This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fa	ilure to report can re	sult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	g deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
				EXPI RES 03-31-2022
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 15-1315	Period: From 10/01/2018 To 09/30/2019	
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed cost report		Date: 2/25/20	20 Time: 1:53 pm
use only	2. [] Manually submitted cost report			
-	3.[0]If this is an amended report enter the number 4.[F]Medicare Utilization. Enter "F" for full or "	of times the provider L" for low.	resubmitted this o	cost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. [N] Initial Report for 9. [N] Final Report for 1. Settled with Audit 1. Settled with	or this Provider CCN12	O.NPR Date: 1.Contractor's Vendo 2.[O]If line 5, co number of tim	or Code: 4 Dumn 1 is 4: Enter nes reopened = 0-9.
DADT II CEDT	FLELCATION			

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 CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Ti t	16
-	
Dat	ie

			Title	XVIII			
Cost Center Descript	i on	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMM	IARY						
1.00 Hospi tal		0	173, 076	-1, 095, 861	0	-237, 141	1.00
2.00 Subprovider - IPF		0	0	0		0	2.00
3.00 Subprovider - IRF		0	0	0		0	3.00
5.00 Swing bed - SNF		0	37, 542	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
10.00 RURAL HEALTH CLINIC I		0		71, 649		0	10.00
11.00 FEDERALLY QUALIFIED HEALT	H CENTER I	0		0		0	11.00
200. 00 Total		0	210, 618	-1, 024, 212	0	-237, 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 CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1315 Peri od: Worksheet S-2 From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 1:53 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 416 E MAUMEE STREET 1.00 PO Box: 1.00 State: IN 2.00 City: ANGOLA Zi p Code: 47803-County: STEUBEN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 CAMERON MEMORIAL 151315 99915 02/01/2003 N 0 3.00 COMMUNITY HOSPITAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF CAMERON MEMORIAL 157315 99915 N 02/01/2003 N 0 7.00 7 00 COMMUNI TY 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA CAMERON HOME HEALTH 157117 99915 04/01/1984 Ρ Ν 12.00 CARE Separately Certified ASC 13.00 13 00 14.00 Hospi tal -Based Hospi ce CAMERON HOSPICE 151561 99915 05/01/1997 14.00 Hospital -Based Health Clinic - RHC CAMERON FAMILY MEDICINE 158530 99915 12/31/2016 Ν 0 0 15.00 15.00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17 00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2 00 1 00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2018 09/30/2019 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 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 Ν Ν 22.01 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) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν N 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 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas N Ν Ν 22.03 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 ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

40. 00	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		40. 00
		V	XVIII	XIX	
	000000000000000000000000000000000000000	1.00	2.00	3. 00	
	Prospective Payment System (PPS)-Capital	l N	l N	N	45.00
	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	I IN	IN IN	45. 00
	Is this facility eligible for additional payment exception for extraordinary circumstances	l N	l N	N	46.00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through	"	''	'`	10.00
	Pt. III.				
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48. 00
	Teaching Hospitals				
	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes	N			56.00
	or "N" for no.				
	If line 56 is yes, is this the first cost reporting period during which residents in approved				57.00
	GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y"				
	for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is				
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	N			58.00
	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.	N			59. 00

110001	n Financial Systems CAMERON MEMOR	RIAL CO	MMUNITY HOSPI			u of Form CMS-2	2552-10
HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der C	F	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Pre 2/25/2020 1:5	pared:
				NAHE 413. 85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
10.00		(111115)		1.00	2. 00	3. 00	
60.00	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?		costs for structions)	N			60.00
	any programs that most the orrest and and gridness.	Y/N	IME	Direct GME	IME	Direct GME	
(1 00	Did and the second seco	1.00	2. 00	3. 00	4. 00	5. 00	(1.00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61. 04
61. 05							61. 05
61. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
		Pr	ogram Name	Program Code	IME FTE Count	FTE Count	
(1 10	Of the FTFe in Line (1 OF enecify each new program		1. 00	2.00	3.00	4.00	(1 10
61. 10	Of the FTEs in line 61.05, specify each new program 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. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0. 00		61. 20
	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 Ser	vi ces	Admi ni strati o	on (HRSA)		1.00	
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai ne ti ons)	d in this cos	t reporting pe			62. 00 62. 01
63. 00	during in this cost reporting period of HRSA THC proc Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Sett	ings	•	neriod2 Enter	N	63. 00
	"Y" for yes or "N" for no in column 1. If yes, comple			67. (see inst	ructions)		55.00
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in No			-This base yea	r is your cost	reporti ng	
64.00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trai n-prima all no l non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio		0.00	0. 000000	64. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1315 Peri od: Worksheet S-2 From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 1:53 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N 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 Ν 75.00 subprovider? Enter "Y" for yes and "N"

Health Financial Systems CAMERON MEMORIAL COMMUNITY HO	SPI TAL	In Lieu	ı of Form CMS	-2552-10
	er CCN: 15-1315 F	Peri od:	Worksheet S-	
		From 10/01/2018 To 09/30/2019	Part I Date/Time Pr	conarod:
		10 09/30/2019	2/25/2020 1:	
		1.00		
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME te	aching program in	1.00	2.00 3.00	76.00
recent cost reporting period ending on or before November 15, 2004? E				76.00
no. Column 2: Did this facility train residents in a new teaching pro				
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3				
indicate which program year began during this cost reporting period.	(see instructions)		
			1. 00	
Long Term Care Hospital PPS			1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N"	for no.		N	80.00
81.00 Is this a LTCH co-located within another hospital for part or all of	the cost reportin	g period? Enter	N	81.00
"Y" for yes and "N" for no. TEFRA Provi ders				
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA?	Enter "Y" for ves	or "N" for no	N	85.00
86.00 Did this facility establish a new Other subprovider (excluded unit) u			14	86.00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				
87.00 Is this hospital an extended neoplastic disease care hospital classif	ied under section		N	87. 00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V	XIX	
		1.00	2. 00	
Title V and XIX Services		11.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospital service	s? Enter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column.				04.00
91.00 Is this hospital reimbursed for title V and/or XIX through the cost refull or in part? Enter "Y" for yes or "N" for no in the applicable co		N	Υ	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certif			N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicable colum				72.00
93.00 Does this facility operate an ICF/IID facility for purposes of title		N	N	93.00
"Y" for yes or "N" for no in the applicable column.				
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for applicable column.	or no in the	N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable of	ol umn	0.00	0. 00	95. 00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for		N N	N	96.00
applicable column.				
97.00 If line 96 is "Y", enter the reduction percentage in the applicable c		0.00	0. 00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or		Y	Υ	98. 00
column 1 for title V, and in column 2 for title XIX.	N TOT HOTH			
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting o	f charges on Wkst	. Y	Υ	98. 01
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, an	d in column 2 for			
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation	of observation	Y	Υ	00.00
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for		Y	Y	98. 02
for title V, and in column 2 for title XIX.				
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical acce		N	N	98. 03
reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N"	for no in column	1		
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimburse	d 101% of	N	N	98. 04
outpatient services cost? Enter "Y" for yes or "N" for no in column 1			IN	70.04
in column 2 for title XIX.	. o. c. c. o v, and			
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RC	E disallowance on	Y	Υ	98. 05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for	or title V, and i	n		
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimburse	d for Wkst D	Υ	Υ	98. 06
Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for ti		'	'	70.00
column 2 for title XIX.	tro ty and th			
Rural Providers				
105.00 Does this hospital qualify as a CAH?	mothod of	Y		105.00
106.00 f this facility qualifies as a CAH, has it elected the all-inclusive for outpatient services? (see instructions)	method of paymen	t N		106. 00
107.00 f this facility qualifies as a CAH, is it eligible for cost reimburs	ement for I&R	N		107. 00
training programs? Enter "Y" for yes or "N" for no in column 1. (see		"		
yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and t		t		
reimbursed. If yes complete Wkst. D-2, Pt. II.				100.00
108.00 s this a rural hospital qualifying for an exception to the CRNA fee CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	schedule? See 42	N		108. 00
101 N 350 CT OIT 3712. 113(0). EITCOL 1 TOIL yes OI N TOI 110.		ı		1

alth Financial Systems CAMERON MEMORIAL COM DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 15-1315	Peri od: From 10/01/2018 To 09/30/2019		-2 repared
	Physi cal	Occupati ona		Respi rator	У
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2. 00 N	3. 00 N	4. 00 Y	109. 0
				1.00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes o	or "N" for no.	If yes,	N	110. 0
			1. 00	2. 00	
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dlumn 1 is Y, ticipating i	period? Ente enter the n column 2.	n N		111. (
Miscellaneous Cost Reporting Information			1.0	0 2.00 3.0	00
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 it for long t	is "E", ente erm care (inc	rin column Iudes	0	115.0
6.00 s this facility classified as a referral center? Enter "Y" 7.00 s this facility legally-required to carry malpractice insur			r "N" for Y		116. (117. (
no. 18.00 is the malpractice insurance a claims-made or occurrence pol	icy? Enter 1	if the polic	y is 1		118.
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	
8.01 List amounts of malpractice premiums and paid losses:		1.00	2. 00	3.00	0118.
io. Of Er 31 dinounts of mar practice premi unis una para resses.		174, 1			0110.
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched			1. 00 N	2.00	118.
and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold	l llarmi occ. nr	roud olon in AC	A N	N	119. 120.
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, " alifies for	Y" for yes or the Outpatien		N	120.
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ıntable devic	es charged to	Y		121.
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information					122.
25.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N	l" for no. If	N		125.
26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2	2.				126.
27.00 f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2	2.				127.
28.00 f this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 f this is a Medicare certified lung transplant center, ente	2.				128. 129.
column 1 and termination date, if applicable, in column 2.					130.
date in column 1 and termination date, if applicable, in col 11.00 f this is a Medicare certified intestinal transplant center	, enter the	certi fi cati on			131.
· ·	umn 2				132.
date in column 1 and termination date, if applicable, in col 32.00 If this is a Medicare certified islet transplant center, ent	er the certi	fication date			1.02
date in column 1 and termination date, if applicable, in col	er the certi !. er the certi				133

Health Financial Systems	CAMERON MEMORIAL CO	MMUNITY HOSPITAL			In Lie	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi der CCN:	15-1315		: 0/01/2018 9/30/2019	Worksheet S- Part I Date/Time Pr 2/25/2020 1:	epared:
					1 00	2.00	_
140.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the ho	for no in column 1. If ome office chain number	yes, and home of (see instruction	fice cost		1. 00 Y	2. 00	140. 00
1.00 If this facility is part of a chain of	2.0		142 +		3. 00	-E +L- L	
office and enter the home office con			1 143 the	name ar	ia addi ess	or the nome	
141.00 Name: 142.00 Street:	Contractor's Name: PO Box:	io est Tramber !	Contract	tor's Nu	ımber:		141. 00 142. 00
143. 00 Ci ty:	State:		Zip Code	e:			143. 00
						1. 00	+
144.00 Are provider based physicians' costs	included in Worksheet	A?				Y	144. 00
145 001 6					1. 00	2. 00	1.15 00
145.00 f costs for renal services are clair inpatient services only? Enter "Y" for no, does the dialysis facility include period? Enter "Y" for yes or "N" for 146.00 Has the cost allocation methodology of Enter "Y" for yes or "N" for no in control of the cost allocation methodology of Enter "Y" for yes or "N" for no in control of the cost allocation methodology of Enter "Y" for yes or "N" for no in control of the cost allocation methodology of Enter "Y" for yes or "N" for no in control of the cost allocation methodology of the cost all	or yes or "N" for no in de Medicare utilization r no in column 2. changed from the previo	column 1. If col for this cost re usly filed cost r	umn 1 is porting eport?	f	N		145. 00
yes, enter the approval date (mm/dd/y	yyyy) in column 2.						
						1. 00	+
147.00 Was there a change in the statistical	basis? Enter "Y" for	yes or "N" for no).			N N	147. 00
148.00 Was there a change in the order of al	location? Enter "Y" fo	r yes or "N" for	no.			N	148. 00
149.00 Was there a change to the simplified	cost finding method? E				1 1 1 · 1/	N	149. 00
		Part A 1.00	2.00		itle V 3.00	Title XIX 4.00	+
Does this facility contain a provide		exemption from	the applic		of the low	er of costs	
or charges? Enter "Y" for yes or "N"	for no for each compon			. (See 4			155 00
155. 00 Hospi tal 156. 00 Subprovi der - IPF		N N	N N		N N	N N	155. 00 156. 00
157. 00 Subprovi der – IRF		N N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N N	N		N	N	159. 00 160. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		IN IN	N N		N N	N N	161.00
To 1. eojomito		LL				1,4	101.00
Multicampus						1. 00	
165.00 Is this hospital part of a Multicampu Enter "Y" for yes or "N" for no.	us hospital that has on	e or more campuse	s in diff	erent C	BSAs?	N	165. 00
	Name			ip Code	CBSA	FTE/Campus	
166.00 If line 165 is yes, for each campus enter the name in column	0	1.00	2.00	3. 00	4. 00	5. 00 0. 0	00 166. 00
O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
Health Information Technology (HIT)	incentive in the Americ	can Pecovory and I	Pai nyostm	ent Act		1. 00	
167.00 s this provider a meaningful user un 168.00 f this provider is a CAH (line 105 i reasonable cost incurred for the HIT	nder §1886(n)? Enter " s "Y") and is a meanin	Y" for yes or "N" gful user (line 1	for no.		r the	Υ	167. 00 168. 00
168.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? Er 169.00 If this provider is a meaningful user	a meaningful user, doe nter "Y" for yes or "N"	s this provider of for no. (see ins	tructions	s)	•	N 0. 0	168. 01 00169. 00
transition factor. (see instructions)							150
					gi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR begi	nning date and ending	date for the reno	rting		1. 00	2. 00	170.00
period respectively (mm/dd/yyyy)	g and onating		9				

Health Financial Systems	CAMERON MEMORIAL COM	MUNITY HOSPITAL	In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA			Worksheet S	-2
			From 10/01/2018 To 09/30/2019	Part Date/Time P	renared:
			097 307 2017	2/25/2020 1	
			1. 00	2. 00	
171.00 f ine 167 is "Y", does this provi	der have any days for indi	ividuals enrolled in	N		0 171.00
section 1876 Medicare cost plans re					
"Y" for yes and "N" for no in colum		enter the number of section	on		
1876 Medicare days in column 2. (se	ee instructions)				

	Financial Systems CAMERON MEMORIAL CO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-1315	Peri od: From 10/01/2018 To 09/30/2019		2
					2/25/2020 1:5	3 pm
				Y/N 1. 00	<u>Date</u> 2. 00	
	General Instruction: Enter Y for all YES responses. Enter I	N for all NO r	esponses. Ent			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					4
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e heginning of	the cost	N		1.0
1.00	reporting period? If yes, enter the date of the change in					'. 0
		`	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home)		Y			3.00
	or medical supply companies) that are related to the provi-	der or its				
	officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and otherelationships? (see instructions)	er similar				
	Trefactionships. (See Thetractions)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Dublic	Υ	A	12/19/2019	4.0
+. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date available.	for Compiled,	'	A	12/ 19/ 2019	4.00
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference on the filed financial statements? If yes, submit revenues are considered to the cost report to the cost revenues are considered to the cost revenues and total revenues are considered to the cost report to the		N			5. 00
				Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If was is t	he provider i	s N		6.00
J. 00	the legal operator of the program?	11 yes, 13 t	ne provider i	3 1		0.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7.00
3. 00	Were nursing school and/or allied health programs approved	and/or renewe	d during the	N		8.00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		cal education	N		9.00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
	Treaching Frogram on worksheet A: IT yes, see Instructions.				Y/N	
					1. 00	
	Bad Debts					4
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12.00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see in	structi ons.	N	14. 0
15. 00	Did total beds available change from the prior cost report		yes, see ins		N t B	15.0
		Y/N	Date	Y/N	Date	
	looso o	1. 00	2. 00	3. 00	4. 00	
6 00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	12/03/2019	Υ	12/02/2010	16 00
16. 00	If either column 1 or 3 is yes, enter the paid-through	l ř	12/03/2019	Y	12/03/2019	16.00

	date of the PS&R Report used in columns 2 and 4. (see			
17 00	instructions) Was the cost report prepared using the PS&R Report for	N I	N	17. 00
17.00	totals and the provider's records for allocation? If	14	IN	17.00
	either column 1 or 3 is yes, enter the paid-through date			
	in columns 2 and 4. (see instructions)			
18.00	If line 16 or 17 is yes, were adjustments made to PS&R	N	N	18.00
	Report data for additional claims that have been billed			
	but are not included on the PS&R Report used to file this			
	cost report? If yes, see instructions.			
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N	N	19. 00
	Report data for corrections of other PS&R Report			
	information? If yes, see instructions.			

Heal th	Financial Systems CAMERON MEMORIAL C	COMMUNITY HOSPI	TAL	In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	_	Provi der CCN: 15-1315 Peri od: From 10/01/To 09/30/		Date/Time F 2/25/2020 1	repared:
			iption	Y/N	Y/N	
20.00	If line 1/ on 17 is yes were adjustments made 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
		Y/N	Date	Y/N	Date	
	III	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	CEPT 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 reporting period? If yes, see instructions.	e due to apprai	sals made du	ring the cost	N	23. 00
24. 00	Were new Leases and/or amendments to existing Leases enter	red into durino	this cost r	eporting period?	Υ	24. 00
05.00	If yes, see instructions			2.16	.,	05.00
25. 00	Have there been new capitalized leases entered into during instructions.	g the cost repo	orting period	? IT yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ing period?	If yes, see	N	26. 00
	i nstructi ons.	·	0.			
27. 00	Has the provider's capitalization policy changed during the	ne cost reporti	ng period? I	f yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new Loans, mortgage agreements or letters of credit e	entered into du	uring the cos	t reporting	Y	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds ([Debt Service	Reserve Fund)	Υ	29. 00
	treated as a funded depreciation account? If yes, see inst	tructions .		,		
30. 00	Has existing debt been replaced prior to its scheduled matinstructions.	turity with new	w debt? If ye	s, see	N	30.00
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new	w debt? If ye	s, see	N	31.00
	instructions.					
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	ervices furnish	ned through c	ontractual	Y	32.00
02.00	arrangements with suppliers of services? If yes, see instr		.ou till ough o	oner do eda.		02.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	oplied pertaini	ng to compet	itive bidding? If	Y	33.00
	no, see instructions. Provider-Based Physicians					
34 00	Are services furnished at the provider facility under an a	arrangement wit	h provider-b	ased physicians?	Y	34.00
0 00	If yes, see instructions.	· ·	·	. ,		
35. 00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		ents with the	provi der-based	Y	35.00
	physicians during the cost reporting period: 11 yes, see i	nstructions.		Y/N	Date	
				1.00	2. 00	
0, 00	Home Office Costs					
36.00	Were home office costs claimed on the cost report?	anananad bu +ba	homo office	N		36.00
37. 00	If line 36 is yes, has a home office cost statement been plf yes, see instructions.	prepared by the	e nome office	ſ		37. 00
38. 00	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 er If line 36 is yes, did the provider render services to other.			s,		39. 00
	see instructions.	•	,			
40. 00	If line 36 is yes, did the provider render services to the instructions.	e nome office?	it yes, see			40.00
		1	00	2	00	
	Cost Report Preparer Contact Information	1	. 00	2.	00	
41. 00	Enter the first name, last name and the title/position	KYLE		SMI TH		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
40.05	respecti vel y.	DI HE A CC				40.05
42. 00	Enter the employer/company name of the cost report preparer.	BLUE & CO				42.00
43. 00	Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems CAMERON MEMORIAL	COMM	MUNITY HOSPITAL			In Lieu	of Form CMS	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN:	15-1315		ri od:	Worksheet S-	2
					Fr To	om 10/01/2018 09/30/2019		oparod:
					10	09/30/2019	2/25/2020 1:	53 pm
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	SEI	NIOR MANAGER					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.							
43.00	Enter the telephone number and email address of the cost							43.00
	report preparer in columns 1 and 2, respectively.							

Health Financial SystemsCAMERON MEMORHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA CAMERON MEMORIAL COMMUNITY HOSPITAL Provider CCN: 15-1315

						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number		Avai I abl e			
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	23	8, 395	77, 616. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)						2.00
3. 00	HMO IPF Subprovider						3. 00
4. 00	HMO I RF Subprovi der					_	4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		23	8, 395	77, 616. 00	0	7. 00
0.00	beds) (see instructions)	04.00		700	0.044.00		0.00
8.00	INTENSIVE CARE UNIT	31. 00	2	730	3, 264. 00	0	8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00				0	12.00
13.00	NURSERY	43. 00	l e	0 105	00 000 00	0	13.00
14.00	Total (see instructions)		25	9, 125	80, 880. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - I PF						16.00
17.00	SUBPROVIDER - I RF						17.00
18. 00 19. 00	SUBPROVI DER						18. 00 19. 00
20.00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY	101. 00				0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				U	23. 00
24. 00	HOSPICE	116. 00	0	0			24.00
24. 00		30.00	l	0			24. 00
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	l .			0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	25			U	27. 00
28. 00	Observation Bed Days		23			0	28. 00
29. 00	Ambul ance Trips					O	29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see Fristraction)						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
52. 01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
	LTCH site neutral days and discharges						33. 01
	1		ı	1	·	·	

Health Financial SystemsCAMERON MEMORHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-1315

Component Title XVIII Title XIX Total All Total Interns Employees On Patients & Residents Payroll 6.00 7.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 889 88 3,217	
Patients & Residents Payroll	
Patients & Residents Payroll	
Patients & Residents Payroll	
6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 889) 88 3,217	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 889 88 3,217	
	1.00
8 exclude Swing Bed, Observation Bed and	
Hospice days)(see instructions for col. 2	
for the portion of LDP room available beds)	
2.00 HMO and other (see instructions) 272 252	2.00
3.00 HMO PF Subprovi der 0 0	3.00
4.00 HMO RF Subprovi der 0 0	4.00
5.00 Hospital Adults & Peds. Swing Bed SNF 257 0 257	5.00
6.00 Hospital Adults & Peds. Swing Bed NF 0 304	6.00
7.00 Total Adults and Peds. (exclude observation 1,146 88 3,778	7.00
beds) (see instructions)	
8.00 INTENSIVE CARE UNIT 43 13 136	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
13. 00 NURSERY 0 468 1	13.00
14.00 Total (see instructions) 1,189 101 4,382 0.00 390.14	14.00
15.00 CAH visits 0 0 0 0	15.00
16. 00 SUBPROVI DER - I PF	16.00
17. 00 SUBPROVI DER - I RF	17.00
18. 00 SUBPROVI DER	18.00
19.00 SKILLED NURSING FACILITY	19.00
20.00 NURSING FACILITY	20.00
21.00 OTHER LONG TERM CARE	21.00
22.00 HOME HEALTH AGENCY 1, 188 246 3, 507 0.00 7.48	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	23. 00
	24.00
	24. 10
	25. 00
	26. 00
	26. 25
	27. 00
	28.00
	29.00
	30.00
	31.00
	32.00
	32. 00
outpatient days (see instructions)	JZ. U I
	33. 00
	33. 00
33. Of Effort at the fleutrian days and discharges Of	JJ. U I

Heal th Fi nancial SystemsCAMERON MEMORHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1315

				To	09/30/2019	Date/Time Prep 2/25/2020 1:5	
		Full Time		Di sch	arges	272372020 1.3	o piii
		Equi val ents			. 5		
	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	343	40	1, 262	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			00	440		0.00
2.00	HMO and other (see instructions)			89	118		2.00
3.00	HMO IPF Subprovider HMO IRF Subprovider				0		3. 00 4. 00
4.00	· ·			•	۷		4. 00 5. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF 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	0	343	40	1, 262	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
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28.00
29. 00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
31.00	1 ' "						
32.00	Labor & delivery days (see instructions)						32. 00 32. 01
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. UT
33. 00	LTCH non-covered days	}		0			33.00
	LTCH site neutral days and discharges						33. 01
33.01	121011 31 to floati ai days and di sonai ges	I		١	ļ	ı	55. 61

		RON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOME F	BEALTH AGENCY STATISTICAL DATA			CN: 15-1315 CCN: 15-7117	Peri od: From 10/01/2018 To 09/30/2019	Worksheet S-4 Date/Time Pre 2/25/2020 1:5	pared:
					Home Health	PPS	<u>- </u>
					Agency I		
0.00	County				STEUBEN 1.	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	D	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	ol	0		0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	57.00	0. (0. 00	0.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		F., *		C+-66		Tabal	
		Enter the number your normal		Staff	Contract	Total	
				1.00	2.00	2.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00	•		0. 02	
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.0		0. 90 0. 00	1
6.00	Direct Nursing Service			3.	0. 00	3. 13	6.00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. (0. 00 2. 08	1
9. 00	Physical Therapy Supervisor			0. (0.00	1
10.00	Occupational Therapy Service			0.4		0. 43	
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. (0. 00 0. 04	1
13.00	Speech Pathology Supervisor			0.0	0. 00	0. 00	
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0.4		0. 43 0. 00	1
16. 00	Home Heal th Ai de			1. 3		1. 35	
17.00	Home Heal th Ai de Supervisor			0.0		0.00	1
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.0	0. 00	0.00	18.00
19. 00					1		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
			i sodes	LUDA Estada	- DED 0-1	T-+-! (!-	
		Without Outliers	With Outliers	LUPA EDISOGE	PEP Only Epi sodes	Total (cols. 1-4)	
	DDC ACTIVITY DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	417	0) :	37 8	462	21.00
22.00	Skilled Nursing Visit Charges	76, 888	0			85, 053	22.00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	444 91, 149	0	1	9 13 48 2, 669	466 95, 666	
25. 00	Occupational Therapy Visits	63	0		1 3	67	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	12, 511	0	1	99 596 0 1	13, 306 4	26. 00 27. 00
28. 00	Speech Pathology Visits Speech Pathology Visit Charges	596	0	1	0 199	795	1
29.00	Medical Social Service Visits	17	0	1	0 1	18	
30.00	Medical Social Service Visit Charges Home Health Aide Visits	3, 950 163	0	•	0 247 5	4, 197 171	30.00 31.00
32.00	Home Health Aide Visit Charges	8, 567	0	15	58 263	8, 988	32.00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1, 107	0)	50 31	1, 188	33.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	6, 437 200, 098	0	1		6, 798 214, 803	1
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	63	Ü		15 1	79	
	outlier) Total Number of Outlier Episodes		0		0	0	
	Total Non-Routine Medical Supply Charges	6, 437	0		59 23	7, 529	38.00

OSPI TAL-B	ASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1315	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8530	From 10/01/2018 To 09/30/2019		
					DUC I	2/25/2020 1:5	53 pr
	·				RHC I	Cost	
					1.	00	
	ic Address and Identification				1500 W MALIMEE	CTDEET	1
00 Stre	eet		Ci	ty	1500 W MAUMEE State	ZIP Code	1
				00	2.00	3. 00	
00 City	, State, ZIP Code, County		ANGOLOA		IN	46703	2
						1. 00	
00 HOSF	PITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rur	al or "U" for	urban		1.00	1 3
<u>'</u>	<u> </u>			Gra	nt Award	Date	
C	C February Free I				1. 00	2. 00	
	ce of Federal Funds nunity Health Center (Section 330(d), PHS	Act)					1 4
	rant Health Center (Section 329(d), PHS Ac						5
	th Services for the Homeless (Section 340	O(d), PHS Act))				1 6
00 Appa	alachian Regional Commission k-Alikes						8
	ER (SPECIFY)						
00 01112	(6) 23777)						
	<u>-</u>				1. 00	2. 00	
yes	s this facility operate as other than a ho or "N" for no in column 1. If yes, indica Enter in subscripts of line 11 the type of ins)	ate number of	other operatio	ns in column		0	10
noui	J.)	Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
Faci	lity hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5. 00	
. 00 CLIN	, , ,			08: 00	17: 00	08: 00	11
<u>'</u>				•	1.00	0.00	
00 Have	e you received an approval for an exception	on to the proc	fuctivity stand	ard?	1. 00 N	2. 00	12
. 00 Is t	by you received an approval for an exception. His a consolidated cost report as defined. For yes or "N" for no in columer of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	1 '''	0	1:
	pers below.	LIST THE Hame	23 Of all provi	aci 3 ana			
				Prov	ider name	CCN number	
OO DUC	/FQHC name, CCN number				1. 00	2. 00	14
. 00 KHC/	Toric Haille, CCN Huiliber	Y/N	V	XVIII	XIX	Total Visits	14
		1. 00	2.00	3. 00	4.00	5. 00	
GME colu 4 th Inte XIX,	e you provided all or substantially all cost? Enter "Y" for yes or "N" for no in umn 1. If yes, enter in columns 2, 3 and ne number of program visits performed by ern & Residents for titles V, XVIII, and as applicable. Enter in column 5 the						15
	per of total visits for this provider.						
1 (366	THOSE doctrons)		Cou	nty			
			4.	00			
00 City	,, State, ZIP Code, County	Tuesday	STEUBEN	aeday	Thur	sday	1
		to	from	esday to	from	to	
			110111				-
		6. 00	7. 00	8. 00	9. 00	10. 00	

Health Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 15-1315	Peri od:	Worksheet S-8	
		Component	CCN: 15-8530	From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
				RHC I	Cost	о рііі
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12: 00				11.00

Heal th	ı Financial Systems	CAME	RON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOSPI 7	TAL-BASED HOSPICE IDENTIFICATION	I DATA		Provi der C	CN: 15-1315	Peri od:	Worksheet S-9	
				Hospi ce CC	N: 15-1561	From 10/01/2018 To 09/30/2019		pared:
						Hospi ce I		<u> </u>
		Undupl i cated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	OBER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4. 00 5. 00	Hospice General Inpatient Care Total Hospice Days							4. 00 5. 00
5.00	Part II - CENSUS DATA FOR COST	DEDODTING DED	LODG BECLUMING	DEFORE OCTORE	D 1 2015			5.00
6. 00	Number of patients receiving	REPURITING PER	TODS BEGINNING	BEFORE OCTOBE	K 1, 2015			6.00
6.00	hospi ce care							0.00
7. 00	Total number of unduplicated							7.00
7.00	Continuous Care hours billable							7.00
	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	I, 2015		
10.00				C)	0	· ·	
11. 00				1, 412	1	0 352	· ·	11. 00
12. 00				C	ł	0 0	0	
13.00				C	1	0 0	0	1
14.00	Total Hospice Days		OT DEBORTING 5	1, 412		0 352		14.00
15 00	PART IV - CONTRACTED STATISTICA	AL DATA FOR CO	SI REPURITNG P					15 00
15.00	Hospice Inpatient Respite Care			C		0 0		15.00
16.00	Hospice General Inpatient Care			c	'I	0 0	l 0	16. 00

Heal th	Financial Systems CAMERON MEMORIAL COMMUN	ITY HOSPITAL	In Lie	u of Form CMS-2	2552-10				
		Provi der CCN: 15-1315	Peri od:	Worksheet S-1					
			From 10/01/2018						
			To 09/30/2019	Date/Time Pre 2/25/2020 1:5					
			· .	2, 20, 2020 110	о р				
				1. 00					
	Uncompensated and indigent care cost computation								
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	rided by line 202 colu	nn 8)	0. 392497	1. 00				
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid			3, 179, 212	2. 00				
3. 00	Did you receive DSH or supplemental payments from Medicaid?			N N	3. 00				
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments from Medi	cai d?		4. 00				
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	rom Medicaid		0	5.00				
6.00	Medi cai d charges			14, 737, 986	6.00				
7. 00	Medicaid cost (line 1 times line 6)			5, 784, 615	7. 00 8. 00				
8. 00	8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2,605,403 < zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions for each line)								
9. 00	Net revenue from stand-alone CHIP			0	9. 00				
10.00	10.00 Stand-alone CHIP charges								
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	11. 00				
12. 00	Difference between net revenue and costs for stand-alone CHIP ((line 11 minus line 9;	if < zero then	0	12.00				
	enter zero)								
13. 00	Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13								
14. 00									
	10)								
15.00	15.00 State or local indigent care program cost (line 1 times line 14)								
16. 00	Difference between net revenue and costs for state or local ind	ligent care program (li	ne 15 minus line	0	16. 00				
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	D and state/Legal indi	gont care progra	mc (coo					
	instructions for each line)	P and State/Tocal Thu	gent care progra	illis (see					
17. 00	Private grants, donations, or endowment income restricted to fu	inding charity care		0	17. 00				
18.00	Government grants, appropriations or transfers for support of h	nospital operations		0	18.00				
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent care progra	ms (sum of lines	2, 605, 403	19. 00				
	8, 12 and 16)	Uni nsured	Insured	Total (col. 1					
		patients	pati ents	+ col . 2)					
		1.00	2. 00	3. 00					
	Uncompensated Care (see instructions for each line)								
20. 00	Charity care charges and uninsured discounts for the entire fac	cility 510, 5	40 0	510, 540	20. 00				
21. 00	(see instructions)	ınts (see 200,3	85 0	200, 385	21 00				
21.00	Cost of patients approved for charity care and uninsured discou instructions)	ints (see 200, 3	03	200, 363	21.00				
22. 00	Payments received from patients for amounts previously written	off as	0 0	0	22. 00				
	chari ty care								
23. 00	Cost of charity care (line 21 minus line 22)	200, 3	85 0	200, 385	23.00				
				4 00					
24 00	Does the amount on line 20 column 2, include charges for patien	at days beyond a Lengt	of stay limit	1. 00 N	24.00				
24.00	imposed on patients covered by Medicaid or other indigent care		TOT Stay Trillet	IV	24.00				
25. 00	If line 24 is yes, enter the charges for patient days beyond th		am's length of	0	25. 00				
26. 00	stay limit Total bad debt expense for the entire hospital complex (see ins	structions)		4, 969, 229	26. 00				
27.00	Medicare reimbursable bad debts for the entire hospital complex	•		4, 909, 229					
27. 01	Medicare allowable bad debts for the entire hospital complex (s			689, 647					
28. 00	Non-Medicare bad debt expense (see instructions)	•		4, 279, 582					
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instructions	s)	1, 921, 100					
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	20)		2, 121, 485					
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		4, 726, 888	31.00				

		RON MEMORIAL COM				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provi der C		Period: From 10/01/2018	Worksheet A	
					To 09/30/2019		pared:
	Cook Cooks Doors at a	Calasiaa	0+1	T-+-1 (1 1	DI: 6:+	2/25/2020 1:5	3 pm
	Cost Center Description	Sal ari es	Other	+ col . 2)	Reclassificat ions (See	Reclassified Trial Balance	
				1 (01. 2)	A-6)	(col. 3 +-	
					,	col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				500 000	- 100 010	
1.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		6, 065, 262				1.00
2. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	2, 189, 196 7, 502, 533			4, 443, 536 7, 502, 533	2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	3, 940, 295	8, 868, 675				5.00
7. 00	00700 OPERATION OF PLANT	902, 479	2, 313, 571			3, 216, 050	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	40, 814			40, 814	8. 00
9.00	00900 HOUSEKEEPI NG	699, 417	478, 696			1, 178, 113	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	454, 704	357, 254 0		-613, 003 603, 028	198, 955 603, 028	10.00 11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	774, 141	44, 603	1		818, 744	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	191, 683	97, 620			289, 303	14.00
15.00	01500 PHARMACY	506, 730	2, 850, 987	3, 357, 71	-145, 220	3, 212, 497	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	499, 859	61, 815	561, 67	1 0	561, 674	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2 101 247	1 010 020	2 110 20	F20 (01	3, 639, 977	30.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	2, 101, 247	1, 018, 039 0		520, 691 117, 514		
43. 00	04300 NURSERY		0	•	63, 706		ł
	ANCILLARY SERVICE COST CENTERS	-1				237.23	
50.00	05000 OPERATING ROOM	1, 425, 308	1, 214, 674	2, 639, 982	·		50.00
51.00	05100 RECOVERY ROOM	0	0	(00 1, 2 10		51.00
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	956, 754	228, 482 911, 069				
60.00	06000 LABORATORY	1, 612, 669 1, 015, 085	1, 589, 453			2, 523, 738 2, 604, 538	
64. 00	06400 I NTRAVENOUS THERAPY	1,013,003	1, 307, 433	2,004,000		2,004,330	64.00
65. 00	06500 RESPI RATORY THERAPY	33, 344	973, 985	1, 007, 329	-88, 861	918, 468	65.00
65. 01	06501 SLEEP LAB	o	0		101, 641	101, 641	65. 01
66.00	06600 PHYSI CAL THERAPY	918, 051	30, 620			948, 671	66.00
69.00	06900 ELECTROCARDI OLOGY	0	422, 572				
69. 01 71. 00	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	69, 962	7, 645 1, 975, 319			77, 607 887, 469	69. 01 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1, 973, 319	1, 7/3, 31	1, 087, 850		•
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0		0	0	73.00
76. 00	03020 CHEMI CAL DEPENDENCY	o	0		0	0	76.00
76. 01	03480 ONCOLOGY	0	1, 492, 288	1, 492, 288	3 0	1, 492, 288	76. 01
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	853, 439	91, 637	945, 076	1	945, 076	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	033, 439	91,037	745, 076		945,070	89.00
90.00	09000 CLINIC	138, 393	24, 871		-	163, 264	90.00
90. 01	09001 CLINIC- MCDONALD	562, 341	1, 131, 286		7 0	1, 693, 627	
90. 02	09002 CLINIC - FAM PRAC, PEDS, & ENT	1, 442, 483	106, 450			1, 548, 933	
90.03	09003 I V THERAPY 09004 OP PSYCH	0	14 100			0 235, 073	90.03
	09100 EMERGENCY	220, 874 1, 910, 478	14, 199 276, 233			2, 192, 308	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 910, 470	270, 233	2, 100, 71	3, 377	2, 172, 300	92.00
	OTHER REIMBURSABLE COST CENTERS	I					
101.00	10100 HOME HEALTH AGENCY	601, 367	114, 946	716, 313	-100, 788	615, 525	101.00
440.00	SPECIAL PURPOSE COST CENTERS		4 570 07/	4 570 07	4 570 07/		140.00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF	o	1, 573, 276 0	1			113. 00 114. 00
	11600 HOSPI CE	65, 987	18, 687	1	-		116.00
118.00	1 1	21, 897, 090	44, 086, 757			65, 972, 296	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190. 00
	07950 DAYCARE-I NFANT/TODDLER	0	0	(0		194.00
	07951 MOB	0	0	2 24	0		194. 01
	207952 COMMUNITY HEALTH 307953 ASSISTED LIVING/CAMERON WOODS	0	2, 240	2, 240			194. 02 194. 03
	107954 EDUCATION	500	34, 277	34, 77	7 0		194.03
	07955 MARKETI NG	325, 411	565, 284			931, 533	
	07956 GUEST MEALS	o	0		9, 975		194. 06
	07957 OUTSI DE LAUNDRY	0	0	(0		194. 07
	8 07958 CANCER CENTER	0	0	1 (01 10	0		194. 08
	07959 URGENT CARE 07960 RHC	1, 477, 384	213, 722	1, 691, 100	-189, 256		194. 09
	07960 RHC	1, 002, 186	67, 455	1, 069, 64		1, 069, 641	
	07962 TRINE STUDENT HEALTH	74, 013	2, 495				194. 12
194. 13	07963 OCCUPATI ONAL HEALTH	299, 299	147, 428	446, 72	7 0	446, 727	194. 13
	07964 IMMUNIZATION CLINIC	48, 701	1, 177			195, 098	194. 14
	07965 FOUNDATION	89, 527	249, 974			344, 275	
194. 16 200. 00	O7967 RETAIL PHARMACY TOTAL (SUM OF LINES 118 through 199)	25, 214, 111	63, 435 45, 434, 244			63, 435 70, 648, 355	
	- -	25,217,111	.5, 157, 244	. 0, 0 10, 330	-, 0	. 5, 5 10, 555	

Health FinancialSystemsCAMERON MEMORIALRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-1315

Cost Center Description				2/25/2020 1: 5	
CALIBORAL SERVICE COST CENTERS	Cost Center Description	Adjustments	Net Expenses		
Description 1.00		(See A-8)			
DEPTREAL SERVICE COST CENTERS 1.00 0.00100 CMP REL COSTS - ENGLE EQUIP 1.20 0.00100 CMP REL COSTS - E		6.00		_	
1.00	GENERAL SERVICE COST CENTERS	0.00	7.00		
2.00 DODODO CAMP REL DOSTS -WIREL EQUIP -22, 620 4, 420, 910 5.0		-264, 869	5, 218, 071		1.00
0.0000 ADMIN ISTRATIVE & CENERAL -3.200, 960 9,710, 905 7,00 800 0.0000 LAURDY & LINER SERVICE -3.001 40,811 10 80,000 11,00 11,000 10 10 10		-22, 620	l '		2.00
7.00 00000 000000	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-188, 613	7, 313, 920		4.00
B.D. DISSIDE LANDRY & LININ SIGNICE 0 40, 814 9, 00 10, 00 1000 10 178, 113 9, 00 10, 00 1000 10 178, 113 9, 00 10, 00 1000 10 178, 113 9, 00 10, 00 1000 10 178, 113 9, 00 10, 00 10 178, 113 10, 00	5. 00 00500 ADMINISTRATIVE & GENERAL	-3, 230, 960	9, 710, 955	5	
9.00 00000 MUSICREEPI NC		-3, 300	3, 212, 750		
10.00 01000 DIETARY -9, 406					
11.00 01100 CAFETER		_		1	
13.00				l .	
14.00 01400 CENTRAL SERVICES & SUPPLY 0 2.99, 303 14.00 15.00				l .	
15.00 1500 MARIANCY -78, 149 3, 134, 348 15.00 16.				l .	
16.00		_			
IMPATTENT ROUTINE SERVICE COST CENTERS -666, 904 2,983, 073 30. 00 300, 00 300, 00 315, 00 610, 00 615, 00 615, 00 637, 00					
31.00 03100 INTENSIVE CARE UNIT 0 117, 514 43.00 03300 UNISERY 0 63, 706 43.00 03300 UNISERY 0 63, 706 43.00 03500 OSE 0500			, , ,		
43.00 0.4300 NURSERY 0 0.3, 70c 43.00		-656, 904	2, 983, 073	3	30.00
MICHILARY SERVICE COST CENTERS 50.00 50.00 61000 678ATI NA FOROM 56.4, 512 1, 441, 222 50.00 52.00	31.00 03100 INTENSIVE CARE UNIT	0	117, 514	1	31.00
		0	63, 706	b	43.00
51.00 6500 RECOVERY ROOM 6.34, 248 55.00 550.00 550.00 560.00 DELIVERY ROOM 6.400 6.477, 728 55.00 560.00 6.000		5/4 540		J	
52.00 05200 DELIVERY ROWN & LABOR ROWN 0 477, 728 55.00 50.00 0500 LABORATORY -1,770 2,602,738 56.00 00 0500 LABORATORY -1,770 2,602,768 60.00 064.00 06400 06400 06400 06400 06400 06400 06400 06400 06400 06400 06400 06400 06400 06500 08ESPRATORY THERAPY 0 078,468 06.00 06500 RESPRATORY THERAPY 0 078,468 06.00 06600 PHYSI CALL THERAPY 0 078,468 06.00 06600 PHYSI CALL THERAPY 0 078,468 06.00 079,00 06600 PHYSI CALL THERAPY 0 078,577 079,00 0					1
54.00 05400 RADI OLOY-DI AGNOSTI C 0 2,523,738 54.00 06.00 06600 LABORATORY -1,770 2,602,768 66.00 06.00 06600 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	+ I			l control of the cont	
60.00					
64.00 06400 NTRAVENOUS THERAPY 0 0 0 66.00		_			1
65. 00 06500 RESPIRATORY THERAPY 0 013, 468 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 048, 671 66. 00 06600 PHYSI CAL THERAPY 0 049, 671 66. 00 06900 LECTROCARDIO LOCY 0 049, 77, 607 69. 01 071, 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 877, 607 69. 01 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 087, 850 72. 00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 087, 850 72. 00 076. 00 03020 CHEMICAL DEPENDENCY 0 0 0 0 075. 00 076. 00 03020 CHEMICAL DEPENDENCY 0 0 0 0 0 0 0 0 0	• • • • • • • • • • • • • • • • • • •			l control of the cont	
66. 00 66.00 PHYSI CAL THERAPY 0 948, 671 66. 00		0	918, 468	3	
69, 00 06900 ELECTROCARDI OLOGY 0 409, 792 69, 00	65. 01 06501 SLEEP LAB	0	101, 641		65. 01
69.01 06901 CARDIAC REHAB 0 77, 607 99.01 71.00 07700 MEDICAL SUPPLIES CHARGED TO PATIENT 0 887, 469 71.00 72.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1,087,850 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 75.00 76.00 03020 CHEMICAL DEPENDENTY 0 0 0 76.00 76.00 03020 CHEMICAL DEPENDENTY 0 0 0 76.00 76.00 03020 CHEMICAL DEPENDENTY 0 1,492,288 76.01 2017PATIENT SERVICE COST CENTERS 76.00 89.00 08900 RURFAL HEALTH CLINIC 0 945,076 88.00 89.00 08900 RURFAL HEALTH CLINIC 0 163,264 90.00 90.00 09000 CLINIC - MCDONALD -1,255,931 437,696 90.01 90.01 09001 CLINIC - MCDONALD -1,255,931 437,696 90.01 90.02 CLINIC - FAM PRAC, PEDS & ENT -1,310,240 238,693 90.02 90.03 09003 VI HERAPY 0 235,073 90.04 90.03 09003 VI HERAPY 0 2,192,308 91.00 90.00 09000 DEPSYCH 0 235,073 90.04 90.00 09000 DEPSYCH 0 250,073 90.04 90.00 09000 DEREGRENCY 0 615,525 90.00 0716ER ET IMBURSABLE COST CENTERS 90.00 90.00 90.00 0716 DO 10100 HEALTH AGENCY 0 615,525 90.00 0716 DO 10100 HONE HEALTH AGENCY 0 0 0 110.00 110.00 110.00 HOSPICE SUPPLIES 0 0 0 0 110.00 110.00 HOSPICE SUPPLIES 0 0 0 110.00 110.00 HOSPICE SUPPLIES 0 0 0 0 110.0	· · · · · · · · · · · · · · · · · · ·	0	948, 671		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 887, 469 71.00 720 07200 MPL DEV. CHARGED TO PATIENTS 0 0 0 73.00	• • • • • • • • • • • • • • • • • • •		l '	1	
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 1,087,850 1,250 0,300 0,700 0,		_	l '	1	
73.00 07300 DRUSS CHARGED TO PATLENTS 0 0 0 75.00				l .	
10 10 10 10 10 10 10 10			, ,		
			l e		
BR 00 BOSIO RURAL HEALTH CLINIC 0 945,076 89.00				3	
89 .00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			., ., ., ., ., .,	1	1
90. 00 09000 CLIN IC 0 01 09001 CLIN IC - MCDONALD -1, 255, 931 437, 696 90. 01 90. 02 09002 CLIN IC - FAM PRAC, PEDS, & ENT -1, 310, 931 238, 693 90. 02 0903 09003 UTHERAPY 0 0 0 0 0 0 0 0 0	88. 00 08800 RURAL HEALTH CLINIC	0	945, 076		88. 00
00. 01 090.01 090.01 01. NIC - MCDOMALD -1, 255, 931 437, 696 90. 01 90. 02 900.02 090.02 090.03 090.03 090.03 V THERAPY 0 0 235, 073 90. 04 900.04 900.04 900.04 900.04 900.05 0 235, 073 90. 04 900.04 900.06 90. 03 90.06 90.			1	1	
90. 02 09002 CLI NIC - FAM PRAC, PEDS, & ENT -1, 310, 240 238, 693 90. 02 90. 03 900. 03 900. 03 900. 04 900. 04 900. 04 900. 04 900. 04 900. 06 900. 04 900. 06 9					1
90. 03 09003 V THERAPY 0 0 235,073 990.04 99004 0P SYCH 90.00 90.004 0P SYCH 90.00 90.004 0P SYCH 90.00 90.004 0P SYCH 90.00 90.004 0P SYCH 90.004 9					
90. 04 990.04 09700 EMERGENCY 0 2.35, 073 99. 04 91. 00 92.00 09200 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 07200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 OBSERVATION BEDS (NON			1		
91.00 09100 EMERCENCY 0 2, 192, 308 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OBSERVATION			1	1	
92.00 09200 095ERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 615,525 101.00 10100 HOME HEALTH AGENCY 0 615,525 101.00 10100 HOME HEALTH AGENCY 0 0 0 113.00 10100 HOME HEALTH AGENCY 0 0 0 114.00 1					
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 615, 525 58PECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 0 0 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 116.		0	2, 172, 300	,	
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		l.	l		1
113.00 11300 INTEREST EXPENSE 0 0 0 114.00		0	615, 525	5	101. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 97, 419 116. 00 116.00 HOSPI CE SUBTOTALS (SUM OF LI NES 1 through 117) -7, 842, 134 58, 130, 162 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 194. 00 194. 00 19751 MOB 0 0 194. 00 194. 10 194. 10 194. 10 194. 10 194. 11 19761 196. 00 196. 00 194. 10 194. 10 194. 11 19761 196. 00 196. 00 194. 10 194. 11 19761 194. 12 194. 13 194. 14 19764 11MUNI ZATI ON CLI NI C 194. 15 194. 16 19765 19765 19					
116. 00 116.00 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) -7, 842, 134 58, 130, 162 118. 00 119. 00 119. 00 119. 00 119. 00 119					
118.00 SUBTOTALS (SUM OF LINES 1 through 117) -7, 842, 134 58, 130, 162 18.00 190.00 190.00 190.00 190.00 190.00 197.00 190.00 197					
NONREI MBURSABLE COST CENTERS 190. 00 190000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00		_			
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 194. 00 194. 10		-1,842,134	58, 130, 162	4	1118.00
194. 00 07950 DAYCARE-INFANT/TODDLER		n	0		190 00
194. 01 07951 MOB 0 0 194. 01 194. 02 17952 COMMUNI TY HEALTH 0 2, 240 194. 03 17953 ASSI STED LI VI NG/CAMERON WOODS 0 0 194. 03 17953 ASSI STED LI VI NG/CAMERON WOODS 0 0 194. 03 17954 EDUCATI ON 0 34, 777 194. 05 07955 MARKETI NG 0 931, 533 194. 06 17956 GUEST MEALS 0 9, 975 194. 06 17957 OUTSI DE LAUNDRY 0 0 0 194. 07 17957 OUTSI DE LAUNDRY 0 0 0 194. 08 1795. 0UTSI DE LAUNDRY 0 0 0 194. 08 1795. 0UTSI DE LAUNDRY 0 0 0 194. 08 1795. 0UTSI DE LAUNDRY 0 0 0 194. 09 17959 URGENT CARE 0 0 1, 501, 850 194. 09 17950 URGENT CARE 0 0 1, 501, 850 194. 10 1794. 11 1794. 11 17961 DBGYN 0 1, 069, 641 194. 11 1794. 12 17962 TRI NE STUDENT HEALTH 0 1, 069, 641 194. 12 1794. 13 17963 OCCUPATI ONAL HEALTH 0 1, 069, 641 194. 12 194. 13 17963 OCCUPATI ONAL HEALTH 0 1, 069, 641 194. 13 17964 UNUNI ZATI ON CLI NI C 0 195, 098 194. 15 1794. 16 17967 RETAIL PHARMACY 0 63, 435 194. 16				l .	
194. 02 07952 COMMUNITY HEALTH 0 2, 240 194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 194. 03 194. 04 07954 EDUCATION 0 34, 777 194. 05 07955 MARKETING 0 931, 533 194. 06 07956 GUEST MEALS 0 9,975 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 07 194. 08 07958 CANCER CENTER 0 0 0 194. 09 194. 09 07959 URGENT CARE 0 1,501, 850 194. 09 194. 10 07960 RHC 0 0 194. 10 07960 RHC 0 194. 11 07961 OBGYN 0 1,069, 641 194. 12 07962 TRINE STUDENT HEALTH 0 76, 508 194. 12 194. 13 07963 OCCUPATIONAL HEALTH 0 76, 508 194. 12 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 194. 15 194. 16 07967 RETAIL PHARMACY 0 6 33, 435 1994. 16			l e		
194. 04 07954 EDUCATI ON		0	2, 240		194. 02
194. 05 07955 MARKETI NG 0 931, 533 194. 06 194. 07 07957 GUEST MEALS 0 9, 975 194. 08 07958 CANCER CENTER 0 0 1, 501, 850 194. 10 07960 RHC 0 0 194. 10 07960 RHC 0 1, 501, 850 194. 12 07962 TRI NE STUDENT HEALTH 0 76, 508 194. 13 07963 OCCUPATI ONAL HEALTH 0 46, 727 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 194. 15 07965 FOUNDATI ON 194. 15 07965 FOUNDATI ON 194. 16 07967 RETAIL PHARMACY 0 63, 435 194. 16		0	0		
194. 06 07956 GUEST MEALS 0 9, 975 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 07 194. 08 07958 CANCER CENTER 0 0 0 1,501, 850 194. 09 07959 URGENT CARE 0 1,501, 850 194. 10 07960 RHC 0 0 194. 11 07961 OBGYN 0 1,069, 641 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 0 76, 508 194. 13 07963 OCCUPATI ONAL HEALTH 0 446, 727 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 195. 098 194. 15 07965 FOUNDATI ON 1 194. 15 07965 FOUNDATI ON 1 194. 15 194. 16 07967 RETAIL PHARMACY 0 63, 435 194. 16		0			
194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 07 194. 08 07958 CANCER CENTER 0 0 0 194. 08 194. 09 07959 URGENT CARE 0 1,501,850 194. 09 194. 10 07960 RHC 0 0 0 194. 10 194. 11 10 194. 12 07962 TRI NE STUDENT HEALTH 0 76,508 194. 13 07963 OCCUPATI ONAL HEALTH 0 446,727 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 195. 098 194. 15 07965 FOUNDATI ON 1 0 0 344, 275 194. 16 07967 RETAIL PHARMACY 0 63,435		0		l .	
194. 08 07958 CANCER CENTER 0 0 194. 08 194. 09 07959 URGENT CARE 0 1, 501, 850 194. 09 194. 10 07960 RHC 0 0 0 194. 10 194. 11 07961 OBGYN 0 1, 069, 641 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 0 76, 508 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 0 446, 727 194. 13 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 195, 098 194. 14 194. 15 07965 FOUNDATI ON 0 344, 275 194. 15 194. 16 07967 RETAI L PHARMACY 0 63, 435 194. 16		0	1		
194. 09 07959 URGENT CARE 0 1,501,850 194. 09 194. 10 07960 RHC 0 0 0 194. 10 194. 11 07961 OBGYN 0 1,069,641 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 0 76,508 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 0 446,727 194. 13 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 195,098 194. 13 194. 15 07965 FOUNDATI ON CLI NI C 0 344, 275 194. 16 07967 RETAI L PHARMACY 0 63,435 194. 16		0]		
194. 10 07960 RHC 0 0 194. 10 194. 11 07961 OBGYN 0 1, 069, 641 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 0 76, 508 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 0 446, 727 194. 13 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 195, 098 194. 14 194. 15 07965 FOUNDATI ON 0 344, 275 194. 16 07967 RETAI L PHARMACY 0 63, 435 194. 16			1 501 050		
194. 11 07961 0BGYN 0 1, 069, 641 194. 12 07962 TRI NE STUDENT HEALTH 0 76, 508 194. 13 07963 OCCUPATI ONAL HEALTH 0 446, 727 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 195, 098 194. 14 194. 15 07965 FOUNDATI ON 0 344, 275 194. 16 07967 RETAIL PHARMACY 0 63, 435 194. 16			, ,		1
194. 12 07962 TRI NE STUDENT HEALTH 0 76, 508 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 0 446, 727 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 195, 098 194. 14 194. 15 07965 FOUNDATI ON 0 344, 275 194. 16 07967 RETAIL PHARMACY 0 63, 435 194. 16					
194. 13 07963 OCCUPATI ONAL HEALTH 0 446, 727 194. 14 07964 IMMUNI ZATI ON CLI NI C 0 195, 098 194. 14 194. 15 07965 FOUNDATI ON 0 344, 275 194. 16 07967 RETAIL PHARMACY 0 63, 435 194. 16		l 0			
194. 14 07964 I MMUNI ZATI ON CLI NI C 0 195, 098 194. 14 194. 15 07965 FOUNDATI ON 0 344, 275 194. 16 07967 RETAIL PHARMACY 0 63, 435 194. 16		0			
194. 15 07965 FOUNDATION 0 344, 275 194. 15 194. 16 07967 RETAIL PHARMACY 0 63, 435 194. 16		0			
	194. 15 07965 FOUNDATI ON	0		l .	
200.00 TOTAL (SUM OF LINES 118 through 199) -7,842,134 62,806,221 200.00	• • • • • • • • • • • • • • • • • • •	_	l '	1	
	200.00 TOTAL (SUM OF LINES 118 through 199)	-7, 842, 134	62, 806, 221		200.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-1315

					То	09/30/2019	Date/Time Prepare 2/25/2020 1:53 pr
		Increases			· · · · · ·		, , , , , , , , , , , , , , , , , , ,
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - LABOR AND DELIVERY						
1.00	ADULTS & PEDI ATRI CS	30.00	515, 176	123, 029			1
2.00	NURSERY EMERGENCY	43. 00 91. 00	51, 425 4, 518	12, 281 1, 079			2
3. 00	EMERGENCY	91.00		1,079 136, 389			3
	B - PROPERTY INSURANCE		371, 119	130, 309			
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	89, 418			1
00	0			89, 418			·
	C - CAFETERIA	<u> </u>		21, 119			
1.00	CAFETERI A	11.00	337, 701	265, 327			1
2.00	GUEST MEALS	194. 06	5, 586	4, 389			2
	0		343, 287	269, 716			
	D - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 563, 739			1
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	6, 888			2
3. 00	ADMI NI STRATI VE & GENERAL	5.00	•	2, 649			3
	0		0	1, 573, 276			
4 00	E - DEPRECIATION EXPENSE	0.00		0.047.450			
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00		2, 247, 452			1
	F - ICU		U	2, 247, 452			
1. 00	INTENSIVE CARE UNIT	31.00	79, 161	38, 353			1
1.00	O CARE UNI		79, 161 79, 161	38, 353			'
	H - PROPERTY TAX		77, 101	30, 333			
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	11, 973			1
1.00	0		ŏ	11, 973			
	J - SLEEP LAB	<u> </u>					
1.00	SLEEP LAB	65. 01	0	101, 641			1
2. 00		0.00	o	0			2
	0		0	101, 641			
	L - PUBLIC RELATIONS						
1. 00	MARKETING	194.05	0	<u>40, 8</u> 38			1
	0		0	40, 838			
4 00	M - HOME HEALTH SALARY	101.00	25 222				
1. 00	HOME HEALTH AGENCY	101.00	2 <u>5, 808</u> 25, 808	<u>0</u>			1
	N - RECOVERY ROOM		25, 808	U			
1. 00	RECOVERY ROOM	51.00	634, 248	0			1
1.00	O RECOVERT ROOM		634, 248	<u>o</u>			'
	O - IMPLANTABLE DEVICES		034, 240	<u> </u>			
1. 00	IMPL. DEV. CHARGED TO	72.00	0	1, 087, 850			1
	PATI ENTS			,			
	0 — — — — —			1, 087, 850			
	P - HOME HEALTH ADMIN						
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	88, 043	0			1
	0		88, 043	0			
	Q - URGENT CARE						
1. 00	ADMI NI STRATI VE & GENERAL	5.00	189, 256	0			1
	U DE LIGORI DE DEGLACO		189, 256	U			
1 00	R - HOSPI CE RECLASS	11/ 00	20 552	0			
1. 00	HOSPICE	116.00	38, 553	<u>0</u>			1
	S - FOUNDATION RECLASS		38, 553	U			
1. 00	FOUNDATION RECLASS	194. 15	4, 774	0			1
1.00	0	174.13	$-\frac{4,774}{4,774}$	<u>o</u>			'
	T - IMMUNIZATION CLINIC RECL	ASS	4, / / 4	O _I			
1. 00	IMMUNIZATION CLINIC	194. 14	O	145, 220			1
		├ ─					1 '
	TOTALS		()I	145, 220			

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1315

					То	09/30/2019 Date/Ti me 2/25/2020	
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10.00		
1. 00	A - LABOR AND DELIVERY DELIVERY ROOM & LABOR ROOM	52. 00	571, 119	136, 389	O		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	0.00	3/1, 119	130, 369			2.00
3. 00		0.00	0	0	0		3.00
0.00		— — 	571, 119	136, 389	— — "		0.00
	B - PROPERTY INSURANCE	<u>'</u>			· · · · · · · · · · · · · · · · · · ·		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	89, 418			1. 00
	0		0	89, 418			
	C - CAFETERIA						
1. 00	DI ETARY	10. 00	343, 287	269, 716			1. 00
2.00		0.00	0	0	0		2. 00
	D - INTEREST EXPENSE		343, 287	269, 716			
1. 00	INTEREST EXPENSE	113. 00	ol	1, 573, 276	9		1.00
2. 00	TWIEREST EXIENSE	0.00	0	1, 373, 270			2.00
3. 00		0. 00	o	0	0		3.00
				1, 573, 276			
	E - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FLXT	100	0	<u>2, 247, 4</u> 52			1. 00
	0		0	2, 247, 452			
	F - ICU						
1. 00	ADULTS & PEDIATRICS	3000	7 <u>9, 1</u> 61	38, 353	0		1. 00
	U DODERTY TAY		79, 161	38, 353			
1. 00	H - PROPERTY TAX ADMINISTRATIVE & GENERAL	5. 00	ol	11, 973	13		1.00
1.00	O GENERAL			1 <u>1, 973</u> 11, 973			1.00
	J - SLEEP LAB		<u> </u>	11, 773			
1.00	RESPIRATORY THERAPY	65. 00	0	88, 861	0		1.00
2.00	ELECTROCARDI OLOGY	69. 00	О	12, 780			2. 00
	0			101, 641			
	L - PUBLIC RELATIONS						
1. 00	ADMINISTRATIVE & GENERAL		0_	4 <u>0, 8</u> 38			1. 00
	0		0	40, 838			
1 00	M - HOME HEALTH SALARY	114 00	25 000	0			1 00
1. 00	HOSPICE	116.00	2 <u>5, 8</u> 08 25, 808	$ \frac{0}{0}$			1.00
	N - RECOVERY ROOM		23, 606	0			
1. 00	OPERATI NG ROOM	50.00	634, 248	0	0		1.00
00	0	= = = = = = = = = = = = = = = = = =	634, 248	— — <u> </u>			
	O - IMPLANTABLE DEVICES	<u>'</u>					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 087, 850	0		1. 00
	PATI ENT						
	0		0	1, 087, 850			
1 00	P - HOME HEALTH ADMIN	101 00	00.043				1 00
1. 00	HOME HEALTH AGENCY	101.00	8 <u>8, 043</u> 88, 043	$ \frac{0}{0}$	0		1.00
	Q - URGENT CARE		00, 043				
1. 00	URGENT CARE	194. 09	189, 256	0	0		1.00
1.00	0	— — 1711. 07	189, 256	— — <u> </u>	— — —		1.00
	R - HOSPI CE RECLASS				<u> </u>		
1.00	HOME HEALTH AGENCY	101.00	38, 553	0	0		1.00
	0		38, 553				
	S - FOUNDATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL		4,774	0			1. 00
	0	00	4, 774	0			
1 00	T - IMMUNIZATION CLINIC RECLA		ما	145 220			1 00
1. 00	TOTALS	1500		14 <u>5, 2</u> 20 145, 220			1.00
500 00	Grand Total: Decreases		1, 974, 249	5, 742, 126			500.00
550.00		I	1, 7,7,277	5, , 72, 120	ı I		1 000.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS | Peri od: | Worksheet A-7 | From 10/01/2018 | Part | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-1315

		n
Acqui si ti ons		
Beginning Purchases Donation Total	Di sposal s and	
Bal ances	Retirements	
1.00 2.00 3.00 4.00	5. 00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		
1. 00 Land 1, 462, 868 0 0		. 00
2.00 Land Improvements 0 0 0		. 00
3.00 Buildings and Fixtures 56,939,487 1,081,429 0 1,081		. 00
4.00 Building Improvements 20,000 0 0		. 00
5.00 Fi xed Equipment 0 0 0		. 00
6.00 Movable Equipment 19,354,014 1,115,107 0 1,115		. 00
7.00 HIT designated Assets 0 0 0		. 00
8.00 Subtotal (sum of lines 1-7) 77,776,369 2,196,536 0 2,196		. 00
9.00 Reconciling Tems 0 0 0		. 00
10.00 Total (line 8 minus line 9) 77, 776, 369 2, 196, 536 0 2, 196	536 512, 455 10.	. 00
Ending Fully		
Bal ance Depreciated		
Assets		
6.00 7.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		
1. 00 Land 1, 419, 368 0		. 00
2.00 Land Improvements 0 0		. 00
3.00 Buildings and Fixtures 58,020,916 0		. 00
4.00 Building Improvements 20,000 0		. 00
5.00 Fixed Equipment 0 0		. 00
6.00 Movable Equipment 20,000,166 0		. 00
7.00 HIT designated Assets 0 0		. 00
8.00 Subtotal (sum of lines 1-7) 79,460,450 0		. 00
9.00 Reconciling Items 0 0		. 00
10.00 Total (line 8 minus line 9) 79,460,450 0	10.	. 00

Heal th	n Financial Systems CAME	ERON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7		
					From 10/01/2018			
					To 09/30/2019	Date/Time Pre	pared:	
						2/25/2020 1:5	3 pm	
SUMMARY OF CAPITAL								
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see	instructions)		
					instructions)			
		9. 00	10.00	11. 00	12.00	13.00		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00	CAP REL COSTS-BLDG & FLXT	6, 065, 262	. 0		0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP		2, 189, 196		0 0	0	2.00	
3. 00	Total (sum of lines 1-2)	6, 065, 262			0 0	0	3.00	
			F CAPITAL					
	Cost Center Description	Other	Total (1)					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Capi tal -Rel at						
			9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2				
1 00	CAD DEL COSTS PLDC & ELVT	NOTICET A, COLO	· · · · · · · · · · · · · · · · · · ·				1 00	

	PART IT - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES I AND 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 065, 262		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 189, 196		2.00		
3.00	Total (sum of lines 1-2)	0	8, 254, 458		3. 00		

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-1								
	CILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-1315			Peri od:	Worksheet A-7		
					From 10/01/2018 To 09/30/2019	Date/Time Pre		
		COMI	 PUTATION OF RA	TLOS	ALLOCATION OF	2/25/2020 1:5 OTHER CAPITAL	3 pm	
		COM	PUTATION OF RA	1103	ALLOCATION OF	UTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
			Leases	for Ratio	instructions)			
				(col. 1 -				
		1. 00	2.00	col. 2) 3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	3.00		
1.00	CAP REL COSTS-BLDG & FLXT	59, 440, 284	0	59, 440, 28	0. 748049	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	20, 020, 166	0	20, 020, 16		0	2.00	
3.00	Total (sum of lines 1-2)	79, 460, 450		79, 460, 450			3.00	
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL								
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
			Capi tal -Rel at					
			ed Costs	through 7)				
	DART III DECONOLITATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00		
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS 0	1 0		5, 215, 099	0	1.00	
2. 00	CAP REL COSTS-BEDG & TTXT	0			2, 225, 266		2.00	
3. 00	Total (sum of lines 1-2)	0	1		7, 440, 365		3.00	
	, , , , , , , , , , , , , , , , , , ,		Sl	JMMARY OF CAPI				
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)		
			(see	instructions)				
			instructions)		ed Costs (see instructions)	9 through 14)		
		11. 00	12. 00	13.00	14.00	15. 00		
	DART III - PECONCILIATION OF CARLTAL COSTS C				00			

-98, 419 -434

-98, 853

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT
CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

89, 418

89, 418

11, 973 0 11, 973 5, 218, 071 1. 00 4, 420, 916 2. 00 9, 638, 987 3. 00

0 0 0

1. 00 2. 00

	Financial Systems	CAMEI	RON MEMORIAL CO	MMUNITY HOSPITAL	In Lieu of Form CMS-2552-			
ADJUST	MENTS TO EXPENSES				Peri od: From 10/01/2018 To 09/30/2019	Worksheet A-8 Date/Time Pre 2/25/2020 1:5	pared:	
				Expense Classification on To/From Which the Amount is				
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
		1. 00	2. 00	3. 00	4. 00	5. 00		
1.00	Investment income - CAP REL	Α	-98, 419	CAP REL COSTS-BLDG & FIXT	1. 00	11	1.00	
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	Α	-434	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00	
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	А	-167	ADMINISTRATIVE & GENERAL	5. 00	0	3. 00	
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00	
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00	
6. 00	expenses (chapter 8) Rental of provider space by	В	-12, 779	CAP REL COSTS-MVBLE EQUIP	2. 00	9	6. 00	
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00	
8. 00	21) Tel evi si on and radi o servi ce		0		0.00	0	8. 00	
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0		
10.00	Provider-based physician adjustment	A-8-2	-2, 736, 711			0		
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0		
12. 00	Related organization transactions (chapter 10)	A-8-1	-356, 347			0		
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		-237, 840	CAFETERI A	0. 00 11. 00	0	14.00	
15. 00 16. 00	Rental of quarters to employee and others Sale of medical and surgical supplies to other than		0		0.00	0		
17. 00	patients Sale of drugs to other than patients	В	-78, 149	PHARMACY	15. 00	0	17. 00	
18. 00	Sale of medical records and	В	-548	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00	
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00	
20. 00 21. 00	books, etc.) Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)	В	-14, 343 0	CAFETERI A	11. 00 0. 00	0		
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00	
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00	
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00	
25. 00	Utilization (chapter 14) Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114. 00		25. 00	
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00	
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00	
	Non-physician Anesthetist	٨		*** Cost Center Deleted *** CLINIC- MCDONALD		0	28.00	
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A A-8-3		*** Cost Center Deleted ***	90. 01 67. 00	0	29. 00 30. 00	
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99	

ADJUSTMENTS TO EXPENSES Provider CCN: 15-1315 Peri od: Worksheet A-8 From 10/01/2018 09/30/2019 Date/Time Prepared: 2/25/2020 1:53 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5.00 68.00 31.00 Adjustment for speech A-8-3 0 *** Cost Center Deleted *** 31.00 pathology costs in excess of limitation (chapter 14) -9, 407 CAP REL COSTS-MVBLE EQUIP 32.00 CAH HIT Adjustment for 32.00 Α 2.00

-4, 718 ADMINISTRATIVE & GENERAL

-9.564 ADMINISTRATIVE & GENERAL

-32, 316 CAP REL COSTS-BLDG & FIXT

-278, 421 ADMI NI STRATI VE & GENERAL

5.00

5.00

5.00

10.00

1.00

33.00

33.03

33.04

ol 33.01

0 33.02

-387 ADMINISTRATIVE & GENERAL ATM SURCHARGE REVENUE 33 05 В 5.00 0 33.05 33.06 DIETICIAN CONSULTATIONS В -2, 130 CAFETERI A 11.00 0 33.06 33.08 HAF EXPENSE -2, 901, 749 ADMI NI STRATI VE & GENERAL 33.08 Α 5.00 PHYSICIAN INCOME GUARANTEE 793 ADMINISTRATIVE & GENERAL 5.00 33.09 33.09 Α OFFSET NON PROVIDE CLINIC OFFSET -903, 544 CLINIC - FAM PRAC, PEDS, & 33.10 Α 90.02 33.10 MOVING EXPENSES -6, 447 ADMINISTRATIVE & GENERAL 33. 11 5.00 33.11 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, -7, 842, 134 50.00 50.00

-9, 405 DI ETARY

Α

Α

В

В

column 6, line 200.)

Depreciation and Interest LOBBYING EXPENSES

EMPLOYEE CHRISTMAS PARTY

RENTAL INCOME OFFSET - CANCER

PHYSICIAN RECRUITMENT

MEALS ON WHEELS

CENTER

33. 01

33.02

33.03

33.04

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

				To 09/30/2019	Date/Time Pre			
				1	2/25/2020 1:5	3 pm		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount			
				Allowable Cost	Included in			
					Wks. A, column			
					5			
	1.00 2.00		3. 00	4. 00	5. 00			
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME							
	OFFICE COSTS:							
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	188, 613	1.00		
2.00	5. 00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	30, 300	2.00		
3.00	7. 00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3, 300	3.00		
4.00	1.00	CAP REL COSTS-BLDG & FIXT	CMO RENTAL	753, 135	887, 269	4.00		
5. 00	0		0	753, 135	1, 109, 482	5.00		
			•	•				

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

			Related Organization(s) and/	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	С	CAMERON MEDICAL	100.00	0.00	6. 00
7.00			0.00	0.00	7. 00
8. 00			0.00	0.00	8. 00
9. 00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Heal th	Financial Syste	ems	CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-					2552-1	
			RELATED ORGANIZATIO		Provider CCN		Period:	Worksheet A-8	
OFFICE		JERVICES TROW	RELATED ORGANIZATIO	INS AND HOWL	Trovider con	v. 15-1515	From 10/01/2018	WOLKSHEET A-C) - 1
UITICL	00313						To 09/30/2019	Date/Time Pre	epared:
								2/25/2020 1:5	3 pm
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A	RESULT OF TRA	ANSACTIONS WI	TH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:								
1.00	-188, 613	0							1.00
2.00	-30, 300	0							2.00
3.00	-3, 300	0							3.00
4.00	-134, 134	9							4.00
5.00	-356, 347								5. 00
* The	amounts on Line	es 1-4 (and sub	scripts as appropri	ate) are tran	sferred in de	etail to Wor	rksheet A column	6 lines as	
			se cost and negative						t which
			columns 1 and/or 2,						
nas not	Related Orga		cordinary randy or 2,	the amount o	ii i owabi c 3iloc	ara be mark	Catca in corumn 4	or this part.	
	and/or Ho								
	aliu/oi no	ille Office							
	Tymo of	Dual page							
	Type of	Busi ness							

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

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

6.00	6.00
7. 00	7.00
8. 00	8.00
9. 00	9.00
10.00	10.00
7. 00 8. 00 9. 00 10. 00 100. 00	100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

6. 00

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-1315

					1	To 09/30/2019	Date/Time Pro 2/25/2020 1:	epared: 53 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00	90. 01	CLINIC- MCDONALD	1, 106, 829	1, 106, 829	0	0	0	1.00
2.00	60.00	LABORATORY	5, 793	1, 770	4, 023	0	0	2.00
3.00		ADULTS & PEDIATRICS	704, 354	656, 904	47, 450	0	0	3.00
4.00		OPERATING ROOM	564, 512	•		0	0	
5. 00		CLINIC - FAM PRAC, PEDS, &	406, 696	406, 696	0	0	0	5.00
		ENT						
6. 00	0. 00		0	1		0	0	
7. 00	0. 00		0	0	0	0	0	
8. 00	0. 00		0	0	0	0	0	
9. 00	0. 00		0	0	0	0	0	7.00
10.00	0. 00		0	0	0	0	0	
200.00			2, 788, 184		51, 473		0	
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1. 00	2.00	8. 00	9. 00	Education	12 13. 00	14.00	
1. 00		CLINIC- MCDONALD	8.00		12.00		14.00	1.00
2.00		LABORATORY			_	-		1
3. 00		ADULTS & PEDIATRICS		-	_	0		
4. 00		OPERATING ROOM		0	_	0		1
5. 00		CLINIC - FAM PRAC, PEDS, &		1	· ·	0		
3.00		ENT			0			3.00
6.00	0.00	LIVI	0	0	0	0	0	6, 00
7. 00	0.00		0	0	0	0	0	
8. 00	0.00		0	0	0	0	0	
9. 00	0.00		l o	Ö	0	0	l o	
10.00	0.00		0	0	0	0	0	1
200.00			0	0	0	0	0	200.00
	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		CLINIC- MCDONALD	0	-	_	.,,	•	1.00
2. 00		LABORATORY	0	-	_	.,,,,		2.00
3. 00		ADULTS & PEDIATRICS	0	Ĭ	_	656, 904	•	3.00
4. 00		OPERATING ROOM	0	-	_	564, 512		4. 00
5. 00		CLINIC - FAM PRAC, PEDS, &	0	0	0	406, 696		5. 00
		ENT	_	_	_	_		
6.00	0.00		0	0	0	0		6.00
7. 00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0. 00			0	0	0 70/ 711		10.00
200. 00			0	0	0	2, 736, 711	l	200.00

REASON	Financial Systems CAME ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	RON MEMORIAL CC FURNISHED BY	Provider Co		In Lie Period: From 10/01/2018 To 09/30/2019 Respiratory	Date/Time Pre 2/25/2020 1:5	-3 pared:	
		Cost						
			1. 00					
1. 00 2. 00 3. 00 4. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst		52 780 365 0	3.00				
5. 00 6. 00	Number of unduplicated offsite visits - supervisors or therapists (see instructions) Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)							
7. 00 8. 00	Standard travel expense rate Optional travel expense rate per mile					3. 25 0. 00		
		Supervi sors 1.00	Therapi sts 2.00	Assistants 3.00	Ai des 4.00	Trai nees 5. 00		
9. 00	Total hours worked	0.00	26, 786. 00			0.00	9. 00	
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	64. 62 33. 15	66. 30 33. 15			0.00	10.00	
12. 00 12. 01 13. 00 13. 01	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		12. 00 12. 01 13. 00 13. 01	
						1. 00		
	Part II - SALARY EQUIVALENCY COMPUTATION							
14. 00 15. 00 16. 00 17. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others)	0 1, 775, 912 73, 460 1, 775, 912	16.00					
	Aides (column 4, line 9 times column 4, line 10) Trainees (column 5, line 9 times column 5, line 10) Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 1,775,91 If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or							
04.00	occupational therapy, line 9, is greater tha amount from line 20. Otherwise complete lin	es 21-23.					04.00	
21. 00 22. 00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,	0.00	21.00					
23. 00	Weighted allowance excluding aides and trainees (line 2 times line 21) Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
04.00	Standard Travel Allowance	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		017111011	1077 5277 6772	10 100		
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					12, 100 0		
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26. 00 27. 00	
28. 00	others) Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 13,286							
	27) Optional Travel Allowance and Optional Trave							
29. 00 30. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		nd 2, line 12)		0	1	
31. 00							31.00	
32. 00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32.00	
33. 00 34. 00							33. 00 34. 00	
35. 00	Optional travel allowance and standard travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
24 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)							
36. 00 37. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)						36. 00 37. 00	
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 and 6)						38. 00 39. 00	
	Optional Travel Allowance and Optional Travel Expense							
40. 00 41. 00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 10)						40. 00 41. 00	
42. 00 43. 00							ł	
73.00	Total Travel Allowance and Travel Expense -				lowing three lin		75.00	
44. 00	46, as appropriate. 00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 46, as appropriate.							

REASONABLE COST DETERMINATION FOR THERMAPY SERVICES FURNISHED BY Provider COI: 16-1315 Period for COI: 16-1315 Per	Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10							
1.00			FURNI SHED BY	Provider Co	Provi der CCN: 15-1315		Parts I-VI Date/Time Pre	pared:
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see Instructions) 0 45.00						,	Cost	
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see Instructions) 0 45.00							1. 00	
Therapists Assistants Aides Trainess Total							0	
PART V - OVERTIME COMPUTATION	40.00	optional travel arrowance and optional trave	Therapi sts	Assi stants	Ai des	Trai nees	Total	40.00
47.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 1.578.50 47.00 48.00 49.00 4		DART V OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
48.00 Overtime rate (see instructions) 99.45 99.46 0.00 0.00 44.00	47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	1, 578. 50	0.00	0.0	0.00	1, 578. 50	47. 00
50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47 by the total overtime worked - column 5, line 47 by the total overtime worked - column 5, line 47 by the total overtime worked - column 5, line 47 by the total overtime worked - column 5, line 47 by the total overtime worked - column 5, line 47 by the total overtime worked - column 5, line 47 by the total overtime worked - column 5, line 49 by the total overtime work year 2,080.00 0.00 0.00 0.00 0.00 2,080.00 51.00		Overtime rate (see instructions) Total overtime (including base and overtime						
(divide the hours in each column o, line 47 by the total overtime worked - column 5, line 47) by the total overtime worked - column 5, line 47) by the total overtime worked - column 5, line 47) 51.00 Allocation of provider's standard work year 2,080.00 0.00 0.00 0.00 0.00 2,080.00 51.00 for one full-time employee times the percentages on line 50) (see instructions) 52.00 Adjusted hourly salary equivalency amount (see instructions) 53.00 Overtime cost limitation (line 51 times line 137,904 0 0 0 0 0 53.00 (see instructions) 54.00 Maximum overtime cost (enter the lesser of 137,904 0 0 0 0 55.00 (see instructions) 55.00 Portion of overtime already included in 104,655 0 0 0 0 0 55.00 line 49 or line 53) 55.00 Portion of overtime already included in 104,655 0 0 0 0 0 55.00 hourly computation at the AMSEA (multiply line 47 times line 52) 56.00 Overtime all owance (line 54 minus line 55 - 33,249 0 0 0 0 33,249 56.00 life against venter zero) (Enter in col umn 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) 57.00 Salary equivalency amount (from line 23) 58.00 Travel all owance and expense - provider site (from lines 33, 34, or 35)) 1, 775, 912 57.00 (see instructions) 1, 33, 249 (see instructions) 1, 30, 34, 34, 35, 34,	F0 00		400.00				400.00	
S1.00 Allocation of provider's standard work year 2,080.00 0.00	50.00	(divide the hours in each column on line 47 by the total overtime worked - column 5,	100.00	0.00	0.0	0.00	100.00	50.00
52.00 Adjusted hourly salary equivalency amount (See instructions) 52.00 0.00	51. 00	Allocation of provider's standard work year for one full-time employee times the	2, 080. 00	0. 00	0.0	0.00	2, 080. 00	51.00
See instructions Solid S	F2 00		// 20	0.00	0.0	0 00		F2 00
52		(see instructions)						
1.00 55.00		52)						
hourly computation at the ÅHSEA (multiply line 47 times line 52)		line 49 or line 53)		0		0 0		
If negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) 1.00		hourly computation at the AHSEA (multiply						
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT	56. 00	if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	33, 249	0		0	33, 249	56.00
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 57.00 Sal ary equivalency amount (from line 23) 1,775,912 57.00 58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 0.58.00 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 0.59.00 60.00 Overtime allowance (from column 5, line 56) 0.59.00 61.00 Equipment cost (see instructions) 0.61.00 62.00 Supplies (see instructions) 0.62.00 63.00 Total allowance (sum of lines 57-62) 1,809,161 63.00 64.00 Total cost of outside supplier services (from your records) 0.64.00 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 0.65.00 LINE 33 CALCULATION 0.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 12,100 100.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 1,186 100.01 101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 1,186 101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 1,186 101.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0.101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0.102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0.102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0.102.00 102.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0.102.00 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 0.102.01 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 0.102.01 102.01 102.01 102.01 102.01 102.01 103.02 103.02 103.03 103.03 103.03 103.0								
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 0 58.00 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 0 59.00 60.00 Overtime allowance (from column 5, line 56) 33, 249 60.00 61.00 Equipment cost (see instructions) 0 61.00 62.00 Supplies (see instructions) 0 62.00 63.00 Total allowance (sum of lines 57-62) 1,809,161 63.00 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 0 64.00 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 0 65.00 LINE 33 CALCULATION 100.00 100.01 100.02 100.01 100.00	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 12, 100 100.00 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 13, 286 100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 1, 186 100.02 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1, 186 101.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1, 186 101.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1, 186 101.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1, 186 101.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1, 186 102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1, 186 102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1, 186 102.00 line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 1, 186 102.00 line 31 = line 29 for respiratory therapy or sum of columns 1-3, line	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 60.00 Overtime allowance (from column 5, line 56) Equipment cost (see instructions) 62.00 Supplies (see instructions) 63.00 Total allowance (sum of lines 57-62) 64.00 Total cost of outside supplier services (from your records) 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0 0 33, 249 0 0 1, 809, 161	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 1, 186 101.00 101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0 101.01 101.02 Line 34 = sum of lines 27 and 31 1, 186 101.02 Line 35 CALCULATION 102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0 102.00 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 0 102.01 101.02 103.03 104.05 105.06 105.07 105.07 106.07 107.08 107.09 107.09 108.09 109.00	100. 01	100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27						100. 01
102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0 102.00 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 0 102.01	101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 101.02 Line 34 = sum of lines 27 and 31						0	101. 01
· · · · · · · · · · · · · · · · · · ·	102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							
102. 02 Line 35 = sum of lines 31 and 32	13 for all others							

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2018 | Part I | To 09/30/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1315

Cost Center Description					To 09/30/2019	Date/Time Pre	
REPART TS	_		CAPITAL RELATED COSTS			2/25/2020 1:5	3 pm
REPART TS	01. 01	No. 1. E	DI DO A FLYT	MANUE FOLLIE	EMBI OVEE	0.1.1.1.1	
REMARKS SERVICE COST CENTERS 1.00 2.00 4.00 4.00 4.00 1.00 1.00 2.00 4.00 4.00 4.00 1.00	Cost Center Description		BLDG & FIXI	MARTE EGOLA		Subtotal	
CRIFFIELD SERVICE DOST CRIVITES O 1.00 2.00 4.00 4A							
DEBERAL SERVICE COST CENTERS							
SEMBRAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLOB & EXTY 1.40, 0110 1.00 00100 CAP REL COSTS-BLOB & EXTY 1.40, 0110 2.00 00000 CAP REL COSTS-BLOB & EXTY 1.40, 0110 2.00 00000 CAP REL COSTS-BLOB & EXTY 1.40, 0110 2.00 00000 CAP REL COSTS-BLOB & EXTY 1.00 2.00 00000 CAP REL COSTS-BLOB & 9.00 00000 CAP REL COSTS BLOB & 9.00 00000 CA			1 00	2.00	4.00	4.0	
1.00 1.00	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
4.00 0.000 DIANG OVER BREFIT IS DEPARTINIST 7,313, 970 7,307, 709 1,808, 775 7,000 7,0		5, 218, 071	5, 218, 071				1.00
5.00 0.0000 CARMINISTRATIVE & CENERAL 9,710,955 485,766 332,706 1,229,346 1,309,756 5.00 8.00 0.0000 CARMORY & LINEN SERVICE 4.00 14,309,756 1.00 8.00 0.0000 CARMORY & LINEN SERVICE 4.00 14,309,756 1.00 8.00 0.0000 CARMORY & LINEN SERVICE 4.00 1,100 1.000 8.00 0.0000 CARMORY & LINEN SERVICE 4.00 1,100 1.000 8.00 0.0000 CAFTERIA 48,701 48,701 50.03 1.11 50.03 1.00 8.00 0.0000 CAFTERIA 3.00,750 5.00 1.000 8.00 0.0000 CAFTERIA 3.00,750 5.00 1.000 8.00 0.0000 CAFTERIA 3.00,750 5.00 1.000 8.00 0.0000 CAFTERIA 4.000 5.000 8.00 0.0000 CAFTERIA 4.000 5.000 8.00 0.0000 CAFTERIA 4.000 5.000 8.00 0.0000 CAFTERIA 5.000 5.000 8.00 0.0000 CAFTERIA 5.0000 5.000 8.00 0.0000 CAFTERIA 5.0000 5.0000 8.00 0.0000 CAFTERIA 5.0000 5.0000 8.00 0.0000 0.0000 0.0000 8.0000 0.0000 0.00							
2.00 0.0000 LAURDY ALLENS SERVICE 4.0, 814 4.8, 701 3.0 2.0 0.0000 LAURDY ALLENS SERVICE 4.0, 814 4.8, 701 3.0 2.0 0.0 0.0000 LAURDY ALLENS SERVICE 4.0, 814 4.8, 701 3.0 4.0, 400 1.19, 535 0.0 0					1 ' ' 1	11 000 775	
0.00 0.0000 LAUNDEY & LINEN SERVICE 40, 814 48, 701 30, 120 0 0							
10.00 0.000 GETARY							1
11.00 01100 CAFFTERI A 348, 715 91,007 56,979 98,844 594,583 11.00 13.00 13.00 1300 CAFFTERI A 348,745 299,303 142,992 88,374 59,385 376,504 14.00 13.00							1
13.00 01300 MURSINK ADMINISTRATION 818, 744 32, 375 50, 880 225, 901 1,177, 900 15.00 15.00 01500 PHABUACY 289, 303 142, 802 88, 374 178, 806 3, 867, 938 15.00 15.00 01500 PHABUACY 3.134, 348 22, 965 32, 737 147, 806 3, 367, 938 15.00 15.							1
14.00 01400 PARBUACY 3.134, 348 52, 965 576, 504 14.00 15.00 1500 PARBUACY 3.134, 348 52, 965 32, 757 17.88 3.3, 67, 981 15.00 1500 PARBUACY 3.134, 348 52, 965 31, 309 14.5 803 7.78, 365 16.00 PARBUACY 3.130 14.5 803 7.78, 365 16.00 PARBUACY 3.130 14.5 803 7.78, 365 16.00 PARBUACY 3.100 PARBUACY 3.100 2.28 172, 310 PARBUACY 3.100 PARBUACY 3.		1			1		1
16. 00							
INPATI ENT ROUTINE SERVICE COST CENTERS 2,983,073 745,870 461,297 740,396 4,980,636 30.0 0.3100	15. 00 01500 PHARMACY						15. 00
30.00		561, 126	0	31, 396	145, 863	738, 385	16. 00
31.00 03100 NTERSIVE CARE UNIT		2 983 073	745 870	461 20	740 396	4 930 636	30.00
## ANCILLARY SERVICE COST CENTERS 0.00 GOSDO DEPRATING ROOM 1, 441, 222 498, 470 308, 286 230, 838 2, 478, 816 50.00							
50.00		63, 706	19, 260	11, 912	15, 006	109, 884	43.00
51.00		4 444 000	100 170	200 00	200 000	0 470 047	
52.00 05200 DELLYRY ROOM & LABOR ROOM		· · ·					•
54 00 05400 RADIOLOGY-DI AGNOSTI C 2, 523, 738 390, 797 241, 694 470, 591 3, 626, 820 64, 00 0600 LABORATORY 2, 602, 768 127, 209 786, 674 296, 211 3, 104, 862 60, 00 60, 00 0600 RADIATORY 10, 600 0, 00		· ·					•
64.00							•
65.00 06500 RESPIRATORY THERAPY 918, 468 23,571 14,578 9,730 966,347 65.00 66.00 06600 SLEEP LAB 101,641 77,379 0 175,380 65.01 66.00 06600 PHYSICAL THERAPY 948,671 275,466 170,366 267,996 1,662,399 66.00 69.00 06900 ELECTROCADIOLOGY 49,9792 17,288 10,692 0 437,772 69.00 09001 CARDINA CREHAB 77,607 36,457 22,547 20,416 157,027 69.00 0700 MEDICAL SUPPLIES CHARGED TO PATIENT 887,469 0 0 0 0 0 0 887,469 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,087,850 0 0 0 0 0 0 0 0 0		2, 602, 768	127, 209		I I		•
65.00		010 440	0		1		
66.00 O6600 PHYSICAL THERAPY 948, 671 275, 466 170, 366 267, 896 1, 662, 399 66, 00 0890 OEDEROENCORDIOLOGY 409, 792 17, 288 10, 692 0 437, 772 69, 00 69, 01 06901 CARDI AC REHAB 77, 607 36, 457 22, 547 20, 416 157, 027 69, 01 71, 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 887, 469 0 0 0 0 887, 469 71, 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 1, 087, 850 0 0 0 0 0 0 887, 469 71, 00 73, 00 730, 00			23, 371				•
0.9901 0.6901 0.6901 0.6801 0.6801 0.6801 0.6801 0.887, 469 71.00 71.00 0.71.00 0.72.00 0.			275, 466				1
171.00 07100 MPLI DEV. CHARGED TO PATIENT 887, 469 0 0 0 887, 469 17.00 17							1
1,087,850 0,00 0,				1			1
173.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			0				1
1. 3480 0NCOLOGY 0 2, 316, 114 76, 01			0	Ò			1
BR 00 OBSOR CHARL HEALTH CLIN IC 945, 076 0 192, 544 249, 041 1,386, 661 88, 00		0	0	(이	-	1
88. 00 08800 RURAL HEALTH CLINIC 945,076 0 192,544 249,041 1,386,661 88. 00 08900 REDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0		1, 492, 288	509, 017	314, 809	위 이	2, 316, 114	76. 01
89.00 08900		945, 076	0	192. 544	249.041	1. 386. 661	88.00
90. 01 09001 CLI NI C - MCDOMALD 437,696 0 129,667 164,096 731,459 90. 01 90. 02 09002 CLI NI C - FAM PRAC, PEDS, & ENT 238,693 0 71,016 420,930 730,639 90. 02 90. 03 09003 V THERAPY 0 0 0 0 0 0 0 0 0			0		· ·		
90. 02 09002 CLI NIC - FAM PRAC, PEDS, & ENT 238, 693 0 71, 016 420, 930 730, 639 90. 02 90. 03 09003 V THERAPY 0 0 0 0 0 0 0 0 0			0				
90. 03 09003 V THERAPY			0				•
90. 04 090.04 0P PSYCH 235, 073 0 50, 114 64, 453 349, 640 90. 04 91. 00 09100 BERGENCY 2, 192, 308 437, 663 270, 679 558, 813 3, 459, 463 91. 00 92. 00 09200 095EVATION BEDS (NON-DISTINCT PART 0 1000			_		· ·		
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME REI MBURSABLE COST CENTERS 101.00 10100 HOME REALTH AGENCY 615,525 0 35,168 146,073 796,766 101.00 10100 HOME REALTH AGENCY 615,525 0 35,168 146,073 796,766 101.00 10100 HOME REALTH AGENCY 615,525 0 35,168 22,975 155,562 114.00 113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 0 35,168 22,975 155,562 116.00 116.00 HOSPI CE 97,419 0 35,168 22,975 155,562 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 58,130,162 5,185,971 4,024,710 6,441,976 56,786,123 118.00 118.			0				
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 615,525 0 35,168 146,073 796,766 101.00 101.00 10100 HOME HEALTH AGENCY 615,525 0 35,168 146,073 796,766 101.00		2, 192, 308	437, 663	270, 679	558, 813		
101. 00						0	92.00
SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 116.00 11600 HOSPI CE 97, 419 0 35, 168 22, 975 155, 562 116.00 116.00 SUBTOTALS (SUM OF LI NES 1 through 117) 58, 130, 162 5, 185, 971 4, 024, 710 6, 441, 976 56, 786, 123 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT. FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 194.00 194.00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 0 0 0 194.00		615, 525	0	35, 168	146, 073	796, 766	101.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 97, 419 0 35, 168 22, 975 155, 562 116. 00 116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 58, 130, 162 5, 185, 971 4, 024, 710 6, 441, 976 56, 786, 123 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 26, 597 16, 449 0 43, 046 190. 00 194. 00 194. 01 194. 01 194. 02 194. 01 195. 01 194. 02 194. 02 194. 02 194. 02 194. 02 194. 03 195. 03 194. 04 194. 02 195. 03 194. 04 194. 03 19755 MARKETI NG 931, 533 0 31, 481 94, 958 1, 057, 972 194. 05 194. 07 19755 GUEST MEALS 9, 975 0 0 1, 630 11, 605 194. 07 194. 08 07955 UTSI DE LAUNDRY 0 0 0 0 0 194. 07 194. 08 07955 UTSI DE LAUNDRY 0 0 0 0 0 194. 08 194. 09 07959 URGENT CARE 1, 501, 850 0 0 0 0 0 194. 13 194. 13 07963 OCCUPATI ONAL HEALTH 446, 727 0 24, 022 87, 338 558, 087 194. 13 194. 14 194. 194. 194. 194. 194. 194. 194. 194.	SPECIAL PURPOSE COST CENTERS					·	
116. 00							
18. 00 SUBTOTALS (SUM OF LINES 1 through 117) 58, 130, 162 5, 185, 971 4, 024, 710 6, 441, 976 56, 786, 123 118. 00		97 119	0	35 169	22 975	155 562	
NONRE MBURSABLE COST CENTERS 190. 00 1							
194. 00 07950 DAYCARE-INFANT/TODDLER 0 0 0 194. 00 194. 01 194. 01 194. 02 194. 02 197952 COMMUNI TY HEALTH 2, 240 0 0 0 0 2, 240 194. 02 194. 03 194. 04 194. 03 194. 04 194. 05 194. 05 194. 06 194. 07 194. 07 194. 07 194. 08 194. 07 194. 08 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 13 194. 13 194. 13 194. 13 194. 13 194. 04 194. 05 194. 06 194. 07 194. 06 194. 07 194. 07 194. 08 194. 07 194. 08 194. 07 194. 08 194. 07 194. 08 194. 07 194. 08 194. 07 194. 08 194. 07 194. 08 194. 07 194. 08 194. 07 194. 10 194. 10 194. 10 194. 11 194. 11 194. 11 194. 11 194. 11 194. 11 194. 13 194. 14 194. 194. 194. 194. 194. 194. 194. 194.	NONREI MBURSABLE COST CENTERS						
194. 01 07951 MOB 194. 02 07952 COMMUNITY HEALTH 2, 240 0 0 0 0 0 2, 240 194. 02 194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 0 0 194. 03 194. 04 07954 EDUCATI ON 194. 05 07955 MARKETI NG 194. 06 07956 GUEST MEALS 194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY 194. 08 07958 CANCER CENTER 0 0 0 0 0 0 0 194. 07 194. 09 07959 URGENT CARE 1, 501, 850 1, 605, 941 1, 606, 941 1, 606, 941 1, 606, 941 1, 606, 941 1, 606, 941 1, 606, 9		1	26, 597	16, 449			
194. 02 07952 COMMUNI TY HEALTH 2, 240 0 0 0 2, 240 194. 02 194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194. 03 194. 04 07954 EDUCATI ON 34, 777 0 0 146 34, 923 194. 04 194. 05 07955 MARKETI NG 931, 533 0 31, 481 94, 958 1, 057, 972 194. 05 194. 07 07956 GUEST MEALS 9, 975 0 0 0 11, 605 194. 06 194. 08 07958 CANCER CENTER 0 0 0 0 0 194. 07 194. 09 07959 URGENT CARE 1, 501, 850 0 178, 307 375, 887 2, 056, 044 194. 08 194. 10 07960 RHC 0 0 0 0 0 0 194. 10 194. 12 07962 TRI NE STUDENT HEALTH 76, 508 0 0 24, 022 87, 338 558, 087 194. 13		1	0	15.003			
194. 04 07954 EDUCATI ON 34, 777 0 0 146 34, 923 194. 04 194. 05 07955 MARKETI NG 931, 533 0 31, 481 94, 958 1, 057, 972 194. 05 194. 06 07956 GUEST MEALS 9, 975 0 0 0 1, 630 11, 605 194. 06 194. 07 194. 08 07957 OUTSI DE LAUNDRY 0 0 0 0 0 194. 07 194. 09 07959 CANCER CENTER 0 0 0 0 0 194. 08 194. 09 07959 URGENT CARE 1, 501, 850 0 178, 307 375, 887 2, 056, 044 194. 09 194. 10 07960 RHC 0 0 0 0 0 0 194. 10 194. 12 07962 TRI NE STUDENT HEALTH 76, 508 0 0 24, 022 87, 338 558, 087 194. 13		_	0	(
194. 05 07955 MARKETI NG 931, 533 0 31, 481 94, 958 1, 057, 972 194. 05 194. 06 07956 GUEST MEALS 9, 975 0 0 1, 630 11, 605 194. 06 194. 07 194. 08 0 0 0 0 0 194. 07 194. 09 07959 CANCER CENTER 0 0 0 0 0 194. 08 194. 09 07959 URGENT CARE 1, 501, 850 0 178, 307 375, 887 2, 056, 044 194. 09 194. 10 07960 RHC 0 0 0 0 0 0 194. 10 194. 11 07961 0BGYN 1, 069, 641 0 99, 151 292, 447 1, 461, 239 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 76, 508 0 0 21, 598 98, 106 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 446, 727 0 24, 022 87, 338 558, 087 194. 13		0	0	(이		
194. 06 07956 GUEST MEALS 9, 975 0 0 1,630 11,605 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 0 194. 07 194. 08 07958 CANCER CENTER 0 0 0 0 0 194. 08 194. 09 07959 URGENT CARE 1,501,850 0 178,307 375,887 2,056,044 194. 09 194. 10 07960 RHC 0 0 0 0 0 0 194. 10 194. 11 07961 0BGYN 1,069,641 0 99,151 292,447 1,461,239 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 76,508 0 0 21,598 98, 106 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 446,727 0 24,022 87,338 558,087 194. 13			0	21 40	1		
194. 07 07957 OUTSI DE LAUNDRY 194. 08 07958 CANCER CENTER 0 0 0 0 0 0 0 194. 07 194. 08 07959 URGENT CARE 1, 501, 850 0 178, 307 194. 10 07960 RHC 0 0 0 0 0 0 0 0 194. 10 194. 11 07961 OBGYN 194. 12 07962 TRI NE STUDENT HEALTH 194. 13 07963 OCCUPATI ONAL HEALTH 194. 13 07963 OCCUPATI ONAL HEALTH 194. 13			0	31,48	1		1
194. 09 07959 URGENT CARE 1,501,850 0 178,307 375,887 2,056,044 194.09 194. 10 07960 RHC 0 0 0 0 194.10 194. 11 07961 0BGYN 1,069,641 0 99,151 292,447 1,461,239 194.11 194. 12 07962 TRI NE STUDENT HEALTH 76,508 0 0 21,598 98,106 194.12 194. 13 07963 OCCUPATI ONAL HEALTH 446,727 0 24,022 87,338 558,087 194.13		1	0				
194. 10 07960 RHC 0 0 0 0 0 194. 10 194. 11 07961 0BGYN 1, 069, 641 0 99, 151 292, 447 1, 461, 239 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 76, 508 0 0 21, 598 98, 106 194. 12 194. 13 07963 0CCUPATI ONAL HEALTH 446, 727 0 24, 022 87, 338 558, 087 194. 13	194. 08 07958 CANCER CENTER		0			0	194. 08
194. 11 07961 0BGYN 1, 069, 641 0 99, 151 292, 447 1, 461, 239 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 76, 508 0 0 21, 598 98, 106 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 446, 727 0 24, 022 87, 338 558, 087 194. 13		1, 501, 850	0	178, 30	375, 887		
194. 12 07962 TRI NE STUDENT HEALTH 76, 508 0 0 21, 598 98, 106 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 446, 727 0 24, 022 87, 338 558, 087 194. 13		1 060 6/1	0	00 15	0 202 AAT		
194. 13 07963 OCCUPATI ONAL HEALTH 446, 727 0 24, 022 87, 338 558, 087 194. 13			0	77, 13			
194. 14 07964 I MMUNI ZATI ON CLI NI C 195, 098 0 3, 432 14, 211 212, 741 194. 14	194. 13 07963 OCCUPATI ONAL HEALTH	446, 727			87, 338	558, 087	194. 13
	194. 14 07964 I MMUNI ZATI ON CLI NI C	195, 098	0	3, 432	2 14, 211	212, 741	194. 14

Health Financial Systems	CAMERON MEMORIAL CO	OMMUNITY HOSPIT	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 10/01/2018 To 09/30/2019	Date/Time Pre	pared:
					2/25/2020 1:5	3 pm
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1. 00	2.00	4. 00	4A	
194. 15 07965 FOUNDATI ON	344, 275	5, 503	3, 40	3 27, 518	380, 699	194. 15
194. 16 07967 RETAIL PHARMACY	63, 435	0	24, 95	8 0	88, 393	194. 16
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0		o o	0	201.00
202.00 TOTAL (sum lines 118 through 20	1) 62, 806, 221	5, 218, 071	4, 420, 91	6 7, 357, 709	62, 806, 221	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1315 Per

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

			'	0 09/30/2019	2/25/2020 1:5	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	•
	E & GENERAL	PLANT	LINEN SERVICE	2.22	10.00	
CENEDAL CEDALCE COCT CENTEDO	5. 00	7. 00	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	11, 808, 775					5.00
7.00 00700 OPERATION OF PLANT	997, 834	5, 307, 090				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	27, 702	43, 678	191, 015			8.00
9. 00 00900 HOUSEKEEPI NG	328, 205	19, 495	43, 137	1, 808, 225		9. 00
10. 00 01000 DI ETARY	124, 837	175, 701	•		859, 636	10.00
11. 00 01100 CAFETERI A	137, 679	81, 640			0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	261, 172	73, 784	1	0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	133, 493	128, 156		10, 176	0	14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	779, 866 170, 977	47, 503 45, 529		15, 829	0	15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	170, 977	45, 529	1 0	l ol	U	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 141, 731	668, 955	37, 791	525, 481	824, 760	30.00
31. 00 03100 NTENSI VE CARE UNI T	52, 839	48, 532			34, 876	31.00
43. 00 04300 NURSERY	25, 444	17, 274	1		0.70.0	43.00
ANCILLARY SERVICE COST CENTERS				, , ,		
50. 00 05000 OPERATING ROOM	573, 985	447, 066		136, 811	0	50.00
51.00 05100 RECOVERY ROOM	311, 859	292, 300	9, 688		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	194, 818	139, 137			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	839, 812	350, 497			0	54.00
60. 00 06000 LABORATORY	718, 949	114, 090		68, 688	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	223, 763	21, 140			0	65.00
65. 01 06501 SLEEP LAB	40, 610	106, 934			0	65. 01
66. 00 06600 PHYSI CAL THERAPY	384, 938	247, 059		68, 688	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	101, 369 36, 361	15, 505 32, 697	1	0	0	69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	205, 499	32, 097	1	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	251, 898	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	251, 070	0		ام	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0		o o	0	76.00
76. 01 03480 0NC0L0GY	536, 310	456, 526	o o	ol	0	76. 01
OUTPATIENT SERVICE COST CENTERS			'			
88. 00 08800 RURAL HEALTH CLINIC	321, 090	279, 221	1, 999	56, 251	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0	0	89. 00
90. 00 09000 CLI NI C	50, 650	21, 880	1	0	0	90.00
90. 01 09001 CLI NI C - MCDONALD	169, 374	188, 039			0	90. 01
90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT	169, 184	102, 986			0	90.02
90. 03 09003 I V THERAPY 90. 04 09004 0P PSYCH	0 80, 961	72 474	0	0	0	90. 03 90. 04
91. 00 09100 EMERGENCY	801, 059	72, 674 392, 530		255, 814	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	001,034	372, 330	30,033	255, 614	U	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY	184, 496	50, 999	71	1, 413	0	101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116. 00 11600 H0SPI CE	36, 021	50, 999		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	10, 414, 785	4, 732, 526	191, 015	1, 793, 244	859, 636	118.00
NONREI MBURSABLE COST CENTERS	9, 968	22.054	. 0	ol	0	190. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194. 00 07950 DAYCARE-INFANT/TODDLER	9, 900	23, 854	0	_		190.00
194. 01 07951 MOB	3, 474	21, 757	1			194.00
194. 02 07952 COMMUNITY HEALTH	519	21,737				194. 02
194. 03 07953 ASSISTED LIVING/CAMERON WOODS	0	0		ol ol		194. 03
194. 04 07954 EDUCATI ON	8, 087	0	o o	ol		194. 04
194. 05 07955 MARKETI NG	244, 980	45, 653	ō	o		194. 05
194. 06 07956 GUEST MEALS	2, 687	0	0	o	0	194.06
194. 07 07957 OUTSI DE LAUNDRY	0	0	0	o	0	194. 07
194. 08 07958 CANCER CENTER	0	0	0	0		194. 08
194. 09 07959 URGENT CARE	476, 089	258, 574	. 0	14, 981		194. 09
194. 10 07960 RHC	0	0	0	0		194. 10
194. 11 07961 OBGYN	338, 359	143, 785	0	0		194. 11
194. 12 07962 TRI NE STUDENT HEALTH	22, 717	0	0	0		194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	129, 228	34, 836		0		194. 13
194. 14 07964 I MMUNI ZATI ON CLI NI C	49, 261	4, 977		0		194. 14
194. 15 07965 FOUNDATION 194. 16 07967 RETAIL PHARMACY	88, 153 20, 468	4, 935 36, 103				194. 15 194. 16
200.00 Cross Foot Adjustments	20, 468	36, 193	٦		Ü	200.00
201.00 Negative Cost Centers		^		٨	0	200.00
202.00 TOTAL (sum lines 118 through 201)	11, 808, 775	5, 307, 090	191, 015	1, 808, 225	859, 636	
	, , , , , , , , , ,	.,, 370		, , , , , , , , , , , , , , , , , , , ,	22., 200	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1315

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

			10	09/30/2019	Date/lime Pre 2/25/2020 1:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	•
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
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						9. 00
10. 00 01000 DI ETARY	075 070					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	875, 278 29, 606	1, 492, 462				11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	18, 101	1, 472, 402	866, 430			14.00
15. 00 01500 PHARMACY	20, 394	0	3, 969	4, 235, 499		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	44, 230	0	62	0	999, 183	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	4// 400	(05,000	0/ 0/4	ما	7 540	00.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	166, 133 5, 556	635, 820 21, 254	26, 344 1, 032	0	7, 512 616	30. 00 31. 00
43. 00 04300 NURSERY	2, 437	9, 272	1, 032	0	1, 968	43.00
ANCILLARY SERVICE COST CENTERS	2/ 10/	7, 2.72	<u> </u>	<u> </u>	.,,,,,	10.00
50. 00 05000 OPERATING ROOM	46, 667	178, 578	78, 783	0	19, 266	50.00
51. 00 05100 RECOVERY ROOM	34, 588	132, 417	0	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 172	69, 506 0	12, 682	0	170 711	52. 00 54. 00
60. 00 06000 LABORATORY	85, 198 76, 524	0	12, 125 203, 073	0	179, 711 295, 647	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	Ö	0	o	273, 317	64.00
65. 00 06500 RESPIRATORY THERAPY	1, 039	0	8, 260	o	23, 261	65.00
65. 01 06501 SLEEP LAB	0	0	0	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	52, 868	0	2, 112	0	79, 485	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0 4, 194	0	741 415	0	43, 401 22, 137	69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 174	Ö	197, 921	ő	22, 137	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	242, 610	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	4, 235, 499	0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0	0	0	0	76.00
76. 01 03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 01
88. 00 08800 RURAL HEALTH CLINIC	0	0	2, 536	ol	62, 771	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o	0	89.00
90. 00 09000 CLINIC	8, 997	34, 364	4, 394	0	31, 663	90.00
90. 01 09001 CLI NI C - MCDONALD	27, 527	0	1, 707	0	24, 158	90. 01
90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT 90.03 09003 V THERAPY	35, 950 0	0	3, 306 0	0	51, 954 0	90. 02 90. 03
90. 04 09004 OP PSYCH	6, 559	0	137	0	4, 019	90.03
91. 00 09100 EMERGENCY	107, 456	411, 251	31, 946	ō	114, 482	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	0.010	-	4 004	ما		
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	26, 810	0	1, 284	0	0	101. 00
113. 00 11300 NTEREST EXPENSE						113. 00
114. 00 11400 UTILIZATION REVIEW-SNF						114.00
116. 00 11600 H0SPI CE	5, 161	0	42	o		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	824, 167	1, 492, 462	835, 481	4, 235, 499	962, 051	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	O	0	ol	0	190. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	0	0	0		194.00
194. 01 07951 MOB	Ö	Ö	0	Ö		194. 01
194. 02 07952 COMMUNI TY HEALTH	0	0	0	0		194. 02
194. 03 07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194. 03
194. 04 07954 EDUCATI ON 194. 05 07955 MARKETI NG	6, 989 10, 753	0	0 382	0		194. 04 194. 05
194.06 07956 GUEST_MEALS	645	0	302 0	0		194. 05
194. 07 07957 OUTSI DE LAUNDRY	0	Ö	0	o		194. 07
194. 08 07958 CANCER CENTER	ō	O	0	o	0	194. 08
194. 09 07959 URGENT CARE	0	0	23, 785	o		194. 09
194. 10 07960 RHC	0	0	0	0		194. 10
194. 11 07961 OBGYN 194. 12 07962 TRI NE STUDENT HEALTH	32, 724	0	1, 885 555	0	37, 132	194. 11 194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	0	0	3, 574	ol Ol		194. 12
194. 14 07964 I MMUNI ZATI ON CLINI C	o	Ö	262	ő		194. 14
194. 15 07965 FOUNDATI ON	O	O	506	O	0	194. 15
194. 16 07967 RETAIL PHARMACY	0	0	0	0	0	194. 16
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	0	0	0	200. 00 201. 00
2011 John Inegative cost centers	<u> </u>		ı O	<u> </u>	0	1201.00

Health Financial Systems	CAMERON MEMORIAL COM	MUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-1315	From 10/01/2018	Worksheet B Part I Date/Time Prepared: 2/25/2020 1:53 pm
Cost Center Description	CAFETERIA	NURSI NG	CENTRAL	PHARMACY	MEDI CAL

						2/25/2020 1:5	3 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI O	SERVICES &		RECORDS &	
			N	SUPPLY		LI BRARY	
		11. 00	13. 00	14. 00	15. 00	16.00	
202.00	TOTAL (sum lines 118 through 201)	875, 278	1, 492, 462	866, 430	4, 235, 499	999, 183	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1315

					To 09/30/2019 Date/Time P 2/25/2020 1	
	Cost Center Description	Subtotal	Intern &	Total	2/20/2020	. 55 piii
			Residents Cost & Post			
			Stepdown			
		24.00	Adjustments	24.00		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 5. 00	OO4OO EMPLOYEE BENEFITS DEPARTMENT OO5OO 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 11. 00	01000 DI ETARY 01100 CAFETERI A					10.00 11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY					15. 00 16. 00
10.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS					10.00
30.00	03000 ADULTS & PEDI ATRI CS	8, 965, 163	0	8, 965, 16	53	30.00
	03100 INTENSIVE CARE UNIT	404, 358				31.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	330, 831	0	330, 83	31	43.00
50. 00	05000 OPERATING ROOM	3, 974, 788	0	3, 974, 78	38	50.00
	05100 RECOVERY ROOM	2, 216, 974	0			51.00
	05200 DELIVERY ROOM & LABOR ROOM	1, 318, 058	0			52.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	5, 237, 483 4, 582, 667	0			54. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö		O	64.00
	06500 RESPI RATORY THERAPY	1, 263, 346	0			65.00
65. 01 66. 00	06501 SLEEP LAB	342, 472	0			65. 01 66. 00
	O6600 PHYSI CAL THERAPY O6900 ELECTROCARDI OLOGY	2, 501, 515 598, 788		_, _, ,		69.00
	06901 CARDI AC REHAB	252, 831	0			69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 290, 889	0			71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1, 582, 358 4, 235, 499	0			72. 00 73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	4, 233, 477	0		ő	76.00
76. 01	03480 ONCOLOGY	3, 308, 950	0	3, 308, 95	50	76. 01
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	2 110 520	0	2, 110, 52	20	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	2, 110, 529 0			0	89.00
90. 00	09000 CLI NI C	370, 684	0			90.00
90. 01	09001 CLINIC- MCDONALD	1, 209, 404	0			90. 01
90. 02 90. 03	09002 CLINIC - FAM PRAC, PEDS, & ENT 09003 IV THERAPY	1, 150, 161	0	1,,	0	90. 02 90. 03
90. 04	09004 OP PSYCH	513, 990	0	1	-	90.03
91.00	09100 EMERGENCY	5, 612, 034	0	5, 612, 03	34	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0)		92.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	1, 061, 839	0	1, 061, 83	39	101.00
	SPECIAL PURPOSE COST CENTERS	, ,				
	11300 I NTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE	247, 785	О	247, 78	35	114. 00 116. 00
118.00		54, 683, 396		•		118.00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-INFANT/TODDLER	76, 868 0	0		0	190. 00 194. 00
	07951 MOB	40, 234	0	•		194.00
194. 02	07952 COMMUNITY HEALTH	2, 759	0			194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0		0	194. 03
	07954 EDUCATI ON 07955 MARKETI NG	49, 999 1, 359, 740	0			194. 04 194. 05
	07956 GUEST MEALS	14, 937	Ö	.,		194. 06
	07957 OUTSI DE LAUNDRY	0	0		0	194. 07
	07958 CANCER CENTER 07959 URGENT CARE	2 920 472	0	•	0	194. 08 194. 09
	07959 DRGENT CARE	2, 829, 473 0			0	194. 09
	07961 0BGYN	2, 015, 124	Ö	•	24	194. 11
	07962 TRI NE STUDENT HEALTH	121, 378	0	121, 37		194. 12
	07963 OCCUPATI ONAL HEALTH 07964 IMMUNI ZATI ON CLINI C	725, 725 267, 241	0			194. 13 194. 14
	07964 FOUNDATION CLINIC	474, 293	_			194. 14
	07967 RETAIL PHARMACY	145, 054				194. 16

Health Financial Systems	CAMERON MEMORIAL C	OMMUNITY HOSPI	In Lie	u of Form CMS-2552-10	
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-1315	Peri od:	Worksheet B
				From 10/01/2018 To 09/30/2019	
				07/30/2017	2/25/2020 1: 53 pm
Cost Center Description	Subtotal	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
200.00 Cross Foot Adjustments	0	0		0	200. 00
201.00 Negative Cost Centers	0	0		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	62, 806, 221	0	62, 806, 2	21	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2018 | Part II | To 09/30/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315

				Ic	09/30/2019	Date/lime Pre 2/25/2020 1:5	
			CAPI TAL REI	LATED COSTS		7272072020 1.0	O piii
	01.01	D:	DIDO A FLVT	MANDLE FOLLID	6 1 1 1 1 1	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FLXT OO200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	27, 056	16, 733	43, 789	43, 789	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	o	485, 768		868, 474	7, 306	5.00
7. 00	00700 OPERATION OF PLANT	0	471, 323		833, 155	1, 568	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	48, 701	30, 120	78, 821	0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	21, 736 195, 903		35, 179 317, 062	1, 215 194	9. 00 10. 00
11. 00	01100 CAFETERI A	0	91, 027	56, 297	147, 324	587	11.00
	01300 NURSI NG ADMI NI STRATI ON	0	32, 375		83, 255	1, 345	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	142, 892	88, 374	231, 266	333	14.00
	01500 PHARMACY	0	52, 965		85, 722	880	1
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	31, 396	31, 396	868	16. 00
30. 00	03000 ADULTS & PEDIATRICS	l	745, 870	461, 297	1, 207, 167	4, 407	30.00
31. 00	03100 NTENSI VE CARE UNI T	0	54, 112		87, 578	138	ı
43.00	04300 NURSERY	0	19, 260	11, 912	31, 172	89	43.00
F0 00	ANCILLARY SERVICE COST CENTERS	1 0	400 470	200 004	007.75	4 074	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	498, 470 325, 909		806, 756 527, 472	1, 374 1, 102	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		155, 136		251, 082	670	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	390, 797	241, 694	632, 491	2, 801	54.00
60.00	06000 LABORATORY	0	127, 209		205, 883	1, 763	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	0	23, 571 0	14, 578 73, 739	38, 149 73, 739	58 0	65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY		275, 466		445, 832	1, 595	66.00
69.00	06900 ELECTROCARDI OLOGY	0	17, 288		27, 980	0	69.00
69. 01	06901 CARDI AC REHAB	0	36, 457	22, 547	59, 004	122	69. 01
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
76. 00	03020 CHEMI CAL DEPENDENCY		0	0	o	0	76.00
76. 01	03480 ONCOLOGY	0	509, 017	314, 809	823, 826	0	•
	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		192, 544 0	1, 482 0	88. 00 89. 00
90. 00	09000 CLINIC	0	0	15, 088	15, 088	240	90.00
	09001 CLINIC- MCDONALD	0	0	129, 667	129, 667	977	90. 01
90. 02	09002 CLINIC - FAM PRAC, PEDS, & ENT	0	0	71, 016	71, 016	2, 506	90. 02
90. 03	09003 I V THERAPY	0	0	0	0	0	90.03
	O9004 OP PSYCH O9100 EMERGENCY	0	0 437, 663	,	50, 114 708, 342	384 3, 326	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART		437,003	270,079	700, 342	3, 320	92.00
	OTHER REIMBURSABLE COST CENTERS				-,		
101.00	10100 HOME HEALTH AGENCY	0	0	35, 168	35, 168	870	101. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						112 00
	11400 UTI LI ZATI ON REVI EW-SNF						113. 00 114. 00
	11600 HOSPI CE	0	0	35, 168	35, 168	137	116.00
118.00	<u> </u>	0	5, 185, 971	4, 024, 710	9, 210, 681	38, 337	118. 00
400.00	NONREI MBURSABLE COST CENTERS		0/ 507	1, 4,0	40.04/		1.00.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-INFANT/TODDLER	0	26, 597	16, 449	43, 046		190. 00 194. 00
	07950 DATCARE-TNFANT/TODDLER	0	0	15, 003	15, 003		194. 00
	07952 COMMUNITY HEALTH	0	0	0	0		194. 02
194. 03	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	O		194. 03
	07954 EDUCATI ON	0	0	-	0		194. 04
	07955 MARKETI NG 07956 GUEST MEALS	0	0	31, 481	31, 481		194. 05 194. 06
	07957 OUTSI DE LAUNDRY	0	0	0	0		194. 00
	07958 CANCER CENTER	0	0	1	Ö		194. 08
194. 09	07959 URGENT CARE	0	0	178, 307	178, 307	2, 237	194. 09
	07960 RHC	0	0	0	0 15:		194. 10
	07961 0BGYN 07962 TRI NE STUDENT HEALTH	0	0	99, 151	99, 151 0		194. 11 194. 12
	07963 OCCUPATI ONAL HEALTH	0	0	24, 022	24, 022		194. 12
194. 14	07964 IMMUNIZATION CLINIC	Ö	0	1	3, 432		194. 14
<u>194</u> . 15	07965 FOUNDATI ON	0	5, 503	3, 403	8, 906	164	194. 15

Health Financial Systems CA	MERON MEMORIAL CO	OMMUNITY HOSPI	ΓAL	In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B		
				From 10/01/2018 To 09/30/2019		nared:	
				- 077 007 2017	2/25/2020 1:5	3 pm	
		CAPI TAL REI	LATED COSTS				
			1	_			
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE		
	Assigned New				BENEFI TS		
	Capi tal				DEPARTMENT		
	Related Costs						
	0	1. 00	2.00	2A	4. 00		
194.16 07967 RETAIL PHARMACY	0	0	24, 95	8 24, 958	0	194. 16	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	5, 218, 071	4, 420, 91	6 9, 638, 987	43, 789	202. 00	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-1315

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 10/01/2018 | Part II |
| To 09/30/2019 | Date/Time Prepared: 2/25/2020 1:53 pm

September Sept						09/30/2019	2/25/2020 1:5	
PRINCELL STATEST COST LEMTING 1.00 1.0		Cost Center Description				HOUSEKEEPI NG	DI ETARY	
CONTROL STRVICT COST CENTERS						9 00	10.00	
1.00 0.000 CAP REL DOSTS-BLUE & FIXT 1.00 0.0000 CAP REL DOSTS-BLUE & FIXT 1.00 0.0000 CAP REL DOSTS-BLUE & SEPREMAL 1.7,400 1.00 0.0000 CAP REL DOSTS-BLUE & SEPREMAL 1.0000 CAP RE		GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
4 - 00 00-000 EMPLOYEE REPRET IS DEPARTMENT 1.00 1	1.00							1.00
DOUGO DOUGO ANNIN STRATIVE & CREENAL 975, 780 706, 726 8.8 324 7.479 8.0 0000 DEPARTOR OF PLANTER 74, 703 706, 726 8.0 0000 DEPARTOR OF PLANTER 74, 703 70, 788 7.479								•
2.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000000 0.000000 0.000000 0.00000000			075 700					•
0.00 0.0000 DAUSSECRY IN SERVICE 2.054 7.779 88.354 9.00 0.0000 DISSECRY IN SERVICE 2.044 7.779 88.354 9.00 0.0000 DISSECRY IN SERVICE 3.00 0.0000 DISSECRY IN SERVICE 3.00 0.0000 0.0000 DISSECRY IN SERVICE 3.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000000				000 704				•
0.00 00000 0005REEPER NG		1 1	1					•
10.00 DIORIDID HETARY 9, 258 30, 00 217 906 357,777 10.00 10.00 CAFTERN 10.211 13.00 10.00 CAFTERN 10.211 13.00 10.00 CAFTERN 10.211 13.00 10.00 CAFTERN 10.00 13.00 CAFTERN 10.00 CAFTERN 10.						84. 027		1
13.00 01300 MIRESHA ADMINISTRATION 19.369 12.654 0 0 0 13.00	10.00		1				357, 722	10.00
14.00 01400 CENTRAL SERVICES & SUPPLY 9,000 21,944 0 773 0 10,00 10,00 1000 1000 1000 1000 1000 10,00 1000		1	1	13, 979	671	2, 785	0	1
15.00 01500 PHASHARY 17, 680 7, 796 0 0 0 10, 00						-		1
10.00 10.0		1			_		-	
INPART ENT ROUTH NE SERVICE COST CENTERS 31.00 00 000 (QUILLES A PEDIA ATRICS 3.00 00 00 (QUILLES A PEDIA		1	1					1
30.00	10.00		12,000	7, 770	0	<u> </u>		10.00
33 00 04300 NUNSERY 1,887 2,988 5,379 7,100 0 43 00	30.00		84, 676	114, 542	17, 480	24, 418	343, 209	30.00
MICHILARY SERVICE COST CENTRES	31.00	03100 INTENSIVE CARE UNIT	3, 919	8, 310		460	14, 513	31.00
50.00	43.00		1, 887	2, 958	5, 379	7, 106	0	43.00
10.00 05100 RECOVERY ROOM 23, 129 50, 050 4, 481 4, 151 0 51, 00 52, 00 6200 RELYPERY ROOM & LABOR ROOM 14, 448 23, 244 1, 566 1, 813 0, 55, 00 54, 00 05400 RADIOLOGY-DIAGNOSTIC 62, 283 60, 015 7, 979 5, 858 0, 54, 00 06, 00 06400 LABORATORY 53, 320 19, 536 388 3, 192 0, 60, 00 06400 IMTRAVENUIS THERRAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	FO 00		42.5(0	7/ 551	/ 052	(250		
52.00 05200 DELIVERY RODIA & LABOR ROOM		1						1
54 00 06400 RADI OLOGY-DI AGNOSTIC 62, 283 60, 015 7, 979 5, 858 0 54, 00							-	1
0.00 0.0000 LABORATORY								•
65.00	60.00	06000 LABORATORY	53, 320	19, 536		3, 192	0	60.00
65. 01 06501 SLEEP LAB			0	_		-	_	1
66. 00 OLGODO PHYSICAL THERAPY 28, 548 42, 304 1, 834 3, 192 0 66. 00							-	1
09.00 06900 CADDIAC RETROCARDIOLOGY 7, 518 2,655 0 0 0 0,0			1				0	•
69.01 0.0901 (CARDI AC REHAB 2 697 5.599 0			1				0	
171.00			1					•
173.00 07300 07300 07400 075 075 075 075 076 0		1	1			O	0	•
76. 00 03.020 CHEMICAL DEPENDENCY 39,755 78,170 0 0 0 0 76,01	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 682	0	0	o	0	72.00
10 03480 0NCOLOGY 0 0 0 0 0 0 0 0 0	73.00		0	0	0	0	0	73. 00
DUTPATIENT SERVICE COST CENTERS		1	0	0		0		1
88.00 OBBOO RUPAL HEALTH CLINIC 23,813 47,811 925 2,614 0 88.00 99.00 99.00 69000 CLINIC 3,756 3,747 0 0 0 99.00 99.00 09.00	76. 01		39, 775	78, 170	0	0	0	76. 01
89.00 08900 CEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	88 00		23 813	<i>4</i> 7 811	925	2 614	0	88 00
99. 00 09000 CLI NI C 09001 CLI NI C 0900		1	1		•			
90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT			3, 756	3, 747	0	o	0	1
90. 03 09003 V THERAPY 0 0 0 0 0 0 0 0 0	90. 01		12, 561	32, 198	722	3, 047	0	90. 01
90. 04 990.04 09004 0P PSYCH 6, 004 12, 444 0 0 0 90.04 91.00 09100 EMERGENCY 59, 409 67, 212 17, 592 11, 888 0 91.00 91.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92.00 092000 0920000 09200000 09200000 09200000 09200000 09200000 092000000 092000000 0920000000000			1				-	1
92.00 09100 BERGENCY 59, 409 67, 212 17, 592 11, 888 0 91.00 92.00 09200		1	-			0	-	
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 01010 0 0 0 0 0 0 0						11 000	-	1
OTHER REIMBURSABLE COST CENTERS 10.0 1010 100		· · · · · · · · · · · · · · · · · · ·	39, 409	07,212	17, 392	11,000	U	1
101.00 10100 101000 10100 10100 10100 10100 10100 10100 101000 101000 101000 101000 101000 101000 101000 101000 101000 101000 101000 101000 101000 101000 1010000 1010000 1010000 10100000 10100000000	72.00							72.00
113. 00 11300 INTEREST EXPENSE	101.00		13, 683	8, 733	33	66	0	101.00
114. 00 11400 HOSPI CE 114. 00 HOSPI CE 114. 00 HOSPI CE 114. 00 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 772, 397 810, 345 88, 354 83, 331 357, 722 118. 00 NONRE! MBURSABLE COST CENTERS 190. 00 190. 00 194. 00 00 00 00 00 00 00 00								
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 772,397 810,345 88,354 83,331 357,722 118.00								1
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 772, 397 810, 345 88, 354 83, 331 357, 722 118.00			2 /71	0.722			0	1
NONREI MBURSABLE COST CENTERS 190		1				- 1		
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 739 4, 085 0 0 0 190. 00 194. 00 194. 00 19750 DAYCARE-I NFANT/TODDLER 0 0 0 0 0 0 194. 00 194. 01 07951 MOB 258 3, 725 0 0 0 194. 01 194. 01 194. 02 197952 COMMUNI TY HEALTH 38 0 0 0 0 0 194. 02 194. 02 194. 03 194. 04 197954 EDUCATI ON 600 0 0 0 0 194. 03 194. 04 197954 EDUCATI ON 600 0 0 0 0 194. 05 194. 05 194. 06 197956 GUEST MEALS 199 0 0 0 0 194. 06 194. 06 194. 07 194. 08 194. 07 197957 OUTSI DE LAUNDRY 0 0 0 0 194. 06 194. 08 194. 09 197959 URGENT CARE 35, 308 44, 275 0 696 0 194. 08 194. 10 197960 RHC 0 0 0 0 0 194. 11 194. 12 107961 DBGYN 25, 094 24, 620 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 1, 685 0 0 0 0 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 9, 584 5, 965 0 0 0 194. 15 194. 16 07964 IMMUNI ZATI ON CLI NI C 3, 6538 845 0 0 0 194. 15 194. 16 07965 FOUNDATI ON 6, 538 845 0 0 0 194. 16 194. 16 07967 RETAIL LEHRAMACY 1, 518 6, 197 0 0 0 194. 16 200. 00 0 0 194. 16 200. 00 0 0 0 194. 16 200. 00 0 0 0 0 194. 16 200. 00 0 0 0 0 0 0 0 0 194. 16 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	110.00		112, 371	010, 343	00, 334	03, 331	337, 722	1110.00
194. 01 07951 MOB 194. 02 07952 COMMUNITY HEALTH 38 0 0 0 0 194. 02 194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 0 0 0 0 194. 02 194. 04 07954 EDUCATION 600 0 0 0 0 0 194. 03 194. 05 07955 MARKETING 18, 169 7, 817 0 0 0 194. 05 194. 06 07956 GUEST MEALS 199 0 0 0 0 0 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 07 194. 08 07958 CANCER CENTER 0 0 0 0 0 194. 08 194. 10 07960 RHC 0 0 0 0 0 0 194. 08 194. 11 07961 DBGYN 194. 12 07962 178 NE STUDENT HEALTH 194. 12 07962 178 NE STUDENT HEALTH 194. 13 07963 OCCUPATIONAL HEALTH 194. 15 07965 FOUNDATION 194. 16 07967 RETAL PHARMACY 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 194. 15 250. 00 0 0 0 0 0 0 0 194. 15 260. 00 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 194. 15 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00		739	4, 085	0	0	0	190.00
194. 02 07952 COMMUNITY HEALTH 38 0 0 0 194. 02 194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 0 0 0 194. 03 194. 04 07954 EDUCATION 600 0 0 0 0 0 194. 03 194. 05 07955 MARKETING 18, 169 7, 817 0 0 0 194. 05 07955 MEALS 199 0 0 0 0 0 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 0 194. 07 194. 08 07958 CANCER CENTER 0 0 0 0 0 194. 07 194. 08 194. 09 07959 URGENT CARE 35, 308 44, 275 0 696 0 194. 09 194. 10 07960 RHC 0 0 0 0 0 194. 10 194. 10 194. 11 07961 OBGYN 25, 094 24, 620 0 0 0 194. 11 194. 12 07962 TRINE STUDENT HEALTH 1, 685 0 0 0 0 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 9, 584 5, 965 0 0 0 194. 13 194. 14 07964 IMMUNI ZATI ON CLI NI C 3, 653 852 0 0 0 194. 13 194. 14 07965 FOUNDATI ON 6, 538 845 0 0 0 194. 15 194. 16 07965 RETAIL PHARMACY 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	0	194. 00
194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 0 194. 03 194. 04 07954 EDUCATION 600 0 0 0 194. 05 07955 MARKETING 18, 169 7, 817 0 0 194. 06 07956 GUEST MEALS 199 0 0 0 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 08 07958 CANCER CENTER 0 0 0 194. 09 07959 URGENT CARE 35, 308 44, 275 0 696 0 194. 10 07960 RHC 0 0 0 0 194. 10 07960 RHC 0 0 0 194. 11 07961 OBGYN 25, 094 24, 620 0 0 194. 12 07962 TRI NE STUDENT HEALTH 1, 685 0 0 0 194. 13 07963 OCCUPATI ONAL HEALTH 9, 584 5, 965 0 0 194. 15 07965 FOUNDATI ON 6, 538 845 0 0 194. 16 07966 FOUNDATI ON 6, 538 845 0 0 200. 00 Negati ve Cost Centers 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 201. 00 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00 0 0 201. 00						0		1
194. 04 07954 EDUCATION 600 0 0 194. 04 194. 05 194. 06 194. 05 194. 06 194. 05 194. 06 194. 05 194. 06 194. 07 194. 08 1978			1	0		0		1
194. 05 07955 MARKETING 194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 0 0 194. 07 194. 08 07958 CANCER CENTER 0 0 0 0 0 0 194. 07 194. 09 07959 URGENT CARE 35, 308 44, 275 0 696 0 194. 09 194. 10 07960 RHC 0 0 0 0 0 0 0 194. 10 194. 11 07961 OBGYN 194. 12 07962 TRI NE STUDENT HEALTH 194. 12 07963 OCCUPATI ONAL HEALTH 194. 13 07963 OCCUPATI ONAL HEALTH 194. 15 07965 FOUNDATI ON 194. 16 07967 RETAIL PHARMACY 200. 00 Cross Foot Adjustments Negative Cost Centers 0 0 0 0 0 0 0 194. 16 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0	_	0		1
194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY 194. 08 07958 CANCER CENTER 0 0 0 0 0 0 194. 08 194. 09 07959 URGENT CARE 35, 308 44, 275 0 696 0 194. 09 194. 10 07960 RHC 0 0 0 0 0 0 0 0 194. 10 194. 11 07961 OBGYN 194. 12 07962 TRI NE STUDENT HEALTH 194. 13 07963 OCCUPATI ONAL HEALTH 194. 14 07964 IMMUNI ZATI ON CLI NI C 194. 15 07965 FOUNDATI ON 194. 15 07965 FOUNDATI ON 200. 00 201. 00 201. 00 201. 00 201. 00 201. 00 2020. 00 2			1	U 7 017	_	0		1
194. 07 07957 OUTSI DE LAUNDRY 194. 08 07958 CANCER CENTER 194. 09 07959 URGENT CARE 194. 10 07960 RPC 194. 11 07961 OBGYN 194. 12 07962 TRI NE STUDENT HEALTH 194. 13 07963 OCCUPATI ONAL HEALTH 194. 14 07964 I MMUNI ZATI ON CLI NI C 194. 15 07965 FOUNDATI ON 194. 16 07967 FOUNDATI ON 200. 00 201. 00 2			1			0		1
194. 08 07958 CANCER CENTER 194. 09 07959 URGENT CARE 194. 10 07960 RHC 194. 11 07961 OBGYN 194. 12 07962 TRI NE STUDENT HEALTH 194. 13 07963 OCCUPATI ONAL HEALTH 194. 14 07964 IMMUNI ZATI ON CLI NI C 194. 15 07965 FOUNDATI ON 194. 16 07967 RETAIL PHARMACY 200. 00 194. 10 0 0 0 0 0 0 194. 10 0 0 0 0 0 194. 11 1, 685 0 0 0 0 0 194. 12 0 0 0 0 194. 13 1, 685 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 0 0 0 0 194. 13 1, 685 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0	_	ol		1
194. 10 07960 RHC 0 0 0 0 194. 10 194. 11 07961 0BGYN 25, 094 24, 620 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 1, 685 0 0 0 0 194. 12 194. 13 07963 0CCUPATI ONAL HEALTH 9, 584 5, 965 0 0 0 194. 13 194. 14 07964 IMMUNI ZATI ON CLI NI C 3, 653 852 0 0 0 194. 14 194. 15 07965 FOUNDATI ON 6 6, 538 845 0 0 0 194. 14 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 194. 16 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	0	o		
194. 11 07961 0BGYN 25, 094 24, 620 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 1, 685 0 0 0 0 194. 12 194. 13 07963 0CCUPATI ONAL HEALTH 9, 584 5, 965 0 0 0 194. 13 194. 14 07964 IMMUNI ZATI ON CLI NI C 3, 653 852 0 0 0 194. 14 194. 15 07965 FOUNDATI ON 6, 538 845 0 0 0 194. 14 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 0 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 0 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 0 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 0 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 0 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 0 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			35, 308	44, 275	0	696	0	194. 09
194. 12 07962 TRI NE STUDENT HEALTH 1, 685 0 0 0 0 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 9, 584 5, 965 0 0 0 194. 13 194. 14 07964 I MMUNI ZATI ON CLI NI C 3, 653 852 0 0 0 194. 14 194. 15 07965 FOUNDATI ON 6, 538 845 0 0 0 194. 15 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 194. 15 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	_	0		1
194. 13 07963 OCCUPATI ONAL HEALTH 9, 584 5, 965 0 0 0 194. 13 194. 14 07964 I MMUNI ZATI ON CLI NI C 3, 653 852 0 0 0 194. 14 194. 15 07965 FOUNDATI ON 6, 538 845 0 0 0 194. 15 194. 16 07967 RETAI L PHARMACY 1, 518 6, 197 0 0 0 194. 15 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00				24, 620	0	0		1
194. 14 07964 IMMUNI ZATI ON CLINI C 3,653 852 0 0 0 194. 14 194. 15 07965 FOUNDATI ON RETAIL PHARMACY 6,538 845 0 0 0 194. 15 200. 00 201. 00 Negati ve Cost Centers 0 0 0 194. 14		1	1	0	0	0		1
194. 15 07965 FOUNDATION 6, 538 845 0 0 194. 15 194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 194. 16 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			1			0		
194. 16 07967 RETAIL PHARMACY 1, 518 6, 197 0 0 194. 16 200. 00 0 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00			1			O O		1
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00						ol		
201.00 Negative Cost Centers 0 0 0 0 201.00				-, . , ,		Ĭ	· ·	
202.00 TOTAL (sum lines 118 through 201) 875,780 908,726 88,354 84,027 357,722 202.00	201.00	Negative Cost Centers	1	_	0	О		201. 00
	202.00	TOTAL (sum lines 118 through 201)	875, 780	908, 726	88, 354	84, 027	357, 722	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-1315

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

			10	09/30/2019	Date/lime Pre 2/25/2020 1:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	•
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
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 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A	175, 557					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	5, 938	122, 541				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3, 630	0	267, 546			14.00
15. 00 01500 PHARMACY	4, 091	0	1, 226	158, 627	41 420	15.00
16. 00 O1600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	8, 871	0	19	0	61, 630	16. 00
30. 00 03000 ADULTS & PEDIATRICS	33, 323	52, 207	8, 135	0	463	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 114	1, 745	319	О	38	31.00
43. 00 04300 NURSERY	489	761	0	0	121	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 0PERATING ROOM	9, 360	14, 662	24, 328	ol	1, 188	50.00
51. 00 05100 RECOVERY ROOM	6, 937	10, 872	24, 320	Ö	1, 100	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 645	5, 707	3, 916	О	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 088	0	3, 744	0	11, 085	54.00
60. 00 06000 LABORATORY 64. 00 06400 NTRAVENOUS THERAPY	15, 349 0	0	62, 707 0	0	18, 236 0	60. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	208	0	2, 551	ol	1, 435	65.00
65. 01 06501 SLEEP LAB	o	0	0	o	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	10, 604	0	652	0	4, 903	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0 841	0	229 128	0	2, 677 1, 365	69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	61, 117	o	1, 303	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	74, 913	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	158, 627	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY 76. 01 03480 ONCOLOGY	0	0	0	0	0	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	<u> </u>	U	l O	<u> </u>	0	76.01
88. 00 08800 RURAL HEALTH CLINIC	0	0	783	0	3, 872	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLINIC 90. 01 09001 CLINIC - MCDONALD	1, 804	2, 821 0	1, 357 527	0	1, 953	90. 00 90. 01
90. 01 09001 CLINIC - MCDONALD 90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT	5, 521 7, 211	0	1, 021	0	1, 490 3, 205	90.01
90. 03 09003 V THERAPY	0	0	0	Ö	0	90. 03
90. 04 09004 OP PSYCH	1, 316	0	42	0	248	90. 04
91.00 09100 EMERGENCY 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART	21, 553	33, 766	9, 865	0	7, 061	91. 00 92. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	5, 377	0	397	0	0	101.00
SPECIAL PURPOSE COST CENTERS			<u> </u>			
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113. 00 114. 00
116. 00 11600 HOSPI CE	1, 035	0	13	o	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	165, 305	122, 541	257, 989	158, 627	59, 340	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				ما	0	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 194.00 07950 DAYCARE-INFANT/TODDLER	0	0	0	0		190. 00 194. 00
194. 01 07951 MOB	o o	0	Ö	Ö		194. 00
194. 02 07952 COMMUNI TY HEALTH	O	0	0	0		194. 02
194. 03 07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194. 03
194. 04 07954 EDUCATI ON 194. 05 07955 MARKETI NG	1, 402 2, 157	0	0 118	0		194. 04 194. 05
194. 06 07956 GUEST MEALS	129	0	0	Ö		194. 06
194. 07 07957 OUTSI DE LAUNDRY	O	0	0	О		194. 07
194. 08 07958 CANCER CENTER	0	0	0	0		194. 08
194. 09 07959 URGENT CARE 194. 10 07960 RHC	0	0	7, 345 0	0		194. 09 194. 10
194. 10 07960 RHC 194. 11 07961 OBGYN	6, 564	0	582	O O		194. 10
194. 12 07962 TRI NE STUDENT HEALTH	0	0	171	ő		194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	0	0	1, 104	o		194. 13
194. 14 07964 I MMUNI ZATI ON CLINI C	0	0	81	0		194. 14
194. 15 07965 FOUNDATI ON 194. 16 07967 RETAI L. PHARMACY		0	156 0	0		194. 15 194. 16
200.00 Cross Foot Adjustments		J		Ĭ	Ü	200.00
201.00 Negative Cost Centers	o	0	0	o	0	201. 00

Health Financial Systems	CAMERON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
				From 10/01/2018		
				To 09/30/2019	Date/Time Pre	
					2/25/2020 1:5	3 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16.00	
202.00 TOTAL (sum lines 118 through 201)	175, 557	122, 541	267, 54	158, 627	61, 630	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315

					To 09/30/2019 Date/Time Pi 2/25/2020 1:	
	Cost Center Description	Subtotal	Intern &	Total	27 207 2020 11	ріі
			Residents Cost & Post			
			Stepdown			
		24.00	Adjustments	27.00		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
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 10. 00	00900 HOUSEKEEPI NG					9.00
11. 00	01000 DI ETARY 01100 CAFETERI A					11.00
13.00	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					10.00
30.00	03000 ADULTS & PEDIATRICS	1, 890, 027	0	,		30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY	118, 859 49, 962	0			31. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	47, 702		49, 90	2	43.00
50.00	O5000 OPERATING ROOM	989, 999	0	1		50.00
	05100 RECOVERY ROOM	628, 194	0			51.00
54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	306, 674 803, 344	0	1		52. 00 54. 00
60.00	06000 LABORATORY	380, 372	Ö			60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	1	0	64.00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	63, 537 96, 811	0			65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY	539, 464	Ö			66.00
69. 00	06900 ELECTROCARDI OLOGY	41, 059	ł			69. 00
	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	69, 756 76, 358	l e			69. 01 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	93, 595				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	158, 627	0			73. 00
76. 00 76. 01	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0 941, 771	0	1	0	76. 00 76. 01
70.01	OUTPATIENT SERVICE COST CENTERS	741, 771		741,77	1	70.01
88. 00	08800 RURAL HEALTH CLINIC	273, 844	0			88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 30, 766	0	1	0	89. 00 90. 00
90. 01	09001 CLI NI C- MCDONALD	186, 710	l e			90.00
90. 02	09002 CLINIC - FAM PRAC, PEDS, & ENT	118, 291	0	118, 29	1	90. 02
90. 03 90. 04	09003 I V THERAPY 09004 OP PSYCH	0 70, 552	0		0	90. 03 90. 04
91. 00	09100 EMERGENCY	940, 014		1		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0	1		92. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	64, 327	0	64, 32	7	101.00
101.00	SPECIAL PURPOSE COST CENTERS	04, 327		04, 32	,	101.00
	11300 INTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	47, 757	0	47, 75	7	114. 00 116. 00
118.00		8, 980, 670	l e			118. 00
400.00	NONREI MBURSABLE COST CENTERS	47.070		47.07	ما	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-INFANT/TODDLER	47, 870 0	l e		0	190. 00 194. 00
	07951 MOB	18, 986		1		194. 01
	07952 COMMUNITY HEALTH	38	l e	1		194. 02
	07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION	0 2, 003	0	1	0	194. 03 194. 04
	07955 MARKETI NG	60, 307				194. 05
194.06	07956 GUEST MEALS	338	l e	33	8	194. 06
	07957 OUTSI DE LAUNDRY 07958 CANCER CENTER	0	0		0	194. 07 194. 08
	07958 CANCER CENTER 07959 URGENT CARE	268, 168	l .	l .	8	194. 08
194. 10	07960 RHC	0	Ö		o	194. 10
	07961 0BGYN	160, 042	0			194. 11
	07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH	1, 985 41, 195	l	1, 98 41, 19		194. 12 194. 13
	07964 I MMUNI ZATI ON CLINI C	8, 103	l	1		194. 13
	07965 FOUNDATION	16, 609		1		194. 15
194. 16	07967 RETAIL PHARMACY	32, 673	0	32, 67	<u> </u>	194. 16

Health Financial Systems CAM	ERON MEMORIAL CO	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-1315	Peri od: From 10/01/2018	Worksheet B Part II
				To 09/30/2019	
Cost Center Description	Subtotal	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
200.00 Cross Foot Adjustments	0	0		0	200. 00
201.00 Negative Cost Centers	0	0		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	9, 638, 987	0	9, 638, 9	87	202.00

	Financial Systems CAME ALLOCATION - STATISTICAL BASIS	RON MEMORIAL C	OMMUNITY HOSPIT	CN: 15-1315 P	eri od:	worksheet B-1	
					rom 10/01/2018 o 09/30/2019		
		CAPI TAL REI	LATED COSTS			, 2, 20, 2020 11 0	, p
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1. 00	2.00	4.00	5A	5. 00	
1 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	113, 789				I	1.00
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00	00200 CAP REL COSTS-BLUG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	590 10, 593 10, 278 1, 062	155, 879 590 13, 494 12, 758	25, 214, 111 4, 212, 820	-11, 808, 775 0	4, 309, 256	2.00 4.00 5.00 7.00
9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	474 4, 272 1, 985 706 3, 116	474 4, 272 1, 985 1, 794 3, 116	699, 417 111, 417 337, 701 774, 141 191, 683	000000000000000000000000000000000000000	1, 417, 388 539, 124 594, 583 1, 127, 900 576, 504	9. 00 10. 00 11. 00 13. 00 14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 155 0					
	INPATIENT ROUTINE SERVICE COST CENTERS		,			·	
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	16, 265 1, 180 420	1, 180	79, 161	0	228, 192	31.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	10, 870	10, 870	791, 060	0	2, 478, 816	50.00
51. 00 52. 00 54. 00 60. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY	7, 107 3, 383 8, 522 2, 774	7, 107 3, 383 8, 522 2, 774	634, 248	0 0	1, 346, 799 841, 342 3, 626, 820 3, 104, 862	51.00 52.00 54.00 60.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 514	-	33, 344	0	966, 347	
65. 01 66. 00 69. 00	06500 RESPIRATORY THERAPY 06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	6, 007 377	2, 600 6, 007	918, 051	0	175, 380 1, 662, 399	65. 01 66. 00
69. 01 71. 00 72. 00 73. 00 76. 00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY	795 0 0 0	795 0 0 0	69, 962 0 0	0 0 0 0	157, 027 887, 469 1, 087, 850 0	69. 01 71. 00 72. 00 73. 00
	03480 ONCOLOGY	11, 100	1				
	OUTPATIENT SERVICE COST CENTERS						
	O8800 RURAL HEALTH CLINIC O8900 FEDERALLY QUALIFIED HEALTH CENTER O9000 CLINIC O9001 CLINIC - MCDONALD O9002 CLINIC - FAM PRAC, PEDS, & ENT	0 0 0	0	138, 393 562, 341	0 0	0 218, 736	89. 00 90. 00 90. 01
90. 03 90. 04 91. 00	09003 I V THERAPY 09004 OP PSYCH 09100 EMERGENCY	0 0 9, 544	0 1, 767	220, 874	0	0 349, 640	90. 03 90. 04 91. 00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	1, 240	500, 579	0	796, 766	101.00
114.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	113, 089	, , , , ,				•
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	580			0		190. 00
194. 01 194. 02	07950 DAYCARE-I NFANT/TODDLER 07951 MOB 07952 COMMUNI TY HEALTH	0 0 0	0 529 0		0 0	15, 003 2, 240	194. 00 194. 01 194. 02
194. 04 194. 05 194. 06	07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS	0 0 0	0 0 1, 110 0	0 500 325, 411 5, 586	0	34, 923 1, 057, 972 11, 605	194.06
194. 08 194. 09	07957 OUTSI DE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC	0 0 0	0 0 6, 287 0	0 0 1, 288, 128 0	0 0 0	0 2, 056, 044	194. 07 194. 08 194. 09 194. 10
194. 11 194. 12 194. 13	07961 OBGYN 07962 TRI NE STUDENT HEALTH 07963 OCCUPATI ONAL HEALTH 07964 I MMUNI ZATI ON CLI NI C	0 0	3, 496 0 847 121	74, 013 299, 299	0 0	1, 461, 239 98, 106 558, 087	194. 11 194. 12 194. 13

CAPITAL RELATED COSTS CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) Reconciliatio ADMINISTRATIV E & GENERAL (ACCUM. COST) EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) SALARIES) SALARIES SALARIE	000. /.	OUTTON OTHER BRIDE		1		From 10/01/2018	normonous B	
BLDG & FIXT (SQUARE FEET) CQUARE							Date/Time Pre	
SQUARE FEET SQUARE FEET BENEFITS DEPARTMENT (GROSS SALARIES) SALARIES SALAR			CAPI TAL REL	ATED COSTS				
SQUARE FEET SQUARE FEET BENEFITS DEPARTMENT (GROSS SALARIES) SALARIES SALAR								
DEPARTMENT (GROSS SALARIES) DEPA		Cost Center Description				Reconciliatio	ADMI NI STRATI V	
1.00 2.00 4.00 5A 5.00			(SQUARE FEET)	(SQUARE FEET)		n		
1.00 2.00 4.00 5A 5.00 194. 15 07965 FOUNDATION 120 120 94, 301 0 380, 699 194. 15 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 201. 00 202. 00 Cost to be allocated (per Wkst. B, Part I) 45. 857429 28. 361203 0. 291809 0. 231556 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D,) 207. 00 NAHE unit cost multiplier (Wkst. D,) 207. 00 208. 00 NAHE unit cost multiplier (Wkst. D,) 209. 00 NAHE unit cost multiplier (Wkst. D,) 200. 00 NAHE unit cost multiplier (Wks							(ACCUM. COST)	
1.00 2.00 4.00 5A 5.00								
194. 15 07965 FOUNDATION 120 120 94, 301 0 380, 699 194. 15 194. 16 07967 RETAIL PHARMACY 0 880 0 0 0 88, 393 194. 16 200. 00 201. 00 Negative Cost Centers 201. 00 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 45. 857429 28. 361203 0. 291809 0. 231556 203. 00 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 206. 00 NAHE unit cost multiplier (Wkst. D, Part II) 207. 00 NAHE unit cost multiplier (Wkst. D, Part III) 207. 00 NAHE unit cost multiplier (Wkst. D, Part III) 207. 00 NAHE unit cost multiplier (Wkst. D, Part IIII) 207. 00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII								
194. 16 07967 RETAIL PHARMACY 200. 00 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NAHE u								
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, 207.00) Cross Foot Adjustments 200.00 201.00 201.00 201.00 7, 357, 709 11, 808, 775 202.00 201.00 7, 357, 709 11, 808, 775 202.00 202.00 203.00 204.00 205.00 206.00 206.00 206.00 206.00 207.00 4, 420, 916 7, 357, 709 208.361203 208.361203 208.361203 208.361203 208.361203 209.00 209.00 209.00 200.00			120			1 0		
201.00 202.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, Part III) 207.00	1		0	880	(0		
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 45.857429 28.361203 0.291809 0.231556 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.001737 0.017173 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00	1						l .	
Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part III) 206. 00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207. 00 NAHE unit cost multiplier (Wkst. D, Part III) 207. 00 NAHE unit cost multiplier (Wkst. D, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	1							
204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 0.001737 0.017173 205.00 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 2	202.00		5, 218, 071	4, 420, 916	7, 357, 709	9	11, 808, 775	202.00
Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	203.00	Unit cost multiplier (Wkst. B, Part I)	45. 857429	28. 361203	0. 291809	9	0. 231556	203.00
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	204.00	Cost to be allocated (per Wkst. B,			43, 789	9	875, 780	204.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		1						
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	205. 00				0. 001737	7	0. 017173	205.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		1 '						
207.00 NAHE unit cost multiplier (Wkst. D, 207.00	206. 00							206. 00
Parts III and IV)	207. 00							207. 00
		Parts III and IV)					l	

	Financial Systems CAME LLOCATION - STATISTICAL BASIS	RON MEMORIAL CO	OMMUNITY HOSPIT		<u> </u>	u of Form CMS-2 Worksheet B-1	
CUST	ILLUCATION - STATISTICAL BASIS		Provider Co		rom 10/01/2018	Date/Time Pre 2/25/2020 1:5	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	, piii
	CENEDAL SEDVICE COST CENTEDS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	129, 037 1, 062 474 4, 272 1, 985 1, 794 3, 116 1, 155 1, 107	72, 341 16, 337 178 549 0 0	6, 397 69 212 0 36 56	0 0 0	24, 420 826 505 569 1, 234	13. 00 14. 00 15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	16, 265	14, 312	1, 859	12, 912	4, 635	30.00
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	16, 263 1, 180 420	594	35 541		4, 633 155 68	31.00
50. 00 51. 00 52. 00 54. 00 60. 00 65. 01 66. 00 69. 01 71. 00 72. 00 73. 00 76. 01 88. 00 90. 01 90. 01 90. 02 90. 03 90. 04 91. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05100 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06501 SLEEP LAB 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY 03480 ONCOLOGY 0UTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC - MCDONALD 09001 CLINIC - FAM PRAC, PEDS, & ENT 09003 IV THERAPY 09004 OP PSYCH 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 870 7, 107 3, 383 8, 522 2, 774 0 514 2, 600 6, 007 377 795 0 0 0 11, 100 6, 789 0 532 4, 572 2, 504 0 1, 767 9, 544	5, 611 3, 669 1, 285 6, 533 316 0 12 766 1, 502 0 0 0 0 0 0 0 0 0 0 0 591 494 0 0	484 316 138 446 243 0 69 62 243 0 0 0 0 0 0 0 0 0 0 232 194 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 302 965 507 2, 377 2, 135 0 29 0 1, 475 0 117 0 0 0 0 0 0 251 768 1, 003 0 183 2, 998	50. 00 51. 00 52. 00 54. 00 60. 00 65. 00 65. 01 66. 00 69. 01 71. 00 72. 00 73. 00 76. 01 88. 00 89. 00 90. 01 90. 00 90. 01 90. 02 90. 03 90. 04
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	1, 240	27	5	0	748	101. 00
113. 00 114. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	1, 240 115, 067	0	0	0	144	113. 00 114. 00 116. 00 118. 00
194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 10 194. 11 194. 12 194. 13	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC 07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC 07965 FOUNDATION 07967 RETAIL PHARMACY Cross Foot Adjustments	580 0 529 0 0 0 1, 110 0 0 6, 287 0 3, 496 0 847 121 120 880	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 53 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 195 300 18 0 0 0 913 0 0	190.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.10 194.11 194.11 194.13 194.13 194.15 194.16 200.00

Heal th Fi	nancial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-:	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO		CAFETERI A	
		PLANT	LINEN SERVICE	`	(MEALS	(FTES)	
		(SQUARE FEET)	(POUNDS OF	SERVI C)	SERVED)		
			LAUNDR)				
		7. 00	8. 00	9. 00	10.00	11. 00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	5, 307, 090	191, 015	1, 808, 22	5 859, 636	875, 278	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	41. 128436	2. 640481	282. 66765	7 63. 875464	35. 842670	203.00
204.00	Cost to be allocated (per Wkst. B,	908, 726	88, 354	84, 02	7 357, 722	175, 557	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	7. 042368	1. 221354	13. 13537	6 26. 580621	7. 189066	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)						

		RON MEMORIAL CO				u of Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 10/01/2018 To 09/30/2019	Worksheet B-1 Date/Time Prepared: 2/25/2020 1:53 pm
	Cost Center Description	NURSING ADMINISTRATION N (DIRECT NRSING HR)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	CENEDAL CEDVICE COCT CENTEDS	13. 00	14. 00	15. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	I				1.00
2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	226, 320 0 0 0	3, 885, 041 17, 796 279	10(D 561, 675	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	96, 417	118, 125	(4, 223	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 223	4, 628	(346	31.00
43.00	04300 NURSERY	1, 406	0	(1, 106	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	27, 080	353, 259	(10, 830	50.00
51. 00	05100 RECOVERY ROOM	20, 080	0		0 0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 540	56, 867		0 0	52.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	54, 369 910, 570		101, 022 166, 194	54. 00 60. 00
64. 00	06400 INTRAVENOUS THERAPY	0	910, 370		0 0	64.00
65.00	06500 RESPI RATORY THERAPY	0	37, 036		13, 076	65. 00
65. 01	06501 SLEEP LAB	0	0 473		0 0 44, 681	65. 01
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	9, 472 3, 321		0 44, 681 0 24, 397	66. 00 69. 00
69. 01	06901 CARDI AC REHAB	0	1, 863	(12, 444	69. 01
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	887, 471		0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	1, 087, 850 0	100		72. 00 73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	0	0			76.00
76. 01	03480 ONCOLOGY	0	1	(0 0	76. 01
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	11, 371		35, 286	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	89.00
90.00	09000 CLI NI C	5, 211	19, 702		17, 799	90.00
90. 01	O9001 CLINIC - MCDONALD O9002 CLINIC - FAM PRAC, PEDS, & ENT	0	7, 652		13, 580	90.01
	09003 IV THERAPY	0	14, 826 0		29, 205	90. 02
	09004 OP PSYCH	0	613	(2, 259	90. 04
	09100 EMERGENCY	62, 363	143, 246	(64, 354	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					92. 00
101.00	10100 HOME HEALTH AGENCY	0	5, 759	(0 0	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE					112 00
	11400 UTI LI ZATI ON REVI EW-SNF					113. 00 114. 00
	11600 H0SPI CE	o	189	(0 0	116.00
118. 00	. 3 /	226, 320	3, 746, 265	100	540, 802	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O		0 0	190. 00
	07950 DAYCARE-I NFANT/TODDLER	0	0			194. 00
	07951 MOB	0	0		0 0	194. 01
	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS	0	0			194. 02 194. 03
	07954 EDUCATION	0	0	(194. 03
	07955 MARKETI NG	0	1, 714	(0	194. 05
	07956 GUEST MEALS	0	0	(0	194.06
	07957 OUTSI DE LAUNDRY 07958 CANCER CENTER	0	0	(194. 07 194. 08
194. 09	07959 URGENT CARE	0	106, 650			194. 09
	07960 RHC	0	0		0 0	194. 10
	07961 0BGYN 07962 TRI NE STUDENT HEALTH	0	8, 454 2, 487		20, 873	194. 11 194. 12
	07963 OCCUPATIONAL HEALTH		2, 487 16, 026			194. 12
194. 14	07964 IMMUNIZATION CLINIC		1, 177			194. 14
	07965 FOUNDATION	0	2, 268		0	194. 15
194. 16	07967 RETAIL PHARMACY	0	0	1	0	194. 16

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10						
COST ALLOC	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1
					rom 10/01/2018 o 09/30/2019	Date/Time Prepared: 2/25/2020 1:53 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
		N	SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT	(COSTED		(TIME SPENT)	
		NRSING HR)	REQUI S.)			
		13. 00	14. 00	15. 00	16.00	
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 492, 462	866, 430	4, 235, 499	999, 183	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 594477	0. 223017	42, 354. 990000	1. 778934	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	122, 541	267, 546	158, 627	61, 630	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 541450	0. 068866	1, 586. 270000	0. 109725	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	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF DATIO OF COCTS TO CHARGES	D: CON 15 1215	David and Wavelinda and C

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-1315 From 10/01/2018 To 09/30/2019 Part I Date/Time Prepared: 2/25/2020 1:53 pm Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 8, 965, 163 8, 965, 163 0 0 30.00 03100 INTENSIVE CARE UNIT 404, 358 0 31.00 31.00 404, 358 0 43.00 04300 NURSERY 330, 831 330, 831 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 974, 788 3, 974, 788 0 50.00 51.00 05100 RECOVERY ROOM 2, 216, 974 2, 216, 974 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 1, 318, 058 52.00 1. 318. 058 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 5, 237, 483 5, 237, 483 0 54 00 60.00 06000 LABORATORY 4, 582, 667 4, 582, 667 0 0 0 0 0 0 0 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 65.00 1, 263, 346 1, 263, 346 0 65.00 65.01 06501 SLEEP LAB 342, 472 C 342, 472 0 65.01 06600 PHYSI CAL THERAPY 2, 501, 515 2, 501, 515 66.00 66.00 0 69.00 06900 ELECTROCARDI OLOGY 598, 788 598, 788 0 69.00 06901 CARDI AC REHAB 252.831 69.01 69 01 252, 831 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 290, 889 1, 290, 889 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 582, 358 1, 582, 358 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 235, 499 73.00 73.00 4, 235, 499 0 0 03020 CHEMI CAL DEPENDENCY 76.00 0 76.00 76.01 03480 ONCOLOGY 3, 308, 950 3, 308, 950 0 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2, 110, 529 0 n 88.00 2, 110, 529 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 0 90.00 09000 CLI NI C 370, 684 370, 684 0 90.00 09001 CLINIC- MCDONALD 09002 CLINIC - FAM PRAC, PEDS, & ENT 90.01 1, 209, 404 1, 209, 404 0 0 0 90.01 90.02 1, 150, 161 1, 150, 161 0 90.02 90.03 09003 IV THERAPY 0 90.03 09004 OP PSYCH 513, 990 0 90.04 90.04 513, 990 0 91 00 09100 EMERGENCY 5, 612, 034 5, 612, 034 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 2, 125, 769 2, 125, 769 0 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 061, 839 1, 061, 839 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 247, 785 247. 785 0 116.00 0 200.00 200,00 Subtotal (see instructions) 56, 809, 165 0 56, 809, 165 0 201.00 Less Observation Beds 2, 125, 769 2, 125, 769 0 201.00 202.00 Total (see instructions) 54, 683, 396 54, 683, 396 0 202.00 Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1315 Peri od: Worksheet C From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 1:53 pm Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 8, 099, 218 30.00 03000 ADULTS & PEDIATRICS 8,099,218 30.00 31.00 03100 INTENSIVE CARE UNIT 342, 500 342, 500 31.00 466, 000 04300 NURSERY 466,000 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0. 000000 2, 479, 232 15, 943, 545 50.00 13, 464, 313 0 249304 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 757, 446 3, 888, 641 4, 646, 087 0.477170 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 115, 992 410, 536 1, 526, 528 0.863435 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 062, 448 30, 268, 208 32, 330, 656 0.161997 0.000000 54.00 54.00 06000 LABORATORY 14, 883, 871 0. 307895 0.000000 60.00 1, 795, 890 13, 087, 981 60 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 1, 698, 292 1,018,463 2, 716, 755 0.465020 0.000000 65.00 1, 003, 941 06501 SLEEP LAB 1,003,941 0.341128 0.000000 65.01 65.01 66.00 06600 PHYSI CAL THERAPY 657, 732 3, 492, 611 4, 150, 343 0.602725 0.000000 66.00 06900 ELECTROCARDI OLOGY 2, 013, 454 2, 188, 274 0. 273635 69 00 174,820 0.000000 69.00 484, 535 0.000000 06901 CARDI AC REHAB 5.633 478, 902 0.521801 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 532, 884 2, 240, 401 2, 773, 285 0. 465473 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 746, 055 988, 973 1, 735, 028 0.912007 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 726, 132 11, 093, 940 12, 820, 072 0.330380 0.000000 73.00 03020 CHEMI CAL DEPENDENCY 76.00 0.000000 0.000000 76.00 10, 598, 557 76.01 03480 ONCOLOGY 15,000 10, 613, 557 0.311766 0.000000 76.01 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 1, 092, 462 88.00 9, 758 88.00 1, 102, 220 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 89.00 90.00 09000 CLI NI C 0 602, 199 602, 199 0.615551 0.000000 90.00 09001 CLINIC- MCDONALD 279, 438 4. 222219 0.000000 90.01 7,000 286, 438 90.01 609, 094 09002 CLINIC - FAM PRAC, PEDS. & ENT 609, 294 0.000000 90.02 90.02 200 1.887695 09003 LV THERAPY 90.03 0 0.000000 0.000000 90.03 90.04 09004 OP PSYCH 0 94,050 94,050 5.465072 0.000000 90.04 91.00 09100 EMERGENCY 547, 591 16, 835, 373 17, 382, 964 0.322847 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 74.415 1, 570, 874 1, 645, 289 1. 292034 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 604, 415 604, 415 101.00

23, 314, 238

23, 314, 238

270, 700

116, 007, 526

116, 007, 526

270, 700

139, 321, 764

139, 321, 764

113 00

114.00

116. 00

200.00

201.00

202.00

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

113. 00 11300 | NTEREST EXPENSE

116. 00 11600 HOSPI CE

200.00

201.00

202.00

114.00 11400 UTILIZATION REVIEW-SNF

			To 09/30/2019	Date/Time Prepared: 2/25/2020 1:53 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
65. 01 06501 SLEEP LAB	0. 000000			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01 06901 CARDI AC REHAB	0. 000000			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000			76.00
76. 01 03480 ONCOLOGY	0. 000000			76. 01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 CLI NI C- MCDONALD	0. 000000			90. 01
90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT	0. 000000			90. 02
90. 03 09003 I V THERAPY	0. 000000			90. 03
90. 04 09004 0P PSYCH	0. 000000			90. 04
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Li€	eu of Form CMS-2552-10
COMPLITATION OF PATIO OF COSTS TO CHAPGES	Provider CCN: 15-1315	Pari od:	Workshoot C

COMPUTATION OF RAT	10 OF COSTS TO CHARGES		Provi der C	CN: 15-1315	Peri od: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Pre 2/25/2020 1:5	pared:
			Ti +I	e XIX	Hospi tal	2/25/2020 1: 5 PPS	3 pm
			11 (1	l l	Costs	113	
Cost C	enter Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
0031 0	enter beserretten	(from Wkst.	Adj .	10141 00313	Di sal I owance	10141 00313	
		B, Part I,					
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT RO	OUTINE SERVICE COST CENTERS						
	& PEDIATRICS	8, 965, 163		8, 965, 1	63 0	8, 965, 163	
	IVE CARE UNIT	404, 358		404, 3		404, 358	31.00
43. 00 04300 NURSER		330, 831		330, 8	31 0	330, 831	43.00
	ERVICE COST CENTERS						
50. 00 05000 OPERAT		3, 974, 788		3, 974, 7		3, 974, 788	
51. 00 05100 RECOVE		2, 216, 974		2, 216, 9		2, 216, 974	
	RY ROOM & LABOR ROOM	1, 318, 058		1, 318, 0		1, 318, 058	
	OGY-DI AGNOSTI C	5, 237, 483		5, 237, 4		5, 237, 483	
60. 00 06000 LABORA		4, 582, 667		4, 582, 6		4, 582, 667	
	ENOUS THERAPY	0		1 0/0 0	0 0	0	
	ATORY THERAPY	1, 263, 346	0			1, 263, 346	
65. 01 06501 SLEEP		342, 472	0	, .		342, 472	
66. 00 06600 PHYSI C		2, 501, 515	0	2,00.,0		2, 501, 515	
69. 00 06900 ELECTR 69. 01 06901 CARDI A		598, 788		598, 7		598, 788 252, 831	
	L SUPPLIES CHARGED TO PATIENT	252, 831		252, 8			
	DEV. CHARGED TO PATIENT	1, 290, 889 1, 582, 358		1, 290, 8 1, 582, 3		1, 290, 889 1, 582, 358	
	CHARGED TO PATTENTS	4, 235, 499		4, 235, 4		4, 235, 499	
	AL DEPENDENCY	4, 233, 477		4, 233, 4	0 0	4, 233, 477	
76. 01 03480 ONCOLO		3, 308, 950		3, 308, 9	-	3, 308, 950	
	SERVICE COST CENTERS	3, 300, 730		3,300,7	30 0	3, 300, 730	70.01
	HEALTH CLINIC	2, 110, 529		2, 110, 5	29 0	2, 110, 529	88. 00
	LLY QUALIFIED HEALTH CENTER	0		2,, 0	0 0	0	89.00
90. 00 09000 CLINIC		370, 684		370, 6	84 0	370, 684	1
90. 01 09001 CLINIC		1, 209, 404		1, 209, 4		1, 209, 404	1
	- FAM PRAC, PEDS, & ENT	1, 150, 161		1, 150, 1		1, 150, 161	1
90. 03 09003 IV THE	RAPY	0			0 0	0	90. 03
90. 04 09004 OP PSY	CH	513, 990		513, 9	90 0	513, 990	90. 04
91. 00 09100 EMERGE	NCY	5, 612, 034		5, 612, 0	34 0	5, 612, 034	91.00
92. 00 09200 OBSERV	ATION BEDS (NON-DISTINCT PART	2, 125, 769		2, 125, 7	69	2, 125, 769	92.00
OTHER REIMBU	JRSABLE COST CENTERS						
101.00 10100 HOME H	EALTH AGENCY	1, 061, 839		1, 061, 8	39	1, 061, 839	101.00
	POSE COST CENTERS						
113. 00 11300 I NTERE							113.00
114. 00 11400 UTI LI Z							114. 00
116. 00 11600 HOSPI C		247, 785		247, 7		247, 785	
	al (see instructions)	56, 809, 165	0			56, 809, 165	
	bservation Beds	2, 125, 769		2, 125, 7		2, 125, 769	
202. 00 Total	(see instructions)	54, 683, 396	0	54, 683, 3	96 0	54, 683, 396	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1315 Peri od: Worksheet C From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 1:53 pm Title XIX Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 8, 099, 218 30.00 03000 ADULTS & PEDIATRICS 8,099,218 30.00 31.00 03100 INTENSIVE CARE UNIT 342, 500 342, 500 31.00 466, 000 04300 NURSERY 466,000 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0. 000000 2, 479, 232 15, 943, 545 50.00 13, 464, 313 0 249304 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 757, 446 3, 888, 641 4, 646, 087 0.477170 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 115, 992 410, 536 1, 526, 528 0.863435 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 062, 448 32, 330, 656 0.161997 30, 268, 208 0.000000 54.00 54.00 06000 LABORATORY 14, 883, 871 0. 307895 0.000000 60.00 1, 795, 890 13, 087, 981 60 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 1, 698, 292 1,018,463 2, 716, 755 0.465020 0.000000 65.00 1, 003, 941 06501 SLEEP LAB 1,003,941 0.341128 0.000000 65.01 65.01 66.00 06600 PHYSI CAL THERAPY 657, 732 3, 492, 611 4, 150, 343 0.602725 0.000000 66.00 06900 ELECTROCARDI OLOGY 2, 013, 454 2, 188, 274 0. 273635 69 00 174,820 0.000000 69.00 484, 535 0.000000 06901 CARDI AC REHAB 5.633 478, 902 0.521801 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 532, 884 2, 240, 401 2, 773, 285 0.465473 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 746, 055 988, 973 1, 735, 028 0.912007 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 726, 132 11, 093, 940 12, 820, 072 0.330380 0.000000 73.00 03020 CHEMI CAL DEPENDENCY 76.00 0.000000 0.000000 76.00 10, 598, 557 76.01 03480 ONCOLOGY 15,000 10, 613, 557 0.311766 0.000000 76.01 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 1, 092, 462 88.00 9, 758 1. 914798 0.000000 88.00 1, 102, 220 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 0.000000 0.000000 89 00 90.00 09000 CLI NI C 0 602, 199 602, 199 0.615551 0.000000 90.00 09001 CLINIC- MCDONALD 279, 438 4. 222219 90.01 7,000 286, 438 0.000000 90.01 609, 094 09002 CLINIC - FAM PRAC, PEDS. & ENT 609, 294 0.000000 90.02 90.02 200 1.887695 09003 LV THERAPY 90.03 0 0.000000 0.000000 90.03 90.04 09004 OP PSYCH 0 94,050 94,050 5. 465072 0.000000 90.04 91.00 09100 EMERGENCY 547, 591 16, 835, 373 17, 382, 964 0.322847 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 74.415 1, 570, 874 1, 645, 289 1. 292034 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 604, 415 604, 415 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPI CE 270, 700 270, 700 116. 00 200.00 Subtotal (see instructions) 23, 314, 238 116, 007, 526 139, 321, 764 200.00 201.00 Less Observation Beds 201.00

23, 314, 238

116, 007, 526

139, 321, 764

202.00

202.00

Total (see instructions)

Cost Center Description				To 09/30/2019	Date/Time Prepared: 2/25/2020 1:53 pm
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.000 ADULTS & PEDI ATRICS 31.00 31.00 31.00 1NTENSI VE CARE UNIT 31.00 42.00 43.			Title XIX	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDI ATRIC S 31.00 31.00 31.00 1.00 1.01 1	Cost Center Description				
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 31					
30.00 03000 ADULTS & PEDI ATRICS 31.00 04300 NIRSERY ATRICS 31.00 04300 NIRSERY CARE UNIT 31.00 04300 NIRSERY ATRICS		11. 00			
31.00 O3100 INTENSIVE CARE UNIT					
A3. 00 04300 NURSERY					
ANCILLARY SERVICE COST CENTERS 50.00					
SOLOD OSCOOL OS					43. 00
S1.00 05100 RECOVERY ROOM 0.477170 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.863435 52.00 05400 RADI OLOGY-DI AGNOSTIC 0.161997 54.00 06000 LABORATORY 0.307895 60.00 06000 LABORATORY 0.307895 60.00 06000 LABORATORY 0.465020 64.00 06400 INTRAVENOUS THERAPY 0.405020 65.00 06500 RESPI RATORY THERAPY 0.465020 65.01 06501 SLEEP LAB 0.341128 65.01 06501 SLEEP LAB 0.341128 65.01 06601 LECTROCARDI OLOGY 0.273635 69.00 06900 ELECTROCARDI OLOGY 0.273635 69.00 06900 ELECTROCARDI OLOGY 0.273635 69.00 06901 CARDIAC REHAB 0.521801 0.71000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.465473 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.465473 77.00 07200 IMPL. Dev. CHARGED TO PATI ENT 0.4954037 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.330380 76.00 03200 CHEMI CAL DEPENDENCY 0.000000 76.00 03200 CHEMI CAL DEPENDENCY 0.000000 76.00 03200 CHEMI CAL DEPENDENCY 0.000000 76.00 03000 CHEMI CAL DEPENDENCY 0.000000 76.00 03000 CHEMICAL DEPENDENCY 0.000000 76.00 03000 CHEMICAL DEPENDENCY 0.000000 0.311766 0.000000 0.00000 CHINIC - FAM PRAC, PEDS, & ENT 1.887695 90.00 0.000000 CHINIC - FAM PRAC, PEDS, & ENT 1.887695 90.00 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0					
S2.00 05200 05200 0521 VERY ROOM & LABOR ROOM 0. 863435 52.00		1			
54.00 05400 RADIOLOGY-DI AGNOSTIC 0.161997 0.307895 0.00000 0.6000 LABORATORY 0.307895 0.000000 0.6400 INTRAVENOUS THERAPY 0.0000000 0.65.00 0.6500 RESPI RATORY THERAPY 0.465020 0.6500 0.6501 SLEEP LAB 0.341128 0.65.01 0.6501 SLEEP LAB 0.341128 0.65.01 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.00000 0.6000 0.00000 0.6000 0.6000 0.6000 0.6000 0.00000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.6000 0.0000 0.60000 0.6000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.60000 0.600000 0.600000 0.600000 0.600000 0.6000000 0.6000000 0.6000000 0.60000000 0.60000000 0.60000000 0.600000000 0.6000000000 0.60000000000		1			l
60.00 06000 LABORATORY 0.307895 60.00					
64.00 06400 INTRAVENOUS THERAPY 0.000000 65.00 06500 RESPI RATORY THERAPY 0.465020 65.00 06500 RESPI RATORY THERAPY 0.465020 65.00 06501 SLEEP LAB 0.341128 65.01 66.00 06600 PHYSI CAL THERAPY 0.602725 66.00 06900 ELECTROCARDI OLOGY 0.273635 69.00 06900 ELECTROCARDI OLOGY 0.273635 69.00 06901 CARDI AC REHAB 0.521801 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.465473 771.00 072.00 IMPL. DEV. CHARGED TO PATI ENT 0.912007 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.912007 72.00 07300 DRUGS CHARGED TO PATI ENTS 0.330380 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.330380 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.330380 076.00 03480 ONCOLOGY 0.311766 000000 76.00 03480 ONCOLOGY 0.311766 000000 03480 ONCOLOGY 0.311766 000000 03480 ONCOLOGY 0.311766 000000 000000 000000 000000 000000					
65. 00 06500 RSPI RATORY THERAPY 0. 465020 65. 01 06501 SLEEP LAB 0. 341128 65. 01 66. 00 06600 PHYSI CAL THERAPY 0. 602725 66. 00 69. 00 06600 PHYSI CAL THERAPY 0. 602725 66. 00 69. 01 06900 ELECTROCARDI OLOGY 0. 273635 69. 00 06901 CARDI AC REHAB 0. 521801 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 465473 77. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 912007 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 330380 73. 00 76. 00 03000 CHEMI CAL DEPENDENCY 0. 000000 76. 00 03020 CHEMI CAL DEPENDENCY 0. 311766 76. 00 000000 000000 000000 0000000					
65. 01 06501 SLEEP LAB 0. 341128 65. 01 66. 00 06600 PHYSI CAL THERAPY 0. 602725 66. 00 69. 01 06900 ELECTROCARDI OLOGY 0. 273635 69. 00 69. 01 06901 CARDI AC REHAB 0. 521801 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 465473 72. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 912007 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 330380 73. 00 76. 00 03202 CHEMI CAL DEPENDENCY 0. 000000 76. 00 76. 01 03480 MOCOLOGY 0. 311766 76. 01 0017PATI ENT SERVICE COST CENTERS 88. 00 89. 00 08800 RURAL HEALTH CLINIC 1. 914798 88. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0. 000000 89. 00 90. 01 09001 CLINIC - FAM PRAC, PEDS, & ENT 1. 887695 99. 01 90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT 1. 887695 99. 03 90. 04 09004 OP PSYCH 5. 465072 99. 04 91. 00 09100 EMERGENCY 99. 04 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 1. 292034 91. 00 00 071ER REIMBURSABLE COST CENTERS 113. 00 114. 00 11400 UTILLIZATION REVIEW-SNF 114. 00 116. 00 11600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 114. 00 11400 UTILLIZATION REVIEW-SNF 114. 00 116. 00 11600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 114. 00 11400 UTILLIZATION REVIEW-SNF 114. 00 116. 00 1600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 116. 00 1600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 116. 00 1600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 116. 00 1600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 116. 00 1600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 116. 00 1600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 116. 00 1600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 116. 00 1600 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 116. 00 16					
66. 00 06600 PHYSICAL THERAPY 0. 6.02725 6.0 06900 ELECTROCARDIOLOGY 0. 273635 69. 01 06901 CARDIAC REHAB 0. 521801 69. 01 06901 CARDIAC REHAB 0. 521801 69. 01 0710.0 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 465473 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 912007 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 912007 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 330380 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 330380 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 330380 75. 00 03020 CHEMICAL DEPENDENCY 0. 000000 76. 01 03480 ONCOLOGY 0. 311766 76. 00 03480 ONCOLOGY 0. 311766 76. 00 03480 ONCOLOGY 0. 311766 76. 00 03800 RURAL HEALTH CLINIC 1. 944798 88. 00 08800 RURAL HEALTH CLINIC 1. 944798 88. 00 09000 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 90. 00 09000 CLINIC 0. 0. 615551 90. 00 9000 CLINIC 0. 0. 000000 90. 00 00000 00000 00000 00000 00000 00000 0000		1			
69. 00 06900 ELECTROCARDIOLOGY 0. 273635 69. 00 06901 CARDI AC REHAB 0. 521801 71. 00 07100 MEDI CARDI AC SUPPLIES CHARGED TO PATIENT 0. 465473 77. 00 77. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 912007 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 330380 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 330380 76. 00 03020 CHEMI CAL DEPENDENCY 0. 000000 76. 00 03020 CHEMI CAL DEPENDENCY 0. 300000 76. 00 03480 ONCOLOGY 0. 311766 76. 00 03480 ONCOLOGY 0. 311766 76. 00 03480 ONCOLOGY 0. 311766 76. 00 03800 RURAL HEALTH CLINIC 1. 914798 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 89. 00 09000 CLINIC 0. 615551 99. 00 09000 CLINIC - MODONALD 4. 222219 90. 01					
69. 01 06901 CARDI AC REHAB 0. 521801 71. 00 77100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 465473 72. 00 73. 00 73.00 73	l •				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 465473 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 912007 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 330380 73. 00 73. 00 03000 CHEMICAL DEPENDENCY 0. 000000 76. 00 03480 ONCOLOGY 0. 311766 76. 00 03800 RURAL HEALTH CLINIC 1. 914798 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 09000 CLINIC 0. 615551 99. 00 09000 CLINIC MCDONALD 4. 222219 99. 01 09001 CLINIC MCDONALD 4. 222219 99. 01 09001 CLINIC MCDONALD 4. 222219 99. 01 09002 CLINIC FAM PRAC, PEDS, & ENT 1. 887695 99. 02 09002 CLINIC FAM PRAC, PEDS, & ENT 1. 887695 99. 02 09002 CLINIC MCDONALD 99. 00 09000 OPSYCH 5. 465072 99. 03 09000 OPSYCH 5. 465072 99. 03 09000 OPSYCH 5. 465072 99. 03 09000 OBSERVATION BEDS (NON-DISTINCT PART 1. 292034 91. 00 07HER REIMBURSABLE COST CENTERS 113. 00 OTHER REIMBURSABLE COST CENTERS 114. 00 114. 00 11400 UTILI ZATION REVIEW-SNF 114. 00 11400 UTILI ZATION REVIEW-SNF 114. 00 11400 UTILI ZATION REVIEW-SNF 114. 00 11600 HOSPICE 5000 500		1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 912007 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 330380 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 330380 76. 00 03480 ORCOLOGY 0. 311766 76. 01 03480 ORCOLOGY 0. 311766 76. 01 000000 000000 000000 000000 000000		1			
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76. 00 03020 CHEMI CAL DEPENDENCY 0. 000000 76. 01 03480 ONCOLOGY 0. 311766 76. 01 0480 ONCOLOGY 0. 311766 76. 01 08800 RURAL HEALTH CLINIC 1. 914798 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 89. 00 09000 CLINIC 0. 6.15551 90. 00 09000 CLINIC ONCOLOGY 0. 00 09000 CLINIC ONCOLOGY 0. 00 09000 CLINIC ONCOLOGY 0. 00 09000 ONCOLOG					
76. 01 03480 ONCOLOGY					
SB. 00 OBBOD RURAL HEALTH CLINIC 1.914798 88. 00 OBBOD RURAL HEALTH CLINIC 1.914798 89. 00 OBBOD FEDERALLY QUALIFIED HEALTH CENTER 0.000000 99. 00 OPODO CLINIC MCDONALD 4.222219 90. 01 09001 CLINIC - MCDONALD 4.222219 90. 01 09002 CLINIC - FAM PRAC, PEDS, & ENT 1.887695 90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT 1.887695 90. 02 09003 V THERAPY 0.000000 90. 03 09004 09 PSYCH 5.465072 90. 04 09004 09 PSYCH 5.465072 90. 04 09100 EMERGENCY 0.322847 91. 00 09100 EMERGENCY 0.322847 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.292034 92. 00 07HER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 10100 HOME HEALTH AGENCY 101.00 114.00 114.00 UTILIZATION REVIEW-SNF 114.00 116.00 11600 HOSPICE 116.00 000 CESS Observation Beds 200. 00 201.00 Less Observation Beds 201.00					
88. 00 89. 00 89. 00 89. 00 89. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 90. 02 90. 03 90. 03 90. 04 90. 04 90. 04 90. 04 90. 04 90. 00		0.311766			70.01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 90. 00 09000 CLINIC 90. 00 09000 CLINIC 90. 00 4. 222219 90. 01 90. 01 90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT 1. 887695 90. 02 90. 03 09003 V THERAPY 0.000000 90. 04 09004 0P PSYCH 5. 465072 90. 03 90. 00 90. 000 90		1 01/708			88 00
90. 00 09000 CLINI C 0. 615551 90. 00 90. 01 09001 CLINI C - MCDONALD 4. 222219 90. 01 90. 02 09002 CLINI C - FAM PRAC, PEDS, & ENT 1. 887695 90. 02 90. 03 09003 IV THERAPY 0. 000000 90. 03 90. 04 09004 09004 09004 09004 09004 09004 09004 09004 09004 09000 09100 EMERGENCY 91. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART 1. 292034 92. 00 0716ER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 92. 00 07100 10100 HOME HEALTH AGENCY 101. 00 10100 10400		1			
90. 01					
90. 02					
90. 03					
90. 04					
91. 00					
92. 00					
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 114.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	· · · · · · · · · · · · · · · · · · ·				
101. 00		11.27200.			72.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					101.00
113. 00 113.00 114.00 114.00 114.00 114.00 116.00 116.00 116.00 200.00 201.00 118.00 119.00 11					
114. 00 11400 UTILIZATION REVIEW-SNF 114.00 116. 00 11600 HOSPICE 116.00 200. 00 Subtotal (see instructions) 200.00 201. 00 Less Observation Beds 201.00					113.00
116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	• • • • • • • • • • • • • • • • • • •				
201.00 Less Observation Beds 201.00	+ I				
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 Heal th Financial
 Systems
 CAMERON MEMORIAL
 COMMUNITY HOSPITAL

 CALCULATION OF OUTPATIENT SERVICE
 COST TO CHARGE RATIOS NET OF
 Provider CCN:

 REDUCTIONS FOR MEDICALD ONLY
 | Peri od: | Worksheet C | From 10/01/2018 | Part II | To 09/30/2019 | Date/Time Prepared: Provi der CCN: 15-1315

					10 09/30/2019	2/25/2020 1:5	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	·	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
				col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	3, 974, 788				0	
	100 RECOVERY ROOM	2, 216, 974	628, 194	1, 588, 78	0	0	51.00
	200 DELIVERY ROOM & LABOR ROOM	1, 318, 058	306, 674	1, 011, 38	4 0	0	52.00
	400 RADI OLOGY-DI AGNOSTI C	5, 237, 483	803, 344	4, 434, 13	9 0	0	
	DOO LABORATORY	4, 582, 667	380, 372	4, 202, 29	5 0	0	60.00
64. 00 064	400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00 065	500 RESPI RATORY THERAPY	1, 263, 346	63, 537	1, 199, 80	9 0	0	65.00
65. 01 065	501 SLEEP LAB	342, 472	96, 811	245, 66	1 0	0	65. 01
66.00 066	600 PHYSI CAL THERAPY	2, 501, 515	539, 464	1, 962, 05	1 0	0	66.00
69.00 069	POO ELECTROCARDI OLOGY	598, 788	41, 059	557, 72	9 0	0	69.00
69. 01 069	901 CARDI AC REHAB	252, 831	69, 756	183, 07	5 0	0	69. 01
71. 00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 290, 889	76, 358	1, 214, 53	1 0	0	71.00
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENTS	1, 582, 358	93, 595	1, 488, 76	3 0	0	72.00
73. 00 073	BOO DRUGS CHARGED TO PATIENTS	4, 235, 499	158, 627	4, 076, 87	2 0	0	73.00
76. 00 030	D20 CHEMI CAL DEPENDENCY	0	0		o o	0	76.00
76. 01 034	480 ONCOLOGY	3, 308, 950	941, 771	2, 367, 17	9 0	0	76. 01
	FPATIENT SERVICE COST CENTERS		·				1
88. 00 088	BOO RURAL HEALTH CLINIC	2, 110, 529	273, 844	1, 836, 68	5 0	0	88. 00
89. 00 089	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
90.00 090	DOO CLI NI C	370, 684	30, 766	339, 91	8 0	0	90.00
90. 01 090	DO1 CLINIC- MCDONALD	1, 209, 404	186, 710	1, 022, 69	4 0	0	90. 01
90. 02 090	DO2 CLINIC - FAM PRAC, PEDS, & ENT	1, 150, 161	118, 291	1, 031, 87	0 0	0	90.02
90. 03 090	DO3 IV THERAPY	0	0		0 0	0	90. 03
90. 04 090	004 OP PSYCH	513, 990	70, 552	443, 43	8 0	0	90.04
91. 00 091	100 EMERGENCY	5, 612, 034	940, 014	4, 672, 02	0 0	0	91.00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART	2, 125, 769	448, 152	1, 677, 61	7 0	0	92.00
OTH	HER REIMBURSABLE COST CENTERS						1
101.00 101	100 HOME HEALTH AGENCY	1, 061, 839	64, 327	997, 51	2 0	0	101.00
SPE	ECLAL PURPOSE COST CENTERS						1
113. 00 113	300 I NTEREST EXPENSE						113.00
114. 00 114	400 UTILIZATION REVIEW-SNF						114.00
116. 00 116	600 HOSPI CE	247, 785	47, 757	200, 02	8 0	0	116.00
200. 00	Subtotal (sum of lines 50 thru 199)	47, 108, 813	7, 369, 974	39, 738, 83	9 0	0	200.00
201.00	Less Observation Beds	2, 125, 769	448, 152	1, 677, 61	7 0		201.00
202. 00	Total (line 200 minus line 201)	44, 983, 044	6, 921, 822	38, 061, 22	2 0	0	202.00

REDUCTIONS FOR MEDICALD ONLY

Peri od: Worksheet C From 10/01/2018 Part II To 09/30/2019 Date/Ti me Prepared: 2/25/2020 1:53 pm

						2/25/2020 1:5	3 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to			
		Operati ng	Part I,	Charge Ratio			
		Cost	column 8)	(col. 6 /			
		Reducti on		col. 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 974, 788	15, 943, 545	0. 24930	4		50.00
51.00	05100 RECOVERY ROOM	2, 216, 974	4, 646, 087	0. 47717	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 318, 058	1, 526, 528	0. 86343	5		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 237, 483	32, 330, 656	0. 16199	7		54.00
60.00	06000 LABORATORY	4, 582, 667	14, 883, 871	0. 30789	5		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.00000	0		64.00
65.00	06500 RESPI RATORY THERAPY	1, 263, 346	2, 716, 755	0. 46502	0		65.00
65. 01	06501 SLEEP LAB	342, 472	1, 003, 941	0. 34112	8		65. 01
66.00	06600 PHYSI CAL THERAPY	2, 501, 515					66.00
69.00	06900 ELECTROCARDI OLOGY	598, 788					69.00
69. 01	06901 CARDI AC REHAB	252, 831					69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 290, 889					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 582, 358					72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 235, 499					73.00
76. 00	03020 CHEMI CAL DEPENDENCY	0					76.00
	03480 ONCOLOGY	3, 308, 950	10, 613, 557				76. 01
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	2, 110, 529	1, 102, 220	1. 91479	8		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89. 00
	09000 CLI NI C	370, 684	602, 199	0. 61555	1		90.00
	09001 CLINIC- MCDONALD	1, 209, 404					90. 01
	09002 CLINIC - FAM PRAC, PEDS, & ENT	1, 150, 161					90. 02
	09003 I V THERAPY	0	1				90. 03
	09004 OP PSYCH	513, 990	94, 050				90.04
	09100 EMERGENCY	5, 612, 034					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 125, 769					92.00
	OTHER REIMBURSABLE COST CENTERS	, , , , , ,	,				
101.00	10100 HOME HEALTH AGENCY	1, 061, 839	604, 415	1. 75680	5		101.00
	SPECIAL PURPOSE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,			-1		
113.00	11300 NTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
	11600 H0SPI CE	247, 785	270, 700	0. 91534	9		116.00
200.00		47, 108, 813					200.00
201.00		2, 125, 769					201. 00
202.00		44, 983, 044	l .				202.00
				'	1		

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2018 To 09/30/2019		narod:
				10 07/30/2017	2/25/2020 1:5	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)	2.00	2.00	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	989, 999	15, 943, 545	0. 06209	611, 294	37, 958	50.00
51. 00 05100 RECOVERY ROOM	628, 194	4, 646, 087			19, 948	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	306, 674	1, 526, 528			19, 940	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	803, 344	32, 330, 656			12, 956	54.00
60. 00 06000 LABORATORY	380, 372	14, 883, 871	0. 02555		11, 575	
64. 00 06400 I NTRAVENOUS THERAPY	0	0			0	64.00
65. 00 06500 RESPIRATORY THERAPY	63, 537	2, 716, 755			10, 080	65. 00
65. 01 06501 SLEEP LAB	96, 811	1, 003, 941			0	65. 01
66. 00 06600 PHYSI CAL THERAPY	539, 464	4, 150, 343		105, 724	13, 742	66.00
69. 00 06900 ELECTROCARDI OLOGY	41, 059	2, 188, 274	0. 01876	159, 966	3, 001	69.00
69. 01 06901 CARDI AC REHAB	69, 756	484, 535	0. 14396	5 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 358	2, 773, 285	0. 02753	281, 692	7, 756	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	93, 595	1, 735, 028	0. 05394	202, 901	10, 945	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	158, 627	12, 820, 072			4, 955	
76. 00 03020 CHEMI CAL DEPENDENCY	0	0	0.00000		0	76. 00
76. 01 03480 ONCOLOGY	941, 771	10, 613, 557	0. 08873	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	273, 844	1, 102, 220			0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90. 00 09000 CLI NI C	30, 766	602, 199			0	90.00
90. 01 09001 CLINI C - MCDONALD	186, 710	286, 438			0	90. 01
90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT 90.03 09003 V THERAPY	118, 291	609, 294 0			0	90. 02 90. 03
90. 03 09003 TV THERAPY 90. 04 09004 OP PSYCH	70, 552	94, 050			0	90.03
91. 00 09100 EMERGENCY	940, 014	17, 382, 964			579	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	448, 152	1, 645, 289				
200.00 Total (lines 50 through 199)	7, 257, 890			3, 353, 813		
200.00 10tal (111100 00 till ough 177)	1, 207, 070	.27,000,701	I	0,000,010	111, 104	_50.00

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 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1315
 Peri od: Worksheet D From 10/01/2018 Part IV To 09/30/2019 Date/Time Prepared: THROUGH COSTS

						2/25/2020 1:5	3 pm
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
65. 01	06501 SLEEP LAB	0	0		0 0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01	06901 CARDI AC REHAB	0	0		0 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03020 CHEMI CAL DEPENDENCY	0	0		0 0	0	76.00
76. 01	03480 ONCOLOGY	0	O		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS				•		
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O		0 0	0	89. 00
90.00	09000 CLI NI C	0	O		0 0	0	90.00
90. 01	09001 CLINIC- MCDONALD	0	0		0 0	0	90. 01
90. 02	09002 CLINIC - FAM PRAC, PEDS, & ENT	0	0		0 0	0	90.02
	09003 I V THERAPY	0	0		0 0	0	90. 03
90. 04	09004 OP PSYCH	0	0		0 0	0	90.04
	09100 EMERGENCY	0	0		0 0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00	,	0	0		0 0		200.00
200.00	1 1122 (11100 00 1111 009.1 177)	1	·	1	-1		

 Heal th Financial
 Systems
 CAMERON MEMORIAL
 COMMUNITY HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 Provider CCN: 15-1315
 THROUGH COSTS

				10 09/30/2019	2/25/2020 1:5	
		Title	e XVIII	Hospi tal	Cost	<u>o p</u>
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	T	T .	T	T		
50. 00 05000 OPERATI NG ROOM	0	0		15, 943, 545	l e	
51.00 05100 RECOVERY ROOM	0	0	(4, 646, 087	l e	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	(1, 526, 528	l e	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		32, 330, 656	l	1
60. 00 06000 LABORATORY	0	0		14, 883, 871		
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	0		2, 716, 755	•	1
65. 01 06501 SLEEP LAB	0	0		1, 003, 941	l	1
66. 00 06600 PHYSI CAL THERAPY	0	0		4, 150, 343		l
69. 00 06900 ELECTROCARDI OLOGY	0	0		2, 188, 274	l	l
69. 01 06901 CARDI AC REHAB	0	0		484, 535		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 773, 285	l .	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		1, 735, 028	l	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		12, 820, 072	l	1
76. 00 03020 CHEMI CAL DEPENDENCY	0	0	l .	-	0.000000	
76. 01 03480 0NCOLOGY	0	0	1 (10, 613, 557	0. 000000	76. 01
OUTPATIENT SERVICE COST CENTERS				4 400 000	0.00000	00.00
88. 00 08800 RURAL HEALTH CLINIC	0	1	1	1, 102, 220		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		(00.100	0.000000	ı
90. 00 09000 CLI NI C	0	0		602, 199	l e	1
90. 01 09001 CLI NI C - MCDONALD	0	0		286, 438	l e	ı
90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT	0	0		609, 294	l e	1
90. 03 09003 I V THERAPY	0	0		04.050	0.000000	
90. 04 09004 OP PSYCH	0	0		94, 050		1
91. 00 09100 EMERGENCY	0			,		1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				1
200.00 Total (lines 50 through 199)	0	0	'I	129, 538, 931		200. 00

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 CAMERON MEMORIAL COMMUNITY HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1315
 THROUGH COSTS

	2/25/2020 1:53	pared: 3 pm
Title XVIII	Hospi tal Cost	
Cost Center Description Outpatient Inpatient Inpatient C	Outpatient Outpatient	
Ratio of Cost Program Program	Program Program	
to Charges Charges Pass-Through	Charges Pass-Through	
(col. 6 ÷ Costs (col. 8	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 OPERATI NG ROOM 0. 000000 611, 294 0	0 0	50.00
51. 00 05100 RECOVERY ROOM 0. 000000 147, 532 0	0 0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0 0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		54.00
60. 00 06000 LABORATORY 0. 000000 452, 913 0	0 0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0 0	64.00
65. 00 06500 RESPI RATORY THERAPY	0 0	65.00
65. 01 06501 SLEEP LAB	0 0	65. 01
66. 00 06600 PHYSI CAL THERAPY 0. 000000 105, 724 0	0 0	66.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 159, 966 0	0 0	69. 00
69. 01 06901 CARDI AC REHAB 0. 000000 0 0	0 0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 281,692 0	0 0	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS 0.000000 202,901 0	0 0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 400, 433 0	0 0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY 0. 000000 0 0	0 0	76.00
76. 01 03480 0NC0L0GY 0. 000000 0 0	0 0	76. 01
OUTPATLENT SERVICE COST CENTERS		
88. 00 08800 RURAL HEALTH CLINIC 0. 000000 0 0	0 0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 0 0	0 0	89.00
90. 00 09000 CLINIC 0. 000000 0 0	0 0	90.00
90. 01 09001 CLI NI C- MCDONALD 0. 000000 0 0	0 0	90. 01
90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT 0.000000 0 0	0 0	90.02
90. 03 09003 I V THERAPY 0. 000000 0 0	0 0	90. 03
90. 04 09004 OP PSYCH 0. 000000 0 0	0 0	90.04
91. 00 09100 EMERGENCY	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 28,229 0	0 0	92.00
200.00 Total (lines 50 through 199) 3,353,813 0	0 0 2	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1315 Peri od: Worksheet D From 10/01/2018 To 09/30/2019 Part V Date/Time Prepared: 2/25/2020 1:53 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 249304 2, 753, 978 50.00 05100 RECOVERY ROOM 0 51.00 0.477170 534, 325 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.863435 0 2, 301 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.161997 7, 459, 917 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0.307895 3, 184, 305 0 60.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0 64.00 Ω 65.00 06500 RESPIRATORY THERAPY 0.465020 452, 441 0 65.00 65.01 06501 SLEEP LAB 0. 341128 4, 161 0 65.01 06600 PHYSI CAL THERAPY 0.602725 1, 054, 658 0 66.00 66.00 06900 ELECTROCARDI OLOGY 571, 992 69.00 69.00 0.273635 0 69.01 06901 CARDI AC REHAB 0.521801 198, 440 0 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 330, 240 0 71.00 0.465473 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.912007 0 ol 72 00 184 759 0 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 330380 0 4, 467, 773 9, 192 0 73.00 76.00 03020 CHEMI CAL DEPENDENCY 0.000000 0 0 76.00 03480 ONCOLOGY 76.01 0. 311766 0 3, 127, 934 0 76.01 0 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLI NI C 0.615551 275, 384 0 90.00 0 90 01 09001 CLINIC- MCDONALD 4. 222219 0 55, 615 90.01 0 o 90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT 1.887695 39, 317 0 90.02 90.03 09003 IV THERAPY 0.000000 0 0 90.03 09004 OP PSYCH 2, 140 0 90.04 90.04 5. 465072 0 91. 00 09100 EMERGENCY 3, 376, 140 0.322847 0 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 292034 0 848, 852 2, 089 0 92.00 11, 281 200.00 Subtotal (see instructions) 28, 924, 672 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 0 Only Charges Net Charges (line 200 - line 201) 0 202.00 202.00 28, 924, 672 11, 281

In Lieu of Form CMS-2552-10 Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1315 Peri od: Worksheet D From 10/01/2018 To 09/30/2019 Part V Date/Time Prepared: 2/25/2020 1:53 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 686, 578 50.00 05100 RECOVERY ROOM 254, 964 51.00 51.00 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 1, 987 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 208, 484 0 54.00 60.00 06000 LABORATORY 980, 432 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 210, 394 0 65.00 65.01 06501 SLEEP LAB 1, 419 65.01 0 66.00 06600 PHYSI CAL THERAPY 635, 669 66.00 06900 ELECTROCARDI OLOGY 156, 517 0 69.00 69.00 69.01 06901 CARDI AC REHAB 103, 546 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 153, 718 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 168, 502 72 00 Ω 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 476, 063 3, 037 73.00 76.00 03020 CHEMI CAL DEPENDENCY 76.00 975, 183 03480 ONCOLOGY 76.01 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLI NI C 169, 513 0 90.00 90 01 09001 CLINIC- MCDONALD 234, 819 0 90.01 90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT 74, 219 0 90.02 90. 03 09003 IV THERAPY 0 90.03 09004 OP PSYCH 90.04 11, 695 90.04 0 91. 00 09100 EMERGENCY 1,089,977 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 096, 746 2,699 92.00 200.00 Subtotal (see instructions) 9, 690, 425 5,736 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00

9, 690, 425

5, 736

202.00

Only Charges

202.00

Net Charges (line 200 - line 201)

In Lieu of Form CMS-2552-10 Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1315 Peri od: Worksheet D From 10/01/2018 To 09/30/2019 Part V Component CCN: 15-Z315 Date/Time Prepared: 2/25/2020 1:53 pm Title XVIII Swing Beds - SNF Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Rei mbursed Charge Ratio Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 249304 50.00 05100 RECOVERY ROOM 0 0 0 51.00 0.477170 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.863435 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.161997 0 0 0 0 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0.307895 0 0 0 60.00 0 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.465020 0 0 65.00 65.01 06501 SLEEP LAB 0. 341128 65.01 0 06600 PHYSI CAL THERAPY 0.602725 0 0 66.00 66.00 0 0 06900 ELECTROCARDI OLOGY 0. 273635 69.00 69.00 0 69.01 06901 CARDI AC REHAB 0.521801 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0.465473 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0.912007 0 72 00 0 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 330380 0 0 73.00 76.00 03020 CHEMI CAL DEPENDENCY 0.000000 0 0 0 0 76.00 03480 ONCOLOGY 76.01 0. 311766 0 0 0 76.01 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLI NI C 0.615551 0 0 90.00 0 0 0 0 0 0 0 0 0 90 01 09001 CLINIC- MCDONALD 4. 222219 0 90.01 0 90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT 1.887695 0 90.02 90.03 09003 IV THERAPY 0.000000 0 0 90.03 09004 OP PSYCH 0 0 90.04 90.04 5. 465072 0 0 91. 00 09100 EMERGENCY 0 91.00 0.322847 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1. 292034 0 0 92.00 200.00 Subtotal (see instructions) 0 0 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00

0

0 202.00

Only Charges

202.00

Net Charges (line 200 - line 201)

		Component (CCN: 15-Z315	To 09/30/2019		
		Title	XVIII	Swing Beds - SNF		—
	Cos					
Cost Center Description	Cost	Cost				
, and the second	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0			50.0	
51.00 05100 RECOVERY ROOM	0	0			51.0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.0	
60. 00 06000 LABORATORY	0	0			60.0	
64.00 06400 INTRAVENOUS THERAPY	0	0			64.0	
65. 00 06500 RESPI RATORY THERAPY	0	0			65.0	
65. 01 06501 SLEEP LAB	0	0			65.0	
66. 00 06600 PHYSI CAL THERAPY	0	0			66.0	
69. 00 06900 ELECTROCARDI OLOGY	0	0			69. (
69. 01 06901 CARDI AC REHAB	0	0			69. (
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71. (
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. (
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			73. (
76. 00 03020 CHEMI CAL DEPENDENCY	0	0			76. (
76. 01 03480 ONCOLOGY	0	0			76. (01
OUTPATIENT SERVICE COST CENTERS	1 .1	.1				
88.00 08800 RURAL HEALTH CLINIC	0	0			88. (
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89. (
90. 00 09000 CLI NI C	0	0			90.0	
90. 01 09001 CLI NI C- MCDONALD	0	0			90.0	
90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT	0	0			90.0	
90. 03 09003 V THERAPY	0	0			90.0	
90. 04 09004 0P PSYCH	0	0			90.0	
91. 00 09100 EMERGENCY	0	0			91. (
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.0	
200.00 Subtotal (see instructions)	0	0			200. (
201.00 Less PBP Clinic Lab. Services-Program	0				201. (UU
Only Charges 202.00 Net Charges (line 200 - line 201)	0	0			202. (00
202.00 Net charges (Title 200 - Title 201)	١	υĮ	I		202.1	00

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2018 Fo 09/30/2019		narod:
				10 09/30/2019	2/25/2020 1:5	
		Ti tl	e XIX	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	1, 890, 027	114, 332	1, 775, 69	4, 303	412. 66	30.00
31.00 INTENSIVE CARE UNIT	118, 859		118, 85	136	873. 96	31.00
43. 00 NURSERY	49, 962		49, 96		106. 76	43.00
200.00 Total (lines 30 through 199)	2, 058, 848		1, 944, 51	4, 907		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	88					30.00
31.00 INTENSIVE CARE UNIT	13	11, 361				31.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	101	47, 675				200. 00

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 1:5	epared: 53 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
43. 00 04300 NURSERY	0	0		o o	0	43.00
200.00 Total (lines 30 through 199)	0	0		o o	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	Per Diem	Inpatient	
, and the second	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)		, ,		
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		3. 55				
30. 00 03000 ADULTS & PEDIATRICS	0	0	4, 30	3 0.00	88	30.00
31. 00 03100 INTENSIVE CARE UNIT	1	0	13		13	
43. 00 04300 NURSERY		0	46			1
200.00 Total (lines 30 through 199)		١				200.00
Cost Center Description	Inpati ent		1,75	·		200.00
oust deliter beset per on	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7. 00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T	0	ŀ				31.00
43. 00 04300 NURSERY						43.00
200.00 Total (lines 30 through 199)	0					200.00
200.00 10tal (111165 30 till ough 199)	ı	l				₁ 200.00

 Heal th Financial
 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1315
 Peri od: Worksheet D From 10/01/2018 Part IV To 09/30/2019 Date/Time Prepared: THROUGH COSTS

						2/25/2020 1:5	3 pm
			Ti tl	e XIX	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 OPERATING ROOM	0	0)	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0)	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0)	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	o	0	1	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	o	0	1	0	0	65.00
65. 01	06501 SLEEP LAB	o	0	1	0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	o	0	1	0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	o	0	1	0 0	0	69.00
69. 01	06901 CARDI AC REHAB	o	0	1	0 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	1	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	1	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	1	0 0	0	73.00
76.00	03020 CHEMI CAL DEPENDENCY	o	0	1	0 0	0	76.00
76. 01	03480 ONCOLOGY	o	0		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS			,			
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0		0 0	0	89. 00
90.00	09000 CLI NI C	o	0		0 0	0	90.00
90. 01	09001 CLINIC- MCDONALD	ol	0		0 0	0	90. 01
90. 02	09002 CLINIC - FAM PRAC, PEDS, & ENT	O	0		0	0	90.02
	09003 I V THERAPY	O	0		0	0	90. 03
90. 04	09004 OP PSYCH	O	0		0	0	90.04
	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		· ·		0	0	92.00
200.00	,		0		o o	Ŭ	200.00
200.00	1 1112 (11100 00 1111 009.1 177)	١	· ·	1	-1	١	

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 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1315
 Peri od: Worksheet D From 10/01/2018 Part IV To 09/30/2019 Date/Time Prepared: THROUGH COSTS

ANCILLARY SERVICE COST CENTERS A					077 007 2017	2/25/2020 1:5	
Medical Education Cost Cost (Sum of Cols.) Cost (Sum of Cols.) Cost (Sum of Cols.) Cost (Sum of Cols.) Col. S) Col. 7) Col. S) Col. S) Col. 7) Col. S) Col. So Col. S) Col. So				e XIX	Hospi tal	PPS	
ANCI LLARY SERVICE COST CENTERS	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
Cost 4) col s 2, 3, and 4, and		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
ANCILLARY SERVICE COST CENTERS		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
ANCILLARY SERVICE COST CENTERS		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
ANCILLARY SERVICE COST CENTERS				and 4)			
50.00 05000 OPERATI NG ROOM 0 0 0 15, 943, 545 0.000000 50.00 51.00 651.00 651.00 651.00 650.00 652.00 652.00 652.00 652.00 652.00 652.00 652.00 652.00 652.00 652.00 652.00 652.00 652.00 652.00 662.00 662.19 662.00 662.19 662.00 662.19 662.00 662.19 662.00 662.19 662.00 662.19 662.00 662.19 662.00 662.00 662.00 662.19 662.00 662		4. 00	5. 00	6. 00	7. 00	8. 00	
51.00 05100 RECOVERY ROOM 0 0 0 4, 646, 087 0.000000 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 1, 526, 528 0.000000 52.00 0.000000 54.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.000000 65.00 0.0000000 0.000000 0.0000000 0.0000000 0.000000 0.00000000					_		
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 1,526,528 0.000000 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 32,330,656 0.000000 54. 00 60. 00 06000 LABORATORY 0 0 0 14,883,871 0.000000 60. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 2,716,755 0.000000 65. 00 65. 00 05500 RESPI RATORY THERAPY 0 0 0 0 1,003,941 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 1,003,941 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 1,003,941 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 1,003,941 0.000000 65. 00 67. 00 06900 ELECTROCARDI OLOGY 0 0 0 2,188, 274 0.000000 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 484, 535 0.000000 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 2,773, 285 0.000000 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 1,735, 028 0.000000 73. 00 76. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 12,820,072 0.000000 73. 00 76. 00 03020 CHEMI CAL DEPENDENCY 0 0 0 0 12,820,072 0.000000 73. 00 76. 01 00400 CHEMI CAL DEPENDENCY 0 0 0 0 12,820,072 0.000000 74. 00 76. 01 00400 CHEMI CAL DEPENDENCY 0 0 0 0 10,613,557 0.000000 75. 01 77. 00 07400 INPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 10,613,557 0.000000 75. 01 78. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 12,820,072 0.000000 75. 01 79. 01 09001 CLI NI C 0 0 0 0 12,820,072 0.000000 75. 01 79. 01 09001 CLI NI C 0 0 0 0 0 0 0 0.000000 90. 01 79. 01 09001 CLI NI C 0 0 0 0 0 0 0 0 0 0 0.000000 90. 01 79. 01 09001 CLI NI C - FAM PRAC, PEDS, & ENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
54. 00		0	0				1
60. 00 06000 LABORATORY 0 0 0 14, 883, 871 0.000000 60. 00 64. 00 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0.000000 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0.000000 65. 00 65. 00 06500 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0	l l	0	0				
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0		0	0				
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 1, 716, 755 0.000000 65. 00 65. 01 06501 SLEEP LAB 0 0 0 0 1, 003, 941 0.000000 65. 01 06600 PHYSI CAL THERAPY 0 0 0 0 1, 003, 941 0.000000 65. 01 06. 00 06900 ELECTROCARDI OLOGY 0 0 0 2, 188, 274 0.000000 69. 00 0 2, 188, 274 0.000000 69. 00 0 0.000000 09. 01 06901 CARDI AC REHAB 0 0 0 0 0 484, 535 0.000000 69. 01 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 2, 773, 285 0.000000 71. 00 0 1, 735, 028 0.000000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 12, 820, 072 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 12, 820, 072 0.000000 73. 00 0.00000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0.0000		0	0		14, 883, 871		
65. 01 06501 SLEEP LAB 0 0 0 0 1,003,941 0.000000 65. 01 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 4,150,343 0.000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 2,188,274 0.000000 69. 00 0 2,188,274 0.000000 69. 00 0 484,535 0.000000 69. 00 0 0 484,535 0.000000 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0		1
66. 00 06600 PHYSI CAL THERAPY 0 0 0 4, 150, 343 0.000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 2, 188, 274 0.000000 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 0 484, 535 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 2, 773, 285 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 1, 735, 028 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 12, 820, 072 0.000000 73. 00 76. 01 03480 ONCOLOGY 0 0 0 0 0.000000 76. 01 76. 01 03480 ONCOLOGY 0 0 0 0 0.000000 76. 01 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0.000000 89. 00 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0.000000 99. 00 90. 01 09000 CLINI C 0 0 0 0 0.000000 90. 00 90. 01 09001 CLINI C - FAM PRAC, PEDS, & ENT 0 0 0 0 0.000000 90. 01 90. 02 09002 CLINI C - FAM PRAC, PEDS, & ENT 0 0 0 0 0.000000 90. 03 90. 04 09004 OP PSYCH 0 0 0 0 0.000000 90. 03 90. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 1, 645, 289 0.000000 91. 00 90. 01 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0.000000 92. 00 90. 01 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0.0000000 92. 00 90. 01 09200 0000000000 0000000000000000		0	0		2, 716, 755	0.000000	65.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 2, 188, 274 0.000000 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 0 484, 535 0.000000 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 2, 773, 285 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 1, 735, 028 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 12, 820, 072 0.000000 73. 00 76. 00 03020 CHEMI CAL DEPENDENCY 0 0 0 0.000000 76. 00 76. 01 03480 ONCOLOGY 0 0 0 0 10, 613, 557 0.000000 76. 01 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0.000000 89. 00 99. 00 09000 CLINI C 0 0 0 0 0.000000 99. 00 99. 01 09001 CLINI C MCDONALD 0 0 0 0 0 0.000000 90. 01 99. 02 09002 CLINI C FAM PRAC, PEDS, & ENT 0 0 0 0 0 0.000000 90. 02 99. 04 09004 OP PSYCH 0 0 0 0 0, 0000000 90. 03 99. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 1, 645, 289 0.000000 92. 00 99. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 1, 645, 289 0.000000 92. 00 90. 01 07200 000000 00000000000000000000		0	0		1, 003, 941		
69. 01		0	0		4, 150, 343		
71. 00		0	0		2, 188, 274		
72. 00	69. 01 06901 CARDI AC REHAB	0	0		484, 535	0.000000	69. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 12, 820, 072 0.000000 73. 00 76. 00 03020 CHEMI CAL DEPENDENCY 0 0 0 0 0 0.000000 76. 00 76. 00 03480 ONCOLOGY 0 0 0 0 10, 613, 557 0.000000 76. 01 00000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 00000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 00000000 76. 01 0000000 76. 01 0000000 76. 01 000000000 76. 01 00000000 76. 01 00000000 76. 01 0000000 76. 01 000000000 76. 01 000000000 76.	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 773, 285	0.000000	71.00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		1, 735, 028	0.000000	72.00
76. 01 03480 ONCOLOGY 0 0 0 10, 613, 557 0.000000 76. 01 0000000 76. 01 0000000 76. 01 0000000 76. 01 00000000 76. 01 0000000000000000000000000000000000	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		12, 820, 072	0.000000	73.00
SERVICE COST CENTERS SERVICE COST COST CENTERS SERVICE COST CO	76.00 03020 CHEMI CAL DEPENDENCY	0	0		0	0.000000	76. 00
88. 00	76. 01 03480 ONCOLOGY	0	0	(10, 613, 557	0.000000	76. 01
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0.000000 89. 00 90. 00 90. 00 90. 01 90. 01 90. 01 10 90. 01 10 10 10 10 10 10 10 10 10 10 10 10	OUTPATIENT SERVICE COST CENTERS						
90. 00	88. 00 08800 RURAL HEALTH CLINIC	0	0		1, 102, 220		
90. 01	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	89. 00
90. 02 09002 CLINIC - FAM PRAC, PEDS, & ENT 0 0 609, 294 0.000000 90. 02 90. 03 09003 V THERAPY 0 0 0 0 0.000000 90. 03 90. 04 09004 0P PSYCH 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	0	0		602, 199	0. 000000	90.00
90. 03	90. 01 09001 CLI NI C- MCDONALD	0	0		286, 438	0. 000000	90. 01
90. 04 09004 0P PSYCH	90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT	0	0		609, 294	0. 000000	90. 02
91. 00 09100 EMERGENCY	90. 03 09003 I V THERAPY	0	0		0	0.000000	90. 03
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 1,645,289 0.000000 92.00	90. 04 09004 OP PSYCH	0	0		94, 050	0.000000	90. 04
	91. 00 09100 EMERGENCY	0	0		17, 382, 964	0.000000	91.00
200.00 Total (Lines 50 through 199) 0 0 129,538,931 200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		1, 645, 289	0.000000	92.00
	200.00 Total (lines 50 through 199)	0	0		129, 538, 931		200. 00

| Peri od: | Worksheet D | From 10/01/2018 | Part IV | To 09/30/2019 | Date/Time Prepared:
 Heal th Financial
 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1315
 THROUGH COSTS

				10 09/30/2019	2/25/2020 1:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS			T	- T		
50.00 05000 OPERATING ROOM	0. 000000	46, 384		0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	14, 171		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	20, 879		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	38, 586		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	33, 599		0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	31, 773		0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	12, 305		0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 522		0	0	69. 00
69. 01 06901 CARDI AC REHAB	0. 000000	105		0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	23, 928		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	32, 294		0	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000	0		0	0	76. 00
76. 01 03480 ONCOLOGY	0. 000000	0		0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	0		0	0	90.00
90. 01 09001 CLINIC- MCDONALD	0. 000000	6, 459		0	0	90. 01
90.02 09002 CLINIC - FAM PRAC, PEDS, & ENT	0. 000000	163		0	0	90. 02
90. 03 09003 I V THERAPY	0. 000000	0		0	0	90. 03
90. 04 09004 OP PSYCH	0. 000000	0		0	0	90. 04
91. 00 09100 EMERGENCY	0. 000000	10, 245		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	17, 012		0	0	92. 00
200.00 Total (lines 50 through 199)		290, 425		0	0	200. 00

Haalah Firanaial Costona	CAMEDON MEMODIAL COMMUNITY HOSDITAL	1 1:-	£ F CMC	DEED 40
Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	in Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1315	Peri od: From 10/01/2018	Worksheet D-1	
			Date/Time Pre 2/25/2020 1:5	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
			1. 00	

DATE 1 ALL PROVIDER COMPONENTS 1.00 Part 1 ALL PROVIDER COMPONENTS 1.00 Part 1 ALL PROVIDER COMPONENTS			Title XVIII	Hospi tal	2/25/2020 1:5 Cost	з рііі
PART 1 - ALL PROVIDER COMPOWERTS Impact and type PART 1 - ALL PROVIDER COMPOWERTS Impact and type PART 1 - ALL PROVIDER COMPOWERTS Impact and type PART 1 - ALL PROVIDER COMPOWERTS Impact and type PART 1 - ALL PROVIDER COMPOWERTS PART 2 - ALL		Cost Center Description				
IMPARTIENT DAYS 1.00 Impartient days (including private room days and swing-bed days, excluding newborn) 4.864 1.00 1.00 Impartient days (including private room days, excluding swing-bed and newborn days) 4.00 2.00 1.00		DADT I ALL DDOVIDED COMPONENTS			1. 00	
Impattent days (Including private room days and swing-bed days, excluding newborn)						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 4.00 do not complete this line. 5.01 Total swing-bed SWF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this line) 7.00 Total swing-bed SWF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this line) 7.00 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this line) 7.00 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this line) 7.00 Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this line) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.00 Swing-bed SWF type inpattent days applicable to title XVII only (including private room days) 7.01 Swing-bed SWF type inpattent days applicable to title XVII only (including pri	1.00		s, excluding newborn)		4, 864	1.00
do not complete this line. 4.0 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost 7.00 reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed M type inpatient days (including private room days) through December 31 of the cost 7.00 Total swing-bed M type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed M type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed M type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days after December 31 of the cost 7.00 Inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 8.00 Swing-bed SM type inpatient days applicable to title WILL only (including private room days) 9.00 Intrough December 31 of the cost reporting period (see instruction this line) 10.00 Swing-bed SM type inpatient days applicable to title WILL only (including private room days) 11.00 Swing-bed SM type inpatient days applicable to title WILL only (including private room days) 12.00 Swing-bed SM type inpatient days applicable to title WILL only (including private room days) 13.00 Swing-bed SM type inpatient days applicable to title WILL only (including private room days) 14.00 Swing-bed SM type inpatient days applicable to title WILL only (including private room days) 15.00 Swing-bed SM type inpatient days applicable to title WILL only (including private room days) 16.00 Swing-bed SM type inpatient days applicable to title WILL only (including private room days) 17.00 Swing-bed NT type Inpatient days applicable to title WILL only (including private room days) 18.00 Swing-bed NT type Inpatient days applicable to service safter					·	
Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SFT type inpatient days (including private room days) after December 31 of the cost 6.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 8.00 Possible Possible NF type inpatient days (including private room days) after December 31 of the cost 8.00 Possible Possible NF type inpatient days applicable to the Program (excluding swing-bed and 8.00 Possible SWF type inpatient days applicable to title XVII only (including private room days) after 8.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after 8.00 Possible SWF type inpatient days applicable to title XVII only (including private room days) after 8.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after 8.00 Swing-bed NF type inpatient days applicable to title SVII only (including private room days) after 8.00 Swing-bed NF type inpatient days applicable to services after 0 on this line) 8.01 Possible NF type inpatient days applicable to services through December 31 of the cost 8.00 Possible NF type inpatient days applicable to services through December 31 of the cost 8.00 Possible AWDISTMENI 8.00 P	3. 00		ys). If you have only pr	rivate room days,	0	3. 00
Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost proporting period (if Cal endar year, enter 0 on this line)	4 00	•	ed days)		3 217	4 00
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22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 X line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 39, 259 z 5.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average per diem private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 32 minus line 33) 36.00 Private room cost differential adjustment (line 3 x line 31) 37.00 Average per diem private room cost differential (line 3 x line 31) 38.00 Average per diem private room cost differential (line 3 x line 35) 37.00 Proyate room cost differential service cost net of swing-bed cost and private room cost differential (line 8, 422, 842) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 48.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 49.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35	21 00		-1		0.0/5.1/2	21 00
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x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 39, 259 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 * line 3) 31.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room charge differential (line 34 x line 31) 34.00 Average per diem private room cost differential (line 3 x line 31) 35.00 Average per diem private room charge differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 842) 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) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22.00] 31		ing partod (initial	١	22.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 19, 259 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Deneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average per diem charge (line 29 + line 3) 31.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room cost differential (line 3 x line 31) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 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) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 44.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00		31 of the cost reportir	ng period (line 6	0	23. 00
7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 1) 25. 00 x 1 line 20) 26. 00 Total swing-bed cost (see instructions) 542, 321 26. 00 (Seneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 8, 422, 842 (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 Private room charges (excluding swing-bed charges) 0 29. 00 (29.	24. 00		r 31 of the cost reporti	ng period (line	0	24.00
x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 34. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 842) 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Ajusted general inpatient routine service cost per diem (see instructions) 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 540. 00 40. 00		7 x line 19)	·			
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 8,422,842 27. 00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29. 00 30. 00 Pri vate room charges (excluding swing-bed charges) 0 29. 00 31. 00 Semi-pri vate room charges (excluding swing-bed charges) 0 30. 00 32. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0 0.000000 33. 00 Average pri vate room per diem charge (line 29 + line 3) 0 0. 00 33. 00 Average semi-pri vate room per diem charge (line 30 + line 4) 0 0. 00 34. 00 Average per diem pri vate room charge differential (line 32 minus line 33)(see instructions) 0 0. 00 34. 00 Average per diem pri vate room cost differential (line 34 x line 31) 0 0. 00 35. 00 Average per diem pri vate room cost differential (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 8, 422, 842 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1,957. 44 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1,957. 44 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	26. 00				542, 321	26.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 27 + line 28) 30.00 Average private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 842) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35)	27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)			
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 33.00 0 .00 34.00 37.00 8, 422, 842 37.00 1, 740, 164 39.00 40.00		, , , , , , , , , , , , , , , , , , , ,	÷ line 28)		-	
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 842) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 957.44 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Average private room per diem charge (line 29 ÷ line 3)	ŕ		0.00	32.00
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 422, 842) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 8, 422, 842 37.00 1, 757.44 38.00 1, 740, 164 39.00	34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)	0.00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,957.44 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,957.44 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
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) 1,957.44 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	,	and private room cost di	fferential (line	8, 422, 842	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,957.44 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,957.44 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,740,164 39.00 40.00			USTMENTS			-
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,740,164 39.00 0 40.00	38. 00			T	1. 957. 44	38.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, , , , , , , , , , , , , , , , , , , ,	•			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,740,164 41.00		Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 740, 164	41.00

	Financial Systems CAMER ATION OF INPATIENT OPERATING COST	RON MEMORIAL CO	Provider C	CN: 15-1315	Peri od:	u of Form CMS-2 Worksheet D-1		
					From 10/01/2018 To 09/30/2019	Date/Time Pre		
			Title XVIII Hospita			2/25/2020 1:5 Cost	3 pili	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42. 00	NURSERY (title V & XIX only)	1. 00 0	2.00	3. 00 0. 0	4.00	5. 00	42.00	
42.00	Intensive Care Type Inpatient Hospital Units			0.0	0	0	42.00	
	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	404, 358	136	2, 973. 2	43	127, 848	43. 00 44. 00 45. 00 46. 00 47. 00	
	Cost Center Description					1. 00		
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			1, 243, 032	48. 00	
49. 00	Total Program inpatient costs (sum of lines			ons)		3, 111, 044		
FO 00	PASS THROUGH COST ADJUSTMENTS			- WI+ D	Dt-			
50. 00	Pass through costs applicable to Program inp	attent routine	services (Tro	m wkst. D, Su	m or Parts I and	0	50.00	
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00	
52.00	Total Program excludable cost (sum of lines					0		
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		elated, non-ph	ysician anest	hetist, and	0	53.00	
54.00	Program di scharges					0	54.00	
55.00	Target amount per discharge						55.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (ling 56 minus	line 53)	0		
58.00	Bonus payment (see instructions)	ing cost and te	arget amount (TTTIC 30 III TIQ3	11110 33)	0		
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	0.00	59.00					
60.00								
61. 00	.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 amount (line 56), otherwise enter zero (see instructions)							
62. 00	Relief payment (see instructions)	matructions)				0	62.00	
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							
65. 00	instructions)(title XVIII only)						64.00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	503, 062	66.00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	·	•	, ,	3,	0	67.00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost rep	orting period	0	68.00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + lin	e 68)		0	69.00	
70.00	PART III - SKILLED NURSING FACILITY, OTHER NI				,		70.0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c)		70.00	
72. 00	Program routine service cost (line 9 x line	,					72.00	
73.00	Medically necessary private room cost applic						73.00	
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)				Part II, column		74. 00 75. 00	
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00	
77. 00	Program capital-related costs (line 9 x line						77.00	
78. 00 79. 00	Inpatient routine service cost (line 74 minu		rovidor rocc	de)			78.00	
80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	,		*.	nus line 79)		80.0	
81. 00	Inpatient routine service cost per diem limi				/		81. 00 82. 00	
82.00	``, ',							
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ns)				83.00	
85.00	Utilization review - physician compensation		ons)				85.0	
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86.00	
	PART IV - COMPUTATION OF OBSERVATION BED PASS					1, 086	 87. 00	
07 00								
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	: line 2)			1, 957. 43		

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 10/01/2018	Worksheet D-1	
				To 09/30/2019		pared: 3 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 890, 027	8, 965, 163	0. 21081	9 2, 125, 769	448, 152	90.00
91.00 Nursing School cost	0	8, 965, 163	0.00000	0 2, 125, 769	0	91.00
92.00 Allied health cost	0	8, 965, 163	0. 00000	0 2, 125, 769	0	92.00
93.00 All other Medical Education	0	8, 965, 163	0. 00000	0 2, 125, 769	0	93. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 1	From	10/01/2018	Worksheet D-1 Date/Time Pre 2/25/2020 1:5	pared:
	Ti tl e XI	Х Н	ospi tal	PPS	•
Cost Center Description					
·				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1 00 Innatient days (including private ro	om days and swing-hed days excluding ne	whorn)		4 864	1 100

	Cost Center Description	PPS	
	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)	4, 864	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 303	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	3, 217	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	257	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	304	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	88	9. 00
10.00	newborn days)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 00
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
40.00	through December 31 of the cost reporting period		40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	468	
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
10.00	reporting period		10.00
19.00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost	129. 14	19. 00
	reporting period		
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	129. 14	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	8, 965, 163	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 &	0	23.00
04.00	x line 18)		04.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	39, 259	25. 00
20.00	x line 20)	07,207	20.00
26.00	Total swing-bed cost (see instructions)	542, 321	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8, 422, 842	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00	Average per diem private room 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	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	-	
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 057 10	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 957. 43 172, 254	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	172, 254	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	172, 254	
		,	

	Financial Systems CAMER FATION OF INPATIENT OPERATING COST	RON MEMORIAL CO	Provi der C	CN: 15-1315	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 10/01/2018 To 09/30/2019	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	2/25/2020 1:5 PPS	3 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	MUDCEDY (+: +Lo V & VLV only)	1. 00	2.00	3. 00 706. 9	4. 00 0 0	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	330, 831	468	706. 9	0 0	0	1 42. UC
	INTENSIVE CARE UNIT CORONARY CARE UNIT	404, 358	136	2, 973. 2	2 13	38, 652	43.00 44.00 45.00 46.00 47.00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					150, 561	48.00
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	ons)		361, 467	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	47, 675	50.00
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	23, 702	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines!	ding capital re	elated, non-ph	ysician anest	netist, and	71, 377 290, 090	52. 00 53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges						54.00
55. 00 56. 00						0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	line 53)	0	57.00			
58. 00 59. 00		0.00	58. 00 59. 00				
39.00	market basket	0.00	39.00				
60. 00 61. 00							
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment	ŕ	ucti ons)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	0	64.00				
65. 00	instructions)(title XVIII only)						65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	I only). For	0	66.00
67. 00							67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of)		70.00 71.00
71.00	, ,	,	THE TO - TIME	۷)			72.00
73.00	Medically necessary private room cost application						73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient (26, line 45)	•			Part II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	•					76.00
77. 00 78. 00	,						77.00
79. 00	Aggregate charges to beneficiaries for excess	,	provi der recor	ds)			79.00
80.00			cost limitation	n (line 78 mi	nus line 79)		80.0
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		1)				81.00
83. 00	Reasonable inpatient routine service costs (see instruction	* .				83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		nns)				84. 00 85. 00
86.00	1	•	,				86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1, 086	07.00
07 00		1				1. U86	87.00
87. 00 88. 00	,		line 2)			1, 957. 43	

Health Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2018 To 09/30/2019		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	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	1, 890, 027	8, 965, 163	0. 21081	9 2, 125, 769	448, 152	90.00
91.00 Nursing School cost	0	8, 965, 163	0.00000	0 2, 125, 769	0	91.00
92.00 Allied health cost	0	8, 965, 163	0.00000	0 2, 125, 769	0	92.00
93.00 All other Medical Education	0	8, 965, 163	0. 00000	0 2, 125, 769	0	93. 00

INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1315	Peri od:	Worksheet D-3	
				From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
		Ti tl e	e XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	1 1 1 1 1 1	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	TENT ROUTINE SERVICE COST CENTERS					
31. 00 03100 43. 00 04300	ADULTS & PEDIATRICS INTENSIVE CARE UNIT NURSERY			1, 416, 248 107, 500		30. 0 31. 0 43. 0
	LARY SERVICE COST CENTERS		1 0000		450.000	
51.00 05100	OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM		0. 2493 0. 4771 0. 8634	70 147, 532	152, 398 70, 398 0	51.0
54. 00 05400	RADI OLOGY-DI AGNOSTI C LABORATORY		0. 1619 0. 3078	97 521, 396	84, 465 139, 450	54.0
55. 00 06500	INTRAVENOUS THERAPY RESPIRATORY THERAPY		0. 0000 0. 4650	20 431, 017	0 200, 432	
66. 00 06600	SLEEP LAB PHYSI CAL THERAPY ELECTROCARDI OLOGY		0. 3411 0. 6027 0. 2736	25 105, 724	0 63, 722 43, 772	1
9. 01 0690°	CARDIAC REHAB MEDICAL SUPPLIES CHARGED TO PATIENT		0. 5218 0. 4654	01 0	131, 120	69.0
3.00 07300	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		0. 9120 0. 3303	80 400, 433	185, 047 132, 295	73.0
6. 01 03480	CHEMI CAL DEPENDENCY ONCOLOGY ITI ENT SERVI CE COST CENTERS		0. 0000 0. 3117		0	
	RURAL HEALTH CLINIC		0.0000	00	0	88. (
9.00 08900	FEDERALLY QUALIFIED HEALTH CENTER		0. 0000 0. 6155	00	0	
09002	CLINIC- MCDONALD CLINIC - FAM PRAC, PEDS, & ENT		4. 2222 1. 8876	95 0	0	90. 0 90. 0
09004	IV THERAPY OP PSYCH		0. 00000 5. 4650	72 0	0	90.0
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART Total (sum of lines 50 through 94 and 96 through 98)		0. 3228 1. 2920		3, 460 36, 473 1, 243, 032	92. (
01. 00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0, 333, 613	1, 243, 032	201.
202. 00	Net charges (line 200 minus line 201)			3, 353, 813		202.0

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONME	CAMERON MEMORIAL COMMUNITY HOSE NT Provider	CCN: 15-1315	Peri od:	eu of Form CMS-2 Worksheet D-3	
			From 10/01/2018		
	Component	CCN: 15-Z315	To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
	Ti t	e XVIII	Swing Beds - SNF		о рііі
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
				col . 2)	
	-	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	5			ı	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 197	l	30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS		0.0400	0.4		
50. 00 05000 OPERATING ROOM		0. 2493		_	1
51. 00 05100 RECOVERY ROOM		0. 4771			
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 8634		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 1619 0. 3078			
64.00 06400 INTRAVENOUS THERAPY		0. 3078		· ·	1
55. 00 06500 RESPIRATORY THERAPY		0. 4650			
55. 00 06500 RESPIRATORY THERAPI 55. 01 06501 SLEEP LAB		0. 4030.		0, 341	1
66. 00 06600 PHYSI CAL THERAPY		0. 6027		_	
59. 00 06900 ELECTROCARDI OLOGY		0. 2736			
59. 01 06901 CARDI AC REHAB		0. 5218		· ·	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	FNT	0. 4654		l .	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 9120			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3303			
76. 00 03020 CHEMI CAL DEPENDENCY		0.0000			
76. 01 03480 ONCOLOGY		0. 3117		4, 101	76.0
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.0
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTE	ER .	0. 0000	00	0	89.0
00. 00 09000 CLI NI C		0. 6155	51 0	0	90.0
PO. 01 09001 CLINIC- MCDONALD		4. 2222	19 0	0	90.0
00.02 09002 CLINIC - FAM PRAC, PEDS, & ENT		1. 8876	95 0	0	90.0
90. 03 09003 I V THERAPY		0.0000	00 0	0	90.0
90. 04 09004 OP PSYCH		5. 4650	72 0	0	90.0
91. 00 09100 EMERGENCY		0. 3228	47 0	0	91.0
02 00 00200 OPSEDVATION PEDS (NON DISTINCT D	ADT	1 2020	24 1 414	1 027	1000

0 91.00 1,827 92.00 129,307 200.00

201. 00 202. 00

1. 292034

259, 708

259, 708

201.00

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

	Financial Systems CAMERON MEMORIAL COMMUI ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1315	Period: From 10/01/2018	Worksheet D-3	;
				To 09/30/2019	Date/Time Pre 2/25/2020 1:5	pared:
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00	03000 ADULTS & PEDIATRICS			109, 028		30.00
31. 00	03100 INTENSIVE CARE UNIT			6, 408		31.00
43.00	04300 NURSERY			8, 718		43.00
	ANCILLARY SERVICE COST CENTERS					4
50. 00	05000 OPERATING ROOM		0. 24930		11, 564	1
51. 00	05100 RECOVERY ROOM		0. 4771		6, 762	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 86343		18, 028	
54.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY		0. 16199 0. 30789		6, 251	
60. 00 64. 00	06400 I NTRAVENOUS THERAPY		0. 3078		10, 345 0	1
65.00	06500 RESPI RATORY THERAPY		0. 46502		14, 775	
65. 01	06501 SLEEP LAB		0. 34112		14, 773	
66. 00	06600 PHYSI CAL THERAPY		0. 60272		7, 417	
69. 00	06900 ELECTROCARDI OLOGY		0. 27363		690	1
69. 01	06901 CARDI AC REHAB		0. 52180	105	55	69. 0°
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4654		11, 138	71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 91200		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 33038		10, 669	
76. 00	03020 CHEMI CAL DEPENDENCY		0.00000		0	
76. 01	03480 ONCOLOGY		0. 31176	66 0	0	76. 0°
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		1. 9147	98 0	0	88.00
39. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
90.00	09000 CLINIC		0. 6155!		0	
	09001 CLINIC- MCDONALD		4. 2222		27, 271	
90. 02	09002 CLINIC - FAM PRAC, PEDS, & ENT		1. 88769		308	
90. 03	09003 I V THERAPY		0. 00000		0	1
	09004 OP PSYCH		5. 4650		0	90.04
91. 00	09100 EMERGENCY		0. 32284		3, 308	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 29203		21, 980	
200. 00				290, 425	150, 561	1
201.00		(line 61)		200 425		201.00
202. 00	Net charges (line 200 minus line 201)		1	290, 425		202. 0

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1315	Peri od: Worksheet E From 10/01/2018 Part B To 09/30/2019 Date/Time Prepared: 2/25/2020 1:53 pm

Title XVIII Riospital Cost				10 09/30/2019	2/25/2020 1:5	
MATE MEDICAL AND OTHER MALTH SERVICES			Title XVIII	Hospi tal		о ріп
MART B - MEDICAL AND OTHER HEALTH SERVICES 9,696.161 1.00 Medical and other services (see instructions) 9,696.161 1.00 1.						
Wedical and other services (see instructions)					1. 00	
Medical and other services reliaburised under OPPS (see Instructions) 0 2.00						
00PS payments		1	11			
0.011 in Payment (see Instructions)		,	ctions)		l e	
0.00		1 . 3				
Enter the hospital specific payment to cost ratio (see instructions)		, , , , , , , , , , , , , , , , , , , ,				
Line 2 times line 5		,	ictions)			
			10113)		l .	
Transitional corridor payment (see Instructions) 0 8.00 0 0 0 0 0 0 0 0 0						
10.00 Organ acquisitions 9,969,161 1.00 Total cost (sum of lines 1 and 10) (see Instructions) 9,969,161 1.00 Total cost (sum of lines 1 and 10) (see Instructions) 12.00 Computation for Lesser GF Cost OR CHARGES 12.00 Anciliary service charges (sum of lines 12 and 13) 12.00 Organ acquisition charges (sum of lines 12 and 13) 12.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 15.00 Organ acquisition charges (sum of lines 12 and 13) 15.00 Organ acquisition charges (sum of lines 12 and 13) 16.00 Ancounts that yould have been realized from patients liable for payment for services on a charge basis 0 16.00 Ancounts that yould have been realized from patients liable for payment for services on a chargebasis 0 16.00 Ancounts that yould have been realized from patients liable for payment for services on a chargebasis 0 16.00 Notes					l .	
11.00 Total cost (sum of lines 1 and 10) (see instructions) 9,996,16 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancil lary service charges 0 12.00 20.00	9.00	, , , , , , , , , , , , , , , , , , , ,	IV, col. 13, line 200		0	9.00
COMPUTATION OF LESSER OF COST OR CHARGES	10.00	Organ acqui si ti ons			0	10.00
Reasonable charges 0 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00	11.00				9, 696, 161	11.00
12.00 Ancil Hary service charges 0 12.00 13.00 Organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69) 0 13.00 13.00 Organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69) 0 13.00 13.00 10.10						
13.00 organ acquisition charges (from Wisst. D.4, Pt. III., col. 4, Iline 69) 0 13.00	10.00					10.00
14.00 Total reasonable charges (sum of lines 12 and 13)			ina (0)			
Customary charges			The 69)		l	
15.00 Aggregate amount actually collected from patients Table for payment for services on a charge basis 0 15.00	14.00				0	14.00
16.00 Amounts that would have been real Ized From patients Iable For Dayment for services on a chargebasis 0 16.00 17.00	15 00		navment for services on	a charge basis	0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e)		, ,	. 3	•		
17.00 Ratio of 1 in = 15 to 1 in = 16 (not to exceed 1.000000) 17.00 1				on a onal gobaci o	l	10.00
9, 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 19, 00 19, 00 18 18 19 19 19 19 19 19	17.00		/		0.000000	17.00
Instructions	18.00	Total customary charges (see instructions)			0	18.00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00 1 1 1 1 1 1 1 1 1	19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19. 00
Instructions 9, 793, 123 21.00						
2.1 0.0 Lesser of cost or charges (see instructions) 9,793,123 21.00 22.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0.23.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0.24.00 0.25.00	20. 00	, , , ,	lly if line 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 23.00	21 00				0.700.100	21 00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.23.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 25.00 26.00 2						
24. 00 Total prospective payment (sum of lines 3. 4, 4.01, 8 and 9) 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 2		· · · · · · · · · · · · · · · · · · ·	ructions)			
COMPUTATION OF REIMBURSEMENT SETILEMENT Deductibles and coin surance amounts (for CAH, see instructions) 72,084 25.00 Deductibles and coin surance amounts relating to amount on line 24 (for CAH, see instructions) 5,114,708 26.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 4,606,331 27.00 Instructions) 27.00 Subtotal ([(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 4,606,331 27.00 Instructions) 0 0 0 0 0 0 0 0 0			i de ti olis)		l	
25.00 Deductible and coin surance amounts (for CAH, see instructions) 72.084 25.00	21.00					21.00
26. 00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 5, 114,708 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) 4,606,331 27,00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 28,00 30. 00 Subtotal (sum of lines 27 through 29) 4,606,331 30,00 31. 00 Subtotal (line 30 minus line 31) 4,603,437 32,00 32. 00 Subtotal (line 30 minus line 31) 4,603,437 32,00 33. 00 Composite rate ESRD (from Wkst. I-5, line 11) 0 0 33,00 34. 00 Allowable Bad bebts (see instructions) 656,379 34,00 35. 00 Allowable bad debts (see instructions) 426,646 35,00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 483,395 36,00 37. 00 Subtotal (see instructions) 483,395 36,00 38. 00 MSP-LCC reconciliation amount from PS& 5,030,083 37,00 39. 00 The REA ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 38,00 39. 99 ReCOVERY	25.00		is)		72, 084	25.00
Instructions	26.00	Deductibles and Coinsurance amounts relating to amount on lin	ne 24 (for CAH, see insti	ructions)	5, 114, 708	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	2 and 23] (see	4, 606, 331	27.00
29.00 ESRD diffect medical education costs (from Wkst. E-4, line 36) 0 29.00 4,606,331 30.00 31.00 Primary payer payments 2,894 31.00 32.00 Subtotal (line 30 minus line 31) 4,603,437 32.00 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad bedst (see instructions) 656,379 34.00 35.00 Allowable bad debts (see instructions) 426,646 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 483,395 36.00 37.00 Subtotal (see instructions) 5,030,083 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 39.97 Pertial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 39.99 PRECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.01 Sequestration adjustment (see instructions) 5,030,083 40.00 40.01		instructions)				
30.00 Subtotal (sum of lines 27 through 29) 4,606,331 30.00 71 mary payer payments 2,894 31.00 2,894 31.00 32.00					l	
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Subtotal (ine 30 minus line 31)					1	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I -5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 656, 379 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 426, 646 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 483, 395 36.00 37.00 Subtotal (see instructions) 5,030,083 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 38.00 39.50 39.50 39.50 39.50 39.97 39.98						
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	32.00		CES)		4, 003, 437	32.00
34.00 Allowable bad debts (see instructions) 656, 379 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 426, 646 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 483, 395 36.00 37.00 Subtotal (see instructions) 5,030,083 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 Polimer 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 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99	33 00	,	023)		0	33 00
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37.00 Subtotal (see instructions) 5,030,083 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.90 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 5,030,083 40.00 40.01 Sequestration adjustment (see instructions) 5,030,083 40.00 40.01 Sequestration adjustment (see instructions) 100,602 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.02 Tentative settlement (for contractors use only) 6,025,342 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, 1515.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Utilier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 93	35.00				426, 646	35.00
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pi oneer 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) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 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) 93.00 PRODUCT PRODU	36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		483, 395	36.00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 91.00 29.00 70.00 39.50 92.00 70.00	37.00	Subtotal (see instructions)			5, 030, 083	37.00
39. 50 Pi oneer 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. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 90 Partial or full credits received from manufacturers for replaced devices (see instructions) 40. 00 Demonstration adjustment (see instructions) 40. 01 Demonstration adjustment amount after sequestration 41. 02 Demonstration payment adjustment amount after sequestration 42. 00 Interim payments 42. 00 Interim payments 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44. 00 Original outlier amount (see instructions) 90. 00 Original outlier amount (see instructions) 0 90. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 The rate used to calculate the Time Value of Money 1 intervalue of Money (see instructions)	38. 00	MSP-LCC reconciliation amount from PS&R			0	38.00
39. 97 Demonstration payment adjustment amount before sequestration 9 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9 RECOVERY OF ACCELERATED DEPRECIATION 9 Subtotal (see instructions) 100,602 40. 01 5, 030, 083 40. 00 40. 01 5, 030, 083 40. 00 40. 01 5, 030, 083 40. 00 40. 01 6, 025, 342 41. 00 41. 00 1nterim payments 100,602 41. 00 1nterim payments 100,602 41. 00 42. 00 43. 00 44. 00 43. 00 44. 00 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 91. 00 91. 00 91. 00 0utlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 0 39. 97 0 39. 98 100 39. 98 100 39. 98 100 39. 99 1	39. 00				0	39.00
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) 5, 030, 083 40. 00 40. 01 Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration 100, 602 40. 01 41. 00 Interim payments Tentative settlement (for contractors use only) 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 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) 0 39. 98 10 39. 98 10 39. 98 10 39. 99 10 39. 99 10 40. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 42. 00 10 4		, , , , , , , , , , , , , , , , , , , ,	ıs)			39. 50
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 5,030,083 40. 00 40. 01 Sequestration adjustment (see instructions) 100,602 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 41. 00 Interim payments 6,025,342 41. 22. 00 Tentative settlement (for contractors use only) 6,025,342 41. 43. 00 Balance due provider/program (see instructions) -1,095,861 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 91. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money (see instructions) 0 93. 00					•	
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TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier 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		, , , , , , , , , , , , , , , , , , ,				
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 0.00 92.00 93.00						
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93.00 Time Value of Money (see instructions) 0 93.00		· · · · · · · · · · · · · · · · · · ·			1	
					l	
74. 00 TOTAL (SUIII OF TITIES AT ALIA A2)					l	
	74. UU	TOTAL (Suil OF FITIES 71 AND 73)			, 0	74.00

Provider CCN: 15-1315 Worksheet E-1 From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 1:53 pm Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 4. 00 1.00 2.00 3.00 1.00 Total interim payments paid to provider 2, 559, 614 6, 025, 342 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 04/23/2019 26,600 3.01 3.02 0 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 26,600 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2, 586, 214 6, 025, 342 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 5.50 0 5.51 0 0 5. 51 5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 173,076 6.01 SETTLEMENT TO PROGRAM 1, 095, 861 6.02 6.02 4, 929, 481 7.00 Total Medicare program liability (see instructions) 2, 759, 290 7.00 Contractor NPR Date

Number

1.00

(Mo/Day/Yr)

2.00

8.00

8.00 Name of Contractor

Health Financial Systems CAMERON MARALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1315 | Period: | Worksheet E-1 | Part | | Component CCN: 15-Z315 | To | O9/30/2019 | Date/Time Prepared: | 2/25/2020 1:53 pm

		Component	00N: 10 2010	10 077 007 2017	2/25/2020 1:5	3 pm
		Title	XVIII	Swing Beds - SNF	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		588, 37	17	0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.02
3. 02				0	0	3.03
3. 04				0		3.04
3. 05				0	0	3.04
3. 03	Provider to Program			<u> </u>		3.03
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51	7.65 CO TIMELATO TO TAXOSAN IIII			0	l o	3.51
3. 52				o	0	3. 52
3. 53				o	0	3. 53
3. 54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		588, 37	77	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					ļ
	TO BE COMPLETED BY CONTRACTOR		Г		ı	
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)					
E 01	Program to Provider TENTATIVE TO PROVIDER			0	0	E 01
5. 01 5. 02	TENTATIVE TO PROVIDER			0	0	5. 01 5. 02
5. 02				0	0	5.02
5.05	Provider to Program			<u> </u>	0	3.03
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51	TENTAL TO TROOTOWN			0	l ő	5.51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		37, 54	12	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	
7.00	Total Medicare program liability (see instructions)		625, 91	19	0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	0.6-
				1	i .	8.00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2					
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Peri od:	Worksheet E	-1
			From 10/01/2018 To 09/30/2019	Part II Date/Time Pi	renared:
			10 07/30/2017	2/25/2020 1:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		- 1		4
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		ne 14		1.00
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2.40			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			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 I				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	certified HII technology	WKSt. S-2, Pt. I		7. 00
0.00	line 168				0.00
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)	(!+ ···-+!)			9.00
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				- 20 00
30.00	, , , , , , , , , , , , , , , , , , ,				30. 00 31. 00
	31.00 Other Adjustment (specify)				
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)					32.00

Health Financial Systems	CAMERON MEMORIAL CO	MMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-1315		Worksheet E-2
			From 10/01/2018	
		Component CCN: 15-Z315	To 09/30/2019	Date/Time Prepared:
				2/25/2020 1:53 pm
'				

				2/25/2020 1:5	3 pm
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		508, 093	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A		130, 600	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru	uctions)			
4. 00	Per diem cost for interns and residents not in approved teaching	program (see		0. 00	4. 00
	instructions)				
5. 00	Program days		257	0	5.00
6. 00	Interns and residents not in approved teaching program (see inst			0	6.00
7. 00	Utilization review - physician compensation - SNF optional method	d only	0	_	7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		638, 693	0	8.00
9.00	Primary payer payments (see instructions)		(00 (00	0	9.00
10.00	Subtotal (line 8 minus line 9)	- 4	638, 693	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable professional applicable professiona	e to physician	0	0	11. 00
12. 00	professional services) Subtotal (line 10 minus line 11)		638, 693	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records) (ovel udo coi neuranco	030, 093	0	13.00
13.00	for physician professional services)	exci due coi risul alice	0	U	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		638, 693		15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		000, 070	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)			Ŭ	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstrati	on) payment	0		16. 55
	adjustment (see instructions)	o., payo			
16. 99	Demonstration payment adjustment amount before sequestration		o	0	16. 99
17.00	Allowable bad debts (see instructions)		o	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		O	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	o	0	18.00
19.00	Total (see instructions)	•	638, 693	0	19.00
19. 01	Sequestration adjustment (see instructions)		12, 774	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
20.00	Interim payments		588, 377	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and	21)	37, 542	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstrati				
200.00	Is this the first year of the current 5-year demonstration period	d under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
004 00	Cost Reimbursement	D 4 DI III II			004 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	t. D-I, Pt. II, IIne			201. 00
202.00	66 (title XVIII hospital))	rot D 2 col 2 lin			202 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from WI 200 (title XVIII swing-bed SNF))	CST. D-3, COL. 3, III	е		202. 00
3U3 UC	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				203.00
204.00	Computation of Demonstration Target Amount Limitation (N/A in fir	est year of the curre	nt 5-vear demons		204.00
	period)	3t year or the curre	iii 5 year demons	ott att on	
205 00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	s line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				
207.00	Program reimbursement under the §410A Demonstration (see instruc				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	•	1		208. 00
	and 3)	·			
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	ons)			209. 00
	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see			215. 00
	instructions)				

Heal th	Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lieu	u of Form CMS-2	552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1315	Peri od: From 10/01/2018 To 09/30/2019		pared:
			Title XVIII	Hospi tal	Cost	
					1. 00	
	PART V - CALCULATION OF REIMBURSEMENT	SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	T REIMBURSEMENT		
1. 00	Inpatient services				3, 111, 044	1.00
2.00 Nursing and Allied Health Managed Care payment (see instructions)				0	2.00	
3. 00	Organ acquisition				0	3.00

		1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1. 00	Inpatient services	3, 111, 044	1.0
2. 00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.0
3. 00	Organ acquisition	0	3.0
4.00	Subtotal (sum of lines 1 through 3)	3, 111, 044	4.0
5. 00	Pri mary payer payments	14, 096	5.0
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)	3, 128, 058	6.0
	COMPUTATION OF LESSER OF COST OR CHARGES		1
	Reasonable charges		1
7. 00	Routi ne servi ce charges	0	7.0
3. 00	Ancillary service charges	0	8.0
9. 00	Organ acquisition charges, net of revenue	0	9.0
10.00	Total reasonable charges	0	10.0
	Customary charges		1
11. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	1 11.0
12. 00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	12.0
	had such payment been made in accordance with 42 CFR 413.13(e)		
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.0
	Total customary charges (see instructions)	0	ı
	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	15.0
. 0. 00	instructions)	<u> </u>	
16 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16.0
. 0. 00	instructions)	<u> </u>	
17. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	-	1
18. 00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.0
	Cost of covered services (sum of lines 6, 17 and 18)	3, 128, 058	
20. 00		334, 080	
	Excess reasonable cost (from line 16)	0	
22. 00	Subtotal (line 19 minus line 20 and 21)	2, 793, 978	
	Coi nsurance	2, , , 0, , , 0	1
24. 00	Subtotal (line 22 minus line 23)	2, 793, 978	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33, 268	1
26. 00	Adjusted reimbursable bad debts (see instructions)	21, 624	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	5, 553	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	2, 815, 602	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	2, 813, 602	29.0
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.5
29. 50	Demonstration payment adjustment defore sequestration	0	
30.00		- 1	
	Subtotal (see instructions)	2, 815, 602	
30. 01	Sequestration adjustment (see instructions)	56, 312	
30. 02		0	
31.00		2, 586, 214	
32.00		0	32.0
	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	173, 076	
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.0

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1315	Peri od: Worksheet E-3 From 10/01/2018 Part VI I To 09/30/2019 Date/Time Prepared: 2/25/2020 1:53 pm

		1	o 09/30/2019	Date/Time Pre 2/25/2020 1:5	
		Title XIX	Hospi tal	PPS	Орш
			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		0		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)		0	0	
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
0.00	Reasonable Charges		104 154		0.00
8. 00 9. 00	Routine service charges Ancillary service charges		124, 154 290, 425	0	8. 00 9. 00
10.00	Organ acquisition charges, net of revenue		290, 425	U	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		414, 579	0	
12.00	CUSTOMARY CHARGES		714, 377		12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	O	0	13.00
	basis	9			
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
	Total customary charges (see instructions)		414, 579	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	414, 579	0	17. 00
10.00	line 4) (see instructions)	viflima 4 avasada lima	0	0	10.00
18. 00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y ii iine 4 exceeds iine	٥	U	18. 00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	•	o	0	1
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.		
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		ol	0	30.00
30.00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
	Deductibles		0	0	
33. 00	Coinsurance		0	0	02.00
34. 00	Allowable bad debts (see instructions)			0	
35. 00	Utilization review		0	Ü	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	o	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	o	0	
	Subtotal (line 36 ± line 37)		O	0	
	Direct graduate medical education payments (from Wkst. E-4)		o		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		237, 141	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-237, 141	0	42.00
43.00	, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				l

Health Financial Systems CAMERON MEMORIAL BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-1315

Peri od: From 10/01/2018 To 09/30/2019 Worksheet G Date/Time Prepared: 2/25/2020 1:53 pm

SUBSETIX ASSETIX 1.00 2.00 3.00 4.00	oni y)				7 077 007 2017	2/25/2020 1:5	3 pm
CUBRENT ASSETS			General Fund			Plant Fund	
1.00 Cash on hand in banks			1.00			4. 00	
Temporary Investments	4 00		0 744 700		0		1 00
Notes receivable 0			2, /11, /33	1	0	0	
Accounts receivable 9,573,255 0 0			0		0	0	
A			9, 573, 255	_	0	Ö	
Inventory	5. 00	Other receivable		1	0	0	5.00
Propal of dependence 10			ł	_	0	0	
9.00 Other current assets 0 0 0 0 0 0 0 0 1 1				1	0	0	
10.00 Due From other Funds			810, 199	0	0	0	
11.00 Total current assets (sum of lines 1-10) 15, 143, 934 0 0			0		0		
FixeD_ASSETS			15. 143. 934	- 1	0	1	
13.00 Land Improvements			197119719	-	-		1
14.00 Accumulated depreciation 0 0 0 0 0 0 0 16.00 Accumulated depreciation -20,879,411 0 0 0 0 0 17.00 Leasehold improvements 0 0 0 0 0 0 0 0 0	12. 00		1, 419, 368	0	0	0	12.00
15.00 Duil dings S8,040,916 O O O O O O O O O		·	0	_	-	1	
16.00 Accumul ated depreciation -20,879,411 0 0 0 19.00 19.00 Accumul ated depreciation 0 0 0 0 19.00 Fixed equipment 0 0 0 0 0 0 0 0 0			0	- 1	0	1	
17.00 Leasehold Improvements 0 0 0 0 19.00 Fixed equipment 0 0 0 0 0 19.00 Fixed equipment 0 0 0 0 0 19.00 Fixed equipment 0 0 0 0 0 19.00 1					0	0	
18.00 Accumulated depreciation 0 0 0 0 0 0 0 0 0			-20, 879, 411	_	0	0	
19.00 Fixed equipment 0 0 0 0 0 0 0 0 0		•	0	0	0		
20.00 Accumulated depreciation 0 0 0 0 0 0 0 0 0			0	0	0	Ö	
21.00 Automobil es and trucks 0 0 0 0 0 0 0 0 0			Ö	Ö	0	Ö	
23.00 Maj or movable equipment	21. 00	·	0	0	0	0	21.00
24. 00 Accumulated depreciation -15, 213, 111 0 0	22. 00	Accumulated depreciation	0	0	0	0	22.00
25.00		, ,		0	0	0	1
Accumulated depreciation		·	-15, 213, 111	1	0	0	
27. 00		Minor equipment depreciable	0	0	0	0	
Accumulated depreciation			0	0	0	0	
29, 00			0		0	0 0	
30.00 Total fixed assets (sum of lines 12-29) 43,367,928 0 0		•	0	1	0	0	
OTHER ASSETS O Investments 23,802,765 O O O O O O O O O		· ·	43, 367, 928	1	0	l	
32.00 Deposits on leases 0 0 0 0 0 0 0 0 0				,	-		
33.00	31. 00	Investments	23, 802, 765	0	0	1	
34.00 Other assets 957,171 0 0 0 0 0 0 0 0 0			0	1	0	0	
35.00 Total other assets (sum of lines 31-34) 24,759,936 0 0 0 0 0 0 0 0 0			0	1	0	0	
Total assets (sum of lines 11, 30, and 35) 83,271,798 0 0				_	0	0	
CURRENT LIABILITIES 2, 209, 732 0 0 0 38.00 Sal aries, wages, and fees payable 2, 335, 033 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·	l '	1	O O	l	
37.00 Accounts payable	00.00		00,271,770	<u> </u>	<u> </u>		00.00
39.00 Payrol taxes payable 0 0 0 0 0 0 0 0 0	37. 00		2, 209, 732	0	0	0	37.00
40.00 Notes and Loans payable (short term) 846, 968 0 0 0 0 0 0 0 0 0	38. 00	Salaries, wages, and fees payable	2, 335, 033	0	0	0	38.00
41.00 Deferred income 0 0 0 0 0 0 42.00 Accelerated payments 0 0 0 0 0 0 0 0 0			0	_	0	0	
42.00 Accelerated payments 0 0 0 0 0 0 0 0 0			846, 968	0	0	0	
43.00 Due to other funds 44.00 Other current liabilities Total current liabilities (sum of lines 37 thru 44) 5,591,566 LONG TERM LIABILITIES 46.00 Mortgage payable Notes payable Unsecured loans Unsecured			0	0	0	0	
44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 49.00 Other long term liabilities (sum of lines 46 thru 49) 57.00 Total liabilities (sum of lines 45 and 50) 60 CAPITAL ACCOUNTS 60 Caperal fund balance 57.00 Donor created - endowment fund balance 57.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60 O O O O O O O O O O O O O O O O O O O		. 3	0		0	0	42. 00 43. 00
45.00 Total current liabilities (sum of lines 37 thru 44) 5,591,566 0 0			199 833		0		
LONG TERM LIABILITIES					0		
47. 00 Notes payable 0 0 0 0 0 0 0 0 0			, , , , , , , , , , , , , , , , , , , ,		-		
48.00 Unsecured Loans 0 0 0 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 10 Total Liabilities (sum of Lines 46 thru 49) 11 Total Liabilities (sum of Lines 45 and 50) 12 CAPLITAL ACCOUNTS 15 CONTROL COUNTS 16 CAPLITAL ACCOUNTS 17 CAPLITAL ACCOUNTS 18 CONTROL COUNTS 18 CONTROL COUNTS 19 CAPLITAL ACCOUNTS 19 CONTROL COUNTS 19 CONTROL COUNTS 19 CONTROL COUNTS 10 CAPLITAL ACCOUNTS 10 CAPLITAL A	46. 00		0	0	0	0	46. 00
49.00 Other long term liabilities 42, 789, 953 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 3	0		0		
50.00 Total long term liabilities (sum of lines 46 thru 49) 51.00 Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS 52.00 General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion Total fund balances (sum of lines 52 thru 58) A4, 890, 279 0 0 0 0 0 0 0 0 0 0 0 0 0			0	_			
51.00 Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS 52.00 General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Coverning body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion Total fund balances (sum of lines 52 thru 58) 48, 381, 519 0 0 34, 890, 279 0 0 0 0 34, 890, 279 0 0 0 0 0 0 0 0 0 0 0 0 0				1	_	· -	
CAPITAL ACCOUNTS 52.00 General fund balance Specific purpose fund Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion Total fund balances (sum of lines 52 thru 58) 34,890,279 0 34,890,279 0 0 34,890,279 0 0 0 0 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·		1	_		
52.00 General fund balance 52.00 General fund balance Specific purpose fund 53.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance For 00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 34,890,279 0 0 34,890,279 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00		40, 301, 317	0	<u> </u>	0	31.00
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 00		34, 890, 279				52.00
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 34,890,279 0	53. 00			1			53.00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 34,890,279 0	54. 00	Donor created - endowment fund balance - restricted			0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 34,890,279 0	55. 00				0		55.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 34,890,279 0		9 ,			0	_	56.00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 34,890,279 0 0		· ·				0	
59.00 Total fund balances (sum of lines 52 thru 58) 34,890,279 0 0	ວຮ. UU					0	58.00
	59 NN		34 890 270		n	0	59.00
OV. VOLTOTAL TRADITICIOS ANA TANA DALANCOS (SAME OF TINOS VERNOL D. 0.3, Z/T; 70) UI UI UI	60.00	Total liabilities and fund balances (sum of lines 51 and	83, 271, 798	1	0	0	
59)			,, -, 0		J		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1
From 10/01/2018
To 09/30/2019 Date/Time Prepa Provider CCN: 15-1315

					To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2.00	3.00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0	38, 549, 829 -3, 659, 550 34, 890, 279		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0000	5. 00 6. 00 7. 00 8. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0	0 34, 890, 279 0 34, 890, 279		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
	sheet (line 11 minus line 18)						
		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 9. 00 10. 00 11. 00 12. 00 14. 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) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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
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	0 0		0		15. 00 16. 00 17. 00 18. 00 19. 00

| Peri od: | Worksheet G-2 | From 10/01/2018 | Parts | & II | To 09/30/2019 | Date/Time Prepared:
 Heal th Financial
 Systems
 CAMERON

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-1315

			To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
	Cost Center Description	I npati ent	Outpati ent	Total	J Pill
		1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	8, 565, 2	18	8, 565, 218	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVIDER - IRF				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)	8, 565, 2 ⁻	18	8, 565, 218	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	342, 50	00	342, 500	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	342, 50	00	342, 500	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8, 907, 7	18	8, 907, 718	17.00
18.00	Ancillary services	13, 767, 5	94, 048, 920	107, 816, 475	18. 00
19.00	Outpati ent servi ces	629, 20	06 19, 991, 028	20, 620, 234	19. 00
20.00	RURAL HEALTH CLINIC	9, 7	1, 092, 462	1, 102, 220	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21.00
22.00	HOME HEALTH AGENCY		604, 415	604, 415	22.00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE		0 270, 700	270, 700	26.00
27.00	HOSPI TALI ST FEES	-3	17 656	339	27. 00
27. 01	OTHER REVENUE	479, 73	6, 360, 147	6, 839, 885	27. 01
27. 02	PROFESSI ONAL FEES	353, 93	1, 713, 699	2, 067, 633	27. 02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 24, 147, 59	92 124, 082, 027	148, 229, 619	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		70, 648, 355		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)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38.00			0		38. 00
39. 00			0		39.00
40.00			0		40.00
41. 00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	nster	70, 648, 355		43.00
	to Wkst. G-3, line 4)				l

Heal th	Financial Systems CAMERON MEMORIAL COM	MUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Peri od:	Worksheet G-3		
			From 10/01/2018		
			To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
				2,20,2020 110	<u>Б.</u>
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			148, 229, 619	1.00
2.00	Less contractual allowances and discounts on patients' accou	ints		82, 167, 059	2.00
3.00	Net patient revenues (line 1 minus line 2)			66, 062, 560	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		70, 648, 355	4.00
5. 00	Net income from service to patients (line 3 minus line 4)			-4, 585, 795	5.00
	OTHER I NCOME			_	
6. 00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			0	7.00
8. 00	Revenues from telephone and other miscellaneous communication	n services		0	8.00
9. 00 10. 00	Revenue from television and radio service Purchase discounts			0	9. 00 10. 00
11. 00	Rebates and refunds of expenses			0	10.00
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
14. 00	Revenue from meals sold to employees and guests			Ö	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		Ö	16. 00
17. 00	Revenue from sale of drugs to other than patients	p		Ö	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
23.00	Governmental appropriations			0	23.00
24.00	OTHER I NCOME			642, 465	
24. 01	CONTRI BUTI ONS		161, 439		
	LOSS ON DISPOSAL OF PROPERTY		-345		
24. 03	CONTRIBUTION TO FOUNDATION		0	24. 03	

0 24.04

24. 05 24. 06

27. 00 28. 00 0 0 -3, 659, 550 29.00

122, 686 0

926, 245 25. 00 -3, 659, 550 26. 00

24. 04 CHANGE IN ASSETS FOUNDATION

24.04 CHANGE IN ASSEIS FOUNDATION
24.05 INVESTMENT INCOME
24.06 OP REVENUE, GROUPED IN OTHER
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
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)

				HHA CCN:	15-/11/	0 09/30/2019	2/25/2020 1:5	
						Home Health	PPS	<u> </u>
		Sal ari es	Empl oyee	Transportatio	Contracted/Pu	Agency I Other Costs	Total (sum of	
		Sararres	Benefits	n (see	rchased	Other Costs	cols. 1 thru	
				instructions)	Servi ces		5)	
	DENIEDAL OFFICIAL OFFICE	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	I		0		0	0	1.00
1.00	Fixtures					J	0	1.00
2.00	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	213, 366	0	0	71, 969	26, 046	311, 381	5.00
	HHA REIMBURSABLE SERVICES				,	_3, 5.5	3.1,700.	
6.00	Skilled Nursing Care	156, 007	0	16, 932	0	0	172, 939	6.00
7.00	Physical Therapy	134, 195	0	0	0	0	134, 195	7.00
8. 00 9. 00	Occupational Therapy Speech Pathology	23, 270 110	0	0	0	0	23, 270 110	8. 00 9. 00
10.00	Medical Social Services	32, 504	0	0	0	0	32, 504	
11. 00	Home Heal th Ai de	41, 915	0	Ö	0	Ö	41, 915	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0		0	_	0	13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES] 0	0	0	0	0	0	14. 00
15. 00	Home Dialysis Aide Services	Ιο	0	0	0	0	0	15.00
16.00	Respi ratory Therapy	0	0		0	0	0	16.00
17. 00	Private Duty Nursing	0	0	0	0	0	0	17.00
18. 00	Clinic	0	0	0	0	0	0	18.00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0	0	0	0	19.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	20.00
22. 00	Homemaker Service		0	o o	0	0	0	22.00
23. 00	All Others (specify)	0	0	0	0	0	0	23.00
23. 50	Tel emedi ci ne	0	0	0	0	0	0	23. 50
24. 00	Total (sum of lines 1-23)	601, 367 Recl assi fi cat	Recl assi fi ed	16,932 Adjustments	71, 969 Net Expenses	26, 046	716, 314	24.00
		ion	Tri al Bal ance	Adjustillents	for			
			(col. 6 +		Allocation			
			col . 7)		(col. 8 +			
		7. 00	8. 00	9. 00	<u>col. 9)</u> 10.00			
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00			
1.00	Capital Related - Bldg. &	0	0	0	0			1.00
	Fixtures	_	_	_	_			
2. 00	Capital Related - Movable	0	0	0	0			2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0	0			3.00
4. 00	Transportation	Ö	0	Ö	0			4.00
5.00	Administrative and General	-84, 527	226, 854					
			220, 034	0	226, 854			5. 00
,	HHA REIMBURSABLE SERVICES	10.011		_				5. 00
6.00	Skilled Nursing Care	-12, 911	160, 028	0	160, 028			5. 00 6. 00
7.00	Skilled Nursing Care Physical Therapy	-12, 911 -641	160, 028 133, 554	0	160, 028 133, 554			5. 00 6. 00 7. 00
	Skilled Nursing Care		160, 028	0 0	160, 028			5. 00 6. 00
7. 00 8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy		160, 028 133, 554 23, 270	0 0 0	160, 028 133, 554 23, 270			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
7. 00 8. 00 9. 00 10. 00 11. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide		160, 028 133, 554 23, 270 110 32, 504 39, 205	0 0 0 0 0	160, 028 133, 554 23, 270 110			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	-641 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205	000000000000000000000000000000000000000	160, 028 133, 554 23, 270 110 32, 504 39, 205			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	-641 0 0 0 0 -2, 710 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0	0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	-641 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205	0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	-641 0 0 0 0 -2, 710 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0	0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Heal th Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	-641 0 0 0 -2, 710 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0	0 0 0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	-641 0 0 0 -2, 710 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0	000000000000000000000000000000000000000	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	-641 0 0 0 -2, 710 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0 0	0 0 0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	-641 0 0 0 -2, 710 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0	0 0 0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0			5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	-641 0 0 0 -2, 710 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0 0	0 0 0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0 0			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	-641 0 0 0 -2, 710 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0 0 0	0 0 0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0 0			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 20. 00 21. 00 22. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	-641 0 0 0 -2, 710 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0 0	0 0 0 0 0 0 0 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0 0			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 23. 50	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	-641 0 0 0 -2, 710 0 0	160, 028 133, 554 23, 270 110 32, 504 39, 205 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	160, 028 133, 554 23, 270 1110 32, 504 39, 205 0 0 0 0 0 0 0			5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00

	Financial Systems LLOCATION - HHA GENERAL SERVICE		RON MEMORIAL CO	Provi der C		Peri od:	worksheet H-1	
				HHA CCN:	15-7117	From 10/01/2018 To 09/30/2019		epared:
						Home Health	PPS	
	<u> </u>		Capital Rel	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	
		0	1. 00	2. 00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. & Fixtures	0	0				0	1.00
2. 00	Capital Related - Movable Equipment	0		0			0	2.00
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	226, 854	0	0		0 0	226, 854	5.00
6. 00	Skilled Nursing Care	160, 028 133, 554	0	0		0 0	160, 028	1
7. 00 3. 00	Physical Therapy Occupational Therapy	23, 270	0	0		0 0	133, 554 23, 270	
9. 00	Speech Pathology	110	0	0			110	
10.00	Medical Social Services	32, 504	0	0		0 0	32, 504	10.00
11.00	Home Health Aide	39, 205	0	0		0 0	39, 205	
2.00	Supplies (see instructions)	0	0	0		0 0	0	12.00
4. 00	Drugs DME	0	0	0		0 0	0	
	HHA NONREIMBURSABLE SERVICES	-						
	Home Dialysis Aide Services	0	0	0		0 0	0	1
6. 00 7. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	16.00 17.00
8. 00	Clinic		0	0			0	
9. 00	Health Promotion Activities	Ö	Ö	0		0 0	0	19.00
0. 00	Day Care Program	0	0	0		0 0	0	20.00
	Home Delivered Meals Program	0	0	0		0 0	0	21.00
2. 00 3. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22.00
3. 50	Telemedicine	0	o	0		0 0	0	23.50
4. 00	Total (sum of lines 1-23)	615, 525	0	0		0 0	615, 525	1
		Admi ni strati v	Total (col s.					
		e & General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	0.00	0.00					
. 00	Capital Related - Bldg. & Fixtures							1.00
2. 00	Capital Related - Movable Equipment							2.00
3. 00	Plant Operation & Maintenance							3.00
. 00	Transportation Administrative and General	226, 854						4. 00 5. 00
. 00	HHA REIMBURSABLE SERVICES	220, 654						3.00
. 00	Skilled Nursing Care	93, 403	253, 431					6.00
. 00	Physi cal Therapy	77, 951	211, 505					7.00
3. 00	Occupational Therapy Speech Pathology	13, 582	36, 852 174					8. 00 9. 00
0.00	Medical Social Services	64 18, 971	51, 475					10.00
1.00	Home Heal th Ai de	22, 883	62, 088					11.00
2.00	Supplies (see instructions)	0	0					12.00

				HHA CCN:		rom 10/01/2018 o 09/30/2019		
						Home Health	PPS	<u> </u>
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant		Reconciliatio		
		Fi xtures	Equi pment	Operation &	n (MILEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1.00	VALUE)	(SQUARE FEET)		54.00		
	OFNEDAL CEDIU OF COCT OFNEDC	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS	0		I	I	0		1.00
1.00	Capital Related - Bldg. & Fixtures	l 0				U		1.00
2. 00	Capital Related - Movable		0			0		2.00
2.00	Equipment		Ü			U		2.00
3. 00	Plant Operation & Maintenance		0	1		0		3.00
4. 00	Transportation (see		0	0)		4.00
	instructions)		·	_				
5.00	Administrative and General	0	0	0	d c	-226, 854	388, 671	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	C	0	160, 028	6.00
7.00	Physi cal Therapy	0	0	0	(0		
8.00	Occupational Therapy	0	0	0	(0	23, 270	
9.00	Speech Pathology	0	0	0	(0	110	1
10. 00	Medical Social Services	0	0	0		0	32, 504	1
11. 00	Home Heal th Ai de	0	0	0		0	39, 205	
12.00	Supplies (see instructions)	0	0	0		0	0	12.00
13.00	Drugs	0	0	0	1	0	0	13.00
14. 00	DME	0	0	0		0	0	14.00
15 00	HHA NONREI MBURSABLE SERVI CES	0	0	0	ı	0	0	15 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0			0	15. 00 16. 00
17. 00	Private Duty Nursing		0				0	17. 00
18. 00	Clinic		0				0	18.00
19. 00	Health Promotion Activities		0				0	19.00
20. 00	Day Care Program		0	0		0	0	20.00
21. 00	Home Delivered Meals Program		0	0	1	0	0	21.00
22. 00	Homemaker Service	l ol	0	Ö	ا	0	Ö	22. 00
23.00	All Others (specify)	0	0	0	d	0	0	23.00
23. 50	Tel emedi ci ne	o	0	0	ol c	0	0	23. 50
24.00	Total (sum of lines 1-23)	0	0	0	(-226, 854	388, 671	24.00
25. 00	Cost To Be Allocated (per	0	0	0	ı c		226, 854	25. 00
26. 00	Worksheet H-1, Part I) Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000		0. 583666	26. 00
				•	-	•		

Health Financial Systems CAMERON MALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 2/25/2020 1:53 pm Provi der CCN: 15-1315 Peri od: From 10/01/2018 To 09/30/2019 HHA CCN: 15-7117 Home Health PPS

						Agency I		
			CAPI TAL REL	LATED COSTS				
Cost	Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
		0	1. 00	2.00	4. 00	4A	5. 00	
2.00 Skilled N 3.00 Physical 4.00 Occupation 5.00 Speech Pa 6.00 Medical S 7.00 Home Heal 8.00 Supplies 9.00 DME 11.00 Home Dial 12.00 Respirato 13.00 Private D 14.00 Clinic 15.00 Health Pr 16.00 Day Care 17.00 Home Deli 18.00 Homemaker 19.00 All Other 19.50 Tel emedic cu 20.00 Total (su 21.00 Unit Cost 26, line of column	nal Therapy thology ocial Services th Aide (see instructions) ysis Aide Services ry Therapy uty Nursing omotion Activities Program vered Meals Program Service s (specify)	0 253, 431 211, 505 36, 852 174 51, 475 62, 088 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	35, 168 0 0 0 0 0 0 0 0 0 0 0 0 0 0	146, 073 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	181, 241 253, 431 211, 505 36, 852 174 51, 475 62, 088 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41, 967 58, 685 48, 975 8, 533 40 11, 919 14, 377 0 0 0 0 0 0 0 0 0 0 0 184, 496	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00
6 decimal		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	
		7. 00	8. 00	9. 00	10.00	11. 00	N 13. 00	
2.00 Skilled N 3.00 Physical 4.00 Occupation 5.00 Speech Pa 6.00 Medical S 7.00 Home Heal 8.00 Supplies 9.00 DME 11.00 Home Dial 12.00 Respirato 13.00 Private D 14.00 Clinic 15.00 Health Pr 16.00 Day Care Home Deli 17.00 Home Deli 18.00 Homemaker 19.00 All Other 19.50 Telemedic Supplies 20.00 Total (su 21.00 Unit Cost 26, line of column	nal Therapy thology ocial Services th Aide (see instructions) ysis Aide Services ry Therapy uty Nursing omotion Activities Program vered Meals Program Service s (specify) ine m of lines 1-19) (2) Multiplier: column 1 divided by the sum 26, line 20 minus , line 1, rounded to	50, 999 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 413 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	26, 810 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 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

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

	i Financiai Systems		RON MEMORIAL CO	WINDINI IT HOSPI	IAL		U OT FORM CMS-2	2002-10
ALLOC	ATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS	Provider CO	CN: 15-1315 15-7117	Peri od: From 10/01/2018 To 09/30/2019	Date/Time Pre	pared:
						Home Health	2/25/2020 1: 5 PPS	3 pm
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Agency I Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14. 00	15. 00	16. 00	24.00	25. 00	26.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	1, 284 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	303, 76 312, 11 260, 44 45, 38 2 63, 33 76, 46	85 0 16 0 80 0 81 0 14 0 14 0 15 0 10 0	303, 785 312, 116 260, 480 45, 385 214 63, 394 76, 465 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 17. 00 18. 00 19. 00 19. 50
	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
1 00		27. 00	28. 00					4 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	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)	125, 077 104, 386 18, 188 86 25, 405 30, 643 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	437, 193 364, 866 63, 573 300 88, 799 107, 108 0 0 0 0 0 0 0 0 0 0 1, 061, 839					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00

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

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-1315 BASIS HHA CCN: 15-7117

COST Center Description SiDG & FIXT MOBLE FOULD SOUARE FEET SO							Home Health	PPS	
Cost Center Description			I CARLEAL DEL	ATED COCTO			Agency I		
SOUANE FEET SOUANE FEET SOUANE FEET DEATHERS CARCIAIN COST) SOUANE FEET SOUANE			CAPITAL REL	LATED COSTS					
SOUANE FEET SOUANE FEET SOUANE FEET DEATHERS CARCIAIN COST) SOUANE FEET SOUANE	Cost Center Descr	rintion	RIDG & FLYT	MVRLE FOLLED	EMDI OVEE	Peconciliatio	ADMINISTRATIV	ODEDATION OF	
1.00	cost center besch	ptron							
1.00			(SQUARE FEET)	(SQUARE TEET)					
1.00							(1000)	(SQUARE TEET)	
1.00									
1.00 Admin istrative and General 0 1,240 500,579 0 181,241 1,240 1,00 2.00 3.00 Physical Therapy 0 0 0 0 0 253,431 0 2.00 3.00 Physical Therapy 0 0 0 0 0 253,431 0 2.00 3.00 Physical Therapy 0 0 0 0 0 253,431 0 2.00 3.00			1. 00	2. 00		5A	5. 00	7. 00	
3.00 Physical Therapy 0 0 0 0 211.505 0 3.00 5.00 Speech Pathology 0 0 0 0 0 174 0 5.00 5.00 Speech Pathology 0 0 0 0 0 174 0 5.00 6.00 Medical Social Services 0 0 0 0 0 0 174 0 5.00 7.00 Home Heal th Aide 0 0 0 0 0 0 0 0 0	1.00 Administrative and Gen	eral	0	1, 240	500, 579	O	181, 241	1, 240	1. 00
4.00	2.00 Skilled Nursing Care		0	0	0	0	253, 431	0	2.00
5.00 Speech Pathology	3.00 Physical Therapy		0	0	0	0	211, 505	0	3.00
0.00 Modical Social Services 0 0 0 0 0 51,475 0 6.00	4.00 Occupational Therapy		0	0	0	0	36, 852	0	4.00
Note Home Heal th Ai de 0	5.00 Speech Pathology		0	0	0	0	174	0	5.00
8. 00 Supplies (see instructions) 0 0 0 0 0 0 0 0 0	6.00 Medical Social Service	S	0	0	0	0	51, 475	0	6.00
9.00 Drugs	•		0		_	1			
10.00 DNE	, , ,	i ons)	0		_	1	_		
11.00 Home Dialysis Aide Services 0 0 0 0 0 0 0 11.00			0		_	1		-	
12.00 Respiratory Therapy 0 0 0 0 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 0 0 0 0 13.00 Private Duty Nursing 0 0 0 0 0 0 14.00 Clinic 0 0 0 0 0 0 0 15.00 Health Promotion Activities 0 0 0 0 0 0 15.00 Day Carre Program 0 0 0 0 0 0 16.00 Day Carre Program 0 0 0 0 0 0 17.00 Home Delivered Meals Program 0 0 0 0 0 0 17.00 Homemaker Service 0 0 0 0 0 0 0 19.00 All Others (specify) 0 0 0 0 0 0 0 19.00 Total (sum of lines 1-19) 1.240 35,168 146,073 0.291808 19.00 Total (sus of the allocated 0 0 0 0 0 0 20.00 Total (sus of the allocated 0 0 0 0 0 0 20.00 Total (sus of the allocated 0 0 0 0 0 0 20.00 Total (sus of the allocated 0 0 0 0 0 0 20.00 Total (sus of the allocated 0 0 0 0 0 0 0 20.00 Total (sus of the allocated 0 0 0 0 0 0 0 0 20.00 Skilled Mursing Care 0 0 0 0 0 0 0 0 30.00 Physical Therapy 0 0 0 0 0 0 0 0 0			0					· ·	
13. 00 Pri Vate Dufy Nursing 0 0 0 0 0 0 0 13. 00		vi ces	0					· ·	
14.00 Clinic 15.00 Health Promotion Activities 0 0 0 0 0 0 0 0 14.00			0	_	_	1	_	- 1	
15. 00 Heal th Promotion Activities 0 0 0 0 0 0 0 15. 00			0					· ·	
10.00 Day Care Program 0 0 0 0 0 0 0 0 0		1+100	0					-	
17.00 Home Deli vered Meals Program 0 0 0 0 0 0 0 0 0	1	rtres	0	0				0	
18. 00	3	roaram	0	0	0		0	0	
19. 00 All Others (specify) 19. 00 10. 0 0 0 0 0 0 0 0 0 0		i ogi alli	0	0	0		0	· ·	
19, 50 Tel emedicine 20, 00 Total (sum of lines 1-19) 0 0 1,240 20,00 21,00 Total (sum of lines 1-19) 0 0 1,240 35,168 146,073 184,496 50,999 21,00 22,00 Unit cost multiplier 20,00000 28,361290 28,361290 29,300 29,300 29,300 20,201556 20,20156 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,201556 20,20156 20,201556 20,20			0	l o	0		0	· ·	
20.00 Total (sum of lines 1-19) 0 1,240 305,059 796,766 1,240 20.00 21.00 146,073 22.00 146,073 22.00 146,073 22.00 146,073 22.00 146,073 22.00 23.35156 22.00 23.3556 22.00 23.3556 22.00 23.3556 22.00 23.3556 22.00 23.3556 22.00 23.3556 22.00 23.3556 22.00 23.3556 23.35290 23.3556 23.35290 23.3556 23.35290 23.3556 23.35290 23.3556 23.35290 23.3556 23.3556 23.35290 23.3556 23.35290 23.3556 23.35290 23.05256 23.3556 23.35290 23.35290 23.3556 23.35290 23.3556 23.35290 23.35290 23.35290 23.3556 23.35290 23.35	1 . 3,		0	0	0		0	0	
21.00 Total cost to be all ocated 2.00 Unit cost multiplier 0.000000 28.361290 0.291808 0.291356 0.231556 41.128226 22.00 Cost Center Description LAUNDRY & SERVIC) SERV		19)	0	1. 240	500, 579		796, 766	1. 240	
22.00 Unit cost multiplier Cost Center Description Cost Center Description LAUNDRY & LINEN SERVICE (POUNS OF LAUNDR)	,		0			1			
LINEN SERVICE (POUNDS OF LAUNDR)	1		0. 000000					41. 128226	22.00
Company Comp	Cost Center Descr	iption	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
LAUNDR S. 00 9.00 10.00 11.00 13.00 14.00 1.00 1.00 13.00 14.00 1.00 1.00 13.00 14.00 1.00 1.00 13.00 14.00 1.00 1.00 13.00 14.00 1.00				7		(FTES)			
NRSING HR REQUIS.				SERVIC)	SERVED)				
1.00			LAUNDR)						
1.00 Administrative and General 27 5 0 748 0 5,759 1.00 2.00 Skilled Nursing Care 0			0.00	0.00	10.00	11 00			
2.00	1 00 Administrative and Con	oral							1 00
3.00 Physical Therapy 0 0 0 0 0 0 0 0 0	•	erai	1		_	1			
4.00 Occupational Therapy 0 0 0 0 0 0 4.00 5.00 Speech Pathology 0 0 <	1		0		_	1	_	· ·	
5.00 Speech Pathology 0 0 0 0 0 5.00 6.00 Medical Social Services 0	3		0	_	_	1	0	· ·	
6.00 Medical Social Services 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	, .		0	_	_	1	0	· ·	
7.00 Home Health Aide 0 0 0 0 0 0 0 0 0 7.00 8.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 0 0 8.00 9.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		S	0		0		0	· ·	
9.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	•		0	0	0	o c	0	0	
10.00 DME 0 0 0 0 0 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 0 11.00 12.00 Respiratory Therapy 0 0 0 0 0 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 0 0 0 0 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 0 0 0 0 0 0 0 14.00 15.00 Health Promotion Activities 0 0 0 0 0 0 0 0 0 0 0 0 15.00 16.00 Day Care Program 0 0 0 0 0 0 0 0 0 0 0 0 16.00 18.00 Homemaker Service 0 0 0 0 0 0 0 0 0	8.00 Supplies (see instruct	i ons)	0	0	0	0	0	0	8.00
11.00 Home Dialysis Aide Services 0 0 0 0 0 0 11.00 12.00 Respiratory Therapy 0 0 0 0 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 0 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 0 0 0 0 14.00 15.00 Heal th Promotion Activities 0 0 0 0 0 0 0 0 0 0 0 15.00 16.00 Day Care Program 0 0 0 0 0 0 0 0 0 0 0 0 16.00 17.00 Home Deli vered Meals Program 0 0 0 0 0 0 0 0 0 16.00 19.00 All Others (specify) 0 0 0 0 0 0 0 0 0 0 0 19.50	9.00 Drugs		0	0	0	0	0	0	9.00
12.00 Respiratory Therapy 0 0 0 0 0 0 12.00 13.00 Private Duty Nursing 0 0 0 0 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 0 0 0 14.00 15.00 Heal th Promotion Activities 0 0 0 0 0 0 0 0 0 15.00 16.00 Day Care Program 0 0 0 0 0 0 0 0 0 0 0 0 16.00 17.00 Home Deli vered Meals Program 0 0 0 0 0 0 0 0 0 0 0 16.00 18.00 Homemaker Servi ce 0 0 0 0 0 0 0 0 0 18.00 19.50 Tel emedi ci ne 0 0 0 0 0 0 0 0 0 19.50 20.00 Total (sum of lines	10. 00 DME		0	0	0	0	0	0	10.00
13.00 Private Duty Nursing 0 0 0 0 0 0 13.00 14.00 Clinic 0 0 0 0 0 0 0 14.00 15.00 Health Promotion Activities 0 0 0 0 0 0 0 0 15.00 16.00 Day Care Program 0 0 0 0 0 0 0 0 0 0 16.00 17.00 Home Delivered Meals Program 0 0 0 0 0 0 0 0 0 0 17.00 18.00 Homemaker Service 0 0 0 0 0 0 0 0 18.00 19.00 All Others (specify) 0 0 0 0 0 0 0 0 19.00 19.50 Tel emedicine 0 0 0 0 0 0 0 0 5,759 20.00	11.00 Home Dialysis Aide Ser	vi ces	0	0	0	0	0	0	11.00
14.00 Clinic 0 0 0 0 0 0 14.00 15.00 Health Promotion Activities 0 0 0 0 0 0 0 15.00 16.00 Day Care Program 0 0 0 0 0 0 0 0 0 16.00 17.00 Home Delivered Meals Program 0 0 0 0 0 0 0 0 0 0 17.00 18.00 Homemaker Service 0 0 0 0 0 0 0 0 0 0 17.00 19.00 All Others (specify) 0 0 0 0 0 0 0 0 0 19.00 19.50 Tel emedicine 0 0 0 0 0 0 0 0 5,759 20.00	12.00 Respiratory Therapy		0	0	0	0	0	0	12.00
15.00 Health Promotion Activities 0 0 0 0 0 0 15.00 16.00 Day Care Program 0 0 0 0 0 0 0 16.00 17.00 Home Delivered Meals Program 0 0 0 0 0 0 0 0 0 17.00 18.00 Homemaker Service 0 0 0 0 0 0 0 0 0 19.00 19.00 All Others (specify) 0 0 0 0 0 0 0 19.00 19.50 Tel emedicine 0 0 0 0 0 0 19.50 20.00 Total (sum of lines 1-19) 27 5 0 748 0 5,759 20.00	13.00 Private Duty Nursing		0	0	0	0	0	0	13.00
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 0 0 17.00 18.00 Homemaker Service 0 0 0 0 0 0 0 18.00 19.00 All Others (specify) 0 0 0 0 0 0 19.00 19.50 Tel emedicine 0 0 0 0 0 0 19.50 20.00 Total (sum of lines 1-19) 27 5 0 748 0 5,759 20.00			0	0	0	0	0		
17.00 Home Delivered Meals Program 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 0 19.00 19.50 Tel emedicine 0 0 0 0 0 0 19.50 20.00 Total (sum of lines 1-19) 27 5 0 748 0 5,759 20.00	•	ıties	0		_	1	_	· ·	
18.00 Homemaker Service 0 0 0 0 0 18.00 19.00 All Others (specify) 0 0 0 0 0 0 19.00 19.50 Tel emedicine 0 0 0 0 0 0 0 19.50 20.00 Total (sum of lines 1-19) 27 5 0 748 0 5,759 20.00	9			_	0		0	· ·	
19.00 All Others (specify) 0 0 0 0 0 19.00 19.50 Tel emedicine 0 0 0 0 0 0 19.50 20.00 Total (sum of lines 1-19) 27 5 0 748 0 5,759 20.00		rogram		0	0			· ·	
19.50 Tel emedicine 0 0 0 0 0 0 19.50 20.00 Total (sum of lines 1-19) 27 5 0 748 0 5,759 20.00					0			· ·	
20.00 Total (sum of lines 1-19) 27 5 0 748 0 5,759 20.00					0		0		
		19)	27	5	0	748	0	- 1	
				1, 413	n	•			
22.00 Unit cost multiplier 2.629630 282.600000 0.000000 35.842246 0.000000 0.222955 22.00			•		0. 000000				

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS BASIS	TO HHA COST CENTERS STATISTICAL Provider CCN: 15-131 HHA CCN: 15-71	From 10/01/2018 Part II
		2/25/2020 1:53 pm

				Home Health	PPS	•
				 Agency I		
	Cost Center Description	PHARMACY	MEDI CAL			
		(COSTED	RECORDS &			
		REQUIS.)	LI BRARY			
			(TIME SPENT)			
		15. 00	16. 00			
1.00	Administrative and General	0	0			1.00
2.00	Skilled Nursing Care	0	0			2. 00
3.00	Physi cal Therapy	0	0			3. 00
4.00	Occupational Therapy	0	0			4. 00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6. 00
7.00	Home Health Aide	0	0			7. 00
8.00	Supplies (see instructions)	0	0			8. 00
9.00	Drugs	0	0			9. 00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18. 00
19.00	All Others (specify)	0	0			19. 00
19. 50	Tel emedi ci ne	0	0			19. 50
20.00	Total (sum of lines 1-19)	0	0			20.00
21.00	Total cost to be allocated	0	0			21.00
22. 00	Unit cost multiplier	0. 000000	0. 000000			22. 00

Heal th	Financial Systems	CAME	RON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST			Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7117	From 10/01/2018 To 09/30/2019		
				Title	e XVIII	Home Health Agency I	PPS	<u> </u>
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
	·	H-2, Part I,	Costs (from	Ancillary	Costs (cols		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col. 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, (OR BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	437, 193		437, 19	93 1, 399	312. 50	1.00
2.00	Physi cal Therapy	3.00	364, 866	0	364, 8	66 1, 253	291. 19	2.00
3.00	Occupational Therapy	4.00	63, 573	0	63, 5 ⁻	73 180	353. 18	3.00
4.00	Speech Pathology	5. 00	300	0	30	50 5	60.00	4.00
5.00	Medical Social Services	6.00	88, 799		88, 79	99 37	2, 399. 97	5.00
6.00	Home Health Aide	7.00	107, 108		107, 10	08 633	169. 21	6.00
7. 00	Total (sum of lines 1-6)		1, 061, 839		1			7.00
			,		Program Visi			
					P	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				to	Deducti bl es		
					Deducti bl es Coi nsurance			
		0	1. 00	2.00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	-						
8.00	Skilled Nursing Care		99915	0	4.0	62		8.00
9.00	Physi cal Therapy		99915	l o	4	66		9.00
10.00	Occupational Therapy		99915	0	1	67		10.00
11. 00	Speech Pathology		99915	0	1	4		11.00
12.00	Medical Social Services		99915	0		18		12.00
13.00	Home Health Aide		99915	0	1	71		13.00
14.00	1			0	1			14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	
	•	H-2 Part I,	Costs (from	Ancillary	Costs (cols		÷ col . 4)	
		col. 28, line	7	Costs (from	1 + 2)	Records)	<u> </u>	
		·	Part I)	Part ÌI)	ĺ	,		
		0	1. 00	2. 00	3.00	4. 00	5. 00	
45.00	Supplies and Drugs Cost Comput				I			45.00
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00	0	0	1	0 0		
			Program Visits		Cost of Services			
			Par	t B	SCI VI CCS	Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	cost center bescription	l lait A	to	Deductibles &	l lait A	to	Deductibles &	
			Deductibles &			Deductibles &		
			Coinsurance	oor risur unce		Coi nsurance	oor risur unice	
		6. 00	7. 00	8.00	9.00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION		,					
4 00	Cost Per Visit Computation	-				0 111 ===		4 00
1. 00	Skilled Nursing Care	0			1	0 144, 375		1.00
2. 00	Physi cal Therapy	0			1	0 135, 695		2.00
3.00	Occupational Therapy	0		l .	1	0 23, 663		3.00
4.00	Speech Pathology	0			1	0 240		4. 00
5.00	Medical Social Services	0			1	0 43, 199		5.00
6.00	Home Health Aide	0			1	0 28, 935		6. 00
7. 00	Total (sum of lines 1-6)	0	1, 188	l	I	0 376, 107		7. 00

711 1 010	FIONMENT OF PATIENT SERVICE COST	rs		Provi der CO	N· 15-1315	Peri od:	Worksheet H-3	2552-10
	TOTAL SERVICE COS	13		HHA CCN:	15-7117	From 10/01/2018 To 09/30/2019	Part I	epared:
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description					,		
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Limitation Cost Computation							
8. 00 9. 00 10. 00 11. 00 12. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services							8. 00 9. 00 10. 00 11. 00 12. 00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00
		Prog	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject	t B Subject to	Part A	Part B Not Subject	Subject to	
			to Deductibles & Coinsurance	Deducti bl es & Coi nsurance		to Deductibles & Coinsurance	Deductibles & Coinsurance	
	1-	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Comput		1	_		_1	_	
	Cost of Medical Supplies Cost of Drugs	0	0 0			0 0		
	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, C	DR BENEFICIARY	
1. 00	Skilled Nursing Care	144, 375						1.00
2.00	Physical Therapy	135, 695						2.00
3.00	Occupational Therapy	23, 663						3.00
4.00	Speech Pathology	240)					4.00
5.00	Medical Social Services	43, 199						5.00
6.00	Home Health Aide	28, 935						6.00
7. 00	Total (sum of lines 1-6)	376, 107						7.00
	Cost Center Description							
		12. 00						
	Limitation Cost Computation	T	T					
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
	Occupational Therapy							10.00
10.00	Chooch Dathalacu							
10. 00 11. 00	Speech Pathology							
10.00	Speech Pathology Medical Social Services Home Health Aide							12.00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2									
APPORTIONMENT OF PATIENT SERVICE COST	ΓS	Provi der C		Peri od: From 10/01/2018	Worksheet H-3 Part II				
HHA CCN: 15-7117 To 09/30/2019 Date/Time F									
			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 Indicated				
			records)	x col. 2)					
	0	1. 00	2. 00	3. 00	4. 00				
PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSPI	ITAL DEPARTME	NTS				
1.00 Physical Therapy	66.00	0. 602725	0		0 col. 2, line 2	. 00	1.00		
2.00 Occupational Therapy							2.00		
3.00 Speech Pathology							3.00		
4.00 Cost of Medical Supplies	71.00	0. 465473	0		0 col. 2, line 1	5. 00	4.00		
5.00 Cost of Drugs	73. 00				0 col. 2, line 1		5. 00		

	Financial Systems CAMERON MEMORIAL COMM TION OF HHA REIMBURSEMENT SETTLEMENT	Provi der Co			i od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7117	Fro To	om 10/01/2018 09/30/2019		
		Title	XVIII	ŀ	Home Health Agency I	PPS	о р.
					Par	t B	
			Part A		Not Subject	Subject to	
				L	to Jeductibles &	Deductibles & Coinsurance	
					Coi nsurance	corrisar ance	
			1.00		2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	OMARY CHARGE	ES				-
_	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0	o	0	1
	Total charges			0	o	0	
_	Customary Charges						
	Amount actually collected from patients liable for payment fo	or services		0	0	0	3
	on a charge basis (from your records) Amount that would have been realized from patients liable for	novmont		0	0	0	١,
00	for services on a charge basis had such payment been made in	accordance		U	ď	U	4
V	with 42 CFR §413.13(b)						
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	000	0. 000000	0.000000	
	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complete		0	0	0	
	only if line 6 exceeds line 1)	(comprete		U	۷	0	-
	Excess of reasonable cost over customary charges (complete on	nlyifline		0	o	0	8
- 1	1 exceeds line 6)					_	
00 F	Primary payer amounts			0	Part A	Part B	9
					Servi ces	Servi ces	
					1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				ما	-	
1	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0	178, 998	10
	Total PPS Reimbursement - Full Episodes withoutliers				ő	9, 975	
1	Total PPS Reimbursement - LUPA Episodes				o	6, 571	
1	Total PPS Reimbursement - PEP Episodes				0	4, 044	
1	Total PPS Outlier Reimbursement - Full Episodes with Outliers	5			0	3, 459	
1	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments				0	0	1
	DME Payments				ő	0	1
	Oxygen Payments				О	0	11
	Prosthetic and Orthotic Payments				0	0	1 -
	Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)	surance)			0	0 203, 047	1
	Excess reasonable cost (from line 8)				0	203, 047	
	Subtotal (line 22 minus line 23)				o	203, 047	
. 00	Coinsurance billed to program patients (from your records)					0	2!
	Net cost (line 24 minus line 25)				0	203, 047	
	Reimbursable bad debts (from your records)	notruptions					2
1	Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin	,)		o	203, 047	28
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	10 27)			o	0	
. 50 F	Pioneer ACO demonstration payment adjustment (see instruction	ns)			o	0	30
	Demonstration payment adjustment amount before sequestration				0	0	
1	Subtotal (see instructions)				0	203, 047	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration				0	4, 060 0	1 .
					ol Ol	198, 987	
. 02	'nterim payments (see instructions)						
. 02 [2. 00]	Interim payments (see instructions) Tentative settlement (for contractor use only)				ol	0	33
1. 02 E 2. 00 I 3. 00 I 4. 00 E	. ,				0 0 0		34

AMAYSIS OF PATHERTS TO HOSPITAL BASED HHAS FOR SERVICES RENDERED Provider COX: 15-1315 Had COX: 15-7117 Part A Peri of 09/30/2019 Dox 09/30/2019 Dox 09/30/2019 Pox 09/30/2019	Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-25						
HHA CON: 15-7117 To 09/30/2019 Bate/Ties Prepared: 27/25/2020 1:5 pm Hore learner 27/25/2020 2.00 1:5 pm Hore learner 27/25/2020 2.00 2			Provider CCN: 15-1315		Peri od:	Worksheet H-5	
Inpatient Part A Repercy Part B Repercy Report B Repercy Repercy Report B Repercy Report B Repercy Report B Repercy Report B Report	TO PRO	OGRAM BENEFICIARIES	HHA CCN:	15-7117 From 10/01/2018 15-7117 To 09/30/2019		Date/Time Pre	
Inpatient Part A	-				Home Health		<u> </u>
mm/dd/yyyy				. 5			
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 198,987 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00 1018 1.00			Inpatien	it Part A	Par	T B	
Total interim payments paid to provider 0 198,997 1.00 2.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interin 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 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)			1. 00	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							
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero the interim rate for the Cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero. (1)	2.00				0	0	2.00
write "NONE" or enter a zero 1.00 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 3.01 3.02 3.03 3.04 3.05 8 9 0 0 0 3.02 3.03 3.04 3.05 8 9 0 0 0 3.03 3.04 3.05 8 9 0 0 0 3.05 8 9 0 0 0 3.05 8 9 0 0 0 3.05 8 9 0 0 0 3.50 8 9 0 0 0 0 5.50 8 9 0 0 0 0 5.50 8 9 0 0 0 5.50 8 0 0 0 0 5.50 8 0 0 0 5.50 8 0 0 0 0 0 5.50 8 0 0 0 0 0 5.50 8 0 0 0 0 0 5.50 8 0 0 0 0 0 5.50 8 0 0 0 0 0 0 5.50 8 0 0 0 0 0 0 5.50 8 0 0 0 0 0 0 5.50 8 0 0 0 0 0 0 0 0 5.50 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00	List separately each retroactive lump sum adjustment					3.00
payment. If none, write "NONE" or enter a zero. (1) Program to Provider 0							
Program to Provider							
3. 01 3. 02 0 0 0 3. 02 3. 03 3. 03 3. 04 3. 05 0 0 0 3. 02 3. 03 3. 04 3. 05 0 0 0 3. 05							
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 3.50-3.98) 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 5.00 5.00 6.01 6.02 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 7.0	3. 01	11 ogram to 11 ovi dei			0	0	3. 01
3.04 0	3. 02				0	0	3. 02
3.05 Provider to Program							
Provider to Program							
3.50 3.51 3.52 0 0 0 3.51 3.52 3.53 3.54 0 0 0 3.53 3.54 3.59 3.50	3.05	Dravidar to Bragram			0	0	3.05
3.51 3.52 3.53 0	3 50	Frovider to Frogram			0	0	3 50
3.52 3.53 3.54 3.99 3.50-3.98 0 0 3.53 3.54 3.99 3.50-3.98 0 0 3.53 3.54 3.99 0 0 3.53 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 3.59 3.50-3.98 0 0 0 0 0 0 0 0 0							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 3.54 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 198,987 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR					0	0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					-		
3.50-3.98 Total Interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) To BE COMPLETED BY CONTRACTOR					-		
198, 987 4.00 198, 987	3. 99				0	0	3. 99
(transfer to Wkst. H-4, Part II, column as appropriate, Iine 32) 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) Program to Provider 0	4.00				0	198. 987	4.00
To BE COMPLETED BY CONTRACTOR						,	
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	Г 00			I			Г 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
Description							
Description							
Provider to Program						-	
0	5. 03	Provider to Program			0	0	5.03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 0.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 198, 987 7.00	5 50	Frovider to Frogram			0	0	5 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 0 0 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 6. 02 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 52				0	0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99				0	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	4 00						4 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00						6.00
7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) Number 0 1.00 2.00		SETTLEMENT TO PROVIDER					
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00							
Number (Mo/Day/Yr) 0 1.00 2.00	7. 00						7. 00
0 1.00 2.00							
8.00 Name of Contractor 8.00			()			
	8. 00	Name of Contractor					8. 00

						2/25/2020 1:5	3 pm
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
				(col. 1 plus	CATI ONS		
		1 00	2.00	col. 2)	4.00	E 00	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT*		0	1	0	0	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP*		0		0	0	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	o	0		0	0	3.00
4. 00	ADMINISTRATIVE & GENERAL*	126	923	1, 049	22, 292	23, 341	4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0	7 <u>2</u> 3	1,047	22, 2,2	23, 341	5.00
6. 00	LAUNDRY & LINEN SERVICE*		0	0	0	0	6.00
7. 00	HOUSEKEEPI NG*		0	0	0	0	7.00
8. 00	DI ETARY*	o o	0	0	0	0	8.00
9. 00	NURSI NG ADMI NI STRATI ON*	0	0	0	0	Ö	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	Ö	10.00
11. 00	MEDI CAL RECORDS*	0	0	0	0	Ö	11.00
12. 00	STAFF TRANSPORTATION*	0	13, 672	13, 672	0	13, 672	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14. 00	PHARMACY*	0	0	0	0	0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	Ö	15.00
16. 00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		· ·	ĺ	J	Ŭ	17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			l.			1
25.00	I NPATI ENT CARE-CONTRACTED**		0	0	0	0	25. 00
26.00	PHYSI CI AN SERVI CES**	o	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	O	0	0	0	0	27. 00
28.00	REGI STERED NURSE**	40, 578	0	40, 578	0	40, 578	28. 00
29.00	LPN/LVN**	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY**	641	0	641	0	641	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	10, 022	0	10, 022	0	10, 022	33.00
34.00	SPI RI TUAL COUNSELI NG**	2, 491	0	2, 491	0	2, 491	34.00
35.00	DI ETARY COUNSELI NG**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	2, 710	0	2, 710	0	2, 710	
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES**	0	0	0	0	0	40.00
41. 00	LABS & DI AGNOSTI CS**	0	0	0	0	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	0	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42. 50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45. 00	PALLI ATI VE CHEMOTHERAPY**	0	0	0	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	3, 964	3, 964	0	3, 964	46. 00
40.05	NONREI MBURSABLE COST CENTERS					-	(0.55
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAL SI NG*	0	0	0	0	0	62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	1
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	
65.00	OTHER PHYSICIAN SERVICES*	0	0		0	0	65.00
66.00	RESI DENTI AL CARE*	0	0		0	0	66.00
67.00	ADVERTI SI NG*	0	0		0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG*		0		0	0	
69.00	THRIFT STORE*		0		0	0	
70.00	NURSING FACILITY ROOM & BOARD*		0			0	
71.00	OTHER NONREIMBURSABLE (SPECIFY)* TOTAL	E4 E40	18, 559	75 107	22, 292	07 410	71. 00 100. 00
100.00	A LOTAL	56, 568	10, 339	75, 127	22, 292	91,419	1100.00

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

Date/Time Prepared: 2/25/2020 1:53 pm Hospi ce CCN: 15-1561

Hospi ce I

				HOSPI CE I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	I	6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS				4
1. 00	CAP REL COSTS-BLDG & FIXT*	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	-		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	23, 341		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPI NG*	0	0		7. 00
8.00	DI ETARY*	0	0		8.00
9.00	NURSI NG ADMI NI STRATI ON*	0	0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	o		10.00
11.00	MEDI CAL RECORDS*	0	o		11.00
12.00	STAFF TRANSPORTATION*	0	13, 672		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	o		13.00
14. 00	PHARMACY*	0	o		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0			15.00
16. 00	OTHER GENERAL SERVICE*	0	1		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS	l			17.00
25. 00	I NPATI ENT CARE -CONTRACTED**	0	0		25. 00
26. 00	PHYSICIAN SERVICES**		1		26.00
	NURSE PRACTITIONER**		-		
27. 00 28. 00		0	1		27.00
	REGISTERED NURSE**	0	40, 578		28. 00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSI CAL THERAPY**	0	641		30.00
31. 00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0			33.00
34.00	SPIRITUAL COUNSELING**	0	2, 491		34.00
35. 00	DI ETARY COUNSELI NG**	0	-		35. 00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	2, 710		37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON**	0	0		39.00
40.00	I MAGING SERVICES**	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	o		42. 50
43.00	OUTPATI ENT SERVI CES**	0	o		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	ol		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	o		45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0			46.00
	NONREI MBURSABLE COST CENTERS	_			10.00
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0			61.00
62. 00	FUNDRAI SI NG*				62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*				63.00
64. 00	PALLIATIVE CARE PROGRAM*				64.00
65.00	OTHER PHYSICIAN SERVICES*		0		65.00
					1
66.00	RESI DENTI AL CARE*		0		66.00
67.00	ADVERTI SI NG*	0	0		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*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	1		71.00
100.00	TOTAL	0	97, 419		100.00
* +	,				

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

						2/25/2020 1:5	3 pm
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED						25. 00
	PHYSI CI AN SERVI CES	0	0	0	0	0	
	NURSE PRACTITIONER	0	0	0	0	0	27.00
	REGI STERED NURSE	0	0	0	0	0	28. 00
	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
	SPI RI TUAL COUNSELI NG	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	C	0	0	35.00
36.00	COUNSELING - OTHER	0	0	O	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	O	0	O	0	0	40.00
41.00	LABS & DIAGNOSTICS	O	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	O	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	o	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	o	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	O	0	O	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	O	0	l c	0	0	46.00
	TOTAL *	O	0	l c	0	0	100.00
* Tran	usfer the amount in column 7 to Wkst 0-5 col	umn 1 line 50			•		

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

	ADJUSTMENTS	TOTAL (col. 5		
		± col. 6)		
	6. 00	7. 00		
DIRECT PATIENT CARE SERVICE COST CENTERS				
25. 00 I NPATI ENT CARE-CONTRACTED			25	5.00
26. 00 PHYSI CI AN SERVI CES	C	0	26	6.00
27. 00 NURSE PRACTITIONER	C	0	27	7.00
28. 00 REGI STERED NURSE	C	0	28	8.00
29. 00 LPN/LVN	C	0	29	9.00
30. 00 PHYSI CAL THERAPY	C	0	30	0.00
31. 00 OCCUPATIONAL THERAPY	C	0	31	1.00
32.00 SPEECH/LANGUAGE PATHOLOGY	C	0	32	2.00
33. 00 MEDICAL SOCIAL SERVICES	C	0	33	3.00
34. 00 SPIRITUAL COUNSELING	C	0	34	4.00
35. 00 DI ETARY COUNSELI NG	C	0	35	5.00
36. 00 COUNSELING - OTHER	C	0	36	6.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	C	0	37	7.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	C	0	38	8.00
39. 00 PATIENT TRANSPORTATION	C	0	39	9.00
40.00 I MAGING SERVICES	C	0	40	0.00
41.00 LABS & DIAGNOSTICS	C	0	41	1.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	C	0	42	2.00
42.50 DRUGS CHARGED TO PATIENTS	C	0	42	2.50
43. 00 OUTPATIENT SERVICES	C	0	43	3.00
44.00 PALLIATIVE RADIATION THERAPY	C	0	44	4.00
45. 00 PALLIATIVE CHEMOTHERAPY	C	0	45	5.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	C	0	46	6.00
100. 00 TOTAL *	C	0	100	0.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

Peri od: From 10/01/2018 To 09/30/2019 Date/Ti me Prepared: 2/25/2020 1:53 pm Provi der CCN: 15-1315 Peri od: CARE Hospi ce CCN: 15-1561

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28. 00	REGI STERED NURSE	40, 578	0	40, 578	0	40, 578	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	641	0	641	0	641	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	10, 022	0	10, 022	0	10, 022	33.00
34.00	SPI RI TUAL COUNSELI NG	2, 491	0	2, 491	0	2, 491	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	2, 710	0	2, 710	0	2, 710	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATI ENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42. 50
43.00	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	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	3, 964	3, 964	0	3, 964	46.00
100.00	TOTAL *	56, 442	3, 964	60, 406	0	60, 406	100.00
* T		1 1:					

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

ADJUSTMENTS TOTAL (col . 5 ± col . 6)
DIRECT PATIENT CARE SERVICE COST CENTERS
DI RECT PATIENT CARE SERVICE COST CENTERS 25.00 1NPATIENT CARE-CONTRACTED 25.00 26.00 27.00 26.00 27.0
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 40, 578 28. 00 29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 641 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 10, 022 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 2, 491 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG 0 0 35. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2, 710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 <
27. 00 NURSE PRACTITIONER 0 0 27. 00 28. 00 REGISTERED NURSE 0 40, 578 28. 00 29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 641 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 10, 022 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 2, 491 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2, 710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39. 00 39. 00 PATI ENT TRANSPORTATI ON 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
28. 00 REGISTERED NURSE 0 40,578 28. 00 29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 641 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 31. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 10, 022 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 2, 491 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2, 710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0
29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 641 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 10, 022 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 2, 491 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2, 710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00
30. 00 PHYSI CAL THERAPY 0 641 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 10, 022 33. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG 0 0 0 35. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2, 710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 41. 00 LABS & DI AGNOSTI CS 0 0 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 42. 00
31.00 OCCUPATIONAL THERAPY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES 0 10,022 33.00 34.00 SPIRI TUAL COUNSELI NG 0 2,491 34.00 35.00 DI ETARY COUNSELI NG 0 0 35.00 36.00 COUNSELI NG - OTHER 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2,710 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 39.00 39.00 PATI ENT TRANSPORTATI ON 0 0 39.00 40.00 I MAGI NG SERVI CES 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42.00
32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 10, 022 33. 00 34. 00 SPIRI TUAL COUNSELI NG 0 2, 491 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2, 710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00
33. 00 MEDI CAL SOCI AL SERVI CES 34. 00 SPIRI TUAL COUNSELI NG 35. 00 DI ETARY COUNSELI NG 36. 00 COUNSELI NG - OTHER 36. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 37. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 38. 00 DI AMBOR NG SERVI CES 39. 00 PATI ENT TRANSPORTATI ON 40. 00 I MAGI NG SERVI CES 40. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 33. 00 44. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE
34. 00 SPIRITUAL COUNSELING 0 2, 491 34. 00 35. 00 DIETARY COUNSELING 0 0 35. 00 36. 00 COUNSELING - OTHER 0 0 36. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 2,710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATION 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00
35. 00 DI ETARY COUNSELI NG 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2, 710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 42. 00
36. 00 COUNSELING - OTHER 0 0 36. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 2, 710 37. 00 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38. 00 39. 00 PATIENT TRANSPORTATION 0 0 39. 00 41. 00 LABS & DI AGNOSTICS 0 0 0 41. 00 LABS & DI AGNOSTICS 0 0 0 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 42. 00
37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 2,710 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00
39. 00 PATIENT TRANSPORTATION 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00
40. 00 I MAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00
41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 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 3,964 46.00
100. 00 TOTAL * 0 60, 406 100. 00

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

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0 46.00

42.50

43.00

44.00

45.00

0 100.00

DRUGS CHARGED TO PATIENTS

PALLIATIVE CHEMOTHERAPY

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

OUTPATIENT SERVICES

42.50

43.00

44.00

45.00

		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	REGISTERED NURSE	0	0	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	SPIRITUAL COUNSELING	0	0	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	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	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	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	0	100.00

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

^{100. 00} TOTAL * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

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0 41.00

0 42.00

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0 46.00

42.50

43.00

44.00

45.00

0 100.00

LABS & DIAGNOSTICS

OUTPATIENT SERVICES

MEDICAL SUPPLIES-NON-ROUTINE

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

DRUGS CHARGED TO PATIENTS

PALLIATIVE CHEMOTHERAPY

41.00

42.00

42.50

43.00

44.00

45.00

100. 00 TOTAL

		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	0	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	SPIRITUAL COUNSELING	0	0	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	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	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	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	0	100.00

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

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

Health Financial Systems	CAMERON MEMORIAL COMM	UNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - DETERMINATION OF EXPENSES FOR ALLOCATION	HOSPITAL-BASED HOSPICE NET	Provi der CCN: Hospi ce CCN:	From 10/01/2018	Worksheet 0-5 Date/Time Prepared: 2/25/2020 1:53 pm
			Hospi so I	

EAPENS	ES FOR ALLOCATION	Hospi ce CCI		To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
				Hospi ce I		
	Descriptions Descriptions		HOSPI CE	GENERAL	TOTAL	
	'		DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
			ĺ	(see	,	
				instructions)		
			1.00	2.00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 35, 168	35, 168	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 22, 975	22, 975	3.00
4.00	ADMI NI STRATI VE & GENERAL		23, 34	1 92, 181	115, 522	4.00
5.00	PLANT OPERATION & MAINTENANCE			0	0	5.00
6.00	LAUNDRY & LINEN SERVICE			0	0	6.00
7.00	HOUSEKEEPING			0	0	7.00
8. 00	DIETARY			0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES			0 42	42	10.00
11. 00	MEDICAL RECORDS			0 0	0	11.00
12. 00	STAFF TRANSPORTATION		13, 67		13, 672	12.00
13. 00	VOLUNTEER SERVICE COORDINATION		13, 07	2	13, 072	13. 00
14. 00	PHARMACY				0	14. 00
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES				0	15. 00
16. 00	OTHER GENERAL SERVICE			0	0	16.00
			'	0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE			U	U	17. 00
50. 00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51. 00	HOSPI CE ROUTI NE HOME CARE		60, 40	-	60, 406	51.00
52.00	HOSPICE INPATIENT RESPITE CARE			0	00, 400	52.00
53. 00				0	0	53.00
53.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS			U	U	53.00
60. 00	BEREAVEMENT PROGRAM			0	0	60.00
61. 00	VOLUNTEER PROGRAM				0	61.00
62. 00	FUNDRAI SI NG				0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	63.00
					0	
64.00	PALLIATIVE CARE PROGRAM			0	-	64.00
65.00	OTHER PHYSI CI AN SERVI CES			0	0	65.00
66. 00	RESI DENTI AL CARE			0	0	66.00
67. 00	ADVERTI SI NG		'	U	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG			0	0	68. 00
69. 00	THRI FT STORE			O	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71. 00	OTHER NONREI MBURSABLE (SPECI FY)			0	0	71.00
	NEGATI VE COST CENTER			0	0	99.00
100.00	TOTAL		97, 41	9 150, 366	247, 785	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-1315 Peri od: Worksheet 0-6 From 10/01/2018 Part I Hospi ce CCN: 09/30/2019 Date/Time Prepared: 15-1561 2/25/2020 1:53 pm Hospi ce I TOTAL CAP REL BLDG CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions **EXPENSES** & FIX EQUI P **BENEFITS DEPARTMENT** 0 1.00 2.00 3.00 ЗА GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 35, 168 35, 168 3.00 EMPLOYEE BENEFITS DEPARTMENT 22, 975 0 35, 168 58, 143 3.00 ADMINISTRATIVE & GENERAL 115, 522 115, 522 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 0 o 0 5.00 LAUNDRY & LINEN SERVICE 0 0 0 6.00 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 0 0 7.00 8.00 DI ETARY 0 0 0 0 0 8.00 0 NURSING ADMINISTRATION 0 9.00 0 0 9.00 0 ROUTINE MEDICAL SUPPLIES 0 42 10.00 42 10.00 11.00 MEDICAL RECORDS 0 0 0 0 0 0 11.00 12.00 STAFF TRANSPORTATION 13, 672 0 13, 672 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 13.00 0 0 14.00 PHARMACY 0 0 0 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 0 15.00 0 0 OTHER GENERAL SERVICE 0 0 16.00 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 C 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 0 50.00 HOSPICE ROUTINE HOME CARE 118, 549 60, 406 58, 143 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 0 C 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 0 60.00 VOLUNTEER PROGRAM 0 0 0 61.00 0 0 61.00 FUNDRAI SI NG 0 62.00 00000000 0 0 0 0 0 62.00 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 PALLIATIVE CARE PROGRAM 0 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 0 0 66.00 67 00 ADVERTI SI NG 0 0 0 67 00 TELEHEALTH/TELEMONI TORI NG 0 68.00 0 0 68.00 69.00 THRIFT STORE 0 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 0 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71 00 0 O 0 0 71.00 99.00 NEGATIVE COST CENTER 0 0 0 99.00 100.00 TOTAL 247, 785 35, 168 58, 143 247, 785 100.00

0 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-1315 Peri od: Worksheet 0-6 From 10/01/2018 Part I Hospi ce CCN: 09/30/2019 Date/Time Prepared: 15-1561 2/25/2020 1:53 pm Hospi ce I ADMI NI STRATI V LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions PLANT 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 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 115, 522 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 0 7.00 8.00 DI ETARY 0 0 0 0 0 0 0 0 0 0 8.00 NURSING ADMINISTRATION 0 9.00 0 9.00 ROUTINE MEDICAL SUPPLIES 37 0 10.00 10.00 11.00 MEDICAL RECORDS 0 11.00 12.00 STAFF TRANSPORTATION 11, 941 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 0 14.00 PHARMACY 0 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15.00 15.00 OTHER GENERAL SERVICE 0 0 16.00 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 C 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 50.00 HOSPICE ROUTINE HOME CARE 103, 544 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE C 0 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 60.00 VOLUNTEER PROGRAM 0 0 61.00 0 61.00 FUNDRAI SI NG 0000000 0 62.00 62.00 0 0 0 0 0 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 67 00 ADVERTI SI NG 0 67 00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 0 Ω 71.00 0 0 0 99.00 NEGATIVE COST CENTER 0 0 0 99.00

115, 522

100.00 TOTAL

не	al th	Financial Systems CAM	ERON MEMORIAL CO	MMUNITY HOSPIT	IAL	In Lie	u of Form CMS-2	2552-10
CC	ST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provi der Co	CN: 15-1315	Peri od:	Worksheet 0-6)
						From 10/01/2018	Part I	
				Hospi ce CCI	N: 15-1561	To 09/30/2019		
_							2/25/2020 1:5	3 pm
						Hospi ce I		
		Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		•	ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATIO	SERVI CE	
			N	SUPPLI ES		N	COORDI NATI ON	
			9. 00	10. 00	11.00	12.00	13.00	
		GENERAL SERVICE COST CENTERS	7. 00	10.00	11.00	12.00	13.00	
	00				I		<u> </u>	4 00
	00	CAP REL COSTS-BLDG & FIXT						1.00
	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	1					5.00
	00	LAUNDRY & LINEN SERVICE	1					6.00
	00	HOUSEKEEPI NG	1					7.00
					•			1
	00	DI ETARY						8.00
	00	NURSI NG ADMI NI STRATI ON	O					9. 00
10	0. 00	ROUTINE MEDICAL SUPPLIES	0	79				10.00
11	. 00	MEDI CAL RECORDS	0			0		11.00
12	2. 00	STAFF TRANSPORTATION	o			25, 613		12.00
1.3	3. 00	VOLUNTEER SERVICE COORDINATION	0			. 0	0	13.00
	. 00	PHARMACY				0	l o	14.00
	5. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	15.00
		OTHER GENERAL SERVICE				0	0	16.00
	00		U			0	U	1
1 /	. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
		LEVEL OF CARE						1
	0. 00		0	0		0	0	
51	. 00	HOSPICE ROUTINE HOME CARE	0	79		0 25, 613	0	51.00
52	2. 00	HOSPICE INPATIENT RESPITE CARE	O	0		0 0	0	52.00
53	3. 00	HOSPICE GENERAL INPATIENT CARE	o	0		0 0	0	53.00
		NONREI MBURSABLE COST CENTERS	· ·					1
60	00	BEREAVEMENT PROGRAM	0			0	0	60.00
	. 00	VOLUNTEER PROGRAM				0	l o	61.00
	2. 00	FUNDRAI SI NG			•	0	ĺ	62.00
					•	0		1
	3. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
	. 00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65	. 00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66	. 00	RESI DENTI AL CARE	0			0	0	66.00
67	. 00	ADVERTI SI NG	0			0	0	67.00
68	3. 00	TELEHEALTH/TELEMONI TORI NG				0	0	68. 00
	0. 00	l e e e e e e e e e e e e e e e e e e e				0	0	69.00
	0.00	NURSING FACILITY ROOM & BOARD					Ĭ	70.00
	. 00						0	1
				^				
	00		0	0		0 0	0	
IC	iu. UC	TOTAL	0	79	l	0 25, 613	1 0	100. 00

			Hospi ce CC	N: 15-1561	0 09/30/2019	Date/IIme Pre 2/25/2020 1:5	
-					Hospi ce I	2/25/2020 1.5	5 рііі
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL		TOTAL	
	'		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
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16. 00	OTHER GENERAL SERVICE	0		(16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE			1			
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			0	
51.00	HOSPICE ROUTINE HOME CARE	0	0			247, 785	
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	1		0	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	(0	0	53.00
(0.00	NONREI MBURSABLE COST CENTERS			1 /	<u> </u>	0	(0.00
60.00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM	0				0	60. 00 61. 00
61.00	1	0				-	
62. 00 63. 00	FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63.00
64.00	PALLIATIVE CARE PROGRAM	0				0	64.00
65.00	OTHER PHYSICIAN SERVICES	0				0	65.00
66.00	RESI DENTI AL CARE		0		ا ا	0	66.00
67. 00	ADVERTI SI NG		0		d d	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG					0	
69. 00	THRIFT STORE					0	69.00
70.00	NURSING FACILITY ROOM & BOARD	l \mathbb{I}			1	0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	n	0	(ا ا	0	1
99. 00	NEGATI VE COST CENTER		0	l d	ol ol	0	99.00
	TOTAL	o	0		o	247, 785	
	•	, ,		•	, ,		•

Health Financial Systems	CAMERON MEMORIAL COMM	IUNI TY HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED STATISTICAL BASIS	HOSPI CE GENERAL SERVI CE COSTS	Provi der CCN:		From 10/01/2018	
		Hospi ce CCN:	15-1561	To 09/30/2019	Date/Time Prepared:

SIAIIS	TICAL BASIS		Hospi ce CCI	N: 15-1561	To 09/30/2019	Date/Time Pre 2/25/2020 1:5	pared:
					Hospi ce I	272072020 1.0	о ріп
	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCI LI ATI O N	ADMINISTRATIV E & GENERAL (ACCUMULATED COSTS)	
		1. 00	2.00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 3. 00 4. 00 5. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE	0 0	34, 646 34, 646 0	33, 93, (4 0 -115, 522 0 0	132, 263 0	1.00 2.00 3.00 4.00 5.00
6. 00 7. 00 8. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY	0 0 0	0 0 0	(0 0 0	7. 00
9. 00 10. 00 11. 00	NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS	0 0 0	0 0 0	(0 0 0 0	0 42 0	9. 00 10. 00 11. 00
12. 00 13. 00 14. 00	STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY	0	0 0	(13, 672 0 0	13. 00 14. 00
16.00	PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE	0 0	0	(0 0	15. 00 16. 00 17. 00
50. 00 51. 00 52. 00 53. 00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0	0	33, 93	0 4 0 5 0	0 118, 549 0 0	52.00
60.00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM	0	0		0	0	00.00
61. 00 62. 00 63. 00 64. 00	VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM	0 0	0 0 0	(0 0 0	61. 00 62. 00 63. 00 64. 00
65. 00 66. 00 67. 00	OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING	0 0	0 0 0	(0 0	0 0 0	65. 00 66. 00 67. 00
70.00	TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY)	0 0	0	(0 0 0 0 0	0	68. 00 69. 00 70. 00 71. 00
99. 00 100. 00	NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	0. 000000	35, 168 1. 015067			115, 522 0. 873426	

Health Financial Systems	IUNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10	
COST ALLOCATION - HOSPITAL-BASED	HOSPICE GENERAL SERVICE COSTS	Provider CCN: 15-1315	Peri od:	Worksheet 0-6

From 10/01/2018 Part II
To 09/30/2019 Date/Time Prepared: STATISTICAL BASIS Hospi ce CCN: 15-1561 2/25/2020 1:53 pm Hospi ce I Cost Center Descriptions PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE (IN-FACILITY OPERATION & (SQUARE FEET) ADMI NI STRATI O (IN-FACILITY MAI NTENANCE DAYS) (DI RECT NURS. (SQUARE FEET) DAYS) HRS.) 5. 00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 6.00 LAUNDRY & LINEN SERVICE 000000000000 6.00 7.00 HOUSEKEEPI NG 7.00 0 8.00 DIFTARY 8.00 NURSING ADMINISTRATION 9.00 0 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 0 11.00 MEDICAL RECORDS 0 11.00 0 STAFF TRANSPORTATION 12.00 12.00 0 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 14.00 **PHARMACY** 0 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 0 16.00 OTHER GENERAL SERVICE 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 0 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 0 51.00 HOSPICE ROUTINE HOME CARE 0 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 0 0 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 Ω 53.00 NONREIMBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 00000000 0 61.00 0 FUNDRAI SI NG 62.00 62 00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0 0 64.00 OTHER PHYSICIAN SERVICES 65.00 0 0 65.00 66.00 RESIDENTIAL CARE 0 Ω 0 66.00 0 0 67.00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.00 99. 00 NEGATI VE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0 100.00

0.000000

0.000000

0.000000

0.000000

0.000000 101.00

101.00 UNIT COST MULTIPLIER

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provi der Co		Peri od:	Worksheet 0-6	
STATI STI CAL BASI S				rom 10/01/2018		
		Hospi ce cci	N: 15-1561 1	To 09/30/2019	2/25/2020 1:5	
				Hospi ce I		
Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	MEDI CAL	RECORDS	TRANSPORTATI 0	SERVI CE	(CHARGES)	
	SUPPLI ES	(PATI ENT	N	COORDI NATI ON		

					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI 0	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)			SERVICE)		
	T	10. 00	11. 00	12. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS	1			1		
1. 00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8. 00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES	1, 764					10.00
11.00	MEDI CAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			45, 387			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	1
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0		0	
16.00	OTHER GENERAL SERVICE			0	0	0	1
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
50. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	0	0) 0	0	0	50.00
51.00	HOSPICE CONTINUOUS HOME CARE	1, 764	0		0	0	00.00
52.00	HOSPICE ROUTINE HOWE CARE HOSPICE INPATIENT RESPITE CARE	1, 764	0	1		0	1
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0			0	
33.00	NONREI MBURSABLE COST CENTERS	<u> </u>	0	, ₁	0	0	33.00
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	1
62.00	FUNDRAI SI NG			0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESI DENTI AL CARE			0	0	0	66.00
67.00	ADVERTI SI NG			0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	0	68. 00
69.00	THRI FT STORE			0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	
99. 00	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0	25, 613			100.00
101.00	UNIT COST MULTIPLIER	0. 044785	0. 000000	0. 564325	0. 000000	0. 000000	101. 00

Health Financial Systems CAMERON	MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE STATISTICAL BASIS	CE COSTS Provider CCN: 15-1315	Period: Worksheet 0-6 From 10/01/2018 Part II
STATION CALE BASIS	Hospi ce CCN: 15-1561	To 09/30/2019 Date/Time Prepared:

Hospi ce CCN: 15-1561 2/25/2020 1:53 pm Hospi ce I Cost Center Descriptions PHYSI CI AN OTHER GENERAL PATI ENT/ ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES (SPECI FY CARE SERVICES (PATIENT BASIS) (IN-FACILITY DAYS) DAYS) 15. 00 16. 00 17.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 6.00 LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 8.00 DIFTARY NURSING ADMINISTRATION 9.00 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 MEDICAL RECORDS 11.00 11.00 STAFF TRANSPORTATION 12.00 12.00 13.00 VOLUNTEER SERVICE COORDINATION 13.00 14.00 **PHARMACY** 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 16.00 OTHER GENERAL SERVICE C 16.00 17.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 0 50.00 0 51.00 HOSPICE ROUTINE HOME CARE 0 51.00 HOSPICE INPATIENT RESPITE CARE 0 52.00 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 53.00 NONREIMBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 60.00 VOLUNTEER PROGRAM 0 61.00 61.00 FUNDRAI SI NG 62.00 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 64.00 OTHER PHYSICIAN SERVICES 65.00 65.00 66.00 RESIDENTIAL CARE 0 0 66.00 0 67.00 ADVERTI SI NG 67.00 68.00 TELEHEALTH/TELEMONI TORI NG 68.00 69.00 THRIFT STORE 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71.00 99. 00 NEGATI VE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 100.00

0.000000

0.000000

0.000000

101.00

101.00 UNIT COST MULTIPLIER

Health Financial Systems	CAMERON MEMORIAL COMM	UNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHAR	ED SERVICE COSTS BY	Provider CCN: 15-1315		Worksheet 0-7
LEVEL OF CARE		Hospi co CCN: 15 1561	From 10/01/2018	Dato/Timo Propared:

2/25/2020 1:53 pm Hospi ce I Charges by LOC (from Provider Records) HCHC HRHC HI RC Cost Center Descriptions From Wkst. C, Cost to Part I, Col. Charge Ratio 9 line 2.00 1.00 3.00 4.00 0 ANCILLARY SERVICE COST CENTERS 1.00 PHYSI CAL THERAPY 66.00 0. 602725 1.00 2.00 OCCUPATIONAL THERAPY 67.00 2.00 3.00 SPEECH PATHOLOGY 68.00 3.00 4.00 DRUGS CHARGED TO PATIENTS 73.00 0.330380 0 0 0 4.00 5.00 DURABLE MEDICAL EQUIP-RENTED 96.00 5.00 6.00 LABORATORY 60.00 0.307895 0 6.00 0 0 MEDICAL SUPPLIES CHARGED TO PATIENT 0 7.00 71.00 0.465473 0 0 7.00 8.00 OTHER OUTPATIENT SERVICE COST CENTER 93.00 8.00 RADI OLOGY-THERAPEUTI C 55.00 9.00 9.00 CHEMI CAL DEPENDENCY 0.000000 10.00 10 00 76.00 O 0 0 10. 01 ONCOLOGY 76.01 0.311766 0 0 10.01 11.00 Totals (sum of lines 1-11) 11.00 Charges by Shared Service Costs by LOC LOC (from Provi der Records) Cost Center Descriptions HGI P HCHC (col. 1 HRHC (col. 1 | HIRC (col. 1 | HGIP (col. 1 x col . 2) 6.00 x col . 5) 9.00 x col. 3) 7.00 x col. 4) 8. 00 5. 00 ANCILLARY SERVICE COST CENTERS 1.00 PHYSI CAL THERAPY 0 0 0 0 1.00 OCCUPATIONAL THERAPY 2.00 2.00 3.00 SPEECH PATHOLOGY 3 00 DRUGS CHARGED TO PATIENTS 4.00 0 0 0 0 0 4.00 5.00 DURABLE MEDICAL EQUIP-RENTED 5.00 6.00 LABORATORY 0 0 0 ol 0 6.00 MEDICAL SUPPLIES CHARGED TO PATIENT 0 7.00 0 0 0 7.00 0 8.00 OTHER OUTPATIENT SERVICE COST CENTER 8.00 9.00 RADI OLOGY-THERAPEUTI C 9.00 CHEMI CAL DEPENDENCY 10.00 10.00 0 0 0 Ωl 10.01 ONCOLOGY 0 0 0 0 10.01 11.00 Totals (sum of lines 1-11) 0 11.00

Health Financial Systems	CAMERON MEMORIAL COMM	MUNITY HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIE	M COST	Provi der CCN: 15-1315	Peri od: From 10/01/2018	Worksheet 0-8

Hospice CCN: 15-1561 From 10/01/2018 Date/Time Prepared: 2/25/2020 1:53 pm

					2/23/2020 1.3	o piii
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPI CE 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	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	e 10)		0		4.00
5.00	Program cost (line 3 times line 4)	ŕ		0		5.00
	HOSPI CE ROUTI NE HOME CARE					ĺ
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,			247, 785	6.00
	line 11)				·	
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				1, 764	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				140. 47	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 11)	1, 41	2 0		9.00
10.00	Program cost (line 8 times line 9)	ŕ	198, 34	4 0		10.00
	HOSPICE INPATIENT RESPITE CARE		<u> </u>			
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,			0	11.00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				0	12.00
	Total average cost per diem (line 11 divided by line 12)				0. 00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 12)		0		14.00
15.00	Program cost (line 13 times line 14)			0		15. 00
	HOSPI CE GENERAL I NPATI ENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			0	16.00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)				0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lin	ne 13)		0		19.00
20.00	Program cost (line 18 times line 19)			0		20.00
	TOTAL HOSPICE CARE			<u>'</u>		
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				247, 785	21.00
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				1, 764	22.00
	Average cost per diem (line 21 divided by line 22)				140. 47	23.00
			1	1	'	'

		RON MEMORIAL CO				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Period: From 10/01/2018	Worksheet M-1	
			Component		To 09/30/2019	Date/Time Pre	
						2/25/2020 1:5	3 pm
					RHC I	Cost	
		Compensati on	Other Costs		Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2.00	3.00	4. 00	col . 4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1. 00	Physician	421, 465	7, 364	428, 82	9 0	428, 829	1.00
2. 00	Physician Assistant	421, 403	7,304		0 0	420, 029	2.00
3. 00	Nurse Practitioner	154, 484	0	154, 48	-	154, 484	3.00
4. 00	Visiting Nurse	134, 404	0	134,40	0 0	154, 464	4.00
5. 00	Other Nurse	176, 363	0	176, 36	-	176, 363	5.00
6. 00	Clinical Psychologist	170, 303	0	170,30	0 0		1
7. 00	Clinical Social Worker	2, 836	0	2, 83	-	2, 836	
8. 00	Laboratory Technician	2,000	0	2,00	0 0	2,000	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	755, 148	7, 364	762, 51	-	1	
11. 00	Physician Services Under Agreement	0	0		o o	0	1
12.00	Physician Supervision Under Agreement	0	0		0 0	0	1
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	6, 385	6, 38	5 0	6, 385	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16. 00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18. 00
19. 00	Other Health Care Costs	0	0		0 0	0	19. 00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6, 385			-,	
22. 00	Total Cost of Health Care Services (sum of	755, 148	13, 749	768, 89	7 0	768, 897	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	_	_	T	_1	T -	
23. 00	Pharmacy	0			0		23.00
24. 00	Dental	0	0		0	1	24.00
25. 00	Optometry	0	0		0	_	
25. 01	Tel eheal th	0			0 0	0	25. 01
25. 02 26. 00	Chronic Care Management				0		25. 02 26. 00
	All other nonreimbursable costs	0	0		0 0	0	
27. 00 28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23		_		0	0	27. 00 28. 00
20.00	through 27)]	l "			l ⁰	20.00

98, 291

98, 291

853, 439

35, 246 140, 933

176, 179

945, 076

35, 246

42, 642 77, 888

91, 637

35, 246 140, 933

176, 179

945, 076

0

0

29.00

30.00

31.00

32.00

through 27)
FACILITY OVERHEAD
29.00 Facility Costs

31.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1315	Peri od: From 10/01/2018	Worksheet M-1
	Component CCN: 15-8530		Date/Time Prepared:

			Component	CCN: 15-8530	10	09/30/2019	2/25/2020 1:5	
						RHC I	Cost	oo piii
		Adjustments	Net Expenses			KIIO I	0031	
		Adj d3tilici1t3	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00	1				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00					
1.00	Physi ci an	O	428, 829					1.00
2. 00	Physician Assistant	ol	.20, 62,	1				2.00
3.00	Nurse Practitioner	ol	154, 484	1				3.00
4. 00	Visiting Nurse	ol	0.017					4.00
5. 00	Other Nurse	ol	176, 363					5.00
6. 00	Clinical Psychologist	ol O	170,000					6.00
7. 00	Clinical Social Worker	ol O	2, 836					7. 00
8. 00	Laboratory Techni ci an	ol O	2,000	1				8.00
9. 00	Other Facility Health Care Staff Costs	Ö	0	1				9.00
10.00	Subtotal (sum of lines 1 through 9)	Ö	762, 512	1				10.00
11. 00	Physician Services Under Agreement	Ö	0 0 0 0 12	1				11.00
12. 00	Physician Supervision Under Agreement	Ö	0	1				12.00
	Other Costs Under Agreement	Ö	0	ł				13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	1				14.00
15. 00	Medical Supplies	0	6, 385	1				15.00
16. 00	Transportation (Health Care Staff)	0	0, 303	1				16.00
	Depreciation-Medical Equipment	0	0	•				17.00
18. 00		0	0					18.00
	Other Health Care Costs	0	0					19.00
20.00	Allowable GME Costs	ď	O					20.00
21. 00	Subtotal (sum of lines 15 through 20)	٥	6, 385					21.00
22. 00	Total Cost of Health Care Services (sum of	0	768, 897					22. 00
22.00	lines 10, 14, and 21)	ď	700, 077					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23 00	Pharmacy	O	0					23.00
24. 00	Dental	ol	0					24.00
25. 00	Optometry	ol O	0					25.00
25. 01	Tel eheal th	ol	0					25. 01
25. 02	4	ol	0					25. 02
26. 00	All other nonreimbursable costs	ol	0					26.00
27. 00	Nonallowable GME costs	Ĭ	ŭ					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	٥	0					28.00
20.00	through 27)	Ĭ	Ü					20.00
	FACILITY OVERHEAD			I				1
29. 00	Facility Costs	ol	35, 246					29. 00
30.00	Administrative Costs	ol	140, 933					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	- 1	176, 179	1				31.00
220	30)	Ĭ	,					
32.00	Total facility costs (sum of lines 22, 28	ol	945, 076					32.00
	and 31)	[,					
		'		•				•

Heal th	Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od: From 10/01/2018	Worksheet M-2	
			Component	CCN: 15-8530	To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
	Luci =	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1					
1. 00	Physi ci an	0. 89					1.00
2.00	Physician Assistant	0.00		_,			2.00
3.00	Nurse Practitioner	1. 18			· ·	0.055	3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 07			6, 216	8, 355	
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	2. 07	8, 355			8, 355	8.00
0.00	through 7)	2.07	0, 333			0, 333	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
7. 00	Transport and Section Section 1997 Semicros						71.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BAS	ED RHC/FQHC SEI	RVI CES			
10.00	0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)				768, 897	10.00	
11.00	.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00	
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			768, 897	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, li	ine 31)		176, 179	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			1, 165, 453	15. 00
16.00	Total overhead (sum of lines 14 and 15)					1, 341, 632	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					1, 341, 632	
	Overhead applicable to hospital-based RHC/FC					1, 341, 632	
20.00	Total allowable cost of hospital-based RHC/F	'QHC services (sum of lines 10	0 and 19)		2, 110, 529	20.00

Heal tr	Financial Systems CAMERON MEMORIAL COMM	UNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1315	Peri od: From 10/01/2018	Worksheet M-3	
SERVI (EES	Component CCN: 15-8530	To 09/30/2019	Date/Time Pre 2/25/2020 1:5	
		Title XVIII	RHC I	Cost	, p
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		2, 110, 529	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		17, 262	
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			2, 093, 267 8, 355	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0, 555	
6. 00	OO Total adjusted visits (line 4 plus line 5)			8, 355	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	250.54	7.00
			Carcuration	OI LIMIT (I)	
			Pri or to Jan.	On or After	
			1 (Rate Period 1)	Jan. 1 (Rate Period 2)	
			1.00	2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	0. 00	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		250. 54	250. 54	9.00
10. 00	Program covered visits excluding mental health services (from	contractor records)	0	1, 283	10.00
11.00	Program cost excluding costs for mental health services (line	9 x line 10)	0	321, 443	11.00
12.00	Program covered visits for mental health services (from contr	•	0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions	•	0	0	13.00
15. 00	Graduate Medical Education Pass Through Cost (see instruction	•		O	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	321, 443	
16. 01	Total program charges (see instructions) (from contractor's re	•		166, 557	1
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		8, 362 16, 138	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0			225, 535	
4/ 05	(Titles V and XIX see instructions.)			044 (70	44.05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	241, 673 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		23, 386	
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		26, 961	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			241, 673	
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		11, 816	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			253, 489 0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00				0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	
26. 00	Net reimbursable amount (see instructions)			253, 489	26. 00
26. 01	, ,			5, 070	1
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 176, 770	
28. 00	1 . 3			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			71, 649	29. 00
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II	,	0	30.00

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/	FOHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1315	Peri od:	Worksheet M-4
VACCINE COST		Component CCN: 15-8530	From 10/01/2018 To 09/30/2019	
				2/25/2020 1:53 pm
		Title XVIII	RHC I	Cost

				2/25/2020 1:5	o piii
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		762, 512	762, 512	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0.000000	0. 004123	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	0	3, 144	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	0	3, 145	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	0	6, 289	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshi	eet M-1, col. 7, line 22)	768, 897	768, 897	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 341, 632	1, 341, 632	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0.000000	0. 008179	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	0	10, 973	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	0	17, 262	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		0		11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	0. 00	92. 31	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	0	128	13.00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	0	11, 816	14.00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (the			17, 262	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				
16. 00	Total Program cost of pneumococcal and influenza vaccine and			11, 816	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)			l	

Health Financial Systems	CAMERON MEMORIAL COM	MUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1315 Component CCN: 15-8530	From 10/01/2018	

		component con. 13-0330	10 077 307 2017	2/25/2020 1:53	
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			176, 770	1. (
2. 00	Interim payments payable on individual bills, either submitt			0	2. (
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3. (
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		_		
3. 01				0	3.
3. 02				0	3.
3. 03				0	3.
3. 04				0	3.
3. 05				0	3.
	Provider to Program		<u>'</u>		
. 50	-			0	3.
. 51				l ol	3.
. 52				ol	3.
. 53				o	3.
8. 54				l ol	3.
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	98)		o	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transf			176, 770	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR		•		
5. 00	List separately each tentative settlement payment after desk	k review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program				
5. 50				0	5.
. 51				0	5.
. 52				0	5.
	99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
	[3ubtotal (Suii 01 111les 5.01-5.49 III llus Suii 01 111les 5.50-5.5	0.00 Determined net settlement amount (balance due) based on the cost report. (1)			6.
. 99	,	cost report. (1)			Ο.
. 99 . 00	,	cost report. (1)		71, 649	
. 99 . 00 . 01	Determined net settlement amount (balance due) based on the	cost report. (1)		71, 649 0	6.
5. 99 5. 00 5. 01 5. 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM	cost report. (1)		0	6. 6.
5. 99 5. 00 5. 01 5. 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER	cost report. (1)	Contractor		6. 6.
5. 99 6. 00 6. 01 6. 02	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM	cost report. (1)		0 248,419 NPR Date	6. 6.
5. 99 6. 00 6. 01 6. 02 7. 00	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM	cost report. (1)	Contractor Number 1.00	0 248, 419	6. 6. 7.