds available change from the pirol cost reporti		yes, see mst		<u>т</u> -t В	15.0
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
	PS&R Data					
5. 00	Was the cost report prepared using the PS&R Report only?	Υ	12/13/2018	Υ	12/13/2018	16. (
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
. 00	Was the cost report prepared using the PS&R Report for	N		N		17. (
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)	N		N		10
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.0
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
		N		N		19.0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R	14				
9. 00	Report data for corrections of other PS&R Report information? If yes, see instructions.	14				

Heal th	Financial Systems DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0045	Peri od: From 10/01/2017	Worksheet S-2 Part II Date/Time Pre 2/27/2019 3:1	epared:		
			iption	Y/N	Y/N			
20.00	LE Line 1/ on 17 in the property and to DCOD		0	1.00	3.00	20.00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00		
	report data for other. Beserve the other day astments.	Y/N	Date	Y/N	Date			
		1. 00	2. 00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)					
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made dui	ring the cost	N	23. 00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	eporting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period <sup>~</sup>	? If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	he cost report	ing period?	lf yes, see	N	26. 00		
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? I	f yes, submit	N	27. 00		
28. 00	Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cos	t reporting	Υ	28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service I	Reserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes	s, see	N	30.00		
31. 00	Has debt been recalled before scheduled maturity without i instructions.	s, see	N	31.00				
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ontractual	N	32.00		
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	itive bidding? If	-	33. 00		
	Provi der-Based Physi ci ans							
34. 00	'	ırrangement wit	h provi der-ba	ased physicians?	Υ	34.00		
35. 00	If yes, see instructions.  If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based	N	35. 00		
	physicians during the cost reporting period? If yes, see i	IISTI UCTI OIIS.		Y/N	Date			
				1. 00	2. 00			
	Home Office Costs							
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office	? N		36. 00 37. 00		
38. 00	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home of			f		38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.			5,		39. 00		
40. 00	If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see			40. 00		
	THE COLORS							
		00						
44 00	Cost Report Preparer Contact Information	MI OLIAET		AL ECCAMBBIAN		1 44 22		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI		41.00		
42. 00	Enter the employer/company name of the cost report preparer.	BLUE AND CO.,	LLC			42.00		
43. 00		317-713-7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00		

Heal th	Financial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE	Provi der	CCN: 15-0045	Peri od: From 10/01/2017	Worksheet S-2 Part II	
					To 09/30/2018	Date/Time Pre 2/27/2019 3:1	pared: 7 pm
				3. 00			
(	Cost Report Preparer Contact Information						
	Enter the first name, last name and the tit		DI RECTOR				41.00
	held by the cost report preparer in columns	1, 2, and 3,					
	respecti vel y.						
42. 00	Enter the employer/company name of the cost	report					42.00
	preparer.						
	Enter the telephone number and email addres						43.00
	report preparer in columns 1 and 2, respect	i vel y.					

Health Financial Systems DEKALB !
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Period: | Worksheet S-3 | From 10/01/2017 | Part | To 09/30/2018 | Date/Time Prepared: Provi der CCN: 15-0045

Component   Worksheet A Line Number   No. of Beds   Bed Days Available   CAH Hours   Title V   Trips							То	09/30/2018	Date/Time Pr 2/27/2019 3:		
Component										Τ	Pili
Component									0/P Visits /	٠	
1.00											
1.00		Component		No	. of Beds			CAH Hours	Title V		
1.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 acclude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2.00			4.00	F 00	+	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)   2	1 00	Hospital Adults & Peds (columns 5 6 7 and					35			n	1 00
Hospice days) (see instructions for col. 2   For the portion of LDP room avail able beds)   2.00   HMO and other (see instructions)   2.00   A.00   MMO IRF Subprovi der   4.00   4.00   6.00   6.00   HMO IRF Subprovi der   4.00   6.00   6.00   HMO IRF Subprovi der   4.00   6.00   6.00   HMO IRF Subprovi der   6.00	1.00		55. 55		2,	10,00	,0	0.00		Ĭ	1.00
For the portion of LDP room available beds)   2.00   MM and other (see instructions)   2.00   3.00   MM IPF Subprovider   3.00   4.00   MM IPF Subprovider   4.00   MM IPF Subprovider   4.00   MM IPF Subprovider   6.00   5.00   6.00   HM IPF Subprovider   6.00   6.00   7.00   Total Adults & Peds. Swing Bed NF   6.00   Mospital Adults & Peds. Swing Bed NF   6.00   6.00   7.00   Total Adults and Peds. (secilude observation beds) (see instructions)   7.00   Total Adults & Peds. Swing Bed NF   7.00   7.00   Total Adults and Peds. (secilude observation beds) (see instructions)   7.00   Total Adults and Peds. (secilude observation beds) (see instructions)   7.00											
3.00   HMO IPF Subprovider		for the portion of LDP room available beds)									
4.00   HMO I RF Subprovider   5.00   Hospit al Adult & a Peds. Swing Bed SNF   6.00   Hospit al Adult & and Peds. (exclude observation beds) (see instructions)   7.00   6.00   7.00	2.00	HMO and other (see instructions)									2.00
5.00   Hospital Adults & Peds. Swing Bed SNF   0.00   0.	3.00	HMO IPF Subprovider									3.00
6.00   Hospital Adults & Peds. Swing Bed NF   7.00   Total Adults and Peds (exclude observation beds) (see instructions)   7.00   Total Adults and Peds (exclude observation beds) (see instructions)   7.00   Deds) (subprovi) DER   Per   Per   Deds) (see instructions)   7.00   Deds) (subprovi) DER   Per   Deds) (see instructions)   7.00   Deds) (subprovi) DER   Deds) (see instructions)   7.00   Deds) (see inst		•									
7.00   Total Adults and Peds. (exclude observation beds) (see instructions)   29   10,585   0.00   0   7.00											
DedS) (see instructions)   8		, ,									
8. 00   INTENSIVE CARE UNIT   31.00   8   2,920   0.00   0   8.00   0.00	7. 00				29	10, 58	35	0. 00		0	7. 00
9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 TOTHER SPECIAL CARE (SPECIFY) 11. 00 TOTHER SPECIAL CARE (SPECIFY) 11. 00 TOTAL (see instructions) 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IFF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER FOR IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 TOTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CMHC 25. 10 CMHC - CORF 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 32. 00 Iotal ancillary labor & delivery room outpatient days (see instructions) 33. 00 ICTH on-covered days 34. 00 ICTH ON-covered day	0.00	1 ' '	24 22		0			0.00			0.00
10.00   BURN INTENSIVE CARE UNIT   10.00			31.00		8	2, 92	20	0.00		٥Į	
11. 00 12. 00 17. 00 18. 00 19										ł	
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 43. 00 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CINIC 26. 00 RURAL HEALTH CINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Bays 29. 00 Ambul ance Trips 30. 00 31. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 33. 00 LTCH non-covered days 31. 00 32. 01 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 3										- 1	
13. 00   NURSERY   43. 00   14. 00   15. 00   14. 00   14. 00   15. 00   14. 00   14. 00   15. 00   14. 00   14. 00   15. 00   14. 00   15. 00   15. 00   14. 00   15. 00   15. 00   16. 00   15. 00   16. 00   16. 00   16. 00   17. 00   SUBPROVI DER - IRF   17. 00   SUBPROVI DER - IRF   18. 00   SUBPROVI DER   18. 00   18. 00   18. 00   19. 00   SKILLED NURSING FACILITY   19. 00   18. 00   19. 00   NURSING FACILITY   20. 00   NURSING FACILITY   21. 00   21. 00   22. 00   01HER LONG TERM CARE   21. 00   22. 00   40. 00   4		1									
14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 21.00 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 25.10 CMHC - CMRC 26.00 RURAL HEALTH CLINIC 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 Ambul ance Trips 30.00 Empl oyee discount days (see instruction) 31.00 Empl oyee discount days (see instructions) 33.00 LTOH non-covered days 37. 13,505 0.00 0.14.00 0.15.00 0.15.00 0.16.00 0.17.00 0.18.00 0.19.00 0			43.00							- 1	
15. 00 CAH visits 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER - IRF 19. 00 SKILLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D.P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (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 Ambul ance Trips 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee discount days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days			43.00		37	13.50	15	0.00			
16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDE CORP 19. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IR		1			37	13,30	,5	0.00			
17. 00   SUBPROVI DER - IRF   17. 00   18. 00   SUBPROVI DER   18. 00   18. 00   SUBPROVI DER   19. 00   SKILLED NURSING FACILITY   19. 00   20. 00   NURSI NG FACILITY   20. 00   20. 00   21. 00   21. 00   22. 00   22. 00   40. MBULATORY SURGI CAL CENTER (D. P. )   23. 00   AMBULATORY SURGI CAL CENTER (D. P. )   24. 00   24. 00   40. MSPICE   116. 00   0   0   24. 00   24. 10   40. MSPICE   10. MSPICE   1										- 1	
18. 00   SUBPROVI DER   18. 00   19. 00   SVILED NURSI NG FACILITY   19. 00   20. 00   19. 00   20. 00   19. 00   20. 00										- 1	
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 - CMHC 26.25 IO CMHC - CORF 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) 30.00 LTCH non-covered days 31.00 LTCH non-covered days 31.00 LTCH non-covered days 31.00 LTCH non-covered days 31.00 LTCH non-covered days											
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   22.00   40ME HEALTH AGENCY   101.00   22.00   23.00   4MBULATORY SURGICAL CENTER (D.P.)   23.00   4MSULATORY SURGICAL CENTER (D.P.)   23.00   24.00   24.00   24.10   40.00   24.10   40.00   24.10   40.00   24.10   25.00   24.10   25.00   24.10   25.00   25.10   25.00   26.00   25.10   26.00   26.25   27.00   26.25   27.00   26.25   27.00   26.25   27.00   27.00   28.00   29.00   28.00   29.00										- 1	
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 25. 10 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 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 31. 00 LTCH non-covered days 32. 00 LTCH non-covered days 33. 00 LTCH non-covered days 30. 00 Sacrossina delivery days (see instructions) 33. 00 LTCH non-covered days 30. 00 Sacrossina delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00 Sacrossina delivery days (see instructions) 33. 00 LTCH non-covered days 33. 00 Sacrossina delivery room outpatient days (see instructions) 33. 00 Sacrossina delivery days (see instructions)	20.00									1	20.00
23. 00	21.00	OTHER LONG TERM CARE								1	21.00
24.00 HOSPICE	22.00	HOME HEALTH AGENCY	101. 00							0	22.00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 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) 33. 00 LTCH non-covered days 30. 00 24. 10 25. 00 25. 10 26. 00 27. 00 28. 00 29. 00 37 37 37 37 30. 00 37 37 30. 00 37 37 37 30. 00 38. 00 39. 00 39. 00 39. 00 39. 00 30. 00	23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
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) 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  25. 00 99. 10 28. 00 29. 10 26. 25 27. 00 26. 25 27. 00 28. 00 29. 00 37 37 37 37 37 37 37 38. 00 29. 00 30. 00 31. 00 32. 00 32. 00 33. 00 30	24.00	HOSPI CE	116. 00		0		0				24.00
25. 10 CMHC - CORF 99. 10 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Total (sum of lines 14-26) 37 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 30. 00 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 00	24. 10	HOSPICE (non-distinct part)	30.00								24. 10
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 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) 33. 00 LTCH non-covered days  26. 00 26. 25 27. 00 28. 00 29. 00 37  0 0 28. 00 29. 00 30. 00 31. 00 32. 01 32. 01 33. 00 32. 01 33. 00										- 1	
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00  27. 00 Total (sum of lines 14-26) 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) 33. 00 LTCH non-covered days  89. 00  0 26. 25 27. 00 28. 00 29. 00 30. 00 30. 00 31. 00 32. 01 32. 01 33. 00			99. 10							0	
27.00   Total (sum of lines 14-26)   27.00   28.00   0bservation Bed Days   0   28.00   29.00   Ambulance Trips   29.00   29.0											
28.00 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) 33.00 LTCH non-covered days 33.00			89. 00								
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 LTCH non-covered days 33.00 LTCH non-covered days		,			37					- 1	
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) 33.00 LTCH non-covered days  30.00 31.00 31.00 32.00 32.01 33.00										٥Į	
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  31.00 0 0 0 32.00 32.01 33.00											
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  32.00 32.01											
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.01					0		0			-	
outpati ent days (see i nstructions) 33.00 LTCH non-covered days 33.00					U		J				
33.00 LTCH non-covered days 33.00	JZ. U1										JZ. U I
	33.00	1 .								١	33.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1											33. 01

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

				'	0 09/30/2010	2/27/2019 3: 1	
		I/P Days	/ O/P Visits	/ Trins	Full Time	Equi val ents	, p
		in the says	, 0, 1, 0, 10	,po		Equi vai onto	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 451	128	4, 595		10.00	1.00
	8 exclude Swing Bed, Observation Bed and	.,	.20	1,070			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 483	1, 114				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	o	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 451	128	4, 595			7.00
7.00	beds) (see instructions)	.,	.20	1,070			,,,,,
8. 00	INTENSIVE CARE UNIT	434	0	1, 125			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	760			13.00
14.00	Total (see instructions)	1, 885	128	6, 480	0.00	485. 15	14.00
15. 00	CAH visits	0	0	0			15.00
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	2, 721	352	6, 633	0.00	13. 65	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	·		.,			23.00
24.00	HOSPICE	2, 558	6	2, 774	0.00	1. 24	24.00
24. 10	HOSPICE (non-distinct part)	,		, 0			24. 10
25. 00	CMHC - CMHC						25.00
25. 10	CMHC - CORF	o	0	0	0.00	0.00	1
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)		-		0.00		
28. 00	Observation Bed Days		17	1, 539			28.00
29. 00	Ambul ance Trips	1, 093		.,			29.00
30. 00	Employee discount days (see instruction)	1, 213		85			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	o	35	74			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	0					33. 01
					•	•	•

Provi der CCN: 15-0045

				10	09/30/2018	Date/IIMe Pre   2/27/2019 3:1	
		Full Time		Di sch	arges		
		Equi val ents			,		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	577	22	1, 945	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			410	2/1		2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider			418	261 0		2.00 3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				٥		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14.00	Total (see instructions)	0.00	ol	577	22	1, 945	14.00
15. 00	CAH visits			-		,	15.00
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	0.00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0. 00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)			0			22.00
	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges		ı	0			33. 01

HOSPI T	AL WAGE INDEX INFORMATION			Provi der C		Peri od:	Worksheet S-3	
						From 10/01/2017 To 09/30/2018	Part II Date/Time Pre 2/27/2019 3:1	pared: 7 pm
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	28, 683, 067	0	28, 683, 06	1, 040, 077. 00	27. 58	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0		0.00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0		0.00	0. 00	3. 00
4. 00	B Physician-Part A -		168, 400	0	168, 400	1, 177. 00	143. 08	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	O		0.00	0. 00	4. 01
5. 00	Physician and Non Physician-Part B		0	0		0.00	0. 00	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	O		0.00	0. 00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0		0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	O		0.00	0. 00	7. 01
8. 00	Home office and/or related organization personnel		0	0		0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 9, 704, 218	-18, 400	9, 685, 818	0. 00 3 300, 164. 00	0. 00 32. 27	
11 00	OTHER WAGES & RELATED COSTS		7.450		7 454	140.00	F0 00	11 00
11. 00 12. 00	Contract Labor: Direct Patient Care		7, 450	0	7, 450			11.00
12.00	Contract labor: Top level management and other management and administrative services		O	O		0.00	0.00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		206, 894	O	206, 894	597. 00	346. 56	13.00
14. 00	Home office and/or related organization salaries and wage-related costs		0	О		0.00	0. 00	14. 00
14. 01	Home office salaries		0	О		0.00	0. 00	14. 01
14. 02	Related organization salaries		0	0		0.00		14.02
15. 00	Home office: Physician Part A - Administrative		0	0		0.00		15.00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0		0.00	0.00	16.00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		6, 646, 033	0	6, 646, 03	3		17. 00
18. 00	instructions) Wage-related costs (other)		0	0				18. 00
19. 00	(see instructions) Excluded areas		2, 893, 528	0	2, 893, 528	3		19. 00
20. 00	Non-physician anesthetist Part A		0	0	)			20.00
21. 00	Non-physician anesthetist Part B		0	0		)		21. 00
22. 00	Physician Part A - Administrative		17, 024	a	17, 024	1		22. 00
22. 01	Physician Part A - Teaching		0	0				22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	[ 0   0				23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0				25. 00
25. 50	Home office wage-related (core)		0	a	)			25. 50
25. 51	Related organization wage-related (core)		0	o	)			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0				25. 52
25. 53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0				25. 53

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0045

Peri od: Worksheet S-3 From 10/01/2017 Part II Date/Time Prepared: 09/30/2018

2/27/2019 3:17 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of (col . 2 ± col . Sal ari es Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 OVERHEAD COSTS - DIRECT SALARIES 225, 669 4, 390, 330 6, 262. 00 173, 008. 00 26,00 Employee Benefits Department 4.00 225, 669 36. 04 26,00 27.00 5.00 4, 390, 330 25. 38 27.00 Administrative & General C 28.00 Administrative & General under 142, 986 142, 986 1, 260. 00 113. 48 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 Operation of Plant 22, 354. 00 30.00 7.00 545, 762 24. 41 30.00 545, 762 31.00 Laundry & Linen Service 8.00 29,872 29, 872 2, 085. 00 14. 33 31.00 Housekeepi ng 32.00 9.00 817, 876 817, 876 57, 872. 00 14. 13 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 553, 878 -357, 679 196, 199 10, 400. 00 18.87 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 14. 36 36.00 11.00 22, 824. 00 36.00 Cafeteri a 0 327, 807 327, 807 Maintenance of Personnel 37.00 12.00 0 0.00 0.00 37.00 38.00 Nursing Administration 13.00 565, 526 565, 526 20, 394. 00 27. 73 38.00 Central Services and Supply 7, 939. 00 16. 76 39.00 14.00 133, 018 0 133, 018 39.00 13, 624. 00 40.00 Pharmacy 15.00 569, 832 C 569, 832 41.83 40.00 Medical Records & Medical 41.00 16.00 620,050 C 620, 050 25, 121. 00 24. 68 41. 00 Records Library Social Service 2, 080. 00 35. 38 42. 00 42.00 17.00 73, 594 0 73, 594 43.00 Other General Service 18.00 0 0 0.00 0.00 43.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0045	From 10/01/2017	Worksheet S-3 Part III Date/Time Prepared: 2/27/2019 3:17 pm

					Т	o 09/30/2018	Date/Time Pre 2/27/2019 3:1	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col . 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		28, 826, 053	0	28, 826, 053	1, 041, 337. 00	27. 68	1.00
	instructions)							
2. 00	Excluded area salaries (see		9, 704, 218	-18, 400	9, 685, 818	300, 164. 00	32. 27	2. 00
	instructions)							
3. 00	Subtotal salaries (line 1		19, 121, 835	18, 400	19, 140, 235	741, 173. 00	25. 82	3. 00
	minus line 2)							
4. 00	Subtotal other wages & related		214, 344	0	214, 344	746. 00	287. 32	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		6, 663, 057	0	6, 663, 057	0. 00	34. 81	5. 00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		25, 999, 236	18, 400		· ·		
7. 00	Total overhead cost (see		8, 638, 521	0	8, 638, 521	365, 223. 00	23. 65	7. 00
	instructions)							

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0045		Worksheet S-3
		From 10/01/2017	Part IV

	To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	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	123, 348	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	6, 674, 519	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	532, 501	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00		63, 128	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	9	107, 978	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	1, 995, 821	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unemployment Insurance	0	19.00
20.00		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))	1	
22.00	Day Care Cost and Allowances	0	22. 00
23.00		59, 290	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9, 556, 585	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
		'	

Health Financial Systems	DEKALB MEMORIAL HOSPITA	L	In Lieu	of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi de		Peri od: From 10/01/2017	Worksheet S-3 Part V
		-	To 09/30/2018	Date/Time Prepared:

		To	09/30/2018	Date/Time Prep 2/27/2019 3:1	
	Cost Center Description	·	Contract	Benefit Cost	
			Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		7, 450	9, 556, 585	1.00
2.00	Hospi tal		7, 450	9, 556, 585	2.00
3.00	Subprovi der - IPF				3.00
4.00	Subprovi der - IRF				4.00
5. 00	Subprovi der - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7.00
8. 00	Hospi tal -Based SNF				8.00
9.00	Hospi tal -Based NF				9.00
10. 00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11.00
12.00	Separately Certified ASC				12.00
13. 00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16. 00	Hospi tal -Based-CMHC				16.00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17.00	Renal Dialysis				17.00
18. 00	Other		0	0	18.00

	Financial Systems HEALTH AGENCY STATISTICAL DATA	DEKALB MEMORIA	AL HOSPITAL Provider C		In Lie Period: From 10/01/2017	u of Form CMS-: Worksheet S-4	
			Component		To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
					Home Health	PPS	
					Agency I		
0.00	County				1.	00	0.00
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	L	1. 00	2. 00	3. 00	4.00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	O	0		0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	136.00	0.0	0.00	0.00	
				Number of Emp	oloyees (Full Ti	me Equivalent)	
		<b>.</b>		61.66	0	T. I. I	
		Enter the number your normal		Staff	Contract	Total	
		0		1.00	2.00	3.00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40. 00	0.0	0.00	0.00	3.00
4. 00	Director(s) and Assistant Director(s)		40.00	0. 9		•	
5.00	Other Administrative Personnel			1.8			
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			5. C 0. C		•	
8.00	Physical Therapy Service			1.6	0.00	1. 67	8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. C 1. C		•	1
11. 00	Occupational Therapy Supervisor			0.0		l	1
12.00	Speech Pathology Service			0. 4			1
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. C 0. C			
15. 00	Medical Social Service Supervisor			0. 0		l .	1
16.00	Home Heal th Aide			1.7		l	1
17. 00 18. 00	Home Heal th Ai de Supervisor Other (specify)			0. C 0. C			
	HOME HEALTH AGENCY CBSA CODES						
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19. 00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			23060			20.00
	contains the first code).						
20. 01	·	5.11.5		99915			20. 01
		Full Ep Without	usodes With Outliers	LUPA Episode:	s 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	1, 097	305		5 0		
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	228, 944 404	63, 574 73		0 3 0		1
24. 00	Physical Therapy Visits  Charges	136, 659	24, 558		-		
25.00	Occupational Therapy Visits	217	44	•	0 0		25.00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	73, 618 38	14, 781 0		0 0		1
28. 00	Speech Pathology Visit Charges	13, 052	0		0 0	13, 052	28. 00
29. 00 30. 00	Medical Social Service Visit Charges	30 9, 517	2, 504		1 0	l .	
31. 00	Medical Social Service Visit Charges Home Health Aide Visits	362	2, 504 103	•	1 0	,	ı
32.00	Home Health Aide Visit Charges	44, 781	12, 668				
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 148	533	4	.0	2, 721	33.00
34. 00	Other Charges	0	0	1	0 0		1
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	506, 571	118, 085	8, 77	8 0	633, 434	35.00
36. 00	Total Number of Episodes (standard/non	131		1	5 0	146	36.00
37. 00	outlier) Total Number of Outlier Episodes		15		0	15	37. 00
	Total Non-Routine Medical Supply Charges	10, 221	7, 735				

Heal th	Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
H0SPI	TAL-BASED HOSPICE IDENTIFICATION	I DATA		Provi der C	CN: 15-0045	Peri od:	Worksheet S-9	
						From 10/01/2017		
				Hospi ce CC	N: 15-1559	To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
						Hospi ce I	2/2//2017 3.1	7 рііі
		Unduplicated				nespi ce i		
		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	
1 00	PART I - ENROLLMENT DAYS FOR C	OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	OBER 1, 2015			4 00
1. 00 2. 00	Hospice Continuous Home Care							1.00 2.00
2. 00 3. 00	Hospice Routine Home Care Hospice Inpatient Respite Care							3.00
3. 00 4. 00	Hospice General Inpatient Care							4.00
5.00	Total Hospi ce Days							5.00
5.00	Part II - CENSUS DATA FOR COST	REPORTING PER	LODS BEGLANLING	BEFORE OCTORE	R 1 2015			3.00
6. 00	Number of patients receiving	KEI OKITINO I EK	DEGITION NO	DEFORE OCTOBE	1, 2013			6.00
0.00	hospi ce care							0.00
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8.00
	/ line 6)							
9. 00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	0ther	Total (sum of	
							col s. 1	
							through 3)	
				1. 00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTIN	G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1			
10.00				0		0 0	_	
11.00				2, 506	l .	6 195		11.00
12.00				30		0 5		12.00
13.00				22	1	0 10 6 210		13.00
14.00	Total Hospice Days PART IV - CONTRACTED STATISTIC	AL DATA EOD CO	ST DEDODTING D	2, 558				14.00
15 00	Hospice Inpatient Respite Care		SI KEPUKITNG P	ERIODS BEGINNI		0 0 0		15. 00
	Hospice General Inpatient Care				l .	0 0		1
10.00	insept of denotal impatricit our			1	1	51	1	1 .0.00

	Financial Systems DEKALB MEMORIAL HOS		15 0045		u of Form CMS-2	
USPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN:		Peri od: From 10/01/2017	Worksheet S-1	U
				To 09/30/2018	Date/Time Pre 2/27/2019 3:1	pared 7 pm
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line	202 colum	n 8)	0. 267275	1. (
	Medicaid (see instructions for each line)					
. 00	Net revenue from Medicaid				2, 493, 576	2. (
. 00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa		from Medic	ai d?		4. (
. 00	If line 4 is no, then enter DSH and/or supplemental payments from	om Medicaid			0	5.
. 00	Medicaid charges				20, 021, 352	
. 00 . 00	Medicaid cost (line 1 times line 6)	ino 7 minuo	oum of Li	noo 2 and E. if	5, 351, 207	7.
. 00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	The / minus	Sulli 01 11	nes 2 and 5; 11	2, 857, 631	8.
	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
. 00	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
1.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 minu	s line 9;	if < zero then	0	12.
	<pre>enter zero) Other state or local government indigent care program (see instr</pre>	ructions for	oach Lino	)		1
3. 00	Net revenue from state or local indigent care program (Not inclu				0	13.
	Charges for patients covered under state or local indigent care				0	
00	10)	program (No	t Theradea	111 111103 0 01	O	' ' '
5. 00	State or local indigent care program cost (line 1 times line 14)	)			0	15.
5. 00	Difference between net revenue and costs for state or local indi	gent care p	rogram (li	ne 15 minus line	0	16.
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/	local indi	gent care progra	ms (see	
7. 00	Private grants, donations, or endowment income restricted to fur	nding charit	y care		0	17.
3. 00	Government grants, appropriations or transfers for support of ho	ospital oper	ati ons		0	18.
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent ca	re program	s (sum of lines	2, 857, 631	19.
	,		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire faci	Li ±v	212, 07	78 137, 328	349, 406	20
). 00	(see instructions)	iity	212,07	137, 320	347, 400	20.
1.00	Cost of patients approved for charity care and uninsured discour	nts (see	56, 68	137, 328	194, 011	21.
	instructions)					
2. 00	Payments received from patients for amounts previously written of	off as		0	0	22.
	charity care		F	407 000	104 014	
3. 00	Cost of charity care (line 21 minus line 22)		56, 68	33 137, 328	194, 011	23.
					1. 00	
1. 00	Does the amount on line 20 column 2, include charges for patient		d a Length	of stay limit	N	24.
5. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the	-	are progra	m's Lenath of	0	25.
	stay limit	. 3		. 3	· ·	
5. 00	Total bad debt expense for the entire hospital complex (see inst	tructions)			8, 082, 228	26.
7. 00	Medicare reimbursable bad debts for the entire hospital complex	(see instru	ctions)		6, 275	27.
7. 01	Medicare allowable bad debts for the entire hospital complex (se	ee instructi	ons)		9, 653	27.
8. 00	Non-Medicare bad debt expense (see instructions)				8, 072, 575	1
9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see in	structi ons	)	2, 160, 975	1
	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 354, 986	30.
0.00	Total unreimbursed and uncompensated care cost (line 19 plus lir				5, 212, 617	

Heal th	Financial Systems	DEKALB MEMORIAL			In Lie	u of Form CMS-:	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 10/01/2017 To 09/30/2018	Date/Time Pre	pared:
						2/27/2019 3:1	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Reclassi fied	
				+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
1.00	00100 CAP REL COSTS-BLDG & FLXT		4, 601, 926	4, 601, 92	6 0	4, 601, 926	1.00
1. 01	00101 MOB WEST		14, 466			14, 466	
1. 02	00102 NORTH ANNEX		2, 224			2, 224	1. 02
1. 03	00103 GARRETT CLINIC		11, 552			11, 552	1
1. 04 1. 05	00104 BUTLER 00105 MOB EAST		2, 560 83, 976			2, 560 83, 976	
1. 03	00107 MEDI CAL ARTS		30, 409			30, 409	
1. 08	00108 SMALTZ WAY		1, 717			1, 717	1. 08
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	1	0	0	2.00
3.00	00300 OTHER CAP REL COSTS		0		0	0	3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	225, 669	7, 720, 756			7, 946, 425	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	4, 390, 330	7, 146, 053			11, 524, 488	
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	545, 762 0	1, 667, 850 0		2 0 29, 872	2, 213, 612 29, 872	1
9. 00	00900 HOUSEKEEPI NG	817, 876	405, 521			1, 223, 397	
10.00	01000 DI ETARY	553, 878	399, 748			308, 211	1
10. 01	01001 SNACK BAR	0	0	1	0	0	10. 01
11.00	01100 CAFETERI A	0	0		615, 543	615, 543	11.00
13.00	01300 NURSING ADMINISTRATION	565, 526	54, 439			619, 965	
14.00	01400 CENTRAL SERVI CES & SUPPLY	133, 018	166, 277			299, 295	1
15.00	01500 PHARMACY	569, 832	41, 621			611, 453	1
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	620, 050 73, 594	91, 503 5, 742			711, 553 79, 336	1
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	73, 374	5, 742	17, 33	5  0	17, 330	17.00
30.00	03000 ADULTS & PEDIATRICS	2, 520, 512	520, 753	3, 041, 26	5 -354, 726	2, 686, 539	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 083, 531	257, 672	1, 341, 20	3 0	1, 341, 203	31.00
43.00	04300 NURSERY	0	0		118, 975	118, 975	43.00
50. 00	ANCILLARY SERVICE COST CENTERS    O5000   OPERATING ROOM	1, 674, 838	1, 103, 779	2, 778, 61	7 0	2, 778, 617	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1,074,036	1, 103, 779		235, 751	2, 776, 617	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 537, 480	733, 926	1		2, 258, 272	
60.00	06000 LABORATORY	1, 184, 692	1, 750, 838			2, 935, 530	
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	550, 741	91, 227			641, 968	
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 CARDI AC REHAB	348, 997 101, 909	1, 143, 646 17, 035			1, 492, 643 137, 344	
69. 00	06900 ELECTROCARDI OLOGY	31, 941	3, 194			48, 269	
70.00	07000 ELECTROENCEPHALOGRAPHY	44, 218	16, 369				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1, 906, 490		0	1, 906, 490	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 398, 399			1, 398, 399	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	3, 107, 950	3, 107, 95	0	3, 107, 950	73.00
90 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	53, 460	5, 214	58, 67	4 0	59 674	90.00
91.00	09100 EMERGENCY	1, 350, 995	183, 685			1, 534, 680	
	09200 OBSERVATION BEDS (NON-DISTINCT	.,,		1, 20 1, 20		.,,	92.00
	OTHER REIMBURSABLE COST CENTERS			,			
	09500 AMBULANCE SERVICES	1, 166, 398	332, 329			1, 498, 727	
	09910 CORF 10100 HOME HEALTH AGENCY	0 745, 171	0 136, 686		0 7 5, 319	0 887, 176	
101.00	SPECIAL PURPOSE COST CENTERS	745, 171	130, 000	001,03	7 5, 317	887, 170	1101.00
113.00	11300   NTEREST EXPENSE		0		0 0	0	113.00
116.00	11600 H0SPI CE	124, 891	208, 234				
118.00		21, 015, 309	35, 365, 766	56, 381, 07	5 12, 400	56, 393, 475	118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CAN		4	1	4	4	100 00
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	4		0 0		190. 00 191. 00
	19200 PHYSICIANS PRIVATE OFFICES		0				192.00
	19201 DEKALB MEDICAL SERVICES	6, 860, 689	1, 354, 528	8, 215, 21	7 -12, 400	8, 202, 817	
	19202 PHARMACARE	729, 679	5, 407, 756			6, 137, 435	
	19203 OUTSOURCED DI ETI CI AN	3, 150	224				192. 03
	19204 BUSI NESS HEALTH	1, 538	81				192.04
	19300 NONPALD WORKERS	0	0		0		193. 00 194. 00
	07950 OTHER NONREIMBURSABLE COST CENT   07951 ADULT DAY CARE		0		0		194.00
	07952 FOUNDATION	72, 702	87, 458	160, 16		160, 160	
200.00		28, 683, 067	42, 215, 817				

 Health Financial
 Systems
 DEKALB MEM

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

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

Peri od: From 10/01/2017 To 09/30/2018 Date/Time Prepared:

			2/27/2019 3:	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
	/ 00	Allocation		
GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00 O0100 CAP REL COSTS-BLDG & FLXT	-470, 771	4, 131, 155		1.00
1. 01   00101   MOB   WEST	-14, 466			1. 01
1. 02 00102 NORTH ANNEX	-2, 224			1. 02
1. 03   00103   GARRETT   CLINIC	-11, 552			1.03
1. 04   00104 BUTLER	0	2, 560		1.04
1. 05 00105 MOB EAST	-83, 976			1.05
1.07   00107   MEDICAL ARTS	-30, 409	o		1. 07
1.08   00108   SMALTZ WAY	0	1, 717		1. 08
2.00 O0200 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	-718, 731			4. 00
5. 00   00500   ADMINI STRATI VE & GENERAL	-3, 497, 893			5. 00
7.00 00700 OPERATION OF PLANT	-2, 805	1		7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	0	,		8. 00
9. 00   00900   HOUSEKEEPI NG	-2, 806			9. 00
10. 00   01000   DI ETARY	0	/		10.00
10. 01   01001   SNACK BAR	0	-1		10.01
11. 00 01100 CAFETERI A	-264, 908			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0			14.00
15. 00   O1500   PHARMACY 16. 00   O1600   MEDI CAL RECORDS & LI BRARY	-935	611, 453 710, 618		15. 00 16. 00
17. 00   01700   SOCIAL SERVICE	-933			17.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	[ 77, 330]		17.00
30. 00 03000 ADULTS & PEDIATRICS	-150, 000	2, 536, 539		30.00
31. 00 03100 INTENSIVE CARE UNIT	-158, 400	1		31.00
43. 00   04300 NURSERY	0	1		43.00
ANCILLARY SERVICE COST CENTERS		· · ·		
50.00   05000   OPERATING ROOM	-942, 020	1, 836, 597		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	235, 751		52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-36, 682			54.00
60. 00   06000   LABORATORY	-8, 680			60.00
60. 01 06001 BLOOD LABORATORY	0			60. 01
65. 00 06500 RESPIRATORY THERAPY	0			65.00
66. 00   06600   PHYSI CAL THERAPY 66. 01   06601   CARDI AC REHAB	-22, 116 -13, 339			66. 00 66. 01
69. 00   06900   ELECTROCARDI OLOGY	-13, 339	124, 005 48, 269		69.00
70. 00 07000 ELECTROCARD OLOGT	0	60, 587		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1, 906, 490		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-1, 250			73.00
OUTPATIENT SERVICE COST CENTERS	., ====	57 1527 153		1
90. 00 09000 CLI NI C	0	58, 674		90.00
91. 00 09100 EMERGENCY	0	1, 534, 680		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT				92.00
OTHER REIMBURSABLE COST CENTERS	050.444			05.00
95. 00   09500   AMBULANCE SERVICES	-253, 466	1, 245, 261		95.00
99. 10   09910   CORF	0	0		99. 10
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	-287	886, 889		101.00
113. 00 11300 I NTEREST EXPENSE	0	0		113.00
116. 00 11600 HOSPI CE	-103			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-6, 687, 819			118.00
NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	4		190. 00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0		192.00
192. 01 19201 DEKALB MEDICAL SERVICES	0	-,,		192. 01
192. 02 19202 PHARMACARE	-922			192. 02
192. 03 19203 OUTSOURCED DI ETI CI AN	0	-/		192. 03
192. 04 19204 BUSI NESS HEALTH	0	1, 619		192.04
193. 00 19300 NONPALD WORKERS	0	0		193.00
194. 00 07950 OTHER NONREI MBURSABLE COST CENT	0	0		194.00
194. 01 07951 ADULT DAY CARE	0	U U		194. 01
194.02 07952 FOUNDATION 200.00  TOTAL (SUM OF LINES 118 through 199)	-5, 621			194. 02 200. 00
200.00   TOTAL (SUM OF LINES 118 through 199)	-6, 694, 362	64, 204, 522		<sub> </sub> 200.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0045	Peri od: Worksheet A-6 From 10/01/2017
		To 09/30/2018 Date/Time Prepared:

					10 09/30/2018 Date/lime F 2/27/2019 3	
		Increases			272772017	
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - CAFETERIA RECLASS					
1.00	CAFETERI A	1100	327, 807	<u>287, 7</u> 36		1.00
	0		327, 807	287, 736		
	B - LABOR DELIVERY NURSERY					
1.00	NURSERY	43.00	97, 532	21, 443		1.00
2.00	DELIVERY ROOM & LABOR ROOM _	52. 00	193, 262	<u>42, 489</u>		2. 00
	0		290, 794	63, 932		
	C - NORTH ANNEX RECLASS					
1.00	HOME HEALTH AGENCY	101. 00	0	5, 319		1.00
2.00	HOSPI CE	116. 00	0	576		2.00
3.00	DEKALB MEDICAL SERVICES	192. 01	0_			3.00
	0		0	11, 895		
	D - RADIOLOGY ADMIN RECLASS					
1.00	ELECTROCARDI OLOGY	<u>69.</u> 00	9, 594	<u>3, 5</u> 40		1.00
	0		9, 594	3, 540		
	E - PHYSICIAN RECLASS					
1. 00	CARDI AC REHAB	6601	1 <u>8, 4</u> 00	0		1.00
	0		18, 400	0		
	F - LAUNDRY SALARY RECLASS					
1. 00	LAUNDRY & LINEN SERVICE	8. 00	2 <u>9, 8</u> 72	0		1.00
	TOTALS		29, 872	0		
500.00	Grand Total: Increases		676, 467	367, 103		500.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-0045	Peri od: From 10/01/2017 To 09/30/2018 Worksheet A-6 Date/Time Prepared: 2/27/2019 3:17 pm
	Doctobeoe	

					10	2/27/2019 3:	
		Decreases		<u> </u>			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	1000		28 <u>7, 7</u> 36	0		1.00
	0		327, 807	287, 736			
	B - LABOR DELIVERY NURSERY						
1.00	ADULTS & PEDIATRICS	30. 00	290, 794	63, 932	0		1.00
2.00		0.00	0	0	0		2. 00
	0		290, 794	63, 932			
	C - NORTH ANNEX RECLASS						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	11, 895	0		1.00
2.00		0. 00	0	0	0		2. 00
3.00		0.00	0_	0	0		3. 00
	0		0	11, 895			
	D - RADIOLOGY ADMIN RECLASS						
1.00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	<u>9, 5</u> 94	<u>3, 5</u> 40			1.00
	0		9, 594	3, 540			
	E - PHYSICIAN RECLASS						
1. 00	DEKALB MEDICAL SERVICES	1 <u>92.</u> 01	1 <u>8, 4</u> 00	0	0		1.00
	0		18, 400	0			
	F - LAUNDRY SALARY RECLASS						
1.00	DI ETARY	10. 00	2 <u>9, 8</u> 72	0	0		1.00
	TOTALS		29, 872	0			
500.00	Grand Total: Decreases		676, 467	367, 103			500.00

Provi der CCN: 15-0045

					o 09/30/2018	Date/Time Prep 2/27/2019 3:1	pared:
		Acqui si ti ons			2/2//2017 3.1	/ pili	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
						Retirements	
		1. 00	2.00	3.00	4.00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	393, 118	0	C	0	0	1.00
2.00	Land Improvements	1, 797, 214	11, 250	C	11, 250	0	2.00
3.00	Buildings and Fixtures	60, 728, 294	434, 696	C	434, 696	0	3.00
4.00	Building Improvements	29, 213	173, 938	C	173, 938	0	4.00
5.00	Fi xed Equi pment	0	0	C	0	0	5.00
6.00	Movable Equipment	25, 452, 640	1, 947, 712	C	1, 947, 712	87, 918	6.00
7.00	HIT designated Assets	0	0	C	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	88, 400, 479	2, 567, 596	C	2, 567, 596	87, 918	8.00
9.00	Reconciling Items	0	0	C	0	0	9.00
10.00	Total (line 8 minus line 9)	88, 400, 479	2, 567, 596	C	2, 567, 596	87, 918	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	393, 118	0				1.00
2.00	Land Improvements	1, 808, 464	0				2.00
3.00	Buildings and Fixtures	61, 162, 990	0				3.00
4.00	Building Improvements	203, 151	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	27, 312, 434	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	90, 880, 157	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	90, 880, 157	0			l	10.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0045

						2/27/2019 3:1	7 pm
			SU	IMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
	DART III DECONOLILIATION OF AMOUNTS FROM WOR	9. 00	10.00	11.00	12. 00	13. 00	
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR	·					4 00
1.00	CAP REL COSTS-BLDG & FIXT	4, 140, 747	0	461, 179	0	0	1.00
1. 01	MOB WEST	14, 466	0	0	0	0	1.01
1. 02	NORTH ANNEX	2, 224	0	0	0	0	1.02
1.03	GARRETT CLINIC	11, 552	0	0	0	0	1.03
1.04	BUTLER	2, 560	0	0	0	0	1.04
1.05	MOB EAST	83, 976	0	0	0	0	1.05
1.07	MEDI CAL ARTS	30, 409	0	0	0	0	1.07
1.08	SMALTZ WAY	1, 717	0	0	0	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3. 00	Total (sum of lines 1-2)	4, 287, 651	0	461, 179	0	0	3. 00
SUMMARY OF CAPITAL							
	Cost Center Description	Other	Total (1)				
	cost center bescription		Total (1)				
		Capital-Related Costs (see					
		instructions)	9 till ough 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1. 00	CAP REL COSTS-BLDG & FLXT	KSHELI A, COLOR	4, 601, 926				1.00
1. 01	MOB WEST	0	14, 466				1.00
1. 01	NORTH ANNEX		2, 224				1.01
1. 02	GARRETT CLINIC		11, 552				1.02
1. 03	BUTLER		2, 560				1.03
1. 04	MOB EAST		83, 976				1.04
1. 03	MEDICAL ARTS		30, 409				1.03
1. 08	SMALTZ WAY		1, 717				1.07
2. 00	CAP REL COSTS-MVBLE EQUIP		1, / 1/				2.00
3.00	Total (sum of lines 1-2)		4, 748, 830				3.00
3.00	Total (Sum Of Titles 1-2)	ı V	4, 140, 030	I			3.00

near tr	i Financiai Systems	DENALD WEWORT	AL HUSPITAL		III LI E	u of Form CM3-2	2002-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	F	eriod: rom 10/01/2017 o 09/30/2018	Worksheet A-7 Part III Date/Time Pre 2/27/2019 3:1	pared:
		COMI	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPI				, p
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 -	instructions)		
				col . 2)			
	PART III - RECONCILIATION OF CAPITAL COSTS C	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	90, 880, 157	0	90, 880, 157	1.000000	0	1.00
1. 01	MOB WEST	0	0	1	0.000000	0	1.01
1. 02 1. 03	NORTH ANNEX GARRETT CLINIC	0	0	0		0	1. 02 1. 03
1. 04	BUTLER	0	Ö	Ö	0. 000000	ő	1.03
1. 05	MOB EAST	0	0	0	0. 000000	0	1.05
1.07	MEDICAL ARTS SMALTZ WAY	0	0	0	0.000000	0	1.07
1. 08 2. 00	CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000 0. 000000		1. 08 2. 00
3. 00	Total (sum of lines 1-2)	90, 880, 157	Ö	90, 880, 157		l e	3.00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
		6. 00	ed Costs 7.00	through 7) 8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1. 00 1. 01	CAP REL COSTS-BLDG & FLXT MOB WEST	0	0	0	4, 131, 155	0	1. 00 1. 01
1. 01	NORTH ANNEX	0	0	0	0	0	1.01
1.03	GARRETT CLINIC	0	0	0	0	0	1.03
1.04	BUTLER MOB EAST	0	0	0	2, 560	0	1.04
1. 05 1. 07	MEDICAL ARTS	0	0		0	0	1. 05 1. 07
1. 08	SMALTZ WAY	0	Ö	Ö	1, 717	0	1. 08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3. 00	Total (sum of lines 1-2)	0		<u>                                     </u>	4, 135, 432	0	3.00
					7.6		
	Cost Center Description	Interest	Insurance	Taxes (see instructions)	Other Capi tal -Relat	Total (2) (sum of cols.	
			(see instructions)	Thistructions)	ed Costs (see	9 through 14)	
			,		instructions)	, , , , , , , , , , , , , , , , , , ,	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS	0	0	0	4, 131, 155	1.00
1. 01	MOB WEST	0	О	0	0	0	1. 01
1.02	NORTH ANNEX	0	0	0	· ·	0	1.02
1. 03 1. 04	GARRETT CLINIC BUTLER	0	0	0		0 2, 560	1. 03 1. 04
1. 05	MOB EAST	0	0	Ö	U	0	1.05
1. 07	MEDI CAL ARTS	0	0	0		0	1.07
1. 08 2. 00	SMALTZ WAY CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1, 717 1 0	1. 08 2. 00
3. 00	Total (sum of lines 1-2)	0	Ö	Ö	ő	_	

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0045	Period: From 10/01/2017	Worksheet A-8	
						Date/Time Pre 2/27/2019 3:1	pared:
				Expense Classification o			, piii
				o/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FLXT	1.00		1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - MOB WEST		0 0	MOB WEST	1. 01	0	1. 01
1. 02	(chapter 2) Investment income - NORTH			IORTH ANNEX	1. 02	0	1. 02
	ANNEX (chapter 2)						
1. 03	Investment income - GARRETT CLINIC (chapter 2)		00	GARRETT CLINIC	1. 03	0	1. 03
1. 04	Investment income - BUTLER (chapter 2)		OE	BUTLER	1. 04	0	1. 04
1. 05	Investment income - MOB EAST		ON	MOB EAST	1. 05	0	1. 05
1. 07	(chapter 2) Investment income - MEDICAL		0	MEDICAL ARTS	1. 07	О	1. 07
1. 08	ARTS (chapter 2) Investment income - SMALTZ WAY		0 5	SMALTZ WAY	1. 08	0	1. 08
2. 00	(chapter 2) Investment income - CAP REL		00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		o		0.00	О	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00		
	suppliers (chapter 8)		0			0	
7. 00	Tel ephone services (pay stations excluded) (chapter				0. 00		7.00
8. 00	21) Tel evi si on and radi o servi ce		О		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-1, 285, 510			0	10.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11.00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
	Laundry and linen service Cafeteria-employees and guests	D	0	NAFETEDI A	0.00		13.00
14. 00 15. 00	Rental of quarters to employee		-264, 908 0 0	AFETERIA	11. 00 0. 00		
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than				3. 33		
17. 00	Sale of drugs to other than	В	-1, 250	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-935 N	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	   0	19. 00
	education (tuition, fees, books, etc.)						
	Vending machines		0		0.00		
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		o		0.00	o	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	OF	RESPI RATORY 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	OF	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)					1	

Peri od: Worksheet A-8 From 10/01/2017 To 09/30/2018 Date/Time Prepared: Provider CCN: 15-0045

				To	09/30/2018		
				Expense Classification on	Worksheet A	2/27/2019 3:1	/ pili
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
25. 00	Utilization review -	1.00		*** Cost Center Deleted ***	114. 00	3.00	25.00
	physicians' compensation		_				
	(chapter 21)						
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27 01	COSTS-BLDG & FIXT			MOD WEST	1 01	0	2/ 01
26. 01 26. 02	Depreciation - MOB WEST Depreciation - NORTH ANNEX			MOB WEST NORTH ANNEX	1. 01 1. 02	0	
26. 02	Depreciation - GARRETT CLINIC			GARRETT CLINIC	1. 02	0	1
26. 04	Depreciation - BUTLER			BUTLER	1. 04	0	1
26. 05	Depreciation - MOB EAST			MOB EAST	1. 05	0	
26. 07	Depreciation - MEDICAL ARTS		0	MEDICAL ARTS	1. 07	0	26. 07
26. 08	Depreciation - SMALTZ WAY			SMALTZ WAY	1. 08	0	
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
20.00	COSTS-MVBLE EQUIP			*** Coot Contor Doloted ***	10.00		20.00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30.00	Adjustment for occupational	A-8-3		*** Cost Center Deleted ***	67. 00	0	30.00
00.00	therapy costs in excess of	7. 0 0		See Senter Bereteu	07.00		00.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)		_				
31. 00	'	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
32 00	CAH HIT Adjustment for		0		0. 00	0	32.00
02.00	Depreciation and Interest				0.00	· ·	02.00
33.00	MI'SC HUMAN RESOURCE REVENUE	В	-24, 612	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33.00
33. 01	MISCELLANEOUS INCOME	В	-221, 403	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	MISC. MAINTENANCE INCOME	В		OPERATION OF PLANT	7. 00	0	
33. 03	MISC. HOUSEKEEPING INCOME	В		HOUSEKEEPI NG	9. 00	0	
33. 04 33. 05	MISC SUGERY REVENUE MISC X-RAY REVENUE	B B		OPERATING ROOM	50.00	0	
33. 06	MISC X-RAT REVENUE	B B		RADI OLOGY-DI AGNOSTI C LABORATORY	54. 00 60. 00	0	1
33. 07	MI SC. ST REVENUE	В		PHYSI CAL THERAPY	66. 00	0	1
33. 08	MISC. CARDIAC REHAB REVENUE	В		CARDI AC REHAB	66. 01	0	1
33.09	EMS COUNTY SUBSIDY	В	-253, 466	AMBULANCE SERVICES	95. 00	0	33.09
33. 10	RENTAL INCOME	В		MOB WEST	1. 01	9	33. 10
33. 11	RENTAL INCOME	В		MOB EAST	1. 05	9	
	RENTAL INCOME	B B		NORTH ANNEX	1. 02	9	
	RENTAL INCOME RENTAL INCOME	B		GARRETT CLINIC MEDICAL ARTS	1. 03 1. 07	9	00. 10
33. 14	RENTAL INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00	9	
33. 16	LOBBYING PORTION OF THA & AHA	Ā		ADMINISTRATIVE & GENERAL	5. 00	Ó	
	DUES		,				
33. 17	LOBBYING PORTION OF LAHHC DUES	Α	-103	HOSPI CE	116. 00	0	33. 17
	- HOS	_				_	
33. 18	LOBBYING PORTION OF LAHHC DUES - HHA	A	-240	HOME HEALTH AGENCY	101. 00	0	33. 18
33. 19	NON-ALLOWABLE MARKETING	А	_320_201	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	NON-ALLOWABLE MARKETING	A		PHYSI CAL THERAPY	66. 00	0	1
33. 21	NON-ALLOWABLE MARKETING	A		CARDI AC REHAB	66. 01	0	1
33. 22	NON-ALLOWABLE MARKETING	Α	-47	HOME HEALTH AGENCY	101. 00	0	33. 22
33. 23	NON-ALLOWABLE MARKETING	Α		PHARMACARE	192. 02	0	
33. 24	NON-ALLOWABLE MARKETING	A		FOUNDATION	194. 02	0	
33. 25	FLOWER/GI FTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 26 33. 27	FLOWER/GIFTS HAF FEE	A A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	
33. 27	SELF-INSURANCE EXP	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1
33. 32	1	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
50. 00	TOTAL (sum of lines 1 thru 49)		-6, 694, 362			_	50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) De	scription - all chapter referen	ices in this co	olumn pertain t	o CMS Pub. 15-1.			

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0045	Period: From 10/01/2017	Worksheet A-8	
					Date/Time Pre 2/27/2019 3:1	pared:
				·	2/21/2019 3: 1	/ pm
			Expense Classification o			
			To/From Which the Amount is	to be Adjusted		
				•		
Cost Contor Doscription	Basis/Code	Amount	Cost Center	Line #	Wkst. A-7	
Cost Center Description		AIIIOUIT	Cost Center	Line #		
	(2)				Ref.	
	1. 00	2. 00	3. 00	4. 00	5. 00	

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0045

					-	Γο 09/30/2018	Date/Time Pre 2/27/2019 3:1	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	7 (211)
		I denti fi er	Remuneration	Component	Component	NOL 7 III OUT TO	ider Component	
							Hours	
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	•	RADI OLOGY-DI AGNOSTI C	36, 356				0	1.00
2.00	•	OPERATING ROOM	644, 348				0	2. 00
3.00		INTENSIVE CARE UNIT	8, 400	8, 400			0	3. 00
4. 00	•	ADULTS & PEDIATRICS	40, 029	0	10,02,		1, 213	4. 00
5.00		ADULTS & PEDIATRICS	150, 000	150, 000	0	197, 500	0	5.00
6.00		INTENSIVE CARE UNIT	150, 000	150, 000	0	197, 500	0	6.00
7.00		OPERATING ROOM	24, 810	24, 810			0	7.00
8.00		OPERATING ROOM	3, 957	0	0,,0,	197, 500	106	8.00
9.00	50.00	OPERATING ROOM	273, 875	271, 525	2, 350	197, 500	24	9. 00
10. 00	0.00		0	0	0		0	10.00
200.00			1, 331, 775					200.00
	Wkst. A Line #	,	Unadjusted RCE		Cost of		Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8. 00	9, 00	Education 12.00	12 13. 00	14. 00	
1. 00		RADI OLOGY-DI AGNOSTI C	0.00	9.00	12.00		14.00	1. 00
2. 00		OPERATING ROOM	0	0		-	0	2. 00
3.00		INTENSIVE CARE UNIT		0	0		0	3.00
4. 00		ADULTS & PEDIATRICS	138, 270	l ~	_	1	0	4. 00
5. 00		ADULTS & PEDIATRICS	130, 270	0, 714		1	0	5. 00
6. 00		INTENSIVE CARE UNIT	0	0	0		0	6. 00
7. 00		OPERATING ROOM	0	0		0	0	7. 00
8. 00		OPERATING ROOM	10, 065	503	0	0	0	8. 00
9. 00		OPERATING ROOM	2, 279	114		0	0	9. 00
10.00	0.00		0	0		0	0	10.00
200.00			150, 614	7, 531	0	l o	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	1	RADI OLOGY-DI AGNOSTI C	0	0	0			1.00
2.00	1	OPERATING ROOM	0	0	0			2. 00
3. 00	•	INTENSIVE CARE UNIT	0	0	0	-,		3.00
4. 00	•	ADULTS & PEDIATRICS	0	138, 270		0		4. 00
5. 00		ADULTS & PEDIATRICS	0	0	0			5. 00
6. 00		INTENSIVE CARE UNIT	0	0	_	150, 000		6. 00
7. 00		OPERATING ROOM	0	0	0			7.00
8. 00		OPERATING ROOM	0	10, 065		0		8. 00
9.00	•	OPERATING ROOM	0	2, 279				9.00
10.00	0.00			150 (14	0	1		10.00
200. 00	I	I	0	150, 614	71	1, 285, 510		200. 00

| Peri od: | Worksheet B | From 10/01/2017 | Part I | To 09/30/2018 | Date/Time Prepared: Provider CCN: 15-0045

				Т	o 09/30/2018	Date/Time Pre 2/27/2019 3:1	
				CAPITAL RELATED COSTS		, =, =,, =,,	
	Cost Center Description	Net Expenses	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT	
	<u>'</u>	for Cost				CLINIC	
		Allocation (from Wkst A					
		col. 7)					
		0	1.00	1. 01	1. 02	1. 03	
1 00	GENERAL SERVICE COST CENTERS	4 121 155	4 121 155				1 00
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB WEST	4, 131, 155 0	4, 131, 155 0	O			1.00 1.01
1. 02	00102 NORTH ANNEX	0	Ö	Ö			1. 02
1. 03	00103 GARRETT CLINIC	0	0	0	0	0	1
1. 04 1. 05	00104 BUTLER 00105 MOB EAST	2, 560	0	0	0	0	
1. 03	00107 MEDI CAL ARTS	0	0		o	0	1
1. 08	00108 SMALTZ WAY	1, 717	0	O	0	0	1
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0					2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	7, 227, 694 8, 026, 595			0	0	
7. 00	00700 OPERATION OF PLANT	2, 210, 807		Ö	_	0	1
8.00	00800 LAUNDRY & LINEN SERVICE	29, 872		O	0	0	1
9.00	00900 HOUSEKEEPI NG	1, 220, 591	39, 433	0	0	0	
10. 00 10. 01	01000 DI ETARY 01001 SNACK BAR	308, 211	20, 698		0	0	
11. 00	01100 CAFETERI A	350, 635	63, 869	Ö	o	0	
13.00	01300 NURSING ADMINISTRATION	619, 965		O	0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	299, 295		0	0	0	
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	611, 453 710, 618			-	0	1
17. 00	01700 SOCIAL SERVICE	79, 336		0		0	
	INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 536, 539 1, 182, 803		0		0	
43. 00	04300 NURSERY	118, 975				0	1
	ANCILLARY SERVICE COST CENTERS		·				
50.00	05000 OPERATING ROOM	1, 836, 597	366, 461	0		0	
52. 00 54. 00	05200   DELI VERY ROOM & LABOR ROOM   05400   RADI OLOGY-DI AGNOSTI C	235, 751 2, 221, 590	284, 973 192, 412	0		0	1
60.00	06000 LABORATORY	2, 926, 850		Ö	-	0	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	641, 968 1, 470, 527	22, 557 107, 743		0	0	
66. 01	06601 CARDI AC REHAB	124, 005			o	0	1
69. 00	06900 ELECTROCARDI OLOGY	48, 269		O	0	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	60, 587	0	0	0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 906, 490 1, 398, 399			0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 106, 700		Ö	-	0	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C 09100 EMERGENCY	58, 674 1, 534, 680		0	0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT	1, 554, 660	138, 970			0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	1, 245, 261	29, 352	0		0	
	09910 CORF   10100 HOME HEALTH AGENCY	886, 889	0	0		0	99. 10 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	000,007			<u> </u>		101.00
	11300 INTEREST EXPENSE						113.00
116. 00 118. 00	11600 HOSPICE	333, 598 49, 705, 656		0			116. 00 118. 00
110.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	49, 705, 656	4, 023, 766		U U	0	]116.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	4	0	C	0		190. 00
	19100 RESEARCH	0	0	0	-		191.00
	19200   PHYSICIANS PRIVATE OFFICES   19201   DEKALB MEDICAL SERVICES	0 8, 202, 817	105, 367	0	0		192. 00 192. 01
	2 19202 PHARMACARE	6, 136, 513		Ö	0		192.02
192. 03	19203 OUTSOURCED DIETICIAN	3, 374	0	0	o	0	192. 03
	19204 BUSI NESS HEALTH	1, 619	0	0	0		192.04
	19300  NONPALD WORKERS   07950  OTHER NONRELMBURSABLE COST CENT	0	0				193. 00 194. 00
	07951 ADULT DAY CARE		0	Ö	o		194. 01
194. 02	07952 FOUNDATI ON	154, 539	0	0	0	0	194. 02
200.00				_		^	200. 00 201. 00
201. 00 202. 00		64, 204, 522	4, 131, 155		0		201.00
_02.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, _ 5 ,, 5 2 2	., ., ,		, 9	O	, 00

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

Peri od: Worksheet B
From 10/01/2017 Part I
To 09/30/2018 Date/Time Prepared: 2/27/2019 3:17 pm Provider CCN: 15-0045

				CAD	LTAL DELATED CO	CTC	2/27/2019 3:1	7 pm
				CAP	ITAL RELATED CO	1515		
		Cost Center Description	BUTLER	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	
		<u>'</u>	1. 04	1. 05	1. 07	1. 08	2. 00	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02		MOB WEST NORTH ANNEX						1. 01 1. 02
1. 02		GARRETT CLINIC						1.02
1. 03		BUTLER	2, 560					1.03
1. 05		MOB EAST	0	0				1.05
1.07		MEDICAL ARTS	O	0	0			1. 07
1. 08		SMALTZ WAY	0	0	0	1, 717		1. 08
2.00	1	CAP REL COSTS-MVBLE EQUIP					0	2.00
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0	0	0	U O	0	4. 00 5. 00
7. 00		OPERATION OF PLANT	0	0	0	0	0	7.00
8. 00		LAUNDRY & LINEN SERVICE	ő	0	Ö	Ö	0	8.00
9.00	1	HOUSEKEEPI NG	O	0	0	o	0	9.00
10.00	01000	DI ETARY	0	0	0	0	0	10.00
10. 01	1	SNACK BAR	0	0	0	0	0	10. 01
11.00		CAFETERI A	0	0	0	0	0	11.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	0	0	0	0	13. 00 14. 00
15. 00		PHARMACY	0	0	0	0	0	15.00
16. 00		MEDICAL RECORDS & LIBRARY	o	0	Ö	Ö	0	16.00
17. 00		SOCIAL SERVICE	0	0	0	0	0	17. 00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	0	0		0	0	30.00
31. 00 43. 00	1	INTENSIVE CARE UNIT NURSERY	0	0		0	0	31. 00 43. 00
43.00		LARY SERVICE COST CENTERS	U <sub>I</sub>	0	U U	U <sub>I</sub>	U	43.00
50. 00		OPERATING ROOM	0	0	0	0	0	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0	o	0	52.00
54.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
60.00	1	LABORATORY	181	0	0	0	0	60.00
60. 01	1	BLOOD LABORATORY	0	0	0	0	0	60. 01 65. 00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0	0	0	0	66.00
66. 01		CARDI AC REHAB	Ö	0	Ö	o	0	66. 01
69. 00		ELECTROCARDI OLOGY	O	0	0	o	0	69. 00
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00		MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
73.00		TIENT SERVICE COST CENTERS	O <sub>I</sub>		<u> </u>	<u> </u>		73.00
90.00		CLINIC	0	0	0	0	0	90.00
91.00	1	EMERGENCY	0	0	0	0	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT						92.00
05 00		REIMBURSABLE COST CENTERS	0	0		٥١		95.00
95. 00 99. 10	1	AMBULANCE SERVICES	0	0		0		99. 10
	1	HOME HEALTH AGENCY	o	0		o		101.00
		AL PURPOSE COST CENTERS	-,		-	-1		
		INTEREST EXPENSE						113. 00
	1	HOSPI CE	0	0		0		116. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181	0	0	0	0	118. 00
100 00		IMBURSABLE COST CENTERS GIFT FLOWER COFFEE SHOP & CAN	ol	0	0	ol	0	190. 00
		RESEARCH	0	0	0	0		190.00
		PHYSICIANS PRIVATE OFFICES	Ö	0	Ö	o		192.00
		DEKALB MEDICAL SERVICES	2, 379	0	O	1, 717		192. 01
		PHARMACARE	0	0	0	0		192. 02
		OUTSOURCED DIETICIAN	0	0	0	0		192.03
		BUSI NESS HEALTH	0	0	0	0		192.04
		NONPALD WORKERS OTHER NONREIMBURSABLE COST CENT	0	0	0	0		193. 00 194. 00
		ADULT DAY CARE	0	0	0	0		194. 00
		FOUNDATI ON	ő	0	o	Ö		194. 02
200.00		Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers	0	0		0		201.00
202.00	יו	TOTAL (sum lines 118 through 201)	2, 560	0	0	1, 717	0	202. 00

Peri od: Worksheet B From 10/01/2017 Part I To 09/30/2018 Date/Ti me Prepared: 2/27/2019 3:17 pm

				''	0 09/30/2016	2/27/2019 3: 1	
	Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		DEPARTMENT	4.0	F 00	7.00	0.00	
	GENERAL SERVICE COST CENTERS	4. 00	4A	5.00	7. 00	8. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 MOB WEST						1.01
1. 02	00102 NORTH ANNEX						1. 02
1. 03	00103 GARRETT CLINIC						1.03
1. 04	00104 BUTLER						1.04
1. 05	00105 MOB EAST						1. 05
1. 07	00107 MEDI CAL ARTS						1.07
1. 08	00108 SMALTZ WAY						1.08
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	7, 227, 694					2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 115, 069	9, 573, 110	9, 573, 110			5.00
7. 00	00700 OPERATION OF PLANT	138, 614	4, 005, 861	701, 951	4, 707, 812		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	7, 587	62, 122		36, 873	109, 881	8.00
9. 00	00900 HOUSEKEEPI NG	207, 727	1, 467, 751	257, 195	61, 300	4, 909	9.00
10.00	01000 DI ETARY	49, 831	378, 740	66, 367	37, 243	703	10.00
10. 01	01001 SNACK BAR	0	0	0	0	0	10. 01
11. 00	01100 CAFETERI A	83, 257	497, 761	87, 223	95, 487	0	11.00
13. 00	01300 NURSING ADMINISTRATION	143, 634	785, 495			0	13.00
	01400 CENTRAL SERVICES & SUPPLY	33, 784	359, 085		38, 880	0	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	144, 728	780, 101	136, 698		0	15.00
	01700 SOCIAL SERVICE	157, 482 18, 692	912, 945 101, 416		75, 815 5, 065	0	16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	10, 072	101, 410	17, 771	3, 003	U	17.00
30. 00	03000 ADULTS & PEDIATRICS	566, 310	3, 345, 063	586, 159	362, 120	27, 972	30.00
31. 00	03100 INTENSIVE CARE UNIT	275, 198	1, 560, 848			9, 496	31.00
43. 00	04300 NURSERY	24, 771	162, 171	28, 417	27, 547	1, 055	43.00
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATING ROOM	425, 380	2, 628, 438		547, 875	19, 246	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	49, 085	569, 809		·	2, 268	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	388, 057	2, 802, 059		287, 664	12, 129	54.00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	300, 892	3, 314, 452 0	580, 795 0	164, 446	0	60.00
60. 01 65. 00	06500 RESPIRATORY THERAPY	139, 879	804, 404	140, 957	33, 723	0	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	88, 639	1, 666, 909		161, 080	2, 588	66.00
66. 01	06601 CARDI AC REHAB	30, 556	211, 262		84, 771	651	66. 01
69. 00	06900 ELECTROCARDI OLOGY	10, 549	58, 818		0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	11, 231	71, 818		0	812	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	1, 906, 490	334, 076	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 398, 399	245, 043	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	3, 106, 700	544, 390	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	10.570	70.050	10.44	ام	001	
	09000 CLI NI C	13, 578	72, 252		0	821	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT	343, 130	2, 036, 780	356, 907	237, 667	20, 446	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS		0				92.00
	09500 AMBULANCE SERVICES	296, 245	1, 570, 858	275, 263	43, 883	5, 370	95.00
	09910 CORF	0	0	0	0	0	99. 10
	10100 HOME HEALTH AGENCY	189, 261	1, 076, 150	188, 575	49, 936	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	31, 720	365, 318				116.00
118. 00		5, 284, 886	47, 653, 385	6, 672, 846	3, 005, 082	108, 537	1118.00
100.00	NONREI MBURSABLE COST CENTERS		4	1	٥	0	100.00
	19000 GIFT FLOWER COFFEE SHOP & CAN 19100 RESEARCH		4	,	0		190. 00 191. 00
	19200 PHYSICIANS PRIVATE OFFICES		0	0	0		192.00
	19201 DEKALB MEDICAL SERVICES	1, 737, 826	10, 050, 106	1, 761, 082	1, 702, 730		192. 01
	19202 PHARMACARE	185, 326	6, 321, 839		0		192.02
192. 03	19203 OUTSOURCED DIETICIAN	800	4, 174	731	0	0	192. 03
192. 04	19204 BUSINESS HEALTH	391	2, 010	352	0	562	192. 04
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 OTHER NONREI MBURSABLE COST CENT	0	0	0	0		194.00
	07951 ADULT DAY CARE	0	0	0	0		194. 01
	07952 FOUNDATION	18, 465	173, 004	30, 316	0		194. 02
200. 00 201. 00			0				200. 00 201. 00
201.00		7, 227, 694	64, 204, 522	9, 573, 110	4, 707, 812		
202.00	TOTAL (Sum Times 110 through 201)	1,221,074	04, 204, 322	7, 575, 110	7, 101, 012	107, 001	1202.00

Peri od: Worksheet B From 10/01/2017 Part I To 09/30/2018 Date/Time Prepared:

			11	09/30/2018	2/27/2019 3:1	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	NURSI NG ADMI NI STRATI O	7 piii
	9. 00	10. 00	10. 01	11. 00	N 13. 00	
GENERAL SERVICE COST CENTERS	7. 00	10.00	10.01	11.00	10.00	
1. 00						1. 00 1. 01 1. 02 1. 03
1. 04   00104   BUTLER 1. 05   00105   MOB EAST 1. 07   00107   MEDICAL ARTS						1. 04 1. 05 1. 07
1. 08   00108   SMALTZ WAY 2. 00   00200   CAP REL COSTS-MVBLE EQUIP 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL 7. 00   00700   OPERATION OF PLANT						1. 08 2. 00 4. 00 5. 00 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	1, 791, 155 14, 472	497, 525				8. 00 9. 00 10. 00
10. 01   01001   SNACK BAR 11. 00   01100   CAFETERI A	0 37, 103	0	0	717, 574		10. 01 11. 00
13.00   01300   NURSING ADMINISTRATION 14.00   01400   CENTRAL SERVICES & SUPPLY	12, 720 15, 108	0	0	20, 282 7, 906	988, 875 28, 743	13. 00 14. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDICAL RECORDS & LIBRARY	13, 896 29, 459	0	0	2, 214 25, 000	0	15. 00 16. 00
17. 00 O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	1, 968	0	0	2, 070	7, 531	17. 00
30. 00 03000 ADULTS & PEDIATRICS	140, 708	405, 573	0	77, 649	282, 516	30. 00
31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY	59, 746 10, 704	91, 952 0	0	33, 423 3, 063	121, 652 11, 129	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS	·					
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	212, 886 165, 547	0	0	57, 016 6, 064	207, 455 22, 049	50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	111, 777	o	0	54, 388	0	54.00
60. 00   06000   LABORATORY	63, 898	0	0	50, 973	13, 302	60.00
60. 01   06001   BLOOD LABORATORY 65. 00   06500   RESPI RATORY THERAPY	13, 104	0	0	18, 812	0	60. 01 65. 00
66. 00 06600 PHYSI CAL THERAPY	62, 590	0	0	12, 728	0	66.00
66. 01   06601   CARDI AC   REHAB 69. 00   06900   ELECTROCARDI OLOGY	32, 939	0	0	4, 822 331	0	66. 01 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o o	o	0	2, 628	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 73.00   07300   DRUGS CHARGED TO PATIENTS	0	0	0	13, 556	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	92, 349	0	0	1, 614 48, 510	5, 901 176, 521	90. 00 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	72, 347			40, 310	170, 321	92.00
OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES	17, 052	0	0	54, 264	0	95. 00
99. 10   09910   CORF 101. 00   10100   HOME   HEALTH   AGENCY	0 19, 403	0	0	0 28, 249	0 102, 775	99. 10 101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300  I NTEREST EXPENSE 116. 00 11600  HOSPI CE	2, 100	o	0	2, 566	9 301	113. 00 116. 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)	1, 129, 529	497, 525	0	528, 128	988, 875	
190. 00 19000 GI FT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191.00
192.00 19200 PHYSICIANS PRIVATE OFFICES 192.01 19201 DEKALB MEDICAL SERVICES	661, 626	0	0	2, 752 166, 246		192. 00 192. 01
192. 02 19202 PHARMACARE	0	Ō	0	18, 378	0	192. 02
192. 03 19203 OUTSOURCED DI ETI CI AN 192. 04 19204 BUSI NESS HEALTH	0	0	0	0		192. 03 192. 04
193. 00 19300 NONPALD WORKERS		0	0	0		192.04
194. 00 07950 OTHER NONREI MBURSABLE COST CENT	0	o	0	o		194.00
194. 01 07951  ADULT DAY CARE 194. 02 07952  FOUNDATI ON	0	0	0	2, 070		194. 01 194. 02
200.00 Cross Foot Adjustments			J	_,		200. 00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118 through 201)	0 1, 791, 155	0 497, 525	0	0 717, 574	0 988, 875	201. 00 202. 00
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Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0045 

			То	09/30/2018	Date/Time Pre 2/27/2019 3:1	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	Subtotal	, Dill
	SERVICES &		RECORDS &	SERVI CE		
	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	24. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01   00101   MOB   WEST						1.01
1. 02   00102   NORTH ANNEX						1.02
1. 03   00103 GARRETT CLINIC 1. 04   00104 BUTLER						1. 03 1. 04
1. 05   00105   MOB EAST						1. 04
1. 07   00107   MEDI CAL ARTS						1. 07
1. 08   00108 SMALTZ WAY						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 00700 OPERATION OF PLANT						7.00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY						9. 00 10. 00
10. 01   01000   DIETARY 10. 01   01001   SNACK BAR						10.00
11. 00   01100   CAFETERI A						11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	512, 645					14.00
15. 00 01500 PHARMACY	0	968, 670				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	0	1, 203, 195			16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	135, 821		17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	93, 842	135, 821	5, 457, 423	30.00
31.00   03100   INTENSIVE CARE UNIT 43.00   04300   NURSERY	0	0	37, 590	0	2, 341, 977	31.00
43.00   04300  NURSERY ANCI LLARY SERVI CE COST CENTERS	U	<u> </u>	4, 146	υĮ	248, 232	43. 00
50. 00 05000 OPERATING ROOM	0	ol	166, 498	O	4, 299, 998	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	Ö	15, 516	ő	1, 307, 147	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	O	0	216, 116	0	3, 975, 141	54.00
60. 00   06000   LABORATORY	o	0	167, 289	0	4, 355, 155	60.00
60. 01   06001   BL00D   LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0	33, 929	0	1, 044, 929	65.00
66. 00   06600   PHYSI CAL THERAPY	0	0	44, 956	0	2, 242, 945	66.00
66. 01   06601   CARDI AC   REHAB 69. 00   06900   ELECTROCARDI OLOGY	0	0	4, 637	0	376, 102	66. 01
69. 00   06900  ELECTROCARDI OLOGY 70. 00   07000  ELECTROENCEPHALOGRAPHY	0	0	11, 131 6, 232	0	80, 587 94, 075	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	512, 645	0	82, 610	o o	2, 835, 821	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	012, 010	0	02,010	o	1, 643, 442	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	Ö	968, 670	47, 342	Ö	4, 680, 658	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	1, 332	0	94, 581	90.00
91. 00   09100   EMERGENCY	0	0	129, 495	0	3, 098, 675	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVICES	O	ام	0	ام	1, 966, 690	95. 00
99. 10   09910   CORF	0	0	0	0	1, 966, 690	99. 10
101.00 10100 HOME HEALTH AGENCY	o o	0	0	o o	1, 465, 088	
SPECIAL PURPOSE COST CENTERS	-1	-1	-1	-1	.,,	
113. 00 11300   NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0	2, 851	0	451, 626	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	512, 645	968, 670	1, 065, 512	135, 821	42, 060, 292	118. 00
NONREI MBURSABLE COST CENTERS			- T	ام		400 00
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
191. 00 19100  RESEARCH 192. 00 19200  PHYSI CLANS PRI VATE OFFI CES	0	0	0	0		191. 00 192. 00
192. 01 19201 DEKALB MEDICAL SERVICES	0	0	107, 984	0	14, 450, 556	
192. 02 19202 PHARMACARE	Ö	o	29, 699	ő	7, 477, 698	
192. 03 19203 OUTSOURCED DIETICIAN	O	0	0	0		192. 03
192. 04 19204 BUSI NESS HEALTH	O	0	0	o		192. 04
193. 00 19300 NONPALD WORKERS	0	0	0	O		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 FOUNDATION	0	0	0	0	205, 390	
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers			0			200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	512, 645	968, 670	1, 203, 195	135, 821	64, 204, 522	
202. 30   10 m. (30m 11103 110 till bugil 201)	312,043	700, 070	1, 200, 170	100,021	J 1, 204, JZZ	_02.00

Health FinancialSystemsDEKALB MEMORIAL HOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION - GENERAL SERVICE COSTSProvider CCN: 15-0045Period:Worksheet B

From 10/01/2017 Part I 09/30/2018 Date/Time Prepared: 2/27/2019 3:17 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 MOB WEST 1.01 1 01 1.02 00102 NORTH ANNEX 1.02 00103 GARRETT CLINIC 1.03 1.03 00104 BUTLER 1.04 1.04 00105 MOB EAST 1.05 1.05 1.07 00107 MEDICAL ARTS 1.07 1.08 00108 SMALTZ WAY 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 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01001 SNACK BAR 10 01 10 01 11. 00 | 01100 | CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 457, 423 30.00 31.00 03100 INTENSIVE CARE UNIT 0 2, 341, 977 31.00 04300 NURSERY 43.00 0 248, 232 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 299, 998 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 307, 147 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0000000 3, 975, 141 54.00 60.00 06000 LABORATORY 4, 355, 155 60 00 60.01 06001 BLOOD LABORATORY 60.01 06500 RESPIRATORY THERAPY 1,044,929 65.00 65.00 2, 242, 945 66.00 06600 PHYSI CAL THERAPY 66,00 06601 CARDI AC REHAB 376, 102 66.01 66.01 69.00 06900 ELECTROCARDI OLOGY 80, 587 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 0 94, 075 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 71.00 2, 835, 821 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 1, 643, 442 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 680, 658 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0 94, 581 91.00 09100 EMERGENCY 0 3, 098, 675 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95 00 0 1, 966, 690 99. 10 09910 CORF 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 1, 465, 088 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST | EXPENSE 113.00 116. 00 11600 HOSPI CE 451, 626 116.00 SUBTOTALS (SUM\_OF\_LINES\_1 through 117) 0 42, 060, 292 118.00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 5 190.00 191. 00 19100 RESEARCH 191. 00 0 0 0 192. 00 19200 PHYSICIANS PRIVATE OFFICES 2, 752 192.00 192. 01 19201 DEKALB MEDICAL SERVICES 14, 450, 556 192, 01 192. 02 19202 PHARMACARE 7, 477, 698 192.02 192. 03 19203 OUTSOURCED DIETICIAN 192. 03 0000000 4, 905 192. 04 19204 BUSINESS HEALTH 2, 924 192. 04 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 OTHER NONREIMBURSABLE COST CENT 0 194.00 194. 01 07951 ADULT DAY CARE 194.01 194. 02 07952 FOUNDATI ON 205, 390 194. 02 200.00 Cross Foot Adjustments 200.00 C 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 64, 204, 522 202.00

						3 077 307 2010	2/27/2019 3: 1	
					CAPI TAL REI	LATED COSTS		
		Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT CLI NI C	
			0	1. 00	1. 01	1. 02	1. 03	
		AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FLXT						1.00
1. 01 1. 02		NORTH ANNEX						1. 01 1. 02
1. 03		GARRETT CLINIC						1.03
1.04	1	BUTLER						1.04
1. 05	1	MOB EAST						1.05
1. 07 1. 08	1	MEDICAL ARTS  SMALTZ WAY						1. 07 1. 08
2. 00		CAP REL COSTS-MVBLE EQUIP						2.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	O	0	0	0	0	1
5.00		ADMINISTRATIVE & GENERAL	0	431, 446		0	0	1
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	1, 656, 440 24, 663	0	0	0	
9. 00		HOUSEKEEPING		39, 433	0	0	0	
10.00	1	DI ETARY	o	20, 698		O	0	
10. 01		SNACK BAR	0	0	0	0	0	
11.00		CAFETERI A	0	63, 869	0	0	0	
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY		21, 896 26, 006	0	0	0	
15. 00	1	PHARMACY	Ö	23, 920		Ö	0	
16. 00		MEDICAL RECORDS & LIBRARY	o	44, 845		0	0	16. 00
17. 00		SOCIAL SERVICE	0	3, 388	0	0	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	ol	242, 214	0	0	0	30.00
31. 00		INTENSIVE CARE UNIT	o	102, 847	ő	Ö	0	
43.00		NURSERY	O	18, 425	0	0	0	43.00
FO 00		LARY SERVICE COST CENTERS		2// 4/1		٥		F0 00
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM		366, 461 284, 973	0	0	0	
54. 00		RADI OLOGY-DI AGNOSTI C	o	192, 412	0	o	0	1
60.00		LABORATORY	0	86, 529	0	0	0	60.00
60. 01	1	BLOOD LABORATORY	0	0	0	0	0	
65. 00 66. 00		RESPIRATORY THERAPY PHYSICAL THERAPY	0	22, 557 107, 743	0	0	0	
66. 01		CARDI AC REHAB	o	56, 701	0	o	0	
69. 00		ELECTROCARDI OLOGY	O	0	0	0	0	69. 00
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PAT IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	
73. 00	1	DRUGS CHARGED TO PATIENTS	o	0		o	0	1
	OUTPA	TIENT SERVICE COST CENTERS						
90.00	1	CLINIC	0	150.070		0	0	
	1	EMERGENCY   OBSERVATION BEDS (NON-DISTINCT	0	158, 970	0	0	0	91.00 92.00
72.00		REIMBURSABLE COST CENTERS						72.00
95.00	09500	AMBULANCE SERVICES	0	29, 352	0	0	0	1
99. 10			0	0	0	0	0	1
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	<u> </u>	0	0	0	0	101.00
113.00		I NTEREST EXPENSE						113. 00
		HOSPI CE	O	0	0	0		116. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	4, 025, 788	0	0	0	118.00
190 00		GIFT FLOWER COFFEE SHOP & CAN	ام	0	0	0	0	190. 00
		RESEARCH	Ö	0	o o	Ö		191.00
		PHYSICIANS PRIVATE OFFICES	o	0	0	0		192. 00
		DEKALB MEDICAL SERVICES	0	105, 367	0	0		192. 01
		PHARMACARE OUTSOURCED DI ETI CI AN		0	0	0		192. 02 192. 03
		BUSINESS HEALTH	Ö	0	o o	Ö	0	192. 04
193.00	19300	NONPALD WORKERS	O	0	0	O	0	193. 00
		OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194.00
		ADULT DAY CARE FOUNDATION		0	0	0		194. 01 194. 02
200.00		Cross Foot Adjustments		O		9	O	200.00
201.00	1	Negative Cost Centers		0	0	О		201.00
202.00	기	TOTAL (sum lines 118 through 201)	0	4, 131, 155	0	O	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2017 | Part II | To 09/30/2018 | Date/Time Prepared: 2/27/2019 3:17 pm

			CAP	TAL RELATED CO	STS	2/27/2019 3: 1	
	Cost Center Description	BUTLER	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	
		1. 04	1. 05	1. 07	1. 08	2. 00	
	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FLXT						1 00
	00100 CAP REL COSTS-BLDG & FIXT						1. 00 1. 01
	00102 NORTH ANNEX						1.02
	00103 GARRETT CLINIC						1.03
1.04	00104 BUTLER						1.04
	00105 MOB EAST 00107 MEDICAL ARTS						1. 05 1. 07
	00108 SMALTZ WAY						1. 08
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	C	
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	0	0	0	C	1
	00800 LAUNDRY & LINEN SERVICE	o	0	Ö	Ö	C	1
9. 00	00900 HOUSEKEEPI NG	0	0	0	0	C	
10. 00 10. 01	01000 DI ETARY 01001 SNACK BAR	0	0	0	0	C	
	01100 CAFETERI A	0	0	0	0	C	1
	01300 NURSING ADMINISTRATION	o	0	Ō	ō	C	1
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	C	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	C	
	01700 SOCIAL SERVICE	0	0		0	C	
.,, 00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			٥		17.00
	03000 ADULTS & PEDIATRICS	0	0		0	C	1
	03100 INTENSIVE CARE UNIT 04300 NURSERY	0	0		0	C	
43.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>		43.00
50.00	05000 OPERATI NG ROOM	0	0	0	0	C	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	C	1
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	181	0	0	0	C	
60. 00	06001 BLOOD LABORATORY	0	0	0	ol	C	1
	06500 RESPIRATORY THERAPY	0	0	0	o	C	1
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	C	
	06601 CARDI AC REHAB 06900 ELECTROCARDI OLOGY	0	0	0	0	C	
	07000 ELECTROENCEPHALOGRAPHY	o	0	Ö	ő	C	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	o	С	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	C	
	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	l Ol	0	0	0	C	73.00
	09000 CLI NI C	0	0	0	0	C	90.00
	09100 EMERGENCY	0	0	0	0	C	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	C	95. 00
99. 10	09910 CORF	0	0		o	C	99. 10
101. 00	10100 HOME HEALTH AGENCY	0	0	0	0	C	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300   NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	О	О	C	116.00
118.00		181	0	0	0	С	118. 00
	NONREIMBURSABLE COST CENTERS  19000 GIFT FLOWER COFFEE SHOP & CAN				ما		1100 00
	19100 RESEARCH	0	0		0		190.00 191.00
	19200 PHYSICIANS PRIVATE OFFICES	Ö	0	-	ō		192.00
	19201 DEKALB MEDICAL SERVICES	2, 379	0	0	1, 717		192. 01
	19202 PHARMACARE 19203 OUTSOURCED DIETICIAN	0	0	0	0		192. 02 192. 03
	19204 BUSINESS HEALTH	0	0	0	0		192.03
	19300 NONPALD WORKERS		0	o	ő	C	193. 00
194.00	07950 OTHER NONREIMBURSABLE COST CENT	0	0	0	o	C	194. 00
	07951 ADULT DAY CARE	0	0	0	0		194. 01 194. 02
194. 02 200. 00	07952 FOUNDATION Cross Foot Adjustments		0		٥		200. 00
201.00	Negative Cost Centers	o	0	0	О		201.00
202. 00	TOTAL (sum lines 118 through 201)	2, 560	0	0	1, 717	C	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0045

Period: Worksheet B From 10/01/2017 Part II To 09/30/2018 Date/Time Prepared:

2/27/2019 3:17 pm Cost Center Description Subtotal **EMPLOYEE** ADMINISTRATIV OPERATION OF LAUNDRY & LINEN SERVICE **BENEFITS** E & GENERAL **PLANT** DEPARTMENT 2A 5.00 7. 00 8. 00 4 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 MOB WEST 1.01 1.01 00102 NORTH ANNEX 1.02 1 02 1.03 00103 GARRETT CLINIC 1.03 00104 BUTLER 1.04 1.04 1.05 00105 MOB EAST 1.05 00107 MEDICAL ARTS 1.07 1 07 1.08 00108 SMALTZ WAY 1.08 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 431, 446 5.00 431, 446 5.00 7.00 00700 OPERATION OF PLANT 1, 656, 440 31,634 1, 688, 074 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 24, 663 491 13, 221 38, 375 8.00 00900 HOUSEKEEPI NG 21, 980 11, 591 9 00 39, 433 1,714 9 00 0 10.00 01000 DI ETARY 20, 698 2, 991 13, 354 246 10.00 01001 SNACK BAR 10.01 10.01 01100 CAFETERI A 3, 931 34, 239 11.00 63.869 0 0 11.00 01300 NURSING ADMINISTRATION 13 00 21, 896 C 6.203 11, 738 0 13.00 01400 CENTRAL SERVICES & SUPPLY 26,006 2,836 13, 941 14.00 14.00 0 15.00 01500 PHARMACY 23, 920 0 6, 160 12,823 0 15.00 01600 MEDICAL RECORDS & LIBRARY 7, 210 16,00 44.845 0 27.185 0 16.00 17.00 01700 SOCIAL SERVICE 3, 388 801 1,816 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 242, 214 0 26, 416 129, 845 9, 769 30.00 03100 INTENSIVE CARE UNIT C 31.00 102, 847 12, 326 55, 134 3, 316 31.00 43.00 04300 NURSERY 18, 425 0 1, 281 9,877 368 43.00 ANCILLARY SERVICE COST CENTERS 6, 721 50.00 05000 OPERATING ROOM 0 20, 757 196, 451 50.00 366, 461 05200 DELIVERY ROOM & LABOR ROOM 284, 973 152, 767 52.00 0 4.500 792 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 192, 412 0 22, 128 103, 147 4, 236 54.00 06000 LABORATORY 60.00 86, 710 0 26, 174 58, 965 0 60.00 60 01 06001 BLOOD LABORATORY 0 60 01 0 0 0 0 06500 RESPIRATORY THERAPY 12, 092 6, 352 65.00 22, 557 0 0 65.00 06600 PHYSI CAL THERAPY 107, 743 0 13, 164 57, 758 904 66.00 66.00 06601 CARDI AC REHAB 66.01 56, 701 1,668 30, 396 228 66.01 06900 ELECTROCARDI OLOGY 69 00 69 00 Ω 464 0 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 567 0 284 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 15, 056 0 71.00 71.00 0 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 11 043 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 C 24,534 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 571 287 90.00 0 09100 EMERGENCY 158, 970 0 85, 220 91.00 91 00 16,084 7.141 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 1, 875 95.00 29, 352 12, 405 15, 735 99. 10 09910 CORF 99. 10 C 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 8, 498 17, 905 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 25 116.00 0 0 2 885 1 938 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 025, 969 300, 721 1,077,527 37, 906 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00 0 191. 00 19100 RESEARCH 0 C 0 0 0 191.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192.00 0 0 192. 01 19201 DEKALB MEDICAL SERVICES 273 192. 01 109, 463 0 79, 386 610, 547 192. 02 19202 PHARMACARE 0 0 49.924 0 0 192.02 192. 03 19203 OUTSOURCED DIETICIAN 0 C 33 0 0 192.03 196 192.04 192. 04 19204 BUSINESS HEALTH 0 16 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 ol 194. 00|07950|OTHER NONREIMBURSABLE COST CENT 0 0 0 194, 00 0 194. 01 07951 ADULT DAY CARE 0 0 0 0 0 194. 01 0 0 194. 02 194. 02 07952 FOUNDATION 0 0 1.366 Cross Foot Adjustments 200.00 0 200.00 201.00 Negative Cost Centers 0 C 0 201.00 TOTAL (sum lines 118 through 201) 431, 446 1, 688, 074 38, 375 202. 00 202.00 4, 135, 432

Cost Contor Description	HOUSEKEEDING	DIETARY	CNIACK BAD	CAFFTERLA	2/27/2019 3: 1	7 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	NURSI NG ADMI NI STRATI O N	
	9. 00	10. 00	10. 01	11. 00	13. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00   00100   CAP REL COSTS-BLDG & FLXT 1.01   00101   MOB WEST						1. 00 1. 01
1. 02   00101   MOD WEST						1. 02
1. 03   00103   GARRETT   CLINIC						1. 03
1. 04   00104   BUTLER						1.04
1.05   00105   MOB EAST						1. 05
1. 07   00107   MEDI CAL ARTS						1. 07
1. 08   00108 SMALTZ WAY						1.08
2.00   00200   CAP REL COSTS-MVBLE EQUIP 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG	74, 718					9. 00
10. 00   01000   DI ETARY	604	37, 893	_			10.00
10. 01   01001   SNACK BAR 11. 00   01100   CAFETERI A	1 540	0	0	102 507		10. 01 11. 00
11.00   O1100   CAFETERI A 13.00   O1300   NURSI NG   ADMINI STRATI ON	1, 548 531	0	0	103, 587 2, 928	43, 296	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	630	Ö	0	1, 141	1, 258	14. 00
15. 00 01500 PHARMACY	580	O	0	320	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1, 229	o	0	3, 609	0	16.00
17. 00 01700 SOCI AL SERVI CE	82	0	0	299	330	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	E 070	30, 890	0	11, 209	12 271	20.00
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT	5, 870 2, 492	7, 003	0	4, 825	12, 371 5, 326	30. 00 31. 00
43. 00   04300   NURSERY	447	7,005	0	442	487	43. 00
ANCILLARY SERVICE COST CENTERS		-				
50.00   05000   OPERATING ROOM	8, 881	0	0	8, 231	9, 083	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	6, 906	0	0	875	965	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	4, 663 2, 666	0	0	7, 851 7, 358	0 582	54. 00 60. 00
60. 00   06000   LABORATORY	2,000	0	0	7, 336 N	0	60.00
65. 00 06500 RESPIRATORY THERAPY	547	ő	0	2, 716	Ö	65.00
66. 00   06600 PHYSI CAL THERAPY	2, 611	o	0	1, 837	0	66.00
66. 01   06601   CARDI AC   REHAB	1, 374	0	0	696	0	66. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	48	0	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PAT	0	0	0	379	0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		ő	0	1, 957	Ö	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0	0	233	258	90.00
91. 00 09100 EMERGENCY	3, 852	0	0	7, 003	7, 729	91.00
92. 00   O9200   OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVI CES	711	ol	0	7, 833	0	95. 00
99. 10 09910 CORF	0	ō	0	0	l e	99. 10
101.00 10100 HOME HEALTH AGENCY	809	0	0	4, 078	4, 500	101. 00
SPECIAL PURPOSE COST CENTERS	Т				Г	
113. 00 11300  I NTEREST EXPENSE 116. 00 11600  HOSPI CE	0.0		0	270	407	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	88 47, 121	37, 893	0	370 76, 238	<b>l</b>	116. 00 118. 00
NONREI MBURSABLE COST CENTERS	77, 121	37, 075	<u> </u>	70, 230	45, 270	110.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	397	l	192.00
192. 01 19201 DEKALB MEDI CAL SERVI CES 192. 02 19202 PHARMACARE	27, 597	0	0	24, 000 2, 653		192. 01 192. 02
192. 03 19203 OUTSOURCED DI ETI CI AN		0	0	2, 003 0		192. 02
192. 04 19204 BUSINESS HEALTH	l o	o	0	0		192. 04
193.00 19300 NONPALD WORKERS	0	o	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENT	0	o	0	0	l .	194. 00
194. 01 07951 ADULT DAY CARE	0	0	0	0	l .	194. 01
194.02 07952 FOUNDATION 200.00 Cross Foot Adjustments	0	O	0	299	0	194. 02 200. 00
201.00 Negative Cost Centers		n	0	0	n	200.00
202.00 TOTAL (sum lines 118 through 201)	74, 718	37, 893		103, 587		
	· •			•		

| Peri od: | Worksheet B | From 10/01/2017 | Part II | To 09/30/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045

					Т	o 09/30/2018	Date/Time Pre 2/27/2019 3:1	
		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	Subtotal	, piii
			SERVICES &		RECORDS &	SERVI CE		
			SUPPLY 14. 00	15. 00	16. 00	17. 00	24. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FLXT						1.00
1. 01 1. 02	1	MOB WEST NORTH ANNEX						1. 01 1. 02
1. 03	1	GARRETT CLINIC						1.03
1. 04		BUTLER						1.04
1.05		MOB EAST						1.05
1. 07 1. 08		MEDICAL ARTS SMALTZ WAY						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						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9.00
10.00	1	DI ETARY						10.00
	1	SNACK BAR						10.01
		CAFETERI A NURSI NG ADMI NI STRATI ON						11. 00 13. 00
		CENTRAL SERVICES & SUPPLY	45, 812					14.00
		PHARMACY	0	43, 803				15.00
	1	MEDICAL RECORDS & LIBRARY	0	0		I I		16.00
17. 00		SOCIAL SERVICE   ENT ROUTINE SERVICE COST CENTERS	O <sub>L</sub>	0	C	6, 716		17.00
30.00		ADULTS & PEDIATRICS	0	0	6, 557	6, 716	481, 857	30.00
		INTENSIVE CARE UNIT	0	0			195, 895	
43. 00		NURSERY	0	0	290	0	31, 617	43.00
50. 00		LARY SERVICE COST CENTERS  OPERATING ROOM	0	0	11, 633	ol	628, 218	50.00
52. 00		DELIVERY ROOM & LABOR ROOM	Ö	0		I I	452, 862	
54.00	1	RADI OLOGY-DI AGNOSTI C	0	0	15, 110	I I	349, 547	1
60.00	1	LABORATORY	0	0	11, 689	1	194, 144	
60. 01 65. 00		BLOOD LABORATORY RESPI RATORY THERAPY	0	0	2, 371	- 1	0 46, 635	
66. 00	1	PHYSI CAL THERAPY	o	0	3, 141	I I	187, 158	1
66. 01		CARDI AC REHAB	0	0	324	l I	91, 387	1
	1	ELECTROCARDI OLOGY	0	0	778	I I	1, 290	1
		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PAT	45, 812	0	435 5, 772		1, 665 66, 640	
	1	IMPL. DEV. CHARGED TO PATIENTS	0	0			11, 043	
73.00		DRUGS CHARGED TO PATIENTS	0	43, 803	3, 308	o	73, 602	73.00
00.00		TIENT SERVICE COST CENTERS CLINIC	ol	0	03		1 442	00.00
90. 00 91. 00		EMERGENCY	0	0		I I	1, 442 295, 047	90. 00 91. 00
	1	OBSERVATION BEDS (NON-DISTINCT			,,,,,,,		270,017	92.00
		REIMBURSABLE COST CENTERS						
95. 00 99. 10		AMBULANCE SERVICES	0	0	-	· •	67, 911 0	95. 00 99. 10
		HOME HEALTH AGENCY	0	0		· •		101.00
		AL PURPOSE COST CENTERS	- 1			- 1		
		INTEREST EXPENSE			400		5 040	113.00
116.00	1	HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 45, 812	0 43, 803	199 74, 458	· •	5, 912 3, 219, 662	116.00
116.00	-	IMBURSABLE COST CENTERS	45, 612	43, 603	74,450	0, 710	3, 219, 002	1118.00
190.00		GIFT FLOWER COFFEE SHOP & CAN	0	0	C	0	0	190. 00
		RESEARCH	0	0		1		191.00
		PHYSICIANS PRIVATE OFFICES DEKALB MEDICAL SERVICES	0	0	7, 545	1	397 858, 811	192.00
		PHARMACARE	o	0	2, 075	I I		192.02
		OUTSOURCED DIETICIAN	0	0	C	o		192. 03
	1	BUSI NESS HEALTH	0	0	C	0		192.04
		NONPALD WORKERS OTHER NONREIMBURSABLE COST CENT	0	0				193. 00 194. 00
		ADULT DAY CARE	ol	0				194. 01
194. 02	07952	FOUNDATI ON	0	0	C	o	1, 665	194. 02
200.00	1	Cross Foot Adjustments					0	200.00
201. 00 202. 00	1	Negative Cost Centers TOTAL (sum lines 118 through 201)	45, 812	0 43, 803	84, 078	6, 716	0 4, 135, 432	201.00 202.00
202.00	1		10, 012	10, 000	01,070	5, , 10	., 100, 102	,_02.00

Health Financial Systems DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0045 Period: Worksheet B

From 10/01/2017 Part II Date/Time Prepared: 09/30/2018 2/27/2019 3:17 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 MOB WEST 1.01 1 01 1.02 00102 NORTH ANNEX 1.02 00103 GARRETT CLINIC 1.03 1.03 00104 BUTLER 1.04 1.04 00105 MOB EAST 1.05 1.05 1.07 00107 MEDICAL ARTS 1.07 1.08 00108 SMALTZ WAY 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 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01001 SNACK BAR 10 01 10 01 11. 00 | 01100 | CAFETERIA 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 481, 857 30.00 31.00 03100 INTENSIVE CARE UNIT 0 195, 895 31.00 04300 NURSERY <u>31</u>, 617 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 628, 218 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 452, 862 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0000000000 349, 547 54.00 06000 LABORATORY 194, 144 60.00 60 00 06001 BLOOD LABORATORY 60.01 60.01 06500 RESPIRATORY THERAPY 65.00 46,635 65.00 66.00 06600 PHYSI CAL THERAPY 187, 158 66,00 06601 CARDI AC REHAB 91, 387 66.01 66.01 69.00 06900 ELECTROCARDI OLOGY 1, 290 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 1, 665 70.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 71.00 66, 640 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 11,043 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73,602 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 1.442 90.00 91.00 09100 EMERGENCY 0 295, 047 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95 00 0 67, 911 99. 10 09910 CORF 0 99.10 101.00 10100 HOME HEALTH AGENCY 0 101.00 35, 790 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST | EXPENSE 113.00 116. 00 11600 HOSPI CE 5, 912 116.00 SUBTOTALS (SUM\_OF\_LINES\_1 through 117) 3, 219, 662 0 118.00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 190.00 191. 00 19100 RESEARCH 191. 00 000000000000 192. 00 19200 PHYSICIANS PRIVATE OFFICES 397 192.00 192. 01 19201 DEKALB MEDICAL SERVICES 858, 811 192, 01 192. 02 19202 PHARMACARE 54,652 192.02 192. 03 19203 OUTSOURCED DIETICIAN 192. 03 33 192. 04 19204 BUSINESS HEALTH 212 192. 04 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 OTHER NONREIMBURSABLE COST CENT 0 194.00 194. 01 07951 ADULT DAY CARE 0 194.01 194. 02 07952 FOUNDATI ON 194. 02 1,665 200.00 Cross Foot Adjustments C 200.00 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 4, 135, 432 202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksnee: 5
From 10/01/2017
To 09/30/2018 Date/Time Prepared: 2/27/2019 3:17 pm Provider CCN: 15-0045 CAPITAL RELATED COSTS

		CAP	TIAL RELATED CO	DSTS		
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MOB WEST (SQUARE FEET)	NORTH ANNEX (SQUARE FEET)	GARRETT CLINIC (SQUARE FEET)	BUTLER (SQUARE FEET)	
	1. 00	1. 01	1. 02	1. 03	1. 04	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT	199, 996					1.00
1. 01   00101   MOB   WEST	0	16, 334				1.01
1. 02   00102   NORTH ANNEX	0	0	3, 616			1. 02
1. 03   00103   GARRETT CLINIC	0	0	0	3, 750		1.03
1. 04   00104 BUTLER	0	0	0	0	4, 977	1.04
1.05   00105 MOB EAST 1.07   00107 MEDICAL ARTS	0	0	0	0	0	1. 05 1. 07
1. 08   00108 SMALTZ WAY	0		0	0	0	1.07
2. 00   00200 CAP REL COSTS-MVBLE EQUIP				O	O	2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	20, 887	0	0	0	0	5.00
7.00 00700 OPERATION OF PLANT	80, 191	2, 931	0	0	0	7.00
8. 00   00800 LAUNDRY & LINEN SERVICE	1, 194	0	0	0	0	8.00
9. 00   00900   HOUSEKEEPI NG	1, 909		0	0	0	9. 00
10. 00   01000   DI ETARY	1, 002		0	0	0	10.00
10. 01   01001   SNACK BAR	0	0	0	0	0	10.01
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	3, 092	0	0	0	0	11.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	1, 060 1, 259	l .	0	0	0	13. 00 14. 00
15. 00   01500   PHARMACY	1, 259	l .	0	0	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	2, 171		0	0	0	16.00
17. 00   01700   SOCI AL   SERVI CE	164	Ö		0	Ö	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	11, 726	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	4, 979	0	0	0	0	31.00
43. 00 04300 NURSERY	892	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS	47.744	1 0	1		0	F0 00
50. 00 05000 OPERATING ROOM	17, 741	0		0	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   54.00   05400   RADIOLOGY-DIAGNOSTIC	13, 796 9, 315		0	0	0	52. 00 54. 00
60. 00   06000   LABORATORY	4, 189	l .	0	784	352	60.00
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60.01
65. 00 06500 RESPIRATORY THERAPY	1, 092	Ö	Ō	0	Ö	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 216	l .	0	0	0	66.00
66. 01   06601   CARDI AC   REHAB	2, 745	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	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 O7300 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
91. 00   09100   EMERGENCY	7, 696			0	Ō	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	1, 421		0	0	U	95.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	1, 617	U	0	101. 00
113. 00 11300   NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	0	0	175	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	194, 895	2, 931				118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0		192.00
192. 01 19201  DEKALB MEDI CAL SERVI CES 192. 02 19202  PHARMACARE	5, 101	13, 403	1, 824	2, 966		192. 01 192. 02
192. 03 19203 OUTSOURCED DIETICIAN		0		0		192. 02
192. 04 19204 BUSI NESS HEALTH	0	0	0	0		192.04
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENT	0	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		194. 02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	4 401 1	_	_	_		201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4, 131, 155	0	0	0	2, 560	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	20. 656188	0. 000000	0. 000000	0. 000000	0. 514366	203. 00
(meet 5)		, 2. 300000	. 2. 200000			

COCT ALLOCATION CTATICTICAL PAGES	Health Financial S	Systems	DEKALB MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-25	52-10
COST ALLOCATION - STATISTICAL BASIS  Provider CCN: 15-0045   Period:   Worksheet B-1   From 10/01/2017   To 09/30/2018   Date/Time Prepared	COST ALLOCATION -	STATISTICAL BASIS		Provi der	CCN: 15-0045	From 10/01/2017	Date/Time Prepa	

						2/27/2019 3:1	7 pm
			CAP	ITAL RELATED C	OSTS		
	Cost Center Description	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT	BUTLER	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	CLI NI C	(SQUARE FEET)	
					(SQUARE FEET)		
		1. 00	1. 01	1. 02	1. 03	1. 04	
204.00	Cost to be allocated (per Wkst. B,						204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part						205.00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B-1 | From 10/01/2017 | To 09/30/2018 | Date/Time Prepared: Provider CCN: 15-0045

1.0.0 00100] BOTTLEW 3  001016] BUTLER 3  1.0.1 001016						o 09/30/2018	Date/Time Pre 2/27/2019 3:1	
CSULARE FFFT]   CSULARE FFFT				CAPI TAL REI	LATED COSTS			
CEREBAL SERVICE COST CENTERS   1.05   1.07   1.08   2.00   4.00		Cost Center Description						
DESIGNAL SERVICE ORDIT CENTERS   1.05   1.07   1.08   2.00   4.00			(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)		
The part of the							• • • • • •	
100			1. 05	1. 07	1. 08	2. 00		
1.01   00101   MOR MEST   1.02   00103   GARRETT CLINI C	1 00							1 00
1.03   OOTION CARPETT CLINIC		†						1.01
1.04   Ontal BITLER								1.02
1.07 00107 NEDICAL ARTS 1.08 00108 SMALTZ WAY 2.00 00200 CAP REL COSTS-WBLE EQUI P 2.00 00200 CAP REL COSTS-WBLE EQUI P 3.160 00200 CAP REL COSTS-WBLE EQUI P 3.00 00200 CAP R 3.00 0020		1 1						1.03
1.08   SMALTZ WAY			37, 481	7				1.05
2.00   00200   CAP BEL COSTS-MMBLE COUP   0   0   0   22, 457, 398   4.0   00400   CMENTYEE BEREITS DEPARTMENT			0					1.07
DOC   DOC   ADMINISTRATIVE & GENERAL   5.019	2. 00	00200 CAP REL COSTS-MVBLE EQUIP			, , , , ,			2.00
0.000   0.000   OPERATION OF PLANT		1 1	-	-		<u>ا</u>		1
0.00 00000 HOUSEKEPING 76 0 0 1,909 877,876 9,0 10.01 0.00 10000 ETARY 204 0 0 1,002 196,199 10.01 0.01 10101 SNACK BAR 0 0 0 0 0 0 0 0 0 1.002 196,199 10.01 0.10 10101 SNACK BAR 0 0 0 0 0 0 0 0 0 0 10.01 0.10 0.11 0.00 11000 CAFTERIA 0 0 0 0 0 0 0 0 0 0 0 0 0 10.01 0.10 0.11 0.00 11000 CAFTERIA 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		-			
10.00   1000   DIETARY   204								
10.00   10100   SNACK BAR			4	1	· -			1
13.00   01300 NNRSING ADMINISTRATION   0   0   1.060   565, 526   13.0   13.0   14.0   01400   CENTRAL SERVICES & SUPPLY   0   0   0   0   1.259   133, 318   14.0   01400   CENTRAL SERVICES & SUPPLY   284   0   0   0   1.156   569, 832   15.0   01700   MEDICAL SERVICE   0   0   0   0   0   1.156   569, 832   15.0   01700   SOCIAL SERVICE   0   0   0   0   0   1.1726   2.229, 718   30.0   03000   MEDICAL SERVICE COST CENTERS	10. 01	01001 SNACK BAR		1	0	0	0	10. 01
14. 00   01400   CENTRAL SERVICES & SUPPLY   0   0   0   1,259   133,018   14. 0   15. 00   1500   PHARMACY   0   0   0   0   1,158   569,822   15. 0   16. 00   01600 MEDICAL RECORDS & LI BRARY   284   0   0   2,171   620,050   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   17. 73,594   17. 0   17. 00   17.		1	0	0				
16. 00   01-600   MEDICAL RECORDS & LIBRARY   284   0			0	ő	Ö	.,		1
17.00   01700   SOCIAL SERVICE   0   0   0   164   73,594   17.0		1 1		1	· -			
INPATI ENT ROUTINE SERVICE COST CENTERS								1
31.00   03100   INTENSIVE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS						
ABOUL LARY SERVICE COST CENTERS     0   0   0   892   97,532   43.0					•			1
50.00   05000   05000   05000   0   0   17,741   1,674,838   50.0   52.00   52.00   62.00			1	1	•			
S2.00   05200   DELLYTERY ROOM & LABOR ROOM   0   0   0   13,796   193,262   52.0	EO 00					17 7/1	1 474 020	FO 00
60.00   06000   LABORATORY								
60.01   06.00   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0		1 1	1	_	· -		1, 527, 886	54.00
65.00   06500   RESPI RATORY THERAPY   0   0   0   1,092   555, 741   65.0   66.01   06600   PHYSI CAL THERAPY   0   0   0   0   5,216   348, 997   66.0   66.01   06601   CARDI AC REHAB   0   0   0   0   2,745   120,309   66.0   67.00   07000   07000   0   0   0   0   0		1 1	0	0				1
66.01   06601   CARDIAC REHAB   0   0   0   2,745   120,309   66.0   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   41,535   69.0   70.00   07000   ELECTROCENCEPHALOGRAPHY   0   0   0   0   0   44,218   70.0   71.00   07100   MDEL CAL SUPPLIES CHARGED TO PAT   0   0   0   0   0   0   0   71.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   74.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   75.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   75.00   07900   07900   07900   07900   0   0   0   0   75.00   07900   07900   07900   07900   0   0   0   0   75.00   07900   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   0   0   0   0   0   0   75.00   07900   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   0   0   0   0   0   0   75.00   07900   07900   07900   07900   0   0   0   0   75.00   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   07900   0   0   0   0   75.00   07900   07900   07900   07900   0   0   0   0   0   75.00   07900   07900   07900   07900   07900   0   0   0   0   75.00   07900   07900   07900   07900   07900   0   0   0   0   0   0   75.00   07900   0	65. 00	06500 RESPIRATORY THERAPY	0	ō			550, 741	65.00
69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   41, 535   69. 0   71. 00   07000   ELECTROCEPHALOGRAPHY   0   0   0   0   44, 218   70. 0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PAT   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUBS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUBS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUBS CHARGED TO PATIENTS   0   0   0   0   0   0   74. 00   07300   DRUBS CHARGED TO PATIENTS   0   0   0   0   0   0   75. 00   09000   CLINIC   0   0   0   0   0   0   0   75. 00   09000   CLINIC   0   0   0   0   0   0   75. 00   09000   CLINIC   0   0   0   0   0   0   75. 00   09200   08SERVATION BEDS (NON-DISTINCT   0   0   0   0   0   0   0   75. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   99. 1   75. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   76. 00   0910   CORPET   0   0   0   0   0   0   0   77. 00   0910   CORPET   0   0   0   0   0   0   0   77. 00   0910   CORPET   0   0   0   0   0   0   77. 00   0910   CORPET   0   0   0   0   0   0   77. 00   0910   CORPET   0   0   0   0   0   0   77. 00   0910   CORPET   0   0   0   0   0   0   77. 00   0910   CORPET   0   0   0   0   0   0   77. 00   0910   CORPET   0   0   0   0   0   0   77. 00   07. 000   07. 000   07. 000   0   77. 00   07. 000   07. 000   07. 000   0   77. 00   07. 000   07. 000   07. 000   0   77. 00   07. 000   07. 000   07. 000   0   77. 00   07. 000   07. 000   07. 000   0   77. 00   07. 000   07. 000   07. 000   0   78. 00   07. 000   07. 000   07. 000   0   79. 00   07. 000   07. 000   07. 000   0   79. 00   07. 000   07. 000   07. 000   0   79. 00   07. 000   07. 000   07. 000   07. 000   0   79. 00   07. 000   07. 000   07. 000   07. 000   07. 000   79. 00   07. 000   07. 000   07. 000   07. 000   07. 000   79. 00   07. 000   07. 000   07. 000   07. 000   07. 000   79. 00   07. 000   07. 000   07. 000   07. 000   79. 00   07. 000   07. 000   07. 000   7		1 1	0	0	0		•	
71. 00		1 1	0	ő	Ö		•	1
72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 0 73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 0   00   00   00   00   0   0   0   0		1	0	0	0	0		
73. 00   07300   DRUGS CHARGED TO PATLENTS   0   0   0   0   0   73. 0								
90. 00   09000   CLINIC   0   0   0   0   0   0   53,460   90. 0   91. 00   9100   09000   EMERGENCY   0   0   0   0   0   0   7,696   1,350,995   91. 0   92. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   1,421   1,166,398   95. 0   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   0   0		07300 DRUGS CHARGED TO PATIENTS		<b>   </b>	0	0	0	
91. 00   09100   EMERGENCY   0   0   0   0   7,696   1,350,995   91. 0   92. 0   0   0   0   0   0   0   0   0   0	90 00						53 460	90 00
OTHER REIMBURSABLE COST CENTERS   O			0	ő	ő	7, 696		
95. 00	92. 00							92.00
99. 10   09910   CORF   0   0   0   0   0   0   0   0   99. 1   101. 00   SPECI AL PURPOSE COST CENTERS  113. 00   11300   INTEREST EXPENSE   113. 00   114, 895   116. 00   11600   HOSPI CE   118. 00   11600   HOSPI CE   119. 00   1194, 895   119. 00   1194, 895   119. 00   1194, 895   119. 00	95. 00		0	0	0	1, 421	1, 166, 398	95.00
113. 00   113.00   INTEREST EXPENSE			1	1		0	0	99. 10
113.00	101.00		0	0	0	0	745, 171	101.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   16, 723   680   0   194, 895   20, 808, 040   118.00   190.00   190.00   190000   190000   19000   19000   19000   19000   19000   19000   19000   19000   19000   19000		11300 INTEREST EXPENSE						113.00
NONRE   MBURSABLE   COST   CENTERS   190. 00   19000   GIFT   FLOWER   COFFEE   SHOP & CAN   0   0   0   0   0   0   190. 00     191. 00   19100   RESEARCH   0   0   0   0   0   0   0     192. 00   19200   PHYSI   CIANS   PRI VATE   OFFI   CES   0   0   0   0   0   0     192. 01   19201   DEKALB   MEDI   CAL   SERVI   CES   20,758   6,460   3,168   5,101   6,842,289   192. 00     192. 02   19202   PHARMACARE   0   0   0   0   729,679   192. 00     192. 03   19203   OUTSOURCED   DI ETI   CIAN   0   0   0   0   3,150     192. 04   19204   BUSI   NESS   HEALTH   0   0   0   0   0   1,538     193. 00   19300   NONPAID   WORKERS   0   0   0   0   0     194. 00   07950   OTHER   NONREI   MBURSABLE   COST   CENT   0   0   0   0     194. 01   07951   ADULT   DAY   CARE   0   0   0   0     194. 02   07952   FOUNDATI   ON   0   0   0     200. 00   Cross   Foot   Adjustments   200. 00     201   202   COST   CENT   0   0   0   0     200. 00   Cross   Foot   Adjustments   200. 00   0      200. 00   COST   CENT   0   0   0   0     200. 200   0   0   0   0     200. 200   0   0   0   0     200. 200   0   0   0   0     200. 200   0   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0   0     200. 200   0   0     200. 200   0   0     200. 200   0   0     200. 200   0   0     200. 200   0   0     200. 200   0   0     200. 200   0     200. 200   0   0     200. 200   0     200.		†	16 722		•			
191. 00   19100   RESEARCH	110.00	,	10, 723	000		194, 695	20, 606, 040	]118.00
192. 00   1920				1	0	0		
192. 01 19201 DEKALB MEDI CAL SERVI CES 20, 758 6, 460 3, 168 5, 101 6, 842, 289 192. 0 192. 02 19202 PHARMACARE 0 0 0 0 0 729, 679 192. 0 192. 03 19203 OUTSOURCED DI ETI CI AN 0 0 0 0 0 3, 150 192. 0 192. 04 19204 BUSI NESS HEALTH 0 0 0 0 0 1, 538 192. 0 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 19300 194. 00 07950 OTHER NONREI MBURSABLE COST CENT 0 0 0 0 0 0 194. 0 194. 01 07951 ADULT DAY CARE 0 0 0 0 0 0 0 194. 0 194. 02 07952 FOUNDATI ON Cross Foot Adjustments 200. 0			0	0	0	0		
192. 03   19203   OUTSOURCED DI ETI CI AN	192. 01	19201 DEKALB MEDICAL SERVICES	20, 758	6, 460	3, 168	5, 101	6, 842, 289	192. 01
192. 04 19204 BUSI NESS HEALTH 0 0 0 0 1,538 192. 0 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENT 0 0 0 0 0 194. 0 194. 01 07951 ADULT DAY CARE 0 0 0 0 0 0 194. 0 194. 02 07952 FOUNDATI ON 0 0 0 72, 702 194. 0 200. 00 Cross Foot Adjustments			0	0	0	0		
194. 00 07950 OTHER NONREIMBURSABLE COST CENT 0 0 0 0 194. 01 194. 01 07951 ADULT DAY CARE 0 0 0 0 0 194. 02 194. 02 07952 FOUNDATION 0 0 0 0 72, 702 194. 02 200. 00 Cross Foot Adjustments 200. 00 Cross Foot Adjustments				0	0	0		
194. 01 07951 ADULT DAY CARE 0 0 0 0 0 194. 0 194. 02 07952 FOUNDATION 0 0 0 72, 702 194. 0 200. 00 Cross Foot Adjustments 200. 0	193.00	19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.02 07952 FOUNDATION 0 0 0 72,702 194.0 200.00 Cross Foot Adjustments 0 200.00			0	0	0	0		
	194. 02	07952 FOUNDATI ON	0	Ö	0	o o		194. 02
201_00    Nogative Cost Centers								200.00
201.00   Negative Cost Centers   201.00   Cost to be allocated (per Wkst. B, 0 0 1,717 0 7,227,694 202.0			0	0	1, 717	0	7, 227, 694	201. 00 202. 00
Part I)				1	<u> </u>			

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS				Period: From 10/01/2017	Worksheet B-1	
				To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
		CAPITAL REL	LATED COSTS			
Cost Center Description	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	EMPLOYEE	
	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	BENEFI TS	
					DEPARTMENT	
					(UNADJUSTED	
					SALARY)	
	1. 05	1. 07	1. 08	2. 00	4. 00	
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 54198	0. 000000	0. 253983	203. 00
204.00 Cost to be allocated (per Wkst. B,					0	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part					0. 000000	205.00
NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						207.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
raits iii and IV)					l	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS DEKALB MEMORIAL HOSPITAL Provi der CCN: 15-0045

	2/2//2017 3. 1		
KEEPI NG	HOUSEKEEPI NG		HOUSEKEEPI NG
E FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)
. 00	9. 00	9. 00	9. 00
149, 267	149, 267	149 267	149 267
1, 206 1	i .		
0 1		l l	
3, 092 1 1, 060 1	1		
1, 259 1	l .		
1, 158 1	1, 158	1, 158	1, 158
2, 455 1	l .		
164 1	164	164	164
11, 726 3	11, 726	11, 726	11, 726
4, 979 3	l .		
892 4	892	892	892
17, 741 5	17, 741	17, 741	17, 741
13, 796 5	13, 796		
9, 315 5			
5, 325 6	1		
1, 092 6		1	- 1
5, 216			
2, 745   6			
0 7	l .	1	
0 7			- 1
0 7			- 1
/	0	0	0
0 9	0		0
7, 696 9	7, 696		7, 696
9			
1, 421 9	1, 421	1, 421	1, 421
0 9	l	l l	
1, 617 10	1, 617	1, 617 10	1, 617
11		1	
175 11		I	
94, 130 11	94, 130	94, 130 1	94, 130
0 19	0	0 1	0
0 19			
0 19			
55, 137 19 0 19			
0 19			
0 19	0	0 1	0
0 19 0 19	0	0 1	0
0 19			
0 19	0	0 1	0
20		2	
701 155 20	1 701 155	20 1, 791, 155 20	1 701 155
771, 135 20	1, 791, 155	1, 771, 100 2	1, 771, 105
		11. 999672 2	
74, 718 20	74, 718	74, 718 2	74, 718

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 10/01/2017 Fo 09/30/2018	Date/Time Pre 2/27/2019 3:1	
Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	n	E & GENERAL	PLANT	LINEN SERVICE	(SQUARE FEET)	
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF		
				LAUNDRY)		
	5A	5. 00	7. 00	8. 00	9. 00	
205.00 Unit cost multiplier (Wkst. B, Part		0. 007897	11. 073259	0. 149878	0. 500566	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

		10. 00	10. 01	11. 00	13. 00	14. 00	
	GENERAL SERVI CE COST CENTERS						4
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 1. 02	00101 MOB WEST						1.01
1. 02	00103 GARRETT CLINIC						1.02
1. 04	00104 BUTLER						1.04
1. 05	00105 MOB EAST						1.05
1. 07	00107 MEDI CAL ARTS						1.07
1.08	00108 SMALTZ WAY						1.08
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	28, 168					10.00
10. 01	01001 SNACK BAR	20, 100	0				10.00
11. 00	01100 CAFETERI A	o	o o	34, 673			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	980	273, 132		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	382	7, 939	100	14.00
15.00	01500 PHARMACY	0	0	107	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	1, 208	0	0	1
17. 00	01700 SOCI AL SERVI CE	0	0	100	2, 080	0	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	20.0(0	ام	0.750	70.000		1 00 00
30.00	03000 ADULTS & PEDIATRICS	22, 962	0	3, 752	78, 032	0	
31. 00 43. 00	03100   INTENSIVE CARE UNIT   04300   NURSERY	5, 206	0	1, 615 148	33, 601 3, 074	0	
43.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	U	140	3, 074	0	43.00
50.00	05000 OPERATING ROOM	0	0	2, 755	57, 300	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö	293	6, 090	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	О	0	2, 628	0	0	54.00
60.00	06000 LABORATORY	0	0	2, 463	3, 674	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
65.00	06500 RESPI RATORY THERAPY	0	0	909	0	0	
66.00	06600 PHYSI CAL THERAPY	0	0	615	0	0	
66. 01	06601 CARDI AC REHAB	0	0	233	0	0	
69. 00 70. 00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY		0	16 127	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		0	0	0	100	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	655	0	0	1
	OUTPATIENT SERVICE COST CENTERS			,	-,		1
90.00	09000 CLI NI C	0	0	78	1, 630	0	90.00
91.00	09100 EMERGENCY	0	0	2, 344	48, 756	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	OTHER REIMBURSABLE COST CENTERS	-1			-1		4
95.00	09500 AMBULANCE SERVI CES	0	0	2, 622	0	0	
	09910 CORF	0	0	1 2/5	20 207	0	
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	0	1, 365	28, 387	0	101.00
113 00	11300 INTEREST EXPENSE	T					113.00
	11600 HOSPI CE	0	0	124	2, 569		116.00
118.00		1	o	25, 519			118.00
	NONREI MBURSABLE COST CENTERS	,	- 1				1
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	133	0		192. 00
	19201 DEKALB MEDI CAL SERVI CES	0	0	8, 033	0		192. 01
	19202 PHARMACARE	0	0	888	0		192.02
	19203  OUTSOURCED DIETICIAN   19204  BUSINESS HEALTH		0	0	0		192. 03 192. 04
	19204  BUSTNESS HEALTH   19300  NONPALD WORKERS		0	0	0		192.04
	07950 OTHER NONREIMBURSABLE COST CENT		0	0	0		194.00
	07951 ADULT DAY CARE		0	n	ol O		194.00
	07952 FOUNDATION		ol	100	o o		194. 02
200.00	1 1		٦	. 30	Ĭ	· ·	200.00
201.00							201.00
201.00	1 1 0	497, 525	0	717, 574	988, 875	512, 645	
202.00		i l					1
	Part I) Unit cost multiplier (Wkst. B, Part I)	17. 662773	0. 000000	20. 695469	ı	5, 126. 450000	

Health Fin	ancial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	CATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 10/01/2017 Fo 09/30/2018	Date/Time Pre 2/27/2019 3:1	
	Cost Center Description	DI ETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	·
		,	ŕ		(DI RECT NRS I NG)	(COSTED REQUIS.)	
		10. 00	10. 01	11. 00	13.00	14.00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	37, 893	0	103, 58	7 43, 296	45, 812	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 345250	0. 000000	2. 98754	0. 158517	458. 120000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet B-1 | From 10/01/2017 | To 09/30/2018 | Date/Time Prepared: Provider CCN: 15-0045

				To	09/30/2018   Date/Time Pre 2/27/2019 3:1	
	Cost Center Description	PHARMACY (COSTED	MEDI CAL	SOCI AL SERVI CE		
		REQUIS.)	RECORDS & LI BRARY	(TIME SPENT)		
			(GROSS REVE			
		15. 00	NUE) 16. 00	17. 00		
	GENERAL SERVICE COST CENTERS					1
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 MOB WEST					1.00
1. 02	00102 NORTH ANNEX					1. 02
1. 03	00103 GARRETT CLINIC					1.03
1.04	00104 BUTLER					1.04
1. 05 1. 07	00105 MOB EAST 00107 MEDICAL ARTS					1.05
1. 08	00108 SMALTZ WAY					1.08
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
10. 01 11. 00	01001 SNACK BAR 01100 CAFETERI A					10.01
	01300 NURSING ADMINISTRATION					13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY	100	1/7 100 710			15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	167, 122, 712 0	100		16.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	100		17.00
30.00	03000 ADULTS & PEDIATRICS	0	13, 035, 458			30.00
31.00	03100   NTENSI VE CARE UNI T	0	5, 221, 591	0		31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	575, 902	0		43.00
50.00	05000 OPERATING ROOM	O	23, 127, 930	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	2, 155, 248			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	30, 009, 365	0		54.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	23, 237, 755 0	0		60.00
65. 00	06500 RESPIRATORY THERAPY		4, 712, 956	0		65.00
66.00	06600 PHYSI CAL THERAPY	o	6, 244, 748	0		66.00
	06601 CARDI AC REHAB	0	644, 077	0		66. 01
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	1, 546, 168 865, 667	0		69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	11, 475, 266	0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0	O		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	100	6, 576, 240	0		73.00
00 00	OUTPATIENT SERVICE COST CENTERS		105 051			1 00 00
90. 00 91. 00	09100 EMERGENCY	0	185, 051 17, 987, 971	0		90.00
	09200 OBSERVATION BEDS (NON-DISTINCT		17,707,771			92.00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES	0	0	0		95.00
	09910 CORF 10100 HOME HEALTH AGENCY	0	0	0		99. 10
	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>		101.00
	11300 INTEREST EXPENSE					113.00
	11600 HOSPI CE	0	396, 054			116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100	147, 997, 447	100		118.00
	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0		190. 00
	19100 RESEARCH	0	0	0		191.00
	19200 PHYSI CLANS PRI VATE OFFI CES	0	14 000 030	0		192.00
	19201 DEKALB MEDICAL SERVICES 19202 PHARMACARE	0	14, 999, 839 4, 125, 426			192. 01 192. 02
	19203 OUTSOURCED DI ETI CI AN	o	0	Ö		192. 03
192.04	19204 BUSINESS HEALTH	0	0	0		192. 04
	19300 NONPALD WORKERS	0	0	0		193.00
	07950 OTHER NONREIMBURSABLE COST CENT 07951 ADULT DAY CARE	0	0	0		194. 00 194. 01
	07951 ADULT DAY CARE		0			194.01
200.00			J			200.00
201.00						201.00
		1				
201.00	Cost to be allocated (per Wkst. B,	968, 670	1, 203, 195	135, 821		202.00
	Cost to be allocated (per Wkst. B, Part I)			135, 821 1, 358. 210000		202.00

Heal th Fina	ncial Systems	DEKALB MEMORI.	AL HOSPITAL		In Lie	u of Form CMS-255	52-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider CO		Peri od: From 10/01/2017 To 09/30/2018	Worksheet B-1 Date/Time Prepar 2/27/2019 3:17 p	
	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)			
		15. 00	16. 00	17. 00			
204. 00	Cost to be allocated (per Wkst. B, Part II)	43, 803	84, 078	6, 71	6	204	04.00
205. 00	Unit cost multiplier (Wkst. B, Part	438. 030000	0. 000503	67. 16000	00	205	5. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					200	6. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					20	7. 00

Heal th	Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od: From 10/01/2017 To 09/30/2018	Date/Time Pre 2/27/2019 3:1	pared: 7 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs  RCE  Di sal I owance	Total Costs	
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	5, 457, 423		5, 457, 42	3 0	5, 457, 423	30.00
	03100 INTENSIVE CARE UNIT	2, 341, 977		2, 341, 97		2, 341, 977	
43.00	04300 NURSERY	248, 232		248, 23	2 0	248, 232	43.00
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	4, 299, 998		4, 299, 99		4, 300, 069	
	05200 DELIVERY ROOM & LABOR ROOM	1, 307, 147		1, 307, 14		1, 307, 147	
	05400 RADI OLOGY-DI AGNOSTI C	3, 975, 141		3, 975, 14		3, 975, 141	
	06000 LABORATORY	4, 355, 155		4, 355, 15	5 0	4, 355, 155	
	06001 BLOOD LABORATORY	0	_		0 0	0	
	06500 RESPI RATORY THERAPY	1, 044, 929		1, 044, 92		1, 044, 929	
66.00	06600 PHYSI CAL THERAPY	2, 242, 945		2, 242, 94		2, 242, 945	
66. 01	06601 CARDI AC REHAB	376, 102	0	376, 10	12 0	376, 102	66. 01

80, 587

94, 075

94, 581

2, 835, 821

1,643,442

4, 680, 658

3, 098, 675

1, 369, 248

1, 966, 690

1, 465, 088

451, 626

43, 429, 540

1, 369, 248

42, 060, 292

80, 587

94, 075

94, 581

2, 835, 821

1, 643, 442

4, 680, 658

3, 098, 675

1, 369, 248

1, 966, 690

1, 465, 088

451, 626

43, 429, 540

1, 369, 248

42, 060, 292

ol

80, 587

94, 075

2, 835, 821

1, 643, 442

4, 680, 658

3, 098, 675

1, 369, 248

1, 966, 690

0 99. 10

451, 626 116. 00

43, 429, 611 200. 00

1, 369, 248 201. 00

42, 060, 363 202. 00

1, 465, 088 101. 00

94, 581

0 0 0

0

71

71

69.00

70.00

71.00

72.00

73.00

90.00

91.00

92.00

95.00

113.00

69. 00 06900 ELECTROCARDI OLOGY

09000 CLI NI C

99. 10 09910 CORF

116. 00 11600 HOSPI CE

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

101.00 10100 HOME HEALTH AGENCY

113. 00 11300 | I NTEREST EXPENSE

71.00

72.00

73.00

90.00

91.00

92.00

200.00

201.00

202.00

07000 ELECTROENCEPHALOGRAPHY

07100 MEDICAL SUPPLIES CHARGED TO PAT

07200 IMPL. DEV. CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS

SPECIAL PURPOSE COST CENTERS

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0045	Peri od: Worksheet C From 10/01/2017 Part I To 09/30/2018 Date/Ti me Prepared:

				Т	o 09/30/2018	Date/Time Pre 2/27/2019 3:1	
			Title	XVIII	Hospi tal	PPS	
			Charges	<u> </u>			
	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						
	03000 ADULTS & PEDIATRICS	11, 063, 766		11, 063, 766			30.00
	03100 INTENSIVE CARE UNIT	4, 854, 316		4, 854, 316			31.00
43.00	04300 NURSERY	575, 902		575, 902	)		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	4, 617, 871	18, 132, 487	22, 750, 358	0. 189008	0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	2, 096, 555	45, 573	2, 142, 128		0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 455, 386	27, 048, 243	29, 503, 629		0.000000	54.00
	06000 LABORATORY	3, 595, 847	21, 419, 669	25, 015, 516		0.000000	60.00
	06001 BLOOD LABORATORY	0	0	C	0. 000000	0.000000	60. 01
65.00	06500 RESPI RATORY THERAPY	3, 327, 192	1, 319, 500	4, 646, 692	0. 224876	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	923, 464	5, 217, 889	6, 141, 353	0. 365220	0.000000	66.00
66. 01	06601 CARDI AC REHAB	16, 932	616, 130	633, 062	0. 594100	0.000000	66. 01
69.00	06900 ELECTROCARDI OLOGY	230, 702	1, 289, 875	1, 520, 577	0. 052998	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 881	848, 889	850, 770	0. 110576	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	3, 659, 680	4, 450, 023	8, 109, 703	0. 349682	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 384, 169	882, 121	3, 266, 290	0. 503153	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 004, 863	5, 462, 638	6, 467, 501	0. 723720	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	857	181, 012	181, 869	0. 520050	0.000000	90.00
91.00	09100 EMERGENCY	2, 440, 922	15, 224, 531	17, 665, 453	0. 175409	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	155, 000	3, 292, 637	3, 447, 637	0. 397156	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 753	6, 693, 857	6, 695, 610	0. 293728	0.000000	95.00
99. 10	09910 CORF	0	0	C			99. 10
101.00	10100 HOME HEALTH AGENCY	0	1, 438, 851	1, 438, 851			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	20, 903	375, 151	396, 054			116. 00
200.00	Subtotal (see instructions)	43, 427, 961	113, 939, 076	157, 367, 037	'		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	43, 427, 961	113, 939, 076	157, 367, 037	'l l		202. 00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0045		Worksheet C Part I Date/Time Prepared: 2/27/2019 3:17 pm
	T1.11 \0.0111		000

					2/27/2019 3:1	7 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT					31.00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 189011				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 610210				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 134734				54.00
60.00	06000 LABORATORY	0. 174098				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60.01
65.00	06500 RESPI RATORY THERAPY	0. 224876				65.00
66.00	06600 PHYSI CAL THERAPY	0. 365220				66.00
66. 01	06601 CARDI AC REHAB	0. 594100				66.01
69.00	06900 ELECTROCARDI OLOGY	0. 052998				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 110576				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 349682				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 503153				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 723720				73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 520050				90.00
91.00	09100 EMERGENCY	0. 175409				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 397156				92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0. 293728				95.00
99. 10	09910 CORF					99. 10
101.00	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300 I NTEREST EXPENSE					113.00
116.00	11600 HOSPI CE					116. 00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds				ļ	201.00
202.00	Total (see instructions)				ļ	202. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 10/01/2017 To 09/30/2018		pared: 7 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3. 00	4. 00	5. 00	

				e ALA	поѕрі таі	COST	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 457, 423		5, 457, 423	0	5, 457, 423	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 341, 977		2, 341, 977		2, 341, 977	
	04300 NURSERY	248, 232		248, 232		248, 232	
	ANCILLARY SERVICE COST CENTERS		·		- 1		
	05000 OPERATING ROOM	4, 299, 998		4, 299, 998	71	4, 300, 069	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 307, 147		1, 307, 147		1, 307, 147	
	05400 RADI OLOGY-DI AGNOSTI C	3, 975, 141		3, 975, 141	0	3, 975, 141	
	06000 LABORATORY	4, 355, 155		4, 355, 155	0	4, 355, 155	
	06001 BLOOD LABORATORY	0		0	0	0	1
	06500 RESPI RATORY THERAPY	1, 044, 929	0	1, 044, 929	0	1, 044, 929	
	06600 PHYSI CAL THERAPY	2, 242, 945		2, 242, 945	0	2, 242, 945	
	06601 CARDI AC REHAB	376, 102		376, 102		376, 102	
	06900 ELECTROCARDI OLOGY	80, 587		80, 587		80, 587	
	07000 ELECTROENCEPHALOGRAPHY	94, 075		94, 075		94, 075	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	2, 835, 821		2, 835, 821	0	2, 835, 821	
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 643, 442		1, 643, 442	-	1, 643, 442	
	07300 DRUGS CHARGED TO PATIENTS	4, 680, 658		4, 680, 658		4, 680, 658	
	OUTPATIENT SERVICE COST CENTERS	1, 000, 000		1,000,000	<u> </u>	1, 000, 000	70.00
	09000 CLI NI C	94, 581		94, 581	0	94, 581	90.00
	09100 EMERGENCY	3, 098, 675		3, 098, 675		3, 098, 675	
	09200 OBSERVATION BEDS (NON-DISTINCT	1, 369, 248	l .	1, 369, 248		1, 369, 248	
	OTHER REIMBURSABLE COST CENTERS	1,007,210		1,007,210		1,007,210	72.00
	09500 AMBULANCE SERVICES	1, 966, 690		1, 966, 690	0	1, 966, 690	95.00
	09910 CORF	1, 700, 070		1, 700, 070	Ö	0,700,070	1
	10100 HOME HEALTH AGENCY	1, 465, 088		1, 465, 088		1, 465, 088	
	SPECIAL PURPOSE COST CENTERS	1, 403, 000		1, 403, 000		1, 403, 000	1101.00
	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	451, 626		451, 626		451, 626	
200.00	Subtotal (see instructions)	43, 429, 540				43, 429, 611	
200.00	Less Observation Beds	1, 369, 248		1, 369, 248		1, 369, 248	
201.00	Total (see instructions)	42, 060, 292				42, 060, 363	
202.00	Total (See Histractions)	42,000,292	1	42,000,292	/ 1]	42,000,303	1202.00

Health Financial Systems	DEKALB MEMORIAL HOSPITA	ıL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi d	er CCN: 15-0045	From 10/01/2017	Worksheet C Part I Date/Time Prepared:

						10 09/30/2018	2/27/2019 3:1	
				Ti tl	e XIX	Hospi tal	Cost	
				Charges				
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·	·	·	+ col. 7)	Rati o	I npati ent	
							Rati o	
			6. 00	7. 00	8. 00	9. 00	10.00	
		IENT ROUTINE SERVICE COST CENTERS						
		ADULTS & PEDIATRICS	11, 063, 766		11, 063, 76	5		30.00
31.00	03100	INTENSIVE CARE UNIT	4, 854, 316		4, 854, 31	5		31.00
43.00	04300	NURSERY	575, 902		575, 90	2		43.00
	ANCI L	LARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4, 617, 871	18, 132, 487			0. 000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2, 096, 555	45, 573	2, 142, 12	0. 610210	0.000000	52.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	2, 455, 386	27, 048, 243	29, 503, 62	9 0. 134734	0.000000	54.00
60.00	06000	LABORATORY	3, 595, 847	21, 419, 669	25, 015, 51		0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0		0.000000	0.000000	60. 01
65.00	06500	RESPI RATORY THERAPY	3, 327, 192	1, 319, 500	4, 646, 69	0. 224876	0.000000	65.00
66.00	06600	PHYSI CAL THERAPY	923, 464	5, 217, 889	6, 141, 35	0. 365220	0.000000	66.00
66. 01	06601	CARDI AC REHAB	16, 932	616, 130	633, 06	0. 594100	0.000000	66. 01
69.00	06900	ELECTROCARDI OLOGY	230, 702	1, 289, 875	1, 520, 57	7 0. 052998	0.000000	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	1, 881	848, 889	850, 77	0. 110576	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3, 659, 680	4, 450, 023	8, 109, 70	0. 349682	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2, 384, 169	882, 121	3, 266, 29	0. 503153	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1, 004, 863	5, 462, 638	6, 467, 50	0. 723720	0.000000	73.00
	OUTPA	TIENT SERVICE COST CENTERS						
90.00	09000	CLI NI C	857	181, 012	181, 86	9 0. 520050	0.000000	90.00
91.00	09100	EMERGENCY	2, 440, 922	15, 224, 531	17, 665, 45	0. 175409	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	155, 000	3, 292, 637	3, 447, 63	7 0. 397156	0.000000	92.00
	OTHER	REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1, 753	6, 693, 857	6, 695, 61	0. 293728	0.000000	95. 00
99. 10	09910	CORF	o	0		o		99. 10
101.00	10100	HOME HEALTH AGENCY	o	1, 438, 851	1, 438, 85	1		101.00
	SPECI.	AL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113. 00
116.00	11600	HOSPI CE	20, 903	375, 151	396, 05	4		116.00
200.00		Subtotal (see instructions)	43, 427, 961	113, 939, 076	157, 367, 03	7		200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43, 427, 961	113, 939, 076	157, 367, 03	7		202. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0045	From 10/01/2017	Worksheet C Part I Date/Time Pre 2/27/2019 3:1	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				

	Title XIX	Hospi tal	Cost
PPS Inpatient			
Ratio			
11. 00			
			30.00
			31.00
			43.00
0. 000000			50.00
0. 000000			52.00
0. 000000			54.00
0. 000000			60.00
0. 000000			60.01
0. 000000			65.00
0. 000000			66.00
0. 000000			66.0
0. 000000			69.00
0. 000000			70.00
0. 000000			71.00
0. 000000			72.00
0. 000000			73.00
0. 000000			90.00
0. 000000			91.00
0. 000000			92.00
0. 000000			95. 00
			99. 10
			101. 0
			113. 00
			116.00
			200. 00
			201. 00
			202. 00
	0. 000000 0. 000000	PPS Inpatient Ratio 11.00  0.000000 0.000000 0.000000 0.000000	Ratio 11.00  0.000000 0.000000 0.000000 0.000000

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2017 Fo 09/30/2018		narod:
				10 077 307 2010	2/27/2019 3:1	7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	481, 857	0	481, 85	6, 134	78. 56	30.00
31.00   INTENSIVE CARE UNIT	195, 895		195, 89	1, 125	174. 13	31.00
43. 00 NURSERY	31, 617		31, 61	7 760	41. 60	43.00
200.00 Total (lines 30 through 199)	709, 369		709, 36	8, 019		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, 451	113, 991			l	30.00
31.00 INTENSIVE CARE UNIT	434	75, 572			ļ	31.00
43. 00 NURSERY	0	0			ļ	43.00
200.00 Total (lines 30 through 199)	1, 885	189, 563				200. 00

Health Financial Systems	DEKALB MEMORI	AL HOSDITAL		In Lie	u of Form CMS-2	neen 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II	pared:
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II,	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Coston to Charges (col. 1 ÷ col. 2)	t Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	col . 26)	2.00	2.00	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
50. 00 O5000 OPERATING ROOM	628, 218	22, 750, 358	0. 02761	4 1, 128, 363	31, 159	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	452, 862					52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	349, 547					
60. 00 06000 LABORATORY	194, 144		•			
60. 01   06001   BLOOD   LABORATORY	0		0.00000		1	60.01
65. 00 06500 RESPIRATORY THERAPY	46, 635					
66. 00   06600   PHYSI CAL THERAPY	187, 158					66.00
66. 01   06601   CARDI AC   REHAB	91, 387			· ·		
69. 00 06900 ELECTROCARDI OLOGY	1, 290					
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 665			· ·	l	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	66, 640				5, 607	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 043	3, 266, 290	0.00338	1 948, 880	3, 208	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	73, 602	6, 467, 501	0. 01138	0 634, 749	7, 223	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 442	181, 869	0. 00792	9 465	4	90.00
91. 00 09100 EMERGENCY	295, 047	17, 665, 453	0. 01670	2 1, 028, 809	17, 183	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT	120, 896	3, 447, 637	0. 03506	6 150, 463	5, 276	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	2, 521, 576	132, 342, 538		9, 662, 164	128, 047	200.00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Period: From 10/01/2017 Fo 09/30/2018	Worksheet D Part III Date/Time Pre 2/27/2019 3:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	.,,	11.00		2.00	0.00	
30.00   03000   ADULTS & PEDIATRICS 31.00   03100   INTENSIVE CARE UNIT 43.00   04300   NURSERY 200.00   Total (lines 30 through 199)	0 0 0	0 0 0 0	(	0 0 0 0 0 0		31.00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	(col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   31.00   03100   INTENSIVE CARE UNIT   43.00   04300   NURSERY   200.00   Total (lines 30 through 199)	0	0 0 0	1, 125 760	0. 00 0. 00	1, 451 434 0 1, 885	31.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
30.00   03000   ADULTS & PEDIATRICS   31.00   03100   INTENSIVE CARE UNIT   43.00   04300   NURSERY   Total (lines 30 through 199)	0 0 0					30. 00 31. 00 43. 00 200. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0045	Peri od: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 3:17 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	Non Physician	Nursing Nursing	Allied Health	Allied Health

				'		2/27/2019 3:1	7 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	0	0	C	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
66. 01	06601 CARDI AC REHAB	0	0	C	0	0	66. 01
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	C	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	0	0	C	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0		C		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					·	95.00
200.00	Total (lines 50 through 199)	0	0	[ C	0	0	200. 00

Health Financial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS				Period: From 10/01/2017	Worksheet D	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient	Total Charges (from Wkst.	Ratio of Cost to Charges	

					2/27/2019 3: 1	7 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	C	22, 750, 358		
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	C	2, 142, 128		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	29, 503, 629		
60. 00   06000   LABORATORY	0	0	C	25, 015, 516	0. 000000	60.00
60. 01  06001   BLOOD LABORATORY	0	0	C	0	0. 000000	60. 01
65. 00   06500   RESPI RATORY THERAPY	0	0	C	4, 646, 692	0. 000000	65.00
66. 00  06600 PHYSI CAL THERAPY	0	0	C	6, 141, 353	0. 000000	66.00
66. 01   06601   CARDI AC REHAB	0	0	C	633, 062	0. 000000	66. 01
69. 00   06900   ELECTROCARDI OLOGY	0	0	C	1, 520, 577	0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	850, 770	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	C	8, 109, 703	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	3, 266, 290	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	6, 467, 501	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	181, 869	0.000000	90.00
91. 00 09100 EMERGENCY	0	0	C	17, 665, 453	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0	C	3, 447, 637	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES					<u>'</u>	95.00
200.00 Total (lines 50 through 199)	0	0	( C	132, 342, 538		200.00

Heal th	Financial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS		Provi der Co		Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Pre 2/27/2019 3:1	pared:
				XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	0. 000000	1, 128, 363		0 3, 956, 635		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	6, 241		0	0	52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 000000	1, 539, 728		0 5, 127, 326		
60.00	06000 LABORATORY	0. 000000	1, 634, 804		0 1, 663, 870	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0. 000000	1, 371, 802		0 172, 258	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	375, 737		0 65, 287	0	66.00
66. 01	06601 CARDI AC REHAB	0. 000000	5, 458		0 183, 003	0	66. 01
69.00	06900 ELECTROCARDI OLOGY	0. 000000	154, 315		0 271, 649	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 26, 280	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 000000	682, 350		0 520, 612	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	948, 880		0 644, 987	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	634, 749		0 1, 849, 683	0	73.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
90.00	09000 CLI NI C	0. 000000	465		0 73, 113	0	90.00
91.00	09100 EMERGENCY	0. 000000	1, 028, 809		0 2, 311, 201		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 000000	150, 463		573, 380		92.00
50	OTHER REIMBURSABLE COST CENTERS	1. 111000			2.27000		1
95.00	09500 AMBULANCE SERVI CES						95.00
200.00		1	9, 662, 164		0 17, 439, 284	0	200. 00

Health Financial Systems	DEKALB MEMORIAL I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0045	Peri od: From 10/01/2017	Worksheet D Part V

AFFORTI	ONWENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Frovider C	F	From 10/01/2017 To 09/30/2018	Part V Date/Time Pre 2/27/2019 3:1	
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	0. 189008			0	747, 836	1
	05200 DELIVERY ROOM & LABOR ROOM	0. 610210		(	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0. 134734			0	690, 825	1
	06000 LABORATORY	0. 174098		(	0	289, 676	1
	06001 BLOOD LABORATORY	0. 000000		(	0	0	
	06500 RESPI RATORY THERAPY	0. 224876	172, 258		0	38, 737	1
	06600 PHYSI CAL THERAPY	0. 365220	· ·		0	23, 844	
	06601 CARDI AC REHAB	0. 594100			0	108, 722	
	06900 ELECTROCARDI OLOGY	0. 052998	· ·	•	0	14, 397	
	07000 ELECTROENCEPHALOGRAPHY	0. 110576	· ·		0	2, 906	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 349682	•	•	0	182, 049	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 503153		•	0	324, 527	
	07300 DRUGS CHARGED TO PATIENTS	0. 723720	1, 849, 683	(	7, 977	1, 338, 653	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 520050			1	38, 022	
	09100 EMERGENCY	0. 175409			93	405, 405	
	09200 OBSERVATION BEDS (NON-DISTINCT	0. 397156	573, 380	(	0	227, 721	92.00
	OTHER REIMBURSABLE COST CENTERS	1					
	09500 AMBULANCE SERVICES	0. 293728					95.00
200.00	Subtotal (see instructions)		17, 439, 284		8, 070	4, 433, 320	
201. 00	Less PBP Clinic Lab. Services-Program				0		201.00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		17, 439, 284	(	8, 070	4, 433, 320	J202. 00

Health Financial Systems	DEKALB MEMOR	IAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der C	CN: 15-0045	From 10/01/2017	Worksheet D Part V Date/Time Pre 2/27/2019 3:1	
		Title	e XVIII	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost	Cost				

					2/27/2019 3:17 pm
		Title	XVIII	Hospi tal	PPS
	Cos	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
		Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM	0	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0			54.00
60. 00   06000   LABORATORY	0	0			60.00
60. 01 06001 BLOOD LABORATORY	0	0			60. 01
65. 00 06500 RESPI RATORY THERAPY	0	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0			66. 00
66. 01   06601   CARDI AC REHAB	0	0			66. 01
69. 00 06900 ELECTROCARDI OLOGY	0	0			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	5, 773			73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	0			90.00
91. 00   09100   EMERGENCY	0	16			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT		0			92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	0				95. 00
200.00 Subtotal (see instructions)	0	5, 789			200. 00
201.00 Less PBP Clinic Lab. Services-Pro	gram 0				201. 00
Only Charges					
202.00   Net Charges (line 200 - line 201)	0	5, 789			202. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0045	Peri od: From 10/01/2017	Worksheet D-1	
			To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1 00 Innotiont days (including private from days	and suing had day	o oveludina newbern)		4 124	1 00

		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS		I	1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			6, 134	1. 00
2.00	Inpatient days (including private room days, excluding swing-			6, 134	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only pr	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation b	ned days)		4, 595	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private re	oom days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om davs) through December	31 of the cost	0	7. 00
7.00	reporting period	uays) till oagii becellber	01 01 110 0031	· ·	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	La the Breeze Coult II a		4 454	0.00
9. 00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	swing-bed and	1, 451	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	room days)	0	10. 00
	through December 31 of the cost reporting period (see instruc		,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, & Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	X only (Therading privat	le room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	14. 00 15. 00
	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT		<u>'</u>		
17. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 c	of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18. 00
10.00	reporting period	des arter becember 31 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	os after December 21 of t	ho cost	0.00	20. 00
20.00	reporting period	es arter becember 31 or t	ille cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction			5, 457, 423	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	ng period (line A	0	23. 00
23.00	x line 18)	or the cost reportin	ig perrod (Trile d	O	23.00
24.00	] 3 11	er 31 of the cost reporti	ng period (line	0	24.00
25 00	7 x line 19)	21 of the cost reporting	nonied (line O	0	25 00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	perrod (Trie 8	U	25. 00
26.00				0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 457, 423	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-be	nd and observation had sh	argas)	0	28. 00
	Private room charges (excluding swing-bed charges)	ed and observation bed cr	iai yes)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nua lina 22) (ana inatrua	v+i ono)	0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		. (1 0115)	0. 00 0. 00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 457, 423	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see		T	889. 70	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			1, 290, 955	39.00
	Medically necessary private room cost applicable to the Progr			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	7 + IINE 4U)		1, 290, 955	41.00

Cost Center Description		Financial Systems	DEKALB MEMORIA		ON 45 0045		u of Form CMS-2	
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F		Worksheet D-1 Date/Time Pre	
Total   Input tent   Input te					20011		2/27/2019 3:1	
1.00		Cost Center Description	I npati ent	Total I npati ent	Average Per Diem (col. 1		Program Cost (col. 3 x	
MISSIEV (FITE V & XIX POLY)   C.   C.   C.   C.   C.   C.   C.   C						4.00		
	42. 00							42.00
44.00   GRONARY CARE UNIT	42.00		2 244 077	1 100	2 001 7	124	002 404	1 42 00
1 00	44. 00 45. 00 46. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	2, 341, 9//	1, 125	2,081.76	5 434	903, 484	43.00 44.00 45.00 46.00 47.00
48.00   Program Inpati ent and Illary service cost (Rist. D-3, col. 3, line 200)   2, 582, 164   48.00   Total Program Inpatient costs (sum of lines 41 through 48) (see instructions)   4, 776, 603   4, 905   785   Through costs applicable to Program Inpatient routine services (from Wist. D, sum of Parts I and 189, 563   50.00   Pass through costs applicable to Program Inpatient routine services (from Wist. D, sum of Parts II and III)   128, 047   51.00   785   7		Cost Center Description					1.00	
47.00   Program inpatient costs (sum of lines 41 through 48)(see instructions)   4.776,603   47.00   49.00   ABSS THROUGH COST ADUSTNEYNS   50.00   ABSS THROUGH COST ADUSTNEYNS   50.00   ABSS THROUGH COST ADUSTNEYNS   50.00   50.00   1115   50.00   50.	48 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)				48 00
50.00 Passs through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 189, 563 and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 128,047 51.00 and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4,458,943 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4,458,943 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4,458,943 53.00 Total Program inpatient operating cost and target amount (line 56 minus III of 50 55.00 Total Program inpatient operating cost and target amount (line 56 minus III of 53) 55.00 Target amount (line 54 x line 55) 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus III of 53) 57.00 Difference between adjusted inpatient operating period ending 1996, updated and compounded by the 59.00 market basket 60.00 Lesser of II inse 33/54 or 55 from prior year cost report; updated by the market basket 60.01 Classer of II inse 53/54 or 55 from prior year cost report; updated by the market basket 60.01 Classer of II inse 53/54 or 55 from prior year cost report; updated by the market basket 60.02 Relate payment (see instructions) 60.03 Allowable Inpatient cost plus incentive payment (see instructions) 60.04 Modicare swing-bed SNF inpatient routine costs (line 64 plus III of 65) of the target amount (line 50), otherwise enter zero (see Instructions) 60.00 Modicare swing-bed SNF inpatient routine costs (line 64 plus III of 65) (title XVIII only) 60.00 Total Medicare swing-bed SNF inpatient routine costs (line 67 + line 68) 60.01 Title Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.01 Title Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.01 Title Vor XIX swing-bed NF in		Total Program inpatient costs (sum of lines			ons)			
and IV)  13.00 Total Program excludable cost (sum of lines 50 and 51)  13.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and d. 4.488,993 (s. 3.00 medical education costs (line 4.9 minus line 52)  14.488,993 (s. 3.00 medical education costs (line 4.9 minus line 5.2)  15.00 Program discharge  10.54.00 Program discharges  10.55.00 Target amount (line 54 x line 55)  10.00 Estable amount (line 55 and 55 from the cost reporting period ending 1996, updated and compounded by the market basket  10.00 Estable amount (line 53/54 or 55 from prior year cost report, updated by the market basket  10.00 Estable amount (line 56), otherwise enter zero (see instructions)  10.00 Estable amount (line 56), otherwise enter zero (see instructions)  10.00 Estable amount (line 56), otherwise enter zero (see instructions)  10.00 Estable payment (see instructions)  10.00 Establ	50. 00	Pass through costs applicable to Program inp	atient routine s	services (fro	m Wkst. D, sum	of Parts I and	189, 563	50.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and education costs (line 49 minus line 52)	51. 00	1 3 11	atient ancillary	y services (f	rom Wkst. D, s	um of Parts II	128, 047	51.00
54.00   Program discharges   0.6 4.00   55.00   Target amount per discharge   0.05   55.00   Target amount per discharge   0.05   55.00   Target amount (line 54 x line 55)   0.5   65.00   Target amount (line 54 x line 55)   0.5   65.00   0.05   65.00   0.05   65.00   0.05   65.00   0.05   65.00   0.05   65.00   0.00   0.05   65.00   0.05   0.		Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital rel	ated, non-ph	ysician anesth	etist, and		
55.00 Target amount per discharge 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Reli ef payment (see instructions) 63.00 Allowable inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (lile 12 x line 19) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (See instructions) 67.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inle 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inle 13 x line 20) 69.00 Total Hille V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 79) 79.00 Aggregar charges to penefic all patient routine service costs (fine 70 + line 2) 79.00 Paggregar charges to penefic all patient routine service costs (fine 70 + line 2) 79.00 Aggregar charges to	E 4 .00							
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Loser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Loser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 Loser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relicef payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (lite XVIII only). For CAM (see instructions) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (see instructions) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (see instructions) 67.00 If lite V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total field nursing facility/doft-nursing facility/doft-nur								
58.00 Bonus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.01 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  60.00 Relider payment (see instructions)  60.10 Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See Instructions) tille XVII in only)  60.10 Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See Instructions) tille XVII in only)  60.10 Total Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions)  60.11 Litle V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See Instructions)  60.11 Litle V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  60.12 Line 12 x line 19)  60.13 Litle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  60.14 Litle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  60.15 Line 14 Line SWE Line SWE AGE ACCILITY, Offler NURSING EACLITY, AND LECFILD ONLY  60.16 Line 31 x line 20)  61.17 Line 14 Line 32 Line 34 Line 35 Line 37 Line 37 Line 37 Line 38 Line 39 Line							1	1
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the analyst basket basket of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 fol.00 lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00 Allowable Inpatient pour line service costs (line 64 plus line 65) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only) 66.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title v or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title v or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title v or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 Total title v or XIX swing-bed NF inpatient routine service cost (line 67 + line 28) 70.00 Skilled outside parenal inpatient routine service costs (line 70 + line 29) 71.00 Aljusted general inpatient routine service costs (line 72 + line 2) 71.00 Per diem capital related costs (line 75 + line 2) 72.00 Per gram (routine service cost (line 75 + line 2) 73.00 Unpatient routine service costs (line 77 + line 2) 74.00 Total Program contracts of the cost per diem (line 10 x line 1			ing cost and tar	get amount (	line 56 minus	line 53)		
6.0.0 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 6.0.0 line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 7.0.0 Relief payment (see instructions) 8.0.1 Relief payment (see instructions) 8.0.1 Relief payment (see instructions) 8.0.2 Relief payment (see instructions) 8.0.1 Relief payment (see instructions) 8.0.2 Relief payment (see instructions) 8.0.3 Relief payment (see instructions) 8.0.4 Relief payment (see instructions) 8.0.5 Relief payment (see instructions) 8.0.4 Relief payment (see instructions) 8.0.5 Relief payment (see instructions) 8.0.6 Relief payment (see instructions) 8.0.7 Relief payment (see instructions) 8.0.7 Relief payment (see instructions) 8.0.8 Relief payment (see instructions) 8.0.8 Relief payment (see instructions) 8.0.8 Relief pa		Lesser of lines 53/54 or 55 from the cost re	· ·					
61.00   If line 53/54 is less than the lower of lines 55, 50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)   0 62.00	60.00		cost renort und	dated by the	market hasket		0.00	60.00
Allowable Inpatient cost plus incentive payment (see instructions)   PARCAMAN INPATIENT ROUTINE SWING BED COST		00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						1
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  70.00 Skilled nursing facility/Other nursing facility/LGF/ID routine service cost (line 37)  70.00 Skilled nursing facility/Other nursing facility/LGF/ID routine service cost (line 37)  70.00 Pogram routine service cost (line 9 x line 71)  71.00 Agusted general inpatient routine service costs (line 2)  72.00 Program general inpatient routine service costs (line 14 x line 35)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Per diem capital -related costs (line 75 + line 2)  76.00 Per diem capital -related costs (line 75 + line 76)  77.00 Program capital related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 75 + line 27)  80.00 Total Program routine service cost (line 75 + line 27)  80.00 Total Program routine service cost (line 75 + line 27)  80.00 Total Program routine service cost (line 75 + line 27)  80.00 Total Program routine service cost (line 9 x line 76)  80.00 Total Program inpatient routine service cost (see instructions)  80.00 Reasonable inpatient routine service cost (see instructions)  81.00 Reasonable inpatient routine service cost (see instr		63.00 Allowable Inpatient cost plus incentive payment (see instructions)						
65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)   CAH (see instructio	64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						0	64.00
Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)   CAH (see instructions)	65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reporting	period (See	0	65.00
Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)   Record   Color	66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line	65)(title XVII	l only). For	0	66.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adj usted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to benefici aries for excess costs (from provider records)  80.00 Total Program routine service cost per diem limitation  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  71.00 Aggregate Charges inpatient routine cost per diem (line 27 + line 2)  889.70 889.70	67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 74 minus line 77)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service cost (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  889.70 880.00	68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	rting period	0	68. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.10 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 889.70 889.70		PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY		0	
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76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Beson the minus line 79 87.00 Records minus line 79 88.00 Adjusted general inpatient costs (line 74 minus line 77) 87.00 Records minus line 79 88.00 Adjusted general inpatient costs (line 74 minus line 77) 87.00 Records minus line 79 88.00 Records minus line 79 89.00		Capital-related cost allocated to inpatient	•		,	art II, column		74.00 75.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 889.70 88.00		Per diem capital-related costs (line 75 ÷ li						76.00
Aggregate charges to beneficiaries for excess costs (from provider records)  79.00  80.00  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00  Inpatient routine service cost per diem limitation  81.00  Reasonable inpatient routine service costs (see instructions)  84.00  Program inpatient ancillary services (see instructions)  85.00  Utilization review - physician compensation (see instructions)  86.00  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00  Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  889.70		, ,	,					
81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  889.70 88.00		,	,	rovi der recor	ds)			79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Program inpatient ancillary services (see instructions)  84.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  889.70 88.00				ost limitatio	n (line 78 min	us line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  84.00 84.00 85.00 86.00								
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Recompleted and the servation of								83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				•				84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			•					85.00
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  1,539 87.00  889.70 88.00	86. 00			rough 85)				86.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 889.70 88.00	87. 00						1. 539	87. 00
	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			889. 70	88. 00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2017 To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	481, 857	5, 457, 423	0. 08829	4 1, 369, 248	120, 896	90.00
91.00 Nursing School cost	0	5, 457, 423	0.00000	0 1, 369, 248	0	91.00
92.00 Allied health cost	0	5, 457, 423	0.00000	0 1, 369, 248	0	92.00
93.00 All other Medical Education	o	5, 457, 423	0. 00000	0 1, 369, 248	0	93. 00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0045	Peri od:	Worksheet D-1	
			From 10/01/2017		
			To 09/30/2018		
				2/27/2019 3:1	7 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 day	rs, excluding newborn)		6, 134	1.00

	Title XIX   Hospital	Cost	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6, 134	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6, 134	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
4 00	do not complete this line.	4 505	4. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	4, 595 0	5. 00
5.00	reporting period	U	5.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
0.00	reporting period		0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	128	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	· ·	.2.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	14. 00 15. 00
15. 00 16. 00	Nursery days (title V or XIX only)	760 0	16.00
10.00	SWING BED ADJUSTMENT	0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
17.00	reporting period	0.00	17.00
20.00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	5, 457, 423	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line $5 \times 1$ ) x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25 00	7 x line 19)		25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 457, 423	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00 30. 00	Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)	0	29. 00 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 minus line 33)(see instructions)	0. 00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	0 5 457 422	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5, 457, 423	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	889. 70	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	113, 882	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total Program general inpatient routine service cost (line 39 + line 40)	0 113, 882	40. 00 41. 00
+1.00	protai program general impatrient routine service cost (TINE 37 + TINE 40)	113,002	4 I. UU

6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	U	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	128	9. 00
7. 00	newborn days)	120	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	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 only (including private room days)	0	13.00
14 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14. 00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)  Total nursery days (title V or XIX only)	760	
16. 00	Nursery days (title V or XIX only)	0	
10.00	SWING BED ADJUSTMENT	0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18.00
	reporting period		
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20.00	reporting period	0.00	20. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	5, 457, 423	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line $\phi$	0	23.00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
23.00	x line 20)	U	23.00
26.00	Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 457, 423	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Pri vate 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)		32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0. 00 0	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		
37.00	27 minus line 36)	3, 437, 423	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	889. 70	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	113, 882	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	113, 882	41. 00

Heal th	Financial Systems DEKALB MEMORIAL HOSPITAL In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0045 Period: From 10/01/2017	Worksheet D-1	
	To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
	Title XIX Hospital	Cost	, p
	Cost Center Description Total Total Average Per Program Days  Inpatient Inpatient Diem (col. 1	Program Cost (col. 3 x	
	Cost         Days         ÷ col . 2)           1.00         2.00         3.00         4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only) 248, 232 760 326. 62 0		42.00
43. 00	Intensive Care Type Inpatient Hospital Units  INTENSIVE CARE UNIT 2,341,977 1,125 2,081.76 0	0	43.00
44. 00	CORONARY CARE UNIT		44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	115, 667	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)  PASS THROUGH COST ADJUSTMENTS	229, 549	49. 00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	O	53.00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)	0.00	55. 00 56. 00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	58. 00 59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60. 00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0.00	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 payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
	(line 12 x line 19)		
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71. 00 72. 00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00	Program capital-related costs (line 9 x line 76)		77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)		78. 00 79. 00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)	1, 539	
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	889. 70 1, 369, 248	
57.00	Table tall on 200 door (time of x time oo) (door instructions)	1, 307, 240	37.00

Health Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2017 To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
Title XIX				Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	481, 857	5, 457, 423	0. 08829	4 1, 369, 248	120, 896	90.00
91.00 Nursing School cost	0	5, 457, 423	0.00000	0 1, 369, 248	0	91.00
92.00 Allied health cost	0	5, 457, 423	0.00000	0 1, 369, 248	0	92.00
93.00 All other Medical Education	0	5, 457, 423	0.00000	0 1, 369, 248	0	93.00

	nancial Systems DEKALB MEMORIAL	_			u of Form CMS-2	
I NPATI ENT	Γ ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0045	Peri od:	Worksheet D-3	
				From 10/01/2017 To 09/30/2018	Date/Time Pre	nared:
				097 307 2010	2/27/2019 3: 1	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS					1
	000 ADULTS & PEDIATRICS			3, 295, 947		30.00
	100 INTENSIVE CARE UNIT			1, 616, 921		31.00
	300 NURSERY					43.00
	CILLARY SERVICE COST CENTERS					
	000 OPERATING ROOM		0. 1890			
	200 DELIVERY ROOM & LABOR ROOM		0. 6102	· ·		
1	400 RADI OLOGY-DI AGNOSTI C		0. 1347			
	000 LABORATORY		0. 1740			
	001 BLOOD LABORATORY		0.0000		_	
	500 RESPI RATORY THERAPY 600 PHYSI CAL THERAPY		0. 2248 0. 3652			
	601 CARDI AC REHAB		0. 3652			
	900 ELECTROCARDI OLOGY		0. 5941			
	900  ELECTROCARDI OLOGT 000  ELECTROENCEPHALOGRAPHY		0. 0329			1
	100 MEDICAL SUPPLIES CHARGED TO PAT		0. 1103			
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 5031			
	300 DRUGS CHARGED TO PATIENTS		0. 7237			73.00
	TPATIENT SERVICE COST CENTERS		0.7207.	20 001,717	107,001	70.00
	000 CLINIC		0. 5200	50 465	242	90.00
	100 EMERGENCY		0. 1754			
	200 OBSERVATION BEDS (NON-DISTINCT		0. 3971			
	HER REIMBURSABLE COST CENTERS					1
	500 AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			9, 662, 164	2, 582, 164	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			9, 662, 164		202.00

Health Financial Systems DEKALB MEMORIAL				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0045	Peri od: From 10/01/2017	Worksheet D-3	3
			To 09/30/2018	Date/Time Pre	nared.
				2/27/2019 3: 1	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col . 2)	
LAIDATLENT DOUTLAGE CEDALOE COCT CENTEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			470.040		
30. 00   03000   ADULTS & PEDI ATRI CS			472, 019		30.00
31. 00   03100   INTENSI VE CARE UNI T			101, 453		31. 00 43. 00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS			0		43.00
50. 00 05000 OPERATING ROOM		0. 1890	08 60, 936	11, 517	50.00
52. 00   05200  DELI VERY ROOM & LABOR ROOM		0. 6102		0	1
54. 00   05400  RADI OLOGY-DI AGNOSTI C		0. 1347		3, 819	
60. 00   06000   LABORATORY		0. 1740		22, 007	60.00
60. 01   06000   ENDORTHORY		0.0000	·	0	1
65. 00 06500 RESPIRATORY THERAPY		0. 2248		15, 066	
66. 00   06600   PHYSI CAL THERAPY		0. 3652		2, 192	
66. 01   06601 CARDI AC REHAB		0. 5941		112	
69. 00 06900 ELECTROCARDI OLOGY		0. 0529		200	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1105	76 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 3496	82 12, 872	4, 501	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5031	53 34, 325	17, 271	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 7237	20 43, 001	31, 121	73.00
OUTPATIENT SERVICE COST CENTERS		,			
90. 00 09000 CLI NI C		0. 5200		0	
91. 00   09100   EMERGENCY		0. 1754		7, 861	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT		0. 3971	56 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1)		427, 667	115, 667	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	427, 667		202.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-004	From 10/01/2017	Worksheet E Part A Date/Time Prepared: 2/27/2019 3:17 pm
•			

			10 04/30/2016	2/27/2019 3: 1	
-		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see				1. 01
	instructions)				
1. 02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	3, 314, 319	1. 02
	instructions)				
1.03	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	prior to October	. 0	1.03
	1 (see instructions)			ļ	
1.04	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1.04
	October 1 (see instructions)				
2.00	Outlier payments for discharges. (see instructions)			5, 147	2.00
2. 01	Outlier reconciliation amount			0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2.02
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost repo	orting period (see instru	ıcti ons)	32. 78	4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the mos	st recent cost reporting	period ending on	0.00	5.00
	or before 12/31/1996.(see instructions)			ļ	
6.00	FTE count for allopathic and osteopathic programs that meet t	0.00	6.00		
	new programs in accordance with 42 CFR 413.79(e)				
7.00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR §412.105(f)(1)(i	v)(B)(2) If the	0.00	7. 01
	cost report straddles July 1, 2011 then see instructions.			ļ	
8.00	Adjustment (increase or decrease) to the FTE count for allopa			0. 00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,				
	1998), and 67 FR 50069 (August 1, 2002).			ļ	
8. 01	The amount of increase if the hospital was awarded FTE cap sl	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teachi	ng hospi tal	0. 00	8. 02
	under § 5506 of ACA. (see instructions)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir	nes (8, 8,01 and 8,02)	see	0. 00	9.00
	instructions)			ļ	
10.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	ds		10.00
11. 00	FTE count for residents in dental and podiatric programs.				11.00
12.00	Current year allowable FTE (see instructions)				12.00
	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that ye	ear ended on or after Sep	tember 30, 1997,	0. 00	14.00
	otherwise enter zero.				
15. 00	Sum of lines 12 through 14 divided by 3.				15.00
16. 00	Adjustment for residents in initial years of the program			0. 00	16.00
	Adjustment for residents displaced by program or hospital clo	sure			17.00
	Adjusted rolling average FTE count			0. 00	18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4	·).		0.000000	19.00
20.00	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
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 42				
23.00	Number of additional allopathic and osteopathic IME FTE resid	lent cap slots under 42 (	CFR 412. 105	0. 00	23.00
	(f)(1)(iv)(C).			ļ	
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see	0.00	25.00
	instructions)			ļ	
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28. 01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	28. 01
29.00	Total IME payment ( sum of lines 22 and 28)			0	29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		0	29. 01
	Di sproporti onate Share Adjustment				[
30.00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (see instruc	ctions)	3. 62	30.00
	Percentage of Medicaid patient days (see instructions)	, ( , , , , , , , , , , , , , , ,	<i>'</i>	19. 23	
	Sum of lines 30 and 31			22. 85	
	Allowable disproportionate share percentage (see instructions	5)		8. 07	ı
	Disproportionate share adjustment (see instructions)	*		66, 867	l
	(		'	, -0,	

	Financial Systems DEKALB MEMORIA			u of Form CMS-2	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0045	Period: From 10/01/2017 To 09/30/2018		
		Title XVIII	Hospi tal	PPS	
				On/After 10/1	
	Uncompensated Care Adjustment		1. 00	2. 00	
35.00	Total uncompensated care amount (see instructions)		0	6, 766, 695, 164	35.00
35. 01	Factor 3 (see instructions)		0. 000000000		35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, en instructions)	iter zero on this line) (s	see 0	392, 813	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment a	amount (see instructions)	0	392, 813	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35		392, 813		36.00
40.00	Additional payment for high percentage of ESRD beneficiary		ugh 46)		10.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excludin 652, 682, 683, 684 and 685 (see instructions)	ig discharges for MS-DRGS	0		40.00
	good, cool and coo (coo theth dott one)		Before 1/1	On/After 1/1	
	<u></u>		1. 00	1. 01	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0	0	41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding M	MS-DRGs 652, 682, 683, 68	34 0	o	41.01
	an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00	1	42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)	682, 683, 684 an 685. (Se	ee 0		43.00
44.00	Ratio of average length of stay to one week (line 43 divide	ed by line 41 divided by 7	0. 000000		44.00
45 00	days)				45.00
45. 00 46. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line		0.00	0.00	45. 00 46. 00
47. 00	Subtotal (see instructions)	41.01)	3, 779, 146		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction			3, 779, 146	•
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, P			266, 031 0	50.00 51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4,				52.00
53.00	Nursing and Allied Health Managed Care payment	,		0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	2 60)		0	54. 01 55. 00
56. 00	Cost of physicians' services in a teaching hospital (see in			Ö	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		0	58. 00 59. 00
60.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			4, 045, 177 0	60.00
61.00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		4, 045, 177	1
62.00				552, 812	
					63. 00 64. 00
63.00					
63. 00 64. 00 65. 00	(See Instructions)			2, 617	66.00
64.00	Allowable bad debts for dual eligible beneficiaries (see in	nstructi ons)			
64. 00 65. 00 66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)			3, 487, 337	1
64. 00 65. 00 66. 00 67. 00 68. 00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo	or applicable to MS-DRGs (		3, 487, 337 0	67.00 68.00
64. 00 65. 00 66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)	or applicable to MS-DRGs (		3, 487, 337	68.00
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A	or applicable to MS-DRGs ( b).(For SCH see instruction astration) adjustment (see	ns)	3, 487, 337 0 0 0 0	68. 00 69. 00 70. 00 70. 50
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration	or applicable to MS-DRGs ( b).(For SCH see instruction astration) adjustment (see on	ns)	3, 487, 337 0 0 0 0 0 0	68. 00 69. 00 70. 00 70. 50 70. 87
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	or applicable to MS-DRGs ( b).(For SCH see instruction distration) adjustment (see on	ns)	3, 487, 337 0 0 0 0	68. 00 69. 00 70. 00 70. 50 70. 87 70. 88
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration	or applicable to MS-DRGs ( b).(For SCH see instruction instration) adjustment (see on	ns)	3, 487, 337 0 0 0 0 0 0	68. 00 69. 00 70. 00 70. 50 70. 87
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 91	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	or applicable to MS-DRGs ( b).(For SCH see instruction instration) adjustment (see on	ns)	3, 487, 337 0 0 0 0 0 0 0	68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	or applicable to MS-DRGs ( b).(For SCH see instruction instration) adjustment (see on	ns)	3, 487, 337 0 0 0 0 0 0 0	68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92
64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 88 70. 88 70. 90 70. 91 70. 92 70. 93	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	or applicable to MS-DRGs ( b).(For SCH see instruction instration) adjustment (see on	ns)	3, 487, 337 0 0 0 0 0 0 0	68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93

Health Financial Systems CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovider CO	CN: 15-0045	Peri od: From 10/01/2017 To 09/30/2018	eu of Form CMS-2 Worksheet E 7 Part A 8 Date/Time Pre	
				10 09/30/2010	2/27/2019 3:1	7 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
70.96 Low volume adjustment for federal fiscal year	(vana) (Entor in co	olump O		0	1.00	70. 96
the corresponding federal year for the period		or unitro		O		70. 70
70. 97 Low volume adjustment for federal fiscal year the corresponding federal year for the period	(yyyy) (Enter in co			2018	355, 397	70. 97
70. 98 Low Volume Payment-3	3	ĺ			0	70. 98
70.99 HAC adjustment amount (see instructions)					0	
71.00 Amount due provider (line 67 minus lines 68 p	lus/minus lines 69 8	₹ 70)			3, 818, 494	
71.01   Sequestration adjustment (see instructions)					76, 370	
71.02 Demonstration payment adjustment amount after	sequestrati on				0	
72.00 Interim payments					3, 716, 395	
73.00 Tentative settlement (for contractor use only		70			0	73.00
74.00 Balance due provider/program (line 71 minus l 73) 75.00 Protested amounts (nonallowable cost report i					25, 729	
75.00 Protested amounts (nonallowable cost report i CMS Pub. 15-2, chapter 1, §115.2  TO BE COMPLETED BY CONTRACTOR (lines 90 through		WILII			145, 666	/5.00
90.00 Operating outlier amount from Wkst. E, Pt. A,		2. 03			0	90.00
plus 2.04 (see instructions)	2, 0. 04 0. 1	00				70.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2					0	91.00
92.00 Operating outlier reconciliation adjustment a	mount (see instructi	ons)			0	92.00
93.00 Capital outlier reconciliation adjustment amo	unt (see instruction	ns)			0	93.00
94.00 The rate used to calculate the time value of	<b>3</b> `	ons)			0.00	
95.00 Time value of money for operating expenses (s					0	
96.00 Time value of money for capital related expen	<u>ses (see instructio</u> r	ns)			0	
					On/After 10/1	
HSP Bonus Payment Amount				1. 00	2. 00	
100.00 HSP bonus amount (see instructions)					0	100.00
HVBP Adjustment for HSP Bonus Payment						1100.00
101.00 HVBP adjustment factor (see instructions)					0. 0000000000	101 00
102.00 HVBP adjustment amount for HSP bonus payment	(see instructions)					102.00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions)					0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (	see instructions)				0	104.00
Rural Community Hospital Demonstration Project	t (§410A Demonstrati	on) Adjι	ustment			
200.00 Is this the first year of the current 5-year century Cures Act? Enter "Y" for yes or "N" f	demonstration period or no.	d under 1	the 21st			200. 00
Cost Reimbursement						
201.00 Medicare inpatient service costs (from Wkst.	D-1, Pt. II, line 49	9)				201.00
202.00 Medicare discharges (see instructions)						202.00
203.00 Case-mix adjustment factor (see instructions)	mitation (N/A : n f:	act vaca	of the our	nt E voca domini		203.00
Computation of Demonstration Target Amount Li	mitation (N/A in fir	si year	or the curre	ent 5-year demon	Stration	
nori ad)						204.00
peri od)				1		
204.00 Medicare target amount	as line 204)					1205 00
204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 tim						205.00
204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 tim 206.00 Medicare inpatient routine cost cap (line 202	times line 205)					
204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 tim 206.00 Medicare inpatient routine cost cap (line 202 Adjustment to Medicare Part A Inpatient Reimbo	times line 205) ursement	tions)				206. 00
204.00 Medicare target amount 205.00 Case-mix adjusted target amount (line 203 tim 206.00 Medicare inpatient routine cost cap (line 202	times line 205) ursement ration (see instruct					205. 00 206. 00 207. 00 208. 00

209.00

210. 00 211. 00

212. 00 213. 00 218. 00

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

210.00 Reserved for future use
211.00 Total adjustment to Medicare IPPS payments (see instructions)

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)
213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4		Provider CCN: 15-0045	Peri od:	Worksheet E Part A Exhibit 4
				Date/Time Prepared:
			10 09/30/2018	2/27/2019 3:17 pm
		Title XVIII	Hospi tal	PPS

							2/27/2019 3: 1	
		W (0 E D ) A			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
1.00		0	1. 00	2. 00	3. 00	4. 00	5. 00	1 00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	0	0	0		0	1.01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	3, 314, 319	0		3, 314, 319	3, 314, 319	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2. 00	October 1 Outlier payments for discharges (see instructions)	2. 00	5, 147	0	0	5, 147	5, 147	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3.00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
F 00	Indirect Medical Education Adj		0.000000	0.000000	0.000000	0.000000		F 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000		0. 000000	0	5.00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for	22. 00 22. 01	0	0	0	0	0	6. 00
0.01	managed care (see instructions)		J	0	o o	J		0.01
7. 00	Indirect Medical Education Adjume Payment adjustment factor	27.00	0.000000	0.000000		0. 000000		l 1 7.00
8. 00	(see instructions)  IME adjustment (see	28. 00	0.000000	0.000000		0. 000000	0	8.00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	
	for managed care (see instructions)							
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	Ü	0	9. 01
40.00	Disproportionate Share Adjustm			0.0007		0.0007		
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0807	0. 0807	0. 0807	0. 0807		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	66, 867	0	0	66, 867	66, 867	11. 00
11. 01	Uncompensated care payments  Additional payment for high pe	36.00 rcentage of ESI	392,813 RD beneficiary	0 di scharges	0	392, 813	392, 813	11. 01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	3, 779, 146 0	0		3, 779, 146 0	3, 779, 146 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	3, 779, 146	0	0	3, 779, 146	3, 779, 146	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	266, 031	0	0	266, 031	266, 031	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	O	O	0	17. 01 17. 02

	Financial Systems LUME CALCULATION EXHIBIT 4		DEKALB MEMORI	Provi der Co		Period: From 10/01/2017 To 09/30/2018		t 4 pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18. 00
19. 00				0		0 4, 045, 177	4, 045, 177	19.00
		W/S L, line	(Amounts from L)					
	r	0	1. 00	2. 00	3. 00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	265, 660 0	0		0 265, 660 0 0	265, 660 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	371 0	0		0 371 0 0	371 0	
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	20.00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.000	0. 0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	266, 031	0		0 266, 031	266, 031	26. 00
		W/S E, Part A	(Amounts to					
		line 0	E, Part A)	2.00	2.00	4.00	Г 00	
27. 00	Low volume adjustment factor	U	1. 00	2. 00	3. 00 0. 00000	4. 00 0 0. 087857	5. 00	27.00
28. 00	Low volume adjustment ractor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.0000	0.087837	0	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				355, 397	355, 397	29. 00
100. 00	Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. 00

From 10/01/2017 Part A Exhibit 5 Date/Time Prepared: 2/27/2019 3:17 pm 09/30/2018 Title XVIII Hospi tal PPS Period to Total (cols. Wkst. E, Pt. Amt. from Period on A, line Wkst. E, Pt. 10/01 after 10/01 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 0 0 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 3, 314, 319 1 02 3.314.319 3. 314. 319 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 5, 147 0 5, 147 5, 147 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 C 0 0 0 2.01 **BPCI** 3.00 2.01 О 0 3.00 Operating outlier reconciliation Managed care simulated payments 4.00 4.00 3.00 0 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21. 00 0.000000 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22. 00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0. 000000 7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 7.00 instructions) IME adjustment (see instructions) 8 00 28 00 8 00 0 0 8.01 IME payment adjustment add on for managed 28. 01 C 0 0 0 8.01 care (see instructions) 9 00 Total IME payment (sum of lines 6 and 8) 29. 00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 0 0 9.01 C 0 lines 6.01 and 8.01) Disproportionate Share Adjustment 0. 0807 0. 0807 10.00 Allowable disproportionate share percentage 33.00 0. 0807 10.00 (see instructions) Di sproporti onate share adjustment (see 66, 867 11.00 34.00 66, 867 0 66, 867 11.00 instructions) 11.01 Uncompensated care payments 36.00 392, 813 0 392, 813 392, 813 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 0 12.00 12.00 46.00 instructions) 13.00 Subtotal (see instructions) 47.00 3, 779, 146 0 3, 779, 146 3, 779, 146 13.00 Hospital specific payments (completed by SCH 48.00 0 14.00 14.00 and MDH, small rural hospitals only.) (see instructions) 3, 779, 146 Total payment for inpatient operating costs 49.00 0 3, 779, 146 3, 779, 146 15.00 15.00 (see instructions) 16,00 Payment for inpatient program capital (from 50.00 266, 031 0 266, 031 266, 031 16.00 Wkst. L, Pt. I, if applicable)
Special add-on payments for new technologies 17.00 0 17.00 54 00 0 0 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 O 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 0 amount (see instructions) 19.00 SUBTOTAL O 4, 045, 177 4, 045, 177 19. 00

Heal th	Financial Systems	DEKALB MEMORI	AL HOSPLTAL		In lie	u of Form CMS-:	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provider C	F	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Exhibi	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	265, 660	(	265, 660	265, 660	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	371	(	371	371	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0.0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	(	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	266, 031	(	266, 031	266, 031	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0	(		0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	355, 397		355, 397	355, 397	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	27, 132	(	27, 132	27, 132	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-51, 372	(	-51, 372	-51, 372	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
						(Am+ +a	

0 70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

Ν

2.00

3. 00

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

32.00

100.00

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0045	From 10/01/2017	Worksheet E Part B Date/Time Prepared: 2/27/2019 3:17 pm
	T: +1 - \0.0111	Henry And	DDC

NAME   MEDICAL AND OTHER HALLS SERVICES   1.00				077 007 2010	2/27/2019 3: 1	7 pm
PART B - MEDICAL AND OTHER REALTH SERVICES   1.00   Moderal and other services (see instructions)   1.5,789   1.00   Moderal and other services (see instructions)   1.5,789   1.00			Title XVIII	Hospi tal		
PART B - MEDICAL AND OTHER REALTH SERVICES   1.00   Moderal and other services (see instructions)   1.5,789   1.00   Moderal and other services (see instructions)   1.5,789   1.00						
Medical and other services (see Instructions)   5,789   1.00					1. 00	
Medical and other services reliabursed under OPPS (see Instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES				
0.000   0PPS payments	1.00	Medical and other services (see instructions)			5, 789	1.00
0.011 in Foyered (see instructions)	2.00	Medical and other services reimbursed under OPPS (see instruc-	tions)		4, 433, 320	2.00
Out	3.00	OPPS payments			3, 561, 584	3.00
Enter the hospital specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)			1, 113	4.00
Line 2 times line 5	4.01	Outlier reconciliation amount (see instructions)			0	4. 01
	5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5.00
5.00   Transitional corridor payment (see instructions)   5.00   0.00	6.00	Line 2 times line 5			0	6.00
9.00   Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200   0, 9, 00	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
0. 00   Organ acquisitions   1.00   Total coat (sum of lines 1 and 10) (see instructions)   1.00   Total coat (sum of lines 1 and 10) (see instructions)   1.00   COMPUTATION OF LESSER OF COST OR CHARGES   1.00   And II arry service charges   1.00   March acquisition charges (som of lines 12 and 13)   1.00	8.00	Transitional corridor payment (see instructions)			0	8.00
1.00   Total cost (sum of lines 1 and 10) (see instructions)   5.789   11.00	9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9. 00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable   Reasonable charges   Reasonable	10.00	Organ acquisitions			0	10.00
COMPUTATION OF LESSER OF COST OR CHARCES   Reasonable charges   Reasonable   Reasonable charges   Reasonable   R	11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 789	11.00
2.00   Ancil lary service charges   8.070   12.00   13.00   10.10   10.11   10.10   10.11   10.10   10.11   10.10   10.11   10.10   10.11   10.10		COMPUTATION OF LESSER OF COST OR CHARGES				
13.00   Organ acquisition charges (From Wist. D.4, Pt. III., col. 4, line 69)   0.13.00   0.30		Reasonabl e charges				
1-0   Total reasonable charges (sum of lines 12 and 13)	12.00	Ancillary service charges			8, 070	12.00
Customary charges   Cust	13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	13.00
Customary charges	14.00	Total reasonable charges (sum of lines 12 and 13)			8, 070	14.00
15.00   Aggregate amount actually collected from patients liable for payment for services on a chargebasis   0   15.00						
had such payment been made in accordance with 42 CFR §413.13(e)	15.00	Aggregate amount actually collected from patients liable for	payment for services on a	charge basis	0	15. 00
had such payment been made in accordance with 42 CFR \$413.13(e)	16.00				0	16.00
18. 00   Total customery charges (see instructions)   9. 00   7. 00						
9, 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   2, 281   19, 00   18   19   19   19   19   19   19   19	17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
Instructions	18.00	Total customary charges (see instructions)			8, 070	18.00
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00	19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds lin	ie 11) (see	2, 281	19.00
Instructions		instructions)				
1. 00   Lesser of cost or charges (see instructions)   0   22. 00   22. 00   23. 00   20. 0	20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds lin	ie 18) (see	0	20.00
22 00   Interns and residents (see instructions)   0   22 00   23 00		instructions)				
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   3, 50, 60   24. 00   COMPUTATION OF REIMBURSEMENT SETITLEMENT   0   0   0   0   0   0   0   0   0	21.00	Lesser of cost or charges (see instructions)			5, 789	21.00
Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9)   3, 562, 697   24, 00   Computation to Pet Huburs Sembent SETTLEMENT	22.00	Interns and residents (see instructions)			0	22. 00
COMPUTATION OF RELIMBURSEMENT SETTLEMENT   Deductibles and coinsurance amounts (for CAH, see instructions)   0   0   25.00	23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
25.00   Deductible sand coin surance amounts (for CAH, see instructions)   0   25.00	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			3, 562, 697	24.00
26.00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   732,785   26.00   27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   27.00   27.00   28.00   29.00   28.00   29.00   28.00   29.00   28.00   29.00   29.00   28.00   29.00		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
27.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   28.00   28.00   29.00   ESRD direct medical education payments (from Wkst. E-4, line 50)   0 29.00   29.0	25.00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		0	25. 00
Instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28, 00   29, 00   29, 00   29, 00   20, 00   2	26.00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instru	ıcti ons)	732, 785	26. 00
28. 00	27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26);	plus the sum of lines 22	and 23] (see	2, 835, 701	27.00
29.00   ESRD diffect medical education costs (from Wkst. E-4, line 36)   29.00   30.		instructions)				
30.00   Subtotal (sum of lines 27 through 29)   2,835,701   30.00   2,835,701   31.00   31.00   2,835,701   32.00			ine 50)		0	
31.00   Primary payer payments   1,847   31.00   2,833,854   2.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   32.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   3.658   35.00   35.00   Adjusted reimbursable bad debts (see instructions)   3.658   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   2,837,512   37.00   37.00   Subtotal (see instructions)   2,837,512   37.00   37.00   Subtotal (see instructions)   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   2,837,512   40.00   40.0		,				
32.00   Subtotal (ine 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   5,627   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   2,837,512   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   Demonstration payment adjustment amount before sequestration   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.98   99.90   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   39.99   Recovery of Accelerate (see instructions)   2,837,512   40.00   40.00   Subtotal (see instructions)   2,837,512   40.00   40.01   40.02   Demonstration adjustment (see instructions)   2,837,512   40.00   40.01   40.02   Demonstration payment adjustment amount after sequestration   2,774,746   41.00   41.00   Interim payments   2,774,746   41.00   41.00   Interim payments   2,774,746   41.00   41.00   Tentative settlement (for contractors use only)   42.00   43		,				•
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I - 5, line I1)   0   33.00     34.00   Allowable bad debts (see instructions)   5, 627     35.00   Adjusted reimbursable bad debts (see instructions)   3, 658     35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00     36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   2, 837, 512     37.00   Subtotal (see instructions)   2, 837, 512     38.00   MSP-LCC reconciliation amount from PS&R   0   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.95     39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99     40.00   Subtotal (see instructions)   2, 837, 512     40.01   Sequestration adjustment (see instructions)   56,750     40.02   Demonstration payment adjustment amount after sequestration   56,750     40.01   Sequestration adjustment (see instructions)   56,750     40.02   Demonstration payment adjustment amount after sequestration   0   42.00     41.00   Interim payments   2, 774, 746     41.00   Tentative settlement (for contractors use only)   42.00     42.00   Tentative settlement (for contractors use only)   6,016     43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00     5715.2   10   BE COMPLETED BY CONTRACTOR   0   90.00     90.00   Original outlier amount (see instructions)   0   91.00     90.00   Ottlier reconciliation adjustment amount (see instructions)   0   91.00     91.00   Ottlier reconciliation adjustment amount (see instructions)   0   91.00     92.00   Time Value of Money (see instructions)   0   93.00						
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33.00   34.00   All owable bad debts (see instructions)   5,627   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   3,658   35.00   36.00   All owable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   2,837,512   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.97   Demonstration payment adjustment amount before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   0   39.99   40.00   Subtotal (see instructions)   2,837,512   40.00   40.01   Sequestration adjustment (see instructions)   56,750   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.02   40.02   40.02   40.02   40.02   40.02   40.02   40.03   40.04   40.02   40.05	32. 00		250)		2, 833, 854	32.00
34.00   Allowable bad debts (see instructions)   5,627   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   3,658   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   2,837,512   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.97   Demonstration payment adjustment amount before sequestration   0   39.97   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   2,837,512   40.00   40.01   40.01   40.02   40.01   40.01   40.02   40.01   40.02   40.01   40.01   40.02   40.01   40.01   40.02   40.01   40.01   40.01   40.01   40.02   40.01	22 22	· ·	JES)			00.00
35.00   Adjusted reimbursable bad debts (see instructions)   3,658   35.00     36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00     37.00   Subtotal (see instructions)   2,837,512   37.00     38.00   MSP-LCC reconciliation amount from PS&R   0   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00     39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.97     39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98     39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99     40.00   Subtotal (see instructions)   56,750   40.01     40.01   Sequestration adjustment (see instructions)   56,750   40.01     40.02   Demonstration payment adjustment amount after sequestration   0   40.02     41.00   Interim payments   2,774,746   41.00     42.00   Tentative settlement (for contractors use only)   6,016   43.00     44.00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					- 1	
36.00						•
37.00   Subtotal (see instructions)   2,837,512   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   39.00   39.50   0   0   0   0   0   0   0   0   0						•
38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       39.50         39.97       Demonstration payment adjustment amount before sequestration       0       39.97         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.99         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.99         40.01       Subtotal (see instructions)       2,837,512       40.00         40.01       Demonstration payment adjustment (see instructions)       56,750       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         41.00       Interim payments       2,774,746       41.00         42.00       Interim payments       2,774,746       41.00         43.00       Balance due provider/program (see instructions)       6,016       43.00         44.00       \$115.2       0       44.00         70.00       Portested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44.00         91.00       Outlier reconciliation ad		· ·	ructions)			
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 Q40. 00 Subtotal (see instructions) 39. 99 Q40. 01 Interim payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Interim payments 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{2}\$ 115. 2  TO BE COMPLETED BY CONTRACTOR  90. 00 Tiginal outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Outlier reconciliation adjustment amount (see instructions) 93. 00 Outlier reconciliation adjustment amount (see instructions) 93. 00 Outlier reconciliation adjustment amount (see instructions) 94. 00 Outlier reconciliation adjustment amount (see instructions) 95. 00 Outlier reconciliation adjustment amount (see instructions) 96. 00 Outlier reconciliation adjustment amount (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions)						
39. 50 39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 40. 01 40. 02 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 Protested amounts (see instructions) 44. 00 Protested amounts (see instructions) 40. 00 40.						•
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50. 39. 99 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Interim payments 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 91. 00 91. 00 91. 00 91. 00 92. 00 93. 97 Time Value of Money (see instructions) 0 39. 97 0 39. 98 0 40. 02 2, 837, 512 40. 00 0 40. 00 2, 837, 512 40. 00 0 40. 00 0 40. 01 0 40. 02 2, 774, 746 0 41. 00 0 42. 00 0 42. 00 0 44. 00 0 56, 750 0 40. 01 0 40. 02 0 40. 02 0 41. 00 0 42. 00 0 42. 00 0 44. 00 0 75 11 11 11 11 11 11 11 11 11 11 11 11 11			- \		U	
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39.98 RECOVERY OF ACCELERATED DEPRECIATION  40.00 Subtotal (see instructions)  50.39.99  40.00 Subtotal (see instructions)  50.750 40.00  40.01 Demonstration payment adjustment amount after sequestration  40.02 Demonstration payment adjustment amount after sequestration  41.00 Interim payments  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.98  39.98  39.98  39.99  2, 837, 512  40.00  2, 774, 746  41.00  42.00  42.00  42.00  42.00  42.00  43.00  44.00  44.00  45.00  46.016  47.00  47.00  48.00  49.00  90.00  91.00  91.00  92.00  93.00		1 3 3 1	S)			•
39. 99 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  50 Sequestration adjustment (see instructions)  50 For 750 Sequestration payment adjustment amount after sequestration  40. 01 Interim payments  41. 00 Interim payments  Tentative settlement (for contractors use only)  42. 00 Balance due provider/program (see instructions)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 First 15-2 Chapter 15-2 C		, , , , , , , , , , , , , , , , , , , ,				
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 50,750 40.01 40.02 Demonstration payment adjustment amount after sequestration 1 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Time Value of Money (see instructions)			ced devices (see instruct	ions)		
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{\text{515.2}}{\text{10 BE COMPLETED BY CONTRACTOR}}  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)						
40.02 Demonstration payment adjustment amount after sequestration  41.00 Interim payments  Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{5}{15}.2\$  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 40.00  41.00 42.00  42.00  44.00  44.00  45.00  46.00  47.00  47.00  47.00  48.00  49.00  49.00  90.00  90.00  90.00  90.00  90.00  90.00		· · · · · · · · · · · · · · · · · · ·				
41.00						
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions)						
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Time Value of Money (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)		1				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \text{8115.2} \]  \[ \text{TO BE COMPLETED BY CONTRACTOR} \]  90.00 Original outlier amount (see instructions) \$\ \text{0 your of the rate used to calculate the Time Value of Money} \]  90.00 The rate used to calculate the Time Value of Money (see instructions) \$\ \text{0 your of Money} \]  93.00 Time Value of Money (see instructions) \$\ \text{0 your of Money} \]  93.00		,				
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00			nco with CMS Dub 15 2 -	hantar 1		
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)	44.00	, , , , , , , , , , , , , , , , , , , ,	nce wrth cMS Pub. 15-2, C	napter I,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	00 00			T	^	00 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00		1				
						1
74.00   10 tai (Suiii 01 11 1165 71 aliu 73)						
	74. UU	Total (Sun Of Titles 71 and 75)		I	υĮ	74.00

Health Financial Systems DEKA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 10/01/2017 Part I
To 09/30/2018 Date/Time Prepared: 2/27/2019 3:17 pm Provi der CCN: 15-0045

					2/27/2019 3: 1	7 pm
			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, 716, 395	5	2, 774, 746	1.00
2.00	Interim payments payable on individual bills, either		(		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER			<u></u>	1 0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER					3. 01 3. 02
3. 02						3. 02
3. 03						3. 03
3. 04						3. 04
3.05	Provider to Program			<u>/ </u>	U	3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	ABSOSTMENTS TO TROOKAW					3. 51
3. 52					l ő	3. 52
3. 53					0	3. 53
3. 54					l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				l ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 716, 395	5	2, 774, 746	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider			\	0	F 01
5. 01 5. 02	TENTATI VE TO PROVI DER		(			5. 01 5. 02
5. 02						5. 02
5.03	Provider to Program			<u>/ </u>	U	5.03
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51	TENTATI VE TO TROGIVIM				0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
0. , ,	5. 50-5. 98)					0. , ,
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		25, 729		6, 016	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 742, 124	1	2, 780, 762	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems D	DEKALB MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0045	Peri od:	Worksheet E-1		
				From 10/01/2017 To 09/30/2018	Part II  Date/Time Pre	nared:	
	2/27/2019 3:17						
	Title XVIII Hospital						
					1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD (					4	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION A						
1. 00						1.00	
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6 su		-12			2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col.					3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 su	m of lines 1, 8	-12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col	. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst.	S-10, col. 3 l	ine 20			6.00	
7.00	CAH only - The reasonable cost incurred for the	e purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168						
8.00	Calculation of the HIT incentive payment (see	instructions)				8.00	
9.00	Sequestration adjustment amount (see instruction	ons)				9.00	
10.00	Calculation of the HIT incentive payment after	sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CA	AH				1	
30.00	Initial/interim HIT payment adjustment (see in:	structions)				30.00	
31.00	Other Adjustment (specify)					31.00	
	Balance due provider (line 8 (or line 10) minus	s line 30 and l	ine 31) (see instruction	ns)		32.00	
						•	

Health Financial Systems	DEKALB MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0045	Peri od: Worksheet E-3 From 10/01/2017 Part VII To 09/30/2018 Date/Time Prepared: 2/27/2019 3:17 pm

			10 09/30/2018	2/27/2019 3:1	
		Title XIX	Hospi tal	Cost	
		,	Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		229, 549		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		229, 549	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		229, 549	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		573, 472		8.00
9.00	Ancillary service charges		427, 667	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 001, 139	0	12.00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis		_	_	
14. 00	Amounts that would have been realized from patients liable for	1 3	0	0	14.00
45.00	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)	0.000000	0.000000	45 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	
16.00	Total customary charges (see instructions)	! &   ! == 1/	1, 001, 139	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y IT Tine 16 exceeds	771, 590	0	17.00
10 00	line 4) (see instructions)	vifling 4 avagada lina		0	10 00
18. 00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y II Tine 4 exceeds Tine	9	U	18.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instr	cuctions)		0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1		229, 549	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1 21.00
22.00	Other than outlier payments	oomprotou ro. rro protro	0	0	22.00
	Outlier payments		o	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		229, 549	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	ı	229, 549	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		229, 549	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		229, 549	0	
			0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		229, 549	0	
41.00	Interim payments		526, 690	0	
42.00	Balance due provider/program (line 40 minus line 41)		-297, 141	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		i I		

Health Financial Systems

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

Provi der CCN: 15-0045

Peri od: Worksheet G
From 10/01/2017
To 09/30/2018 Date/Time Prepared: 2/27/2019 3:17 pm

——————————————————————————————————————					2/27/2019 3:1	
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	o	0	0	2.00
3.00	Notes recei vabl e	0	0	0	0	3.00
4.00	Accounts receivable	25, 299, 797	0	0	0	4.00
5. 00	Other recei vable	149, 520		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7.00	Inventory	1, 841, 904		0	0	7.00
8. 00	Prepai d expenses	317, 048	0	0	0	8.00
9. 00 10. 00	Other current assets			0	0	9.00
11. 00	Due from other funds Total current assets (sum of lines 1-10)	11, 300, 664		0	l	10.00 11.00
11.00	FIXED ASSETS	11, 300, 004	·]	0		11.00
12. 00	Land	393, 118	ol ol	0	0	12.00
13. 00	Land improvements	1, 808, 464		0	-	13.00
14. 00	Accumulated depreciation	-1, 791, 661		0	1	14.00
15. 00	Bui I di ngs	61, 162, 990		0	l	15.00
16. 00	Accumulated depreciation	-33, 827, 206		0	Ō	16.00
17. 00	Leasehold improvements	881, 033		0	0	17.00
18.00	Accumul ated depreciation	-10, 046		0	0	18.00
19.00	Fi xed equi pment		0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Maj or movable equipment	26, 634, 552	. 0	0	0	23.00
24.00	Accumulated depreciation	-20, 318, 062	. 0	0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	34, 933, 182	0	0	0	30.00
	OTHER ASSETS	1				
31. 00	Investments	18, 826, 725		0	1	31.00
32. 00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	50.4.005	0	0	0	33.00
34. 00	Other assets	524, 035		0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19, 350, 760		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	65, 584, 606	0	0	U	36.00
37. 00	Accounts payable	4, 278, 367	·l ol	0	0	37.00
38. 00	Salaries, wages, and fees payable	2, 791, 423		0	l	38.00
39. 00	Payrol I taxes payable	2,771,423		0	Ö	39.00
40. 00	Notes and Loans payable (short term)	601, 054		0	Ö	40.00
41. 00	Deferred income	001,001		0	Ö	41.00
42. 00	Accel erated payments			· ·		42.00
43. 00	Due to other funds		o	0	0	43.00
44.00	Other current liabilities	166, 600	o	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7, 837, 444		0	1	45.00
	LONG TERM LIABILITIES		•		•	
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11, 112, 409	0	0	0	47.00
48.00	Unsecured Loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11, 112, 409	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18, 949, 853	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	46, 634, 753				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EO 00	replacement, and expansion	14 404 750	_	^	_	E0 00
59.00	Total fund balances (sum of lines 52 thru 58)	46, 634, 753		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65, 584, 606	ή	0		60.00
	1~~/	I	ı		I	I

Provider CCN: 15-0045

| Peri od: | Worksheet G-1 | From 10/01/2017 | To 09/30/2018 | Date/Time Prepared:

				T	0 09/30/2018	Date/Time Pre 2/27/2019 3:1	
		General	Fund	Speci al Pu	rpose Fund	Endowment Fund	
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	1. 00	47, 894, 314 -1, 259, 561 46, 634, 753	3.00	0	0.00	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00 7. 00 8. 00	Additions (credit adjustments) (specify)	0 0 0 0		0 0 0 0		0 0 0 0	5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0	0 46, 634, 753	0 0 0 0	0	0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	46, 634, 753	0		0	
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0	0			9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	O	0			17. 00 18. 00 19. 00

| Peri od: | Worksheet G-2 | From 10/01/2017 | Parts | & II | To 09/30/2018 | Date/Time Prepared: Health Financial Systems

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

			To 09/30/2018	Date/Time Pre 2/27/2019 3:1	
	Cost Center Description	I npati ent	Outpati ent	Total	/ pili
	oost contor boson per on	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	11, 639, 6	58	11, 639, 668	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	11, 639, 6	58	11, 639, 668	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	4, 854, 3	16	4, 854, 316	
12.00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	4, 854, 3	16	4, 854, 316	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	16, 493, 9		16, 493, 984	17. 00
18. 00	Ancillary services	17, 265, 8			
19. 00	Outpatient services	9, 495, 4	91 29, 642, 961		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, 438, 851	1, 438, 851	22.00
23.00	AMBULANCE SERVICES	1, 7	53 6, 693, 857	6, 695, 610	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	20, 9	375, 151	396, 054	26. 00
27.00	DEKALB MEDICAL SERVICES		0 14, 999, 839	14, 999, 839	27. 00
27. 01	OTHER INCOME		11 33, 560	33, 571	27. 01
27. 02	SELF INSURANCE	549, 9	91 1, 864, 588	2, 414, 579	27. 02
27. 03	PHARMACARE		0 5, 606, 740	5, 606, 740	27. 03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	. 43, 827, 9	63 136, 593, 803	180, 421, 766	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		70, 898, 884		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33. 00			0		33. 00
34.00			0		34.00
35. 00			0		35.00
36.00	Total additions (sum of lines 30-35)		C	)	36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0	1	40. 00
41. 00			0	1	41.00
42.00	Total deductions (sum of lines 37-41)		0	)	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	70, 898, 884	-	43.00
	to Wkst. G-3, line 4)	I	1	I	

	<del>_</del>	RIAL HOSPITAL	_	u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0045	Peri od:	Worksheet G-3	
			From 10/01/2017 To 09/30/2018	Date/Time Pre	pared:
				2/27/2019 3:1	
1 00	Table of the form	11 202		1.00	1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			180, 421, 766	
2.00	Less contractual allowances and discounts on patients' ac	counts		114, 459, 038	
3.00	Net patient revenues (line 1 minus line 2)			65, 962, 728	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		70, 898, 884	
5. 00	Net income from service to patients (line 3 minus line 4)			-4, 936, 156	5.00
	OTHER I NCOME			_	
6. 00	Contributions, donations, bequests, etc			0	
7. 00	Income from investments			0	
8. 00	Revenues from telephone and other miscellaneous communica	tion services		0	
9. 00	Revenue from television and radio service			0	
	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	1
12.00	Parking lot receipts			0	
	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	
16.00	Revenue from sale of medical and surgical supplies to oth	er than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22. 00
	Governmental appropriations			0	23.00
	MISC INCOME			2, 456, 543	24.00
	INTEREST AND DIVIDEND			472, 162	
	NET UNREALIZED GAINS ON INVESTMENT			265, 359	
24. 03	NET REALIZED GAINS ON INVESTMENTS			500, 897	
	GAIN ON DISPOSAL OF PPE			-18, 366	
	Total other income (sum of lines 6-24)			3, 676, 595	1
	Total (line 5 plus line 25)			-1, 259, 561	1
	OTHER EXPENSES (SPECIEV)				27 00

0 27.00

-1, 259, 561 29. 00

0 28.00

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

27.00 OTHER EXPENSES (SPECIFY)

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

0

5.319

0

887, 176

C

-287

0

886, 889

23.50

24.00

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

23.50

Heal th	Financial Systems		DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HHA GENERAL SERVICE	COST			CN: 15-0045	Peri od:	Worksheet H-1	
				HHA CCN:	15-7157	From 10/01/2017 To 09/30/2018	Part     Date/Time Pre	pared:
						Home Health	2/27/2019 3: 1 PPS	7 pm
						Agency I	113	
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportati o	Subtotal	
		for Cost	Fi xtures	Equi pment	Operation 8		(cols. 0-4)	
		Allocation (from Wkst.			Maintenance	;		
		H, col. 10)	1.00				44.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3.00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. &	0	0				0	1.00
2. 00	Fixtures Capital Related - Movable	0		0			0	2.00
	Equi pment			-				
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3. 00 4. 00
5. 00	Administrative and General	283, 992	Ö	0		0 0	283, 992	1
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	331, 700	0	0	xI	0 0	331, 700	6.00
7. 00	Physical Therapy	134, 219		0	•	0 0	134, 219	1
8.00	Occupational Therapy	57, 881	0	0		0 0	57, 881	
9. 00 10. 00	Speech Pathology Medical Social Services	25, 636 0	0	0	,	0 0	25, 636 0	9. 00 10. 00
11.00	Home Heal th Ai de	53, 461	0	0		0 0	53, 461	
12. 00 13. 00	Supplies (see instructions) Drugs	0	0	0		0 0	0	
14. 00	DME	ō		0		0 0	Ö	1
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	Ιο	0	0	1	0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0	1	0 0	Ö	16.00
17.00	, ,	0	0	0		0 0	0	17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0	,	0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	21. 00 22. 00
23. 00	All Others (specify)	o o	0	0		0 0	Ö	23. 00
23. 50	Telemedicine Total (sum of lines 1-23)	0 886, 889	0	0	•	0 0	0 886, 889	
24.00	Total (Suil Of Titles 1-23)	Admi ni strati v	Total (col s.		<u>′I</u>	0 0	880, 889	24.00
		e & General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS	5.00	6.00			<u> </u>		
1. 00	Capital Related - Bldg. &							1.00
2. 00	Fixtures   Capital Related - Movable							2.00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5.00	Administrative and General	283, 992						5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	156, 245	487, 945					6.00
7.00	Physi cal Therapy	63, 223	197, 442					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	27, 265 12, 076						8. 00 9. 00
10.00	Medical Social Services	0						10.00
11.00	Home Heal th Ai de	25, 183 0						11. 00 12. 00
12. 00 13. 00	Supplies (see instructions) Drugs	0						13.00
14. 00	DME	0	0					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
16.00	Respi ratory Therapy	0	O					16.00
17. 00 18. 00	Private Duty Nursing Clinic	0						17. 00 18. 00
19.00	Health Promotion Activities	0	O					19. 00
20. 00 21. 00	3	0						20. 00 21. 00
22. 00	Homemaker Service	0	0					22.00
	All Others (specify)	0	0					23.00
	Telemedicine Total (sum of lines 1-23)		0 886, 889					23. 50 24. 00
. ==								

HHA CCN: 15-7157   From 10/01/2017   Part II me Prepared: 2/27/2019 3:17 pm				DEKALB MEMORI					
Capital Related Costs   Bidgs & Fixtures (SOUARE FEET)   COULAR (SOUARE FEET)   COULAR (SOUARE FEET)   COULAR (SOUARE FEET)   COULAR (AULE)   COULAR (AULE)	COST A	LLOCATION - HHA STATISTICAL BA:	SIS				From 10/01/2017	Part II Date/Time Pre	pared:
Capital Related Costs   Bidgs & Fixtures (SOUARE FEET)   Final Poperation & Maintenance (SOUARE FEET)   Fixtures (SOUAR							Home Health	PPS	
Bidgs & Fixtures   CQUARE FEET)   Equipment   CQULAR   CQUARE FEET)   CQUARE FEET)   Fixtures   CQUARE FEET)   Fixtures   CQUARE FEET)   CQ							Agency I		
Fixtures			Capital Rel	ated Costs					
Fixtures			Bl das &	Movabl e	Plant	Transportatio	Reconciliatio	Administrativ	1
COUARE FEET   COULAR   Maintenance   COUARE FEET   COULAR   COUARE FEET   COULAR   COUARE FEET   COULAR									
CEMERAL SERVICE COST CENTERS					•			(ACCUM. COST)	
CADIT CONTROL SERVICE COST CENTERS   Capital Related - Bidg. & OFIXTURES   Capital Related - Bidg. & OFIXTURES   Capital Related - Bidg. & OFIXTURES   Capital Related - Movable   OFIXTURES   OFIXT			, , ,		(SQUARE FEET)				
1.00   Capital Related - Bidg. &			1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
Fixtures   Capital Related - Movable   Equipment   Capital Related - Movable   Capital Related - Capital Related							_		
Equipment	1. 00	Fixtures	0				0		1.00
3.00	2. 00	•		0			0		2.00
4.00   Transportation (see   0   0   0   0   0   0   0   1   4.00	2 00			0		,	0		2 00
Instructions   Administrative and General   0   0   0   0   0   0   0   0   0			0	0		,	0		
Administrative and General   0   0   0   0   -283,992   602,897   5.00     HHA REIMBURSABLE SERVICES	4.00		l 0	Ü	·	'l	3		4.00
HHA REIMBURSABLE SERVICES	5 00		0	0	0		- 283 992	602 897	5 00
6.00         Skilled Nursing Care         0         0         0         0         331,700         6.00           7.00         Physical Therapy         0         0         0         0         0         134,219         7.00           8.00         Occupational Therapy         0         0         0         0         0         57,881         8.00           9.00         Speech Pathology         0         0         0         0         0         25,636         9.00           10.00         Medical Social Services         0         0         0         0         0         0         10.00           11.00         Home Health Aide         0         0         0         0         0         0         0         0         10.00           12.00         Supplies (see instructions)         0         0         0         0         0         0         0         0         0         0         10.00         11.00           13.00         Drugs         0         0         0         0         0         0         0         0         13.00         14.00           14.HA NONEL IMBURSABLE SERVICES         0         0         0         0 <td></td> <td></td> <td><u> </u></td> <td></td> <td></td> <td></td> <td>200, 7,2</td> <td>002,077</td> <td>1 0.00</td>			<u> </u>				200, 7,2	002,077	1 0.00
8.00 Occupational Therapy 0 0 0 0 0 0 57,881 8.00 9.00 Speech Pathology 0 0 0 0 0 0 0 25,636 9.00 10.00 Medical Social Services 0 0 0 0 0 0 0 0 0 10.00 11.00 Home Health Aide 0 0 0 0 0 0 0 0 53,461 11.00 12.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 0 12.00 13.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 13.00 14.00 DME 0 0 0 0 0 0 0 0 0 0 0 0 14.00 HHA NONREIMBURSABLE SERVICES			0	0	0		0 0	331, 700	6.00
9.00   Speech Pathology   0   0   0   0   0   0   25,636   9.00   10.00   Medical Social Services   0   0   0   0   0   0   11.00   Home Heal th Aide   0   0   0   0   0   12.00   Supplies (see instructions)   0   0   0   0   0   13.00   Drugs   0   0   0   0   0   14.00   DME   0   0   0   0   0   15.00   Home Delivered Meals Program   0   0   0   0   16.00   Drivate Duty Promotion Activities   0   0   0   0   19.00   Day Care Program   0   0   0   0   19.00   Home Delivered Meals Program   0   0   0   0   25,636   9.00   0   0   0   0   0   0   0   0   0	7.00	Physi cal Therapy	0	0	0	)	0	134, 219	7.00
10.00 Medical Social Services 0 0 0 0 0 0 0 0 0 10.00 11.00 11.00 Home Heal th Aide 0 0 0 0 0 0 0 0 53, 461 11.00 12.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 12.00 13.00 Drugs 0 0 0 0 0 0 0 0 0 0 13.00 14.00 DME 0 0 0 0 0 0 0 0 0 0 14.00 HHA NONREI MBURSABLE SERVICES	8.00	Occupational Therapy	0	0	0		0	57, 881	8.00
11.00   Home Heal th Ai de   0   0   0   0   0   0   53,461   11.00     12.00   Supplies (see instructions)   0   0   0   0   0   0     13.00   Drugs   0   0   0   0   0   0     14.00   DME			0	0	0		0 0	25, 636	9. 00
12.00   Supplies (see instructions)   0   0   0   0   0   0   12.00     13.00   Drugs   0   0   0   0   0   0   0     14.00   DME   DME			0	0	0	)	0		
13.00   Drugs   Drugs   DME   DME			0	0	0		0		1
14.00			0	0	0	)	0		1
HHA NONREIMBURSABLE SERVICES   15.00   Home Dialysis Aide Services   0   0   0   0   0   0   15.00			0	0	0		0		
15.00       Home Dialysis Aide Services       0       0       0       0       0       0       15.00         16.00       Respiratory Therapy       0       0       0       0       0       0       0       0       16.00         17.00       Pri vate Duty Nursing       0       0       0       0       0       0       0       0       0       17.00         18.00       Clinic       0       0       0       0       0       0       0       0       18.00         19.00       Health Promotion Activities       0       0       0       0       0       0       0       0       0       0       19.00         20.00       Day Care Program       0 <t< td=""><td>14.00</td><td></td><td>0</td><td>0</td><td></td><td>)  (</td><td>) 0</td><td>0</td><td>14.00</td></t<>	14.00		0	0		)  (	) 0	0	14.00
16.00       Respiratory Therapy       0       0       0       0       0       0       16.00         17.00       Private Duty Nursing       0       0       0       0       0       0       0       17.00         18.00       Clinic       0       0       0       0       0       0       0       18.00         19.00       Heal th Promotion Activities       0       0       0       0       0       0       0       19.00         20.00       Day Care Program       0	15 00					1	1		15 00
17.00     Private Duty Nursing     0     0     0     0     0     17.00       18.00     Clinic     0     0     0     0     0     0     18.00       19.00     Heal th Promotion Activities     0     0     0     0     0     0     19.00       20.00     Day Care Program     0				-	1	1	-	1	
18.00       Clinic       0       0       0       0       0       0       18.00         19.00       Health Promotion Activities       0       0       0       0       0       0       19.00         20.00       Day Care Program       0				-	-	1		1	
19.00     Health Promotion Activities     0     0     0     0     0     19.00       20.00     Day Care Program     0     0     0     0     0     0     0     0     0     0     20.00       21.00     Home Delivered Meals Program     0     0     0     0     0     0     0     0     0     21.00       22.00     Homemaker Service     0     0     0     0     0     0     0     0     0     22.00       23.00     All Others (specify)     0     0     0     0     0     0     0     23.00       24.00     Total (sum of lines 1-23)     0     0     0     0     -283,992     602,897     24.00				0				1	
20.00     Day Care Program     0     0     0     0     0     0     20.00       21.00     Home Delivered Meals Program     0     0     0     0     0     0     0     21.00       22.00     Homemaker Service     0     0     0     0     0     0     0     0     22.00       23.00     All Others (specify)     0     0     0     0     0     0     0     0     23.00       23.50     Tel emedicine     0     0     0     0     0     -283,992     602,897     24.00				0			0	1	
21.00     Home Delivered Meals Program     0     0     0     0     0     0     21.00       22.00     Homemaker Service     0     0     0     0     0     0     0     22.00       23.00     All Others (specify)     0     0     0     0     0     0     0     0     23.00       23.50     Tel emedicine     0     0     0     0     0     0     23.50       24.00     Total (sum of lines 1-23)     0     0     0     0     -283,992     602,897     24.00				0	0		0 0	l o	
22.00     Homemaker Service     0     0     0     0     0     0     22.00       23.00     All Others (specify)     0     0     0     0     0     0     0     23.00       23.50     Tel emedicine     0     0     0     0     0     0     0     23.50       24.00     Total (sum of lines 1-23)     0     0     0     0     -283,992     602,897     24.00			O	0			o o	Ö	
23.50 Telemedicine 0 0 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 0 -283,992 602,897 24.00			o	0	0		0	0	
23.50 Telemedicine 0 0 0 0 0 0 23.50 24.00 Total (sum of lines 1-23) 0 0 0 0 -283,992 602,897 24.00	23.00		o	0	0	)	0	0	23.00
		Tel emedi ci ne	o	0	0	)	0	0	23. 50
			0	0	0	)	-283, 992	602, 897	
25. 00   Cost To Be Allocated (per 0 0 0 0 0 283, 992 25. 00	25. 00	Cost To Be Allocated (per	0	0	0	)	O	283, 992	25.00

0. 471046 26. 00

0.000000

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0.000000

0.000000

Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

					Home Health Agency I	PPS	
		CAPI TAL		-	Ageney :		
Cost Center Description	HHA Trial	RELATED COSTS BLDG & FLXT	MOB WEST	NORTH ANNEX	GARRETT	BUTLER	
	Bal ance (1) 0	1. 00	1. 01	1. 02	CLI NI C 1. 03	1. 04	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 120 minus column 26, line 1, rounded to 6 decimal places.	0 487, 945 197, 442 85, 146 37, 712 0 78, 644 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	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	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 19. 00 19. 50 20. 00 21. 00
		CAPI TAL REL	ATED COSTS				
Cost Center Description	MOB EAST	MEDICAL ARTS	SMALTZ WAY	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) (2) 21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	1. 05 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	1.08 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	4A 189, 261 487, 945 197, 442 85, 146 37, 712 0 78, 644 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00

<sup>(1)</sup> 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.

Peri od: Worksheet H-2
From 10/01/2017 Part I
To 09/30/2018 Date/Time Prepared: 2/27/2019 3:17 pm HHA CCN: 15-7157

							2/2//2019 3:	7 PIII
						Home Health Agency I	PPS	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	
		E & GENERAL	PLANT	LINEN SERVICE				
	1	5. 00	7. 00	8. 00	9. 00	10. 00	10. 01	
1.00	Administrative and General	33, 164		0			(	
2.00	Skilled Nursing Care	85, 504		0	-	_	(	1
3.00	Physi cal Therapy	34, 598		0		0	(	
4.00	Occupational Therapy	14, 920		0	1	0	(	1
5. 00 6. 00	Speech Pathology Medical Social Services	6, 608	0	0		0		
7. 00	Home Heal th Ai de	13, 781	0	0	1	0		1
8. 00	Supplies (see instructions)	13, 761	0	0	-	0		
9. 00	Drugs		0	0	· ·	0		
10.00	DME		0	Ö	-			10.00
11. 00	Home Dialysis Aide Services	0	0	0	-	_		1
12. 00	Respiratory Therapy	Ö	0	Ö	-			12.00
13. 00	Private Duty Nursing	0	0	Ö	o o	0	Ċ	1
14.00	Clinic	0	0	0	o c	0		14.00
15.00	Health Promotion Activities	0	0	0	o c	0	(	15.00
16.00	Day Care Program	0	0	0	0	0	(	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	(	
18. 00	Homemaker Service	0	0	0	1	0	(	
	All Others (specify)	0	0	0		0	(	
19. 50	Tel emedi ci ne	0	0	0	· ·	0	(	
20.00	Total (sum of lines 1-19) (2)	188, 575	49, 936	0	19, 403	0	(	20.00
21. 00	Unit Cost Multiplier: column							21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	
	Cost Center Description		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	SERVI CE	
1.00		11.00	ADMI NI STRATI 0 N 13. 00	SERVICES & SUPPLY 14.00	15. 00	RECORDS & LI BRARY 16. 00	SERVI CE 17. 00	1.00
1.00	Administrative and General		ADMI NI STRATI 0 N 13. 00 102, 775	SERVI CES & SUPPLY 14. 00 0	15. 00 C	RECORDS & LI BRARY 16. 00	SERVI CE 17.00	
2.00	Administrative and General Skilled Nursing Care	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0	SERVICES & SUPPLY 14. 00 0	15. 00 0	RECORDS & LI BRARY 16. 00	SERVI CE 17. 00	2.00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	11.00	ADMI NI STRATI 0 N 13. 00 102, 775	SERVI CES & SUPPLY  14. 00  0 0 0	15. 00 0 0	RECORDS & LI BRARY 16. 00	17. 00	2.00 3.00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0	15.00 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0	17. 00	2.00 3.00 4.00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0	SERVI CES & SUPPLY  14. 00  0  0  0  0  0 0	15. 00 C C C	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0	17. 00	2.00 3.00 4.00 5.00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0	15. 00 C C C C	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	2.00 3.00 4.00 5.00 6.00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0	SERVI CES & SUPPLY  14. 00  0  0  0  0  0 0	15.00 C C C C C	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0	17. 00	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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0	15.00 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0	SERVI CES & SUPPLY 14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00 C C C C C C C C C C	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0  0  0  0  0  0  0  0  0  0  0  0	15. 00 C C C C C C C C C C C C	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 C C C C C C C C C C C C	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00 CC CC CC CC CC CC CC CC CC CC CC CC C	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  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
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00 00 00 00 00 00 00 00 00 00 00 00 00	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Heal th Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  17. 00  () () () () () () () () () () () () ()	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	11. 00 28, 249 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  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 19.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	11.00	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  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 19.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	11. 00 28, 249 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  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 19.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	11. 00 28, 249 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  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 19.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	11. 00 28, 249 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  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 19.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	11. 00 28, 249 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI 0 N 13. 00 102, 775 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY  14. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY  16. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CE  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 19.00

<sup>(1)</sup> 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.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 15-0045 Peri od: Worksheet H-2 From 10/01/2017 Part I Date/Time Prepared: HHA CCN: 15-7157 09/30/2018 2/27/2019 3:17 pm Home Health PPS Agency I Total HHA Cost Center Description Subtotal Intern & Subtotal Allocated HHA Resi dents A&G (see Part Costs Cost & Post II) Stepdown Adjustments 24. 00 26.00 25. 00 27.00 28. 00 Administrative and General 1.00 422, 788 1.00 422, 788 0 2.00 Skilled Nursing Care 573, 449 573, 449 232, 608 806, 057 2.00 3.00 Physical Therapy 232, 040 232, 040 94, 122 326, 162 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 4.00 Occupational Therapy 100, 066 100,066 40, 590 140, 656 4.00 5.00 Speech Pathology 17, 978 44, 320 44, 320 62, 298 5.00 6.00 Medical Social Services 6.00 7.00 Home Health Aide 92, 425 92, 425 37, 490 129, 915 7.00 8.00 0 8.00 Supplies (see instructions) C 0 0 0 9.00 Drugs C 0 0 9.00 10.00 DME 0 10.00 Home Dialysis Aide Services 0 0 11.00 0 0 11.00 Respiratory Therapy 0 0 0 0 12.00 12.00 Private Duty Nursing 13.00 0 0 13.00 14.00 Clinic 0 14.00 Health Promotion Activities 0 15.00 0 0 15.00 0 0 16.00 16.00 Day Care Program 0 17.00 Home Delivered Meals Program 0 0 17.00 Homemaker Service 0 0 0 18.00 0 18.00 All Others (specify) 0 0 19.00 C 0 19 00 19.50 Tel emedi ci ne 0 0 0 19.50

1, 465, 088

422, 788

0.405630

1, 465, 088

20.00

21.00

1, 465, 088

20.00

21.00

Total (sum of lines 1-19) (2)

Unit Cost Multiplier: column

6 decimal places.

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

<sup>(1)</sup> 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 HOSPITAL	In Lieu of Form CMS-2552-10
	TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0045	Peri od: Worksheet H-2
BASIS	HHA CCN: 15-7157	From 10/01/2017   Part II To 09/30/2018   Date/Time Prepared:
		2/27/2019 3: 17 pm
		Home Health PPS

						Home Health	PPS	
		CAPI TAL				Agency I		
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	MOB WEST	NORTH ANNEX	GARRETT	BUTLER	MOB EAST	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	CLINIC	(SQUARE FEET)	(SQUARE FEET)	
		1. 00	1. 01	1. 02	(SQUARE FEET) 1.03	1. 04	1. 05	
1. 00	Administrative and General	0	0	1, 617			0	1.00
2.00	Skilled Nursing Care	0	0	0	ı	0	0	2.00
3.00	Physi cal Therapy	0	0	0	C	0	0	3.00
4. 00	Occupational Therapy	0	0	0	0	0	0	4.00
5. 00	Speech Pathology Medical Social Services	0	0	0		0	0	5.00
6. 00 7. 00	Home Health Aide		0	0	0	0	0	6. 00 7. 00
8. 00	Supplies (see instructions)	0	0	0		0	0	8.00
9. 00	Drugs	l o	Ö	Ö	o o	0	Ö	9.00
10.00	DME	0	0	0	o	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0		_	0	11.00
12.00	Respiratory Therapy	0	0	1	0	_	0	12.00
13. 00 14. 00	Private Duty Nursing	0	0	0	0	_	0	13. 00 14. 00
15. 00	Health Promotion Activities		0	0			0	15.00
16. 00	Day Care Program	0	0	0		0	0	16.00
17. 00	Home Delivered Meals Program	0	0	Ö	O	0	0	17. 00
18.00	Homemaker Service	0	0	0	o c	0	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Tel emedi ci ne	0	0	0	0	0	0	19.50
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated	0	0	1, 617		0	0	20. 00 21. 00
22. 00	Unit cost multiplier	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	•
		CAPI	TAL RELATED CO					
	0	MEDICAL ARTO	CMALTZ WAY	MANUE FOLLIE	EMBLOVEE	D	ADMINI CEDATIV	
	Cost Center Description	MEDICAL ARTS (SQUARE FEET)	SMALTZ WAY (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	n	ADMINISTRATIV E & GENERAL	
		(SQUARE TEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT	"	(ACCUM. COST)	
					(UNADJUSTED		(	
		4 07	1.00	0.00	SALARY)		5.00	
1. 00	Administrative and General	1. 07	1. 08	2.00	4. 00 745, 171	5A 0	5. 00 189, 261	1.00
2. 00	Skilled Nursing Care	0	0		743, 171	_	487, 945	
3. 00	Physical Therapy	l o	Ö	-	o o	_		3.00
4.00	Occupational Therapy	0	0	0	o	0	85, 146	4.00
5.00	Speech Pathology	0	0	0	O	0	37, 712	5. 00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7. 00 8. 00	Home Health Aide	0	0	0		0	78, 644	7. 00 8. 00
9. 00	Supplies (see instructions) Drugs		0	0		0	0	1
10. 00	DME	0	0	Ö	Ö	0	Ö	10.00
11. 00	Home Dialysis Aide Services	0	0	0	O	0	0	11.00
12.00	Respiratory Therapy	0	0	0	O	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 16. 00	Health Promotion Activities Day Care Program		0	0		0	0	15. 00 16. 00
17. 00			0	0		0	0	17.00
18. 00	Home Delivered Meals Program Homemaker Service		o o	0	ol c	0	0	18.00
		0	0	0	0	0	0	18. 00 19. 00
18. 00 19. 00 19. 50	Homemaker Service All Others (specify) Telemedicine	0 0	0	0 0 0	0	0 0 0	0 0 0	19. 00 19. 50
18. 00 19. 00 19. 50 20. 00	Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	0 0 0	0	0 0 0	745, 171		0 0 0 1, 076, 150	19. 00 19. 50 20. 00
18. 00 19. 00 19. 50	Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated	0 0 0 0 0 0,000000	0 0 0 0 0 0.000000	0	189, 261		0 0 0 1, 076, 150 188, 575 0. 175231	19.00 19.50 20.00 21.00

				HHA CCN:	15-7157	09/30/2018	2/27/2019 3:1	
						Home Health	PPS	
						Agency I		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	SNACK BAR	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS	(MEALS	(FTES)	
		(SQUARE FEET)	(POUNDS OF		SERVED)	SERVED)		
			LAUNDRY)					
	1	7. 00	8. 00	9. 00	10.00	10. 01	11. 00	
1.00	Administrative and General	1, 617	0	1, 617	0	0	1, 365	1.00
2. 00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3. 00	Physi cal Therapy	0	0	0	0	0	0	3.00
4. 00	Occupational Therapy	0	0	0	0	0	0	4.00
5. 00	Speech Pathology	0	0	0	0	0	0	5.00
6. 00	Medical Social Services	0	0	0	0	0	0	6.00
7. 00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0		0	0	8.00
9.00	Drugs	0	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	0	0	11.00
12.00	Respiratory Therapy	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	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
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19)	1, 617	0	1, 617	0	0	1, 365	20.00
21. 00	Total cost to be allocated	49, 936	0	19, 403	0	0	28, 249	
22. 00	Unit cost multiplier	30. 881880	0.000000		0.000000	0.000000	20. 695238	22.00
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL		
		ADMI NI STRATI O	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	SERVICE		
		N (DIRECT NRS	(COSTED	REQUIS.)	(GROSS REVE	(TIME SPENT)		
		ING)	REQUIS.)		NUE)			
		13. 00	14. 00	15. 00	16. 00	17. 00		
1. 00	Administrative and General	28, 387	0	0		0		1.00
2. 00	Skilled Nursing Care	0	0	Ö	ő	0		2. 00
3. 00	Physi cal Therapy	0	0	o		0		3.00
4. 00	Occupational Therapy	0	0	0	0	0		4. 00
5. 00	Speech Pathology	0	0	o o	ő	0		5. 00
6. 00	Medical Social Services	0	0	o	o o	o		6.00
7. 00	Home Health Aide	0	0	o	0	0		7.00
8. 00	Supplies (see instructions)	0	0	o	o	0		8.00
9. 00	Drugs	0	0	o	Ō	o		9. 00
10.00	DME	0	0	o	0	0		10.00
11. 00	Home Dialysis Aide Services	0	0	o	0	0		11.00
12.00	Respiratory Therapy	0	0	o	0	0		12.00
13. 00	Private Duty Nursing	0	0	o	0	0		13.00
14.00	Clinic	0	0	o	0	o		14.00
15.00	Health Promotion Activities	0	0	o	0	o		15.00
16.00	Day Care Program	0	0	o	0	0		16.00
17.00	Home Delivered Meals Program	0	0	o	0	0		17.00
18.00	Homemaker Service	0	0	o	0	0		18.00
19. 00	All Others (specify)	0	0	O	О	0		19.00
19. 50	Tel emedi ci ne	0	0	o	0	ol		19.50
20.00	Total (sum of lines 1-19)	28, 387	0	ol	0	ol		20.00
21.00	Total cost to be allocated	102, 775	0	o	0	o		21.00
22.00	Unit cost multiplier	3. 620495	0. 000000	0. 000000	0. 000000	0. 000000		22.00

Heal th	Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COS	ΓS		Provi der C	CN: 15-0045	Peri od:	Worksheet H-3	
				HHA CCN:	15-7157	From 10/01/2017 To 09/30/2018	Part I Date/Time Prep 2/27/2019 3:17	
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2, Part I)	Costs (from Part II)	1 + 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION							
1 00	Cost Per Visit Computation	2.00	00/ 057		00/ 05	7 2 270	245.00	1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	2. 00 3. 00	•	0	806, 05 326, 16		245. 90 249. 74	1. 00 2. 00
3. 00	Occupational Therapy	4.00		0			219. 78	3. 00
4. 00	Speech Pathology	5. 00	•	0			798. 69	4. 00
5. 00	Medical Social Services	6. 00		O	02, 2.	0 89	0.00	5. 00
6. 00	Home Health Aide	7. 00	1		129, 91		104. 60	6. 00
7.00	Total (sum of lines 1-6)		1, 465, 088	0				7. 00
					Program Visit			
			1					
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	art B Subject to		
	cost center bescription	COST LINII IS	CDSA NO. (1)	Pai L A	to	Deducti bl es		
					Deducti bl es			
					Coi nsurance			
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	1	100010		.1			
8.00	Skilled Nursing Care Skilled Nursing Care		23060	0	l	13		8.00
8. 01 9. 00	Physical Therapy		99915 23060	0		13		8. 01 9. 00
9. 01	Physical Therapy	•	99915	0	46			9. 01
10.00	Occupational Therapy	•	23060	0	1	5		10. 00
10. 01	Occupational Therapy		99915	0	25			10. 01
11.00	Speech Pathology		23060	0		0		11.00
11. 01	Speech Pathology		99915	0	) 3	38		11.01
12.00	Medical Social Services	•	23060	0		0		12.00
12. 01	Medical Social Services	•	99915	0		39		12.01
13.00	Home Health Aide	•	23060	0	1	9		13.00
13. 01	Home Heal th Ai de		99915	0				13.01
14.00	Total (sum of lines 8-13)  Cost Center Description	From Wkst.	Facility	Shared	2,72 Total HHA	Total Charges	Ratio (col 3	14. 00
	cost center bescription	H-2 Part I.	Costs (from	Ancillary	Costs (cols.		÷ col. 4)	
		col. 28, line		Costs (from	1 + 2)	Records)		
			Part I)	Part II)	Í	ĺ		
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	8. 00	0	0	ıl	0 0	0. 000000	15 00
	Cost of Drugs	9. 00	1			o o	0. 000000	
	9		Program Visits		Cost of			
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to Deductibles &	Deductibles & Coinsurance		to Deductibles &	Deductibles & Coinsurance	
			Coi nsurance	corrisul ance		Coi nsurance	COLLISULATICE	
		6. 00	7. 00	8. 00	9. 00	10.00	11.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION Cost Per Visit Computation							
1. 00	COST LIMITATION	0	1, 437			0 353, 358		1. 00
1. 00 2. 00	COST LIMITATION Cost Per Visit Computation	0 0				0 353, 358 0 119, 875		1. 00 2. 00
	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy	1	480 261			0 119, 875 0 57, 363		
2. 00 3. 00 4. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology	1	480 261 38			0 119, 875 0 57, 363 0 30, 350		2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	1	480 261 38 39			0 119, 875 0 57, 363 0 30, 350 0 0		2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00	COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology	1	480 261 38			0 119, 875 0 57, 363 0 30, 350		2. 00 3. 00 4. 00

	ı Financial Systems FIONMENT OF PATLENT SERVICE COS	TS	DEKALB MEMORI	AL HOSPITAL Provider Co	CN: 15-0045	In Lie	u of Form CMS- Worksheet H-3	
				HHA CCN:	15-7157	From 10/01/2017 To 09/30/2018	Part I	pared:
				Title	XVIII	Home Health Agency I	PPS	7 рііі
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	8.00	9.00	10.00	11.00	
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01 14. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 11. 00 12. 01 13. 00 13. 01 14. 00
	,	Progr	ram Covered Cha	arges	Cost of			
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11.00	
15 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations 0		0		0 0		1 1 5 00
15. 00 16. 00	Cost of Drugs		0 882	0		0 0	C	1
	Cost Center Description  PART I - COMPUTATION OF LESSER COST LIMITATION	Total Program Cost (sum of cols. 9-10) 12.00 OF AGGREGATE	PROGRAM COST, /	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, O	R BENEFICIARY	
1 00	Cost Per Visit Computation	252.250						1 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	353, 358 119, 875 57, 363 30, 350 0 48, 744						1.00 2.00 3.00 4.00 5.00 6.00
7. 00	Total (sum of lines 1-6)  Cost Center Description	609, 690						7. 00
		12. 00						
g nn	Limitation Cost Computation							8 00
8. 00 8. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy							8. 00 8. 01 9. 00 9. 01 10. 00

Heal th	Financial Systems		DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF PATIENT SERVICE COS		Provi der C		Peri od:	Worksheet H-3		
				HHA CCN:	15-7157	From 10/01/2017 To 09/30/2018		
				Title	XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indi cated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	ITAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 365220	0		0 col. 2, line 2	. 00	1.00
1.01	Physical Therapy 1	66. 01	0. 594100	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. 349682	0	1	0 col. 2, line 1	5. 00	4.00
5. 00	Cost of Drugs	73.00	0. 723720	0		0 col. 2, line 1		5. 00
					•	·		

ALCUI	Financial Systems DEKALB MEMORI ATION OF HHA REIMBURSEMENT SETTLEMENT	AL HOSPITAL Provider C	CN: 15-0045	Peri od:	u of Form CMS-2 Worksheet H-4	
SALCOLATION OF THIS RETWINDURSEMENT SETTLEMENT		HHA CCN: 15-7157		From 10/01/2017		
		Title	XVIII	Home Health Agency I	PPS	<i>7</i> p
			Part A	Par Not Subject	t B Subject to	
				to Deductibles & Coinsurance	Deductibles & Coinsurance	
			1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR C Reasonable Cost of Part A & Part B Services	USTOMARY CHARGI	ES			-
00	Reasonable cost of Part A & Part B Services  Reasonable cost of services (see instructions)			0 0	0	1.
00	Total charges			0 882	0	2.
	Customary Charges					
00	Amount actually collected from patients liable for payment on a charge basis (from your records)			0 0	0	
00	Amount that would have been realized from patients liable for services on a charge basis had such payment been made with 42 CFR §413.13(b)			0 0	0	4.
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000		0. 000000	5
00 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable co	st (complete		0 882 0 882	0	6 7
00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete	only if line		0 0	0	8
00	1 exceeds line 6) Primary payer amounts			0 0	0	9
	,			Part A Services	Part B Services	
	DADT LL COMPUTATION OF HIM DELABORDERS OF THE FUELT			1. 00	2. 00	
. 00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)			0	0	10
. 00	Total PPS Reimbursement - Full Episodes without Outliers			0	312, 131	
. 00	Total PPS Reimbursement - Full Episodes with Outliers			0	42, 773	
. 00	Total PPS Reimbursement - LUPA Episodes			0	5, 801	13
. 00	Total PPS Reimbursement - PEP Episodes			0	0	14
. 00	Total PPS Outlier Reimbursement - Full Episodes with Outli	ers		0	11, 614	
.00	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			0	0	16
. 00	DME Payments			0	0	1
. 00	Oxygen Payments			0	0	19
. 00	Prosthetic and Orthotic Payments			0	0	
. 00	Part B deductibles billed to Medicare patients (exclude co	i nsurance)		0	272 210	21
. 00 . 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0	372, 319 0	22
. 00	Subtotal (line 22 minus line 23)			0	372, 319	
. 00	Coinsurance billed to program patients (from your records)				0	25
. 00	Net cost (line 24 minus line 25)			0	372, 319	26
	Reimbursable bad debts (from your records)					27
. 00	Reimbursable bad debts for dual eligible beneficiaries (se		)		070 040	28
. 00 . 00	Total costs - current cost reporting period (line 26 plus OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	11ne 2/)		0	372, 319 0	1
. 50	Pioneer ACO demonstration payment adjustment (see instruct	ions)		0	0	30
. 99	Demonstration payment adjustment amount before sequestrati	,		0	0	30
. 00	Subtotal (see instructions)			0	372, 319	
. 01	Sequestration adjustment (see instructions)			0	7, 446	
1. 02	Demonstration payment adjustment amount after sequestration	n		0	0	31
2.00	Interim payments (see instructions)			0	364, 873	
3. 00 4. 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 3	2 and 33)		0	0	
	parance due provider/program (TITE 31 millus TITES 31.01, 3					1
. 00	Protested amounts (nonallowable cost report items) in acco	rdance with CM:	S Pub. 15-2.	0	0	35

Health Financial Systems DEKALB MEMORIA ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED DEKALB MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0045

TO PROGRAM BENEFICIARIES HHA CCN: 15-7157

				Home Health Agency I	PPS	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3.00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	364, 873 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0 0	3. 03 3. 04
3. 05				0		3. 05
0.00	Provider to Program			<u> </u>	0	0.00
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 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0 0	3. 54 3. 99
3. 77	3. 50-3. 98)					3. 77
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	364, 873	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
F 01	Program to Provider				0	5. 01
5. 01 5. 02				0	0	5.01
5. 03				o		5. 03
	Provider to Program				-	
5.50				0	0	5.50
5. 51				0	0	5. 51
5. 52	0.11.1.1. (			0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM  Total Modicare program Liability (see instructions)			0	0 364, 873	6. 02 7. 00
7. 00	Total Medicare program liability (see instructions)			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

0

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O 69.00

0 70.00

0 71.00 333, 700 100. 00

OTHER PHYSICIAN SERVICES\*

TELEHEALTH/TELEMONI TORI NG\*

71.00 OTHER NONREIMBURSABLE (SPECIFY)\*

NURSING FACILITY ROOM & BOARD\*

RESIDENTIAL CARE\*

ADVERTI SI NG\*

THRIFT STORE\*

65.00

66.00

67 00

68.00

69 00

70.00

100.00 TOTAL

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

<sup>\*\*</sup> See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

					Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5			
			± col. 6)			
		6. 00	7. 00			
4 00	GENERAL SERVICE COST CENTERS					4
1.00	CAP REL COSTS-BLDG & FIXT*	0	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	9, 185			3.00
4. 00	ADMINISTRATIVE & GENERAL*	-102	188, 995			4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0	0			5.00
6. 00	LAUNDRY & LINEN SERVICE*	0	0			6.00
7.00	HOUSEKEEPI NG*	0	0			7.00
8. 00	DI ETARY*	0	1, 341			8.00
9.00	NURSI NG ADMI NI STRATI ON*	0	0			9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0			10.00
11.00	MEDICAL RECORDS*	0	0 107			11.00
12.00	STAFF TRANSPORTATION*	0	9, 187			12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0			13.00
14.00	PHARMACY*	0	0			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0			15.00
16. 00 17. 00	OTHER GENERAL SERVICE*	0	0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17. 00
25 00	DI RECT PATIENT CARE SERVI CE COST CENTERS			I		25 00
25. 00	I NPATI ENT CARE-CONTRACTED**	0	0			25.00
26. 00	PHYSI CI AN SERVI CES**	0	0			26.00
27. 00	NURSE PRACTITIONER**	0	01 212			27.00
28. 00 29. 00	REGI STERED NURSE**	0	91, 312			28. 00
	LPN/LVN**	0	0			29. 00
30.00	PHYSI CAL THERAPY**	0	0			30.00
31.00	OCCUPATIONAL THERAPY**	0	0			31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	10 100			32.00
33.00	MEDICAL SOCIAL SERVICES**	0	19, 432			33.00
34.00	SPIRITUAL COUNSELING**	0	14, 146			34.00
35. 00	DI ETARY COUNSELI NG**	0	0			35.00
36.00	COUNSELING - OTHER**	0	0			36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0			37.00
38.00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0			38.00
39.00	PATIENT TRANSPORTATION**	0	0			39.00
40.00	I MAGING SERVI CES**	0	0			40.00
41.00	LABS & DI AGNOSTI CS**	0	0			41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0			42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0			42.50
43.00	OUTPATIENT SERVICES**	0	0			43.00
44.00	PALLIATIVE CHEMOTHERAPY**	0	0			44.00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	0			45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0			46. 00
(0.00	NONREI MBURSABLE COST CENTERS			I		1,0,00
60.00	BEREAVEMENT PROGRAM *	0	0			60.00
61.00	VOLUNTEER PROGRAM *	0	0			61.00
62.00	FUNDRAL SI NG*	0	0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0			63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0			64.00
65.00	OTHER PHYSICIAN SERVICES*					65.00
66.00	RESI DENTI AL CARE*	0	0			66.00
67.00	ADVERTI SI NG*	0	0			67.00
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0			68.00
69.00	THRIFT STORE*	0	0			69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0			71.00
100.00	J TUTAL	-102	333, 598	<u> </u>		100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

13, 805

102, 912

0

0

0

13, 805

0

0 36.00

102, 912 100. 00

34.00

35.00

30.00	COONSELING - OTHER	0	U	U		0	30.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATI ENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00

102, 912

13,805

0

0

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col . 6)	
	DI DEGT. DATIENT, GADE, CEDIULGE, COCT. GENTEDO	6. 00	7.00	
05 00	DIRECT PATIENT CARE SERVICE COST CENTERS			05.00
25. 00	I NPATI ENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27. 00	NURSE PRACTITIONER	0	0	27.00
28. 00	REGI STERED NURSE	0	89, 107	28. 00
29. 00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	13, 805	34.00
35. 00	DI ETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	102, 912	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

34.00

35.00

100.00 TOTAL \*

SPIRITUAL COUNSELING

DIETARY COUNSELING

36. 00 COUNSELING - OTHER

Heal th	Financial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE INPATIENT	Provi der C	CN: 15-0045	Peri od:	Worksheet 0-3	1
RESPI T	E CARE		Hospi ce CC	N: 15-1559	From 10/01/2017 To 09/30/2018		
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED		0		0 0	0	0.00
	PHYSI CI AN SERVI CES	0	0	1	0 0	0	20.00
	NURSE PRACTITIONER	0	0		0	0	27.00
	REGI STERED NURSE	1, 152	0	1, 1	52 0	1, 152	
	LPN/LVN	0	0		0	0	/
	PHYSI CAL THERAPY	0	0	1	0	0	00.00
	OCCUPATI ONAL THERAPY	0	0	1	0	0	01.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	1	0	0	02.00
33.00	MEDICAL SOCIAL SERVICES	0	0	1	0 0	0	33.00
34.00	SPIRITUAL COUNSELING	178	0	1	78 0	178	34.00
35.00	DI ETARY COUNSELI NG	0	0	1	0 0	0	35.00
36.00	COUNSELING - OTHER	0	0	)	0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00	I MAGING SERVICES	0	0	)	0 0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	)	0 0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	)	0 0	0	42.00

42.50

45.00

46.00

330 100. 00

0 43.00 0 44.00

0

42.50 DRUGS CHARGED TO PATIENTS

45. 00 PALLIATIVE CHEMOTHERAPY

43.00 OUTPATIENT SERVICES
44.00 PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	1, 152	28. 00
29. 00	LPN/LVN	0	0	29.00
30. 00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	o	33.00
34.00	SPIRITUAL COUNSELING	0	178	34.00
35.00	DI ETARY COUNSELING	0	o	35.00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	o	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1, 330	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

<sup>100.00</sup> TOTAL \* 1,330 Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Health F	inancial Systems	DEKALB MEMORIAL	HOSPI TAI		In lie	u of Form CMS-2	2552-10
	S OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE		Provi der CCI	V: 15-0045	Peri od:	Worksheet 0-4	
I NPATI EN		o o control	Hospi ce CCN:		From 10/01/2017 To 09/30/2018		
			nospi ce cciv.	13-1339	10 077 307 2010	2/27/2019 3:1	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col . 2)			
-		1. 00	2. 00	3. 00	4. 00	5. 00	
_	IRECT PATIENT CARE SERVICE COST CENTERS		ما				05.00
	NPATIENT CARE-CONTRACTED		0		0	0	20.00
	PHYSI CI AN SERVI CES	0	0		0	0	26.00
	JURSE PRACTITIONER	1 050	U	1 0	0 0	1 050	27. 00
	REGI STERED NURSE	1, 053	U	1, 0	0	1, 053	
	PHYSI CAL THERAPY	0	0		0	0	29. 00 30. 00
	OCCUPATIONAL THERAPY	0	0				31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0			0	32.00
	MEDICAL SOCIAL SERVICES	19, 432	0	19, 43	32 0	19, 432	
	SPIRITUAL COUNSELING	163	Ö	17, 4		163	
	DI ETARY COUNSELING	0	Ö		0 0	0	35.00
	COUNSELING - OTHER	o	o		0 0	0	36.00
	HOSPICE AIDE & HOMEMAKER SERVICES	0	o		0 0	0	37. 00
	OURABLE MEDICAL EQUIPMENT/OXYGEN	0	o		0 0	0	38.00
39. 00 P	PATI ENT TRANSPORTATION	0	О		0 0	0	39.00
40. 00 I	MAGING SERVICES	O	О		0 0	0	40.00
41. 00 L	ABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 N	MEDICAL SUPPLIES-NON-ROUTINE	0	0		0 0	0	42.00
	DRUGS CHARGED TO PATIENTS	0	0		0	0	42. 50
43.00 0	OUTPATIENT SERVICES	0	0		0	0	43.00
	PALLIATIVE RADIATION THERAPY	0	O		0	0	44.00
	PALLI ATI VE CHEMOTHERAPY	0	0		0	0	45. 00
46.00 0	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	

<sup>100.00</sup> TOTAL \*  $^{\star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED		0	25. 00
26. 00	PHYSI CI AN SERVI CES			26.00
27. 00	NURSE PRACTITIONER		o o	27.00
28. 00	REGI STERED NURSE		1, 053	28.00
29. 00	LPN/LVN		1, 000	29.00
30.00	PHYSI CAL THERAPY	0	o o	30.00
31. 00	OCCUPATIONAL THERAPY	0	o o	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33. 00	MEDICAL SOCIAL SERVICES	0	19, 432	33.00
34.00	SPIRITUAL COUNSELING	0	163	34.00
35.00	DI ETARY COUNSELI NG	0	o	35.00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	o	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38. 00
39.00	PATIENT TRANSPORTATION	0	o	39.00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	20, 648	100.00

0 45.00 0 46.00 20,648 100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th	Financial Systems DEKALB MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der C		Period: From 10/01/2017	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CC	N: 15-1559	To 09/30/2018		
				Hospi ce I		
	Descriptions		HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
				e EXPENSES FROM	of cols. 1 +	
			i nstructi ons		2)	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1. 00	CAP REL COSTS-BLDG & FIXT		1	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		1	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		9, 18			3.00
4.00	ADMINISTRATIVE & GENERAL		188, 99	·	255, 576	4.00
5.00	PLANT OPERATION & MAINTENANCE			0 5, 404	5, 404	5.00
6.00	LAUNDRY & LINEN SERVICE			0 71	71	6.00
7.00	HOUSEKEEPI NG			0 2, 100	2, 100	7.00
8.00	DI ETARY		1, 34	.1 0	1, 341	8.00
9.00	NURSI NG ADMI NI STRATI ON			0 9, 301	9, 301	9. 00
10.00	ROUTINE MEDICAL SUPPLIES			0 0	0	10.00
11.00	MEDI CAL RECORDS			0 2, 851	2, 851	11.00
12.00	STAFF TRANSPORTATION		9, 18	:7	9, 187	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY			0 0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	15.00
16.00	OTHER GENERAL SERVICE			0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		102, 91	2	102, 912	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		1, 33	0	1, 330	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		20, 64	.8	20, 648	53.00
	NONREI MBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPI CE/PALLIATI VE MEDICINE FELLOWS			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
/ F 00	OTHER RUNGLOLAN OFFINA OFF		1	a l		

0 65.00

0 66.00

0

0 70.00

0 71.00

0 99.00 451,626 100.00

67.00

68. 00 69. 00

118, 028

333, 598

65. 00 OTHER PHYSICIAN SERVICES
66. 00 RESIDENTIAL CARE

68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE

70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER
100.00 TOTAL

67. 00 ADVERTISING

Health FinancialSystemsDEKALB MEMOCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS Provider CCN: 15-0045 | Period: | Worksheet 0-6 | From 10/01/2017 | To 09/30/2018 | Date/Time Prepared: | Provi der CCN: 15-0045

			nospi ce co	10 1007	077 007 2010	2/27/2019 3: 1	7 pm
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBL		SUBTOTAL	
	<b>'</b>	EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o			0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	40, 905	0		0 40, 905	5	3.00
4.00	ADMINISTRATIVE & GENERAL	255, 576	0		0	255, 576	4.00
5.00	PLANT OPERATION & MAINTENANCE	5, 404	0		0 0	5, 404	5.00
6.00	LAUNDRY & LINEN SERVICE	71	0		0 0	71	6.00
7.00	HOUSEKEEPI NG	2, 100	0		0 0	2, 100	7. 00
8.00	DI ETARY	1, 341	0		0 0	1, 341	8. 00
9.00	NURSI NG ADMI NI STRATI ON	9, 301	0		0 0	9, 301	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	l ol	0		o c	0	1
11.00	MEDI CAL RECORDS	2, 851	0		o c	2, 851	11.00
12.00	STAFF TRANSPORTATION	9, 187	0		0 0	9, 187	
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0	0	1
14. 00	PHARMACY		0		0		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		0		0		1
16. 00	OTHER GENERAL SERVICE		0		0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	١	0		0	1 0	17. 00
.,, 00	LEVEL OF CARE				<u> </u>		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	O				0	50.00
51.00	HOSPICE ROUTINE HOME CARE	102, 912			39, 917	142, 829	
52. 00	HOSPICE INPATIENT RESPITE CARE	1, 330	0		0 516	1	
53. 00	HOSPICE GENERAL INPATIENT CARE	20, 648	0	l .	0 472		
	NONREI MBURSABLE COST CENTERS	, , , , , ,		•		, ,	
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	o	0		0 0	o l	61.00
62.00	FUNDRAI SI NG	o	0		0 0	o l	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	0		0 0	o l	64.00
65.00	OTHER PHYSICIAN SERVICES	l ol	0		0 0	o l	65.00
66.00	RESI DENTI AL CARE	o	0		0 0	0	66.00
67.00	ADVERTI SI NG	o	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	ol	0		0 0	0	68.00
69.00	THRI FT STORE	o	0		0 0	0	1
70.00	NURSING FACILITY ROOM & BOARD	l	_			0	1
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	ol o	71.00
99. 00	NEGATI VE COST CENTER	0	0		o c	ol	99.00
	TOTAL	451, 626	0		0 40, 905	451, 626	
	1	, , , , , , , , , , , , , , , , , , , ,	·	1	1	1	

Provi der CCN: 15-0045 | Peri od: | Worksheet 0-6 | From 10/01/2017 | To 09/30/2018 | Date/Time Prepared: | Peri od: | Pe

					.0 07,00,2010	2/27/2019 3: 1	7 pm
					Hospi ce I		•
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	<b>'</b>	E & GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS			•			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	255, 576					4.00
5.00	PLANT OPERATION & MAINTENANCE	7, 045	12, 449				5.00
6.00	LAUNDRY & LINEN SERVICE	93	. 0	16	4		6.00
7.00	HOUSEKEEPI NG	2, 738	0		4, 838		7. 00
8.00	DI ETARY	1, 748	0		0	3, 089	8.00
9. 00	NURSI NG ADMI NI STRATI ON	12, 125	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	, 0	0		0		10.00
11. 00	MEDI CAL RECORDS	3, 717	0		0		11.00
12. 00	STAFF TRANSPORTATION	11, 976	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14. 00	PHARMACY		0		Ö		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		0		Ö		15.00
16. 00	OTHER GENERAL SERVICE		0		Ö		16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES		0		0		17.00
17.00	LEVEL OF CARE	<u> </u>		1			17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	186, 195					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	2, 406	6, 473	8	6 2, 516	1, 614	1
		27, 533	5, 976			1, 475	1
00.00	NONREI MBURSABLE COST CENTERS	27,000	3,7,0	·	2,022	., ., 0	00.00
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAI SI NG	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64. 00	PALLIATIVE CARE PROGRAM	o	0		0		64.00
65. 00	OTHER PHYSICIAN SERVICES	o	0		0		65.00
66. 00	RESI DENTI AL CARE		0		ol ől	0	1
67. 00	ADVERTI SI NG		0		0	Ŭ	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0		0		68.00
69. 00	THRI FT STORE		0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD		O				70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		o	0	1
	NEGATI VE COST CENTER		0		ol ol	0	
	TOTAL	255, 576	12, 449	16	4 4, 838	_	100.00
	i ·	,,			., 000	-, 00,	1

In Lieu of Form CMS-2552-10 Health Financial Systems DEKALB MEMORIAL HOSPITAL COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0045 Worksheet 0-6 From 10/01/2017 Part I Date/Time Prepared: Hospi ce CCN: 15-1559 09/30/2018 2/27/2019 3:17 pm Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS TRANSPORTATI O SERVI CE COORDI NATI ON SUPPLI ES Ν N 9.00 10.00 11.00 12.00 13.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 2 00 CAP REL COSTS-MVBLE EQUIP 3.00 EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL 4.00 5.00 PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 8.00 DI ETARY NURSING ADMINISTRATION 9.00 21, 426 ROUTINE MEDICAL SUPPLIES 10.00 C 11.00 MEDICAL RECORDS 0 6,568 12.00 STAFF TRANSPORTATION 0 21, 163 0 VOLUNTEER SERVICE COORDINATION 13.00 0 0 14.00 PHARMACY 0 0 0

In Lieu of Form CMS-2552-10 Health Financial Systems DEKALB MEMORIAL HOSPITAL COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0045 Peri od: Worksheet 0-6 From 10/01/2017 Part I Date/Time Prepared: Hospi ce CCN: 15-1559 09/30/2018 2/27/2019 3:17 pm Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES CARE SERVICES 14.00 15.00 16.00 17.00 18.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 OTHER GENERAL SERVICE 16,00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 17.00 LEVEL OF CARE

Health Financial Systems	DEKALB MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der CCN	: 15-0045	Peri od:	Worksheet 0-6	
STATI STI CAL BASI S				From 10/01/2017		
		Hospi ce CCN:	15-1559	To 09/30/2018		
					2/27/2019 3: 1	7 pm
				Hospi ce I		
Cost Center Descriptions	CAP REL BLDG (	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	

			Hospi ce CC	N: 15-1559   T	o 09/30/2018	Date/Time Pre 2/27/2019 3:1	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACCUMULATED COSTS)	
			17.202)	SALARI ES)		""	
		1. 00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS				1		
1.00	CAP REL COSTS-BLDG & FLXT	175					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	124, 892			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0		-255, 576	196, 050	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	l c	0	5, 404	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	(	0	71	6.00
7.00	HOUSEKEEPI NG	0	0	(	0	2, 100	7.00
8. 00	DI ETARY	0	0	(	0	1, 341	8. 00
9.00	NURSING ADMINISTRATION	0	0	(	0	9, 301	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	(	0	0	10.00
11.00	MEDICAL RECORDS	0	0	(	0	2, 851	11.00
12.00	STAFF TRANSPORTATION	0	0	(	0	9, 187	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	(	0	0	13.00
14.00	PHARMACY	0	0	l c	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	l c	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	l c	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE	•					1
50.00	HOSPICE CONTINUOUS HOME CARE			C	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			121, 875	0	142, 829	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	91	0	1, 576	0	1, 846	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	84	. 0	1, 441	0	21, 120	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	C	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	C	0	0	61.00
62.00	FUNDRAI SI NG	0	0	C	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	C	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	C	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	C	0	0	65.00
66.00	RESI DENTI AL CARE	0	0	C	0	0	66.00
67. 00	ADVERTI SI NG	0	0	(	0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	(	0	0	68. 00
69. 00	THRI FT STORE	0	0	(	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD				0		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	C	0	0	1 00
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I		0	40, 905		255, 576	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 327523	<b> </b>	1. 303627	101.00

Health Financial Systems	DEKALB MEMORIAL I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPI STATISTICAL BASIS		Provi der CCN: 1 Hospi ce CCN:	From 10/01/2017 To 09/30/2018	Worksheet 0-6 Part II Date/Time Prepared: 2/27/2019 3:17 pm

			Hospi ce CC	N: 15-1559 T	o 09/30/2018	Date/Time Pre 2/27/2019 3:1	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMINISTRATIO	
		MAI NTENANCE	(IN-FACILITY		DAYS)	N	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS. )	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS		,	,		,	
1. 00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	175					5.00
6.00	LAUNDRY & LINEN SERVICE	0	67	'			6.00
7.00	HOUSEKEEPI NG	0		175			7. 00
8.00	DI ETARY	0		0	67		8. 00
9. 00	NURSI NG ADMI NI STRATI ON	0		0		21, 606	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11. 00	MEDI CAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16. 00	OTHER GENERAL SERVICE	0		0		0	16.00
	PATIENT/RESIDENTIAL CARE SERVICES	0		0		_	17. 00
	LEVEL OF CARE			-			
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					21, 084	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	91	35	91	35		52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	84					53.00
00.00	NONREI MBURSABLE COST CENTERS	<u> </u>	0.2		02		00.00
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61. 00	VOLUNTEER PROGRAM	0	l .	Ö		0	61.00
62. 00	FUNDRAI SI NG	0		0		0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		Ö	63.00
64. 00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0		0		Ö	65.00
66. 00	RESI DENTI AL CARE	0	0		0	0	66.00
67. 00	ADVERTI SI NG	0		7	0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG					0	68.00
69. 00	THRIFT STORE					0	69.00
70. 00	NURSING FACILITY ROOM & BOARD					l o	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	ł
	NEGATIVE COST CENTER		T C	1		l	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	1) 12, 449	164	4, 838	3. 089	21 426	100.00
	UNIT COST MULTIPLIER	71. 137143					
101.00	TOWN TOOST MIDERITERS	1 /1.13/143	2. 44//01	27.043/14	1 40. 104476	0. 771007	1101.00

Heal th	Financial Systems	DEKALB MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der C		Peri od:	Worksheet 0-6	· )
STATIS	STICAL BASIS				From 10/01/2017	Part II	
			Hospi ce CC	N: 15-1559	To 09/30/2018	Date/Time Pre 2/27/2019 3:1	eparea:
					Hospi ce I	2/2//2019 3. 1	т ріп
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATIO		(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON	ĺ	
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)			SERVICE)		
		10. 00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT					I	1.00
2.00	CAP REL COSTS-MVBLE EQUIP					I	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					I	3. 00
4.00	ADMINISTRATIVE & GENERAL					I	4. 00
5.00	PLANT OPERATION & MAINTENANCE					I	5.00
6.00	LAUNDRY & LINEN SERVICE					I	6. 00
7.00	HOUSEKEEPI NG					I	7. 00
8.00	DI ETARY					I	8. 00
9. 00	NURSI NG ADMI NI STRATI ON					I	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0				I	10.00
11. 00	MEDI CAL RECORDS		2, 774			I	11.00
12. 00	STAFF TRANSPORTATION			100		I	12.00
13.00	VOLUNTEER SERVICE COORDINATION				0	I	13. 00
14. 00	PHARMACY				0	0	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			1	0	0	
16. 00	OTHER GENERAL SERVICE				0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE			1	_	_	
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	0	
51. 00	HOSPICE ROUTINE HOME CARE	0	2, 707			0	1 0 00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	35		0	0	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	32		0 0	0	53.00
(0.00	NONREI MBURSABLE COST CENTERS	1					(0.00
60.00	BEREAVEMENT PROGRAM			l .	0	0	1 00.00
61.00	VOLUNTEER PROGRAM			1	0	0	1 0 00
62.00	FUNDRAL SI NG			1	0	0	1
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	0	1 00.00
64.00	PALLIATIVE CARE PROGRAM			1	0	0	64.00

65.00

68.00

69. 00 70. 00

71.00

99.00

0 66.00

0 67.00

0

0 100. 00 0. 000000 101. 00

0

0.000000

21, 163 211. 630000

6, 568 2. 367700

0.000000

65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESIDENTIAL CARE

68. 00 | TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD
71. 00 OTHER NONE BURSABLE (SPECIFY)

99.00 NEGATIVE COST CENTER
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)
101.00 UNIT COST MULTIPLIER

ADVERTI SI NG

67.00

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPI STATISTICAL BASIS	CE GENERAL SERVICE COSTS	Provider CCN:		Peri od: From 10/01/2017	Worksheet 0-6 Part II
STATISTICALE BASIS		Hospi ce CCN:	15-1559	To 09/30/2018	Date/Time Prepared:

						2/27/2019 3:17 pm
					Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL			
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
		E SERVICES	(SPECI FY	CARE SERVICE		
		(PATI ENT	BASIS)	(IN-FACILITY	<b>/</b>	
		DAYS)		DAYS)		
		15. 00	16. 00	17. 00		
	GENERAL SERVICE COST CENTERS	T	T	,		
4	CAP REL COSTS-BLDG & FLXT					1.0
	CAP REL COSTS-MVBLE EQUIP					2.0
	EMPLOYEE BENEFITS DEPARTMENT					3.0
	ADMINISTRATIVE & GENERAL					4.0
5. 00	PLANT OPERATION & MAINTENANCE					5.0
5. 00	LAUNDRY & LINEN SERVICE					6.0
7. 00	HOUSEKEEPI NG					7.0
8. 00	DIETARY					8.0
9. 00	NURSING ADMINISTRATION					9. 0
10.00	ROUTINE MEDICAL SUPPLIES					10.0
11.00	MEDI CAL RECORDS					11.0
12.00	STAFF TRANSPORTATION					12.0
13.00	VOLUNTEER SERVICE COORDINATION					13.0
4	PHARMACY					14.0
	PHYSICIAN ADMINISTRATIVE SERVICES	0				15. 0
1	OTHER GENERAL SERVICE		0			16. 0
4	PATI ENT/RESI DENTI AL CARE SERVI CES		Ĭ		0	17. 0
	LEVEL OF CARE					
	HOSPICE CONTINUOUS HOME CARE	0	0			50.0
	HOSPICE ROUTINE HOME CARE	0	0			51.0
4	HOSPICE INPATIENT RESPITE CARE	0	0		0	52. 0
	HOSPICE GENERAL INPATIENT CARE	0	0		0	53. 0
	NONREI MBURSABLE COST CENTERS		-			
	BEREAVEMENT PROGRAM		0			60.0
	VOLUNTEER PROGRAM	•	0			61.0
	FUNDRAI SI NG		0			62. 0
4	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.0
	PALLI ATI VE CARE PROGRAM		0			64.0
	OTHER PHYSICIAN SERVICES		٥			65. 0
4	RESI DENTI AL CARE	0	١		0	66.0
4	ADVERTI SI NG					67.0
	TELEHEALTH/TELEMONI TORI NG					68.0
	THRIFT STORE			J		69.0
	NURSING FACILITY ROOM & BOARD		١	1		70.0
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	70.0
	NEGATIVE COST CENTER		١	1	٥	99.0
			0			
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		l ~		0	100.0
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.00000	00	101. 0

Heal th	Financial Systems	DEKALB MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF HOSPITAL-BASED HOSPICE SHARED	SERVICE COSTS BY	Provi der CO	CN: 15-0045	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCI	N: 15-1559	From 10/01/2017 To 09/30/2018		pared: 7 pm
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
		Part I, Col. 9 line	Charge Ratio				
		0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66. 00	0. 365220		0	0	1.00
1. 01	CARDI AC REHAB	66. 01	0. 594100		0	0	1.01
2 00	OCCUPATIONAL THERAPY	67.00					2 00

				Jan 19		· · · · · · · · · · · · · · · · · · ·	
	Cost Center Descriptions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
	cost conten baser per one	Part I, Col.	Charge Ratio	110110			
		9 line					
		0	1.00	2.00	3. 00	4. 00	
-	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66.00			0	0	1.00
1.01	CARDI AC REHAB	66. 01	0. 594100	0	0	0	1. 01
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00		0	0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00			0	0	
6. 01	BLOOD LABORATORY	60. 01	0. 000000		0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00		0	0	0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8. 00
9.00	RADI OLOGY-THERAPEUTI C	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11. 00	Totals (sum of lines 1-11)						11.00
		Charges by		Shared Service	Costs by LOC		
		LOC (from					
		Provi der					
		Records)	110110 ( 1 4	110110 ( ) 4	111.00 ( ) 4	1101.5 ( ) 4	
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
		5. 00	x col . 2) 6.00	x col. 3) 7.00	x col. 4) 8.00	x col. 5) 9.00	
	ANCILLARY SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1. 00	PHYSI CAL THERAPY	0	0	0		0	1.00
1. 00	CARDI AC REHAB	0		·	0	0	1.00
2. 00	OCCUPATIONAL THERAPY		0	J	O	· ·	2.00
3. 00	SPEECH PATHOLOGY						3.00
4. 00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
5. 00	DURABLE MEDICAL EQUIP-RENTED			ı	O		5.00
6. 00	LABORATORY	0	0	0	0	0	
6. 01	BLOOD LABORATORY	0	0	· -	0	Ö	•
7. 00	MEDICAL SUPPLIES CHARGED TO PAT	0	0	·	0	Ö	•
8. 00	OTHER OUTPATIENT SERVICE COST CENTER				O		8.00
9. 00	RADI OLOGY-THERAPEUTI C						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
	Totals (sum of lines 1-11)		0	0	0	n	11.00
50	1.222.2 (22 0. 1.1.00 1 1.)	I	1	١	Ü	·	

Health Financial Systems	DEKALB MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	•	Provi der	CCN: 15-0045	Peri od:	Worksheet 0-8
		Hospi ce C	CN: 15-1559	From 10/01/2017	Nate/Time Prepared:

	Hos	spice CCN	l: 15-1559   T	o 09/30/2018	Date/Time Pre 2/27/2019 3:1	
				Hospi ce I	2,2,,20,, 0,,	, p
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7,	col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0. 00	1
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10	0)	C			4.00
5. 00	Program cost (line 3 times line 4)			0		5.00
	HOSPICE ROUTINE HOME CARE					
6. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7,	col. 7,			377, 504	6. 00
	line 11)					
7. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				2, 707	7. 00
8. 00	Total average cost per diem (line 6 divided by line 7)				139. 45	ı
9. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	11)	2, 506			9. 00
10. 00			349, 462	837		10.00
44.00	HOSPICE INPATIENT RESPITE CARE				45.005	
11. 00		col. 8,			15, 295	11.00
10.00	line 11)				25	10.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				35 437. 00	
13.00	Total average cost per diem (line 11 divided by line 12)	10)	30		437.00	14.00
14. 00 15. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	12)		-		15.00
15.00	Program cost (line 13 times line 14) HOSPICE GENERAL INPATIENT CARE		13, 110	)		15.00
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, o	201 0			58, 827	16. 00
10.00	line 11)	201. 9,			30, 027	10.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)	i			32	17. 00
18. 00		•			1, 838. 34	
19. 00		13)	22	o	1,000.01	19.00
20.00		.0)	40, 443			20.00
20.00	TOTAL HOSPICE CARE		107 110	,		20.00
21. 00					451, 626	21.00
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				2, 774	
23. 00						23.00

	<i></i>	DRI AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0045	Peri od: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Pre 2/27/2019 3:1	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			265, 660	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			371	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the co	st reporting period (see ins	tructions)	16. 11 0. 00	
4. 00 5. 00	Number of interns & residents (see instructions) Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education percentage (see Fish detrois)		1 columns 1 and	0.00	
0.00	1.01) (see instructions)	y the sam of trines I and I. o	i, corumis rana	O	0.00
7.00	Percentage of SSI recipient patient days to Medicare Par	t A patient days (Worksheet	E, part A line	0.00	7.00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see i	nstructions)		0. 00	
9.00	Sum of lines 7 and 8			0.00	
10.00	Allowable disproportionate share percentage (see instruc	ctions)		0.00	
11. 00 12. 00				0 266, 031	11.00
12.00	Total prospective capital payments (see Histructions)			200, 031	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions	•		0	
2.00	Program inpatient ancillary capital cost (see instruction			0	
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2 Capital cost payment factor (see instructions)	2)		0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	
0.00	The transfer of the program capital cost (Time of X Time 1)			0	0.00
	DADT LLL COMPUTATION OF EVOEDTION DAMENTO			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs (see Instructions)  Program inpatient capital costs for extraordinary circum	netances (see instructions)		0	
3. 00	Net program inpatient capital costs (line 1 minus line 2			0	
4. 00	Applicable exception percentage (see instructions)			0. 00	
5.00	Capital cost for comparison to payments (line 3 x line 4	.)		0	
6.00	Percentage adjustment for extraordinary circumstances (s	see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraord	linary circumstances (line 2	x line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9. 00	Current year capital payments (from Part I, line 12, as			0	
10.00	Current year comparison of capital minimum payment level			0	
11. 00	Carryover of accumulated capital minimum payment level of Worksheet L, Part III, line 14)	over capitai payment (from pr	for year	0	11.00
12. 00		al payments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive,			0	
	Carryover of accumulated capital minimum payment level of			0	
14.00	(if line 12 is negative, enter the amount on this line)		Ŭ .		
14. 00	(11 Title 12 13 negative, effect the amount on this Title)				
15. 00	Current year allowable operating and capital payment (se	,		0	
15. 00 16. 00	Current year allowable operating and capital payment (se	,		0	