### CAMERON MEMORIAL COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1315 Worksheet S Peri od. From 10/01/2017 Parts I-III AND SETTLEMENT SUMMARY 09/30/2018 Date/Time Prepared: То 2/21/2019 3:49 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 2/21/2019 Time: 3:49 pm use only ]Manually submitted cost report 2 [ ]If this is an amended report enter the number of times the provider resubmitted this cost report ]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4 

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF 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 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si	an	ied)
(5)	gr	icuj

Officer or Administrator of Provider(s)

Title

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	68, 595	-647, 133	0	-87, 239	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	-23, 057	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		7,484		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200. 00 Total	0	45, 538	-639, 649	0	-87, 239	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX			der CCN: 1	5-1315	Period: From 10/01/ To 09/30/	2017	of For Workshe Part I Date/Ti 2/21/20	et S-2 me Pre	2 epared
	1.00	2.00		3.00		4	1.00			
	Hospital and Hospital Health Care Co		-							
. 00	Street: 416 E MAUMEE STREET	PO Box:	7: - 0	- 17002	0					1.0
. 00	City: ANGOLA	State: IN		e: 47803-		ty: STEUBEN	Dayma	nt Curat		2.0
		Component Name	CCN Number	CBSA Number	Provi der Type	Date Certified		nt Syst 0, or		
			Number	Number	Type	Certifieu	V	XVIII		-
		1.00	2.00	3.00	4.00	5.00	6.00	_	8.00	-
	Hospital and Hospital-Based Componer		2.00	3.00	4.00	5.00	0.00	1.00	0.00	
. 00	Hospi tal	CAMERON MEMORIAL	151315	99915	1	02/01/2003	N	0	Р	3. (
. 00		COMMUNITY HOSPITAL	131313	////15		02/01/2003			'	5. 1
.00	Subprovider - IPF									4.
00	Subprovider - IRF									5.
. 00	Subprovider - (Other)									6.
00	Swing Beds - SNF	CAMERON MEMORIAL	15Z315	99915		02/01/2003	N	0	N	7.
00	owning bedd own	COMMUNITY	102010	////0		02/01/2000				/.
. 00	Swing Beds - NF			1						8.
. 00	Hospital-Based SNF									9.
0. 00	Hospital-Based NF									10.
1.00	Hospi tal -Based OLTC									11.
2.00	Hospi tal -Based HHA	CAMERON HOME HEALTH	157117	99915		04/01/1984	N	P	Í N	12.
		CARE								
3.00	Separately Certified ASC			1						13.
4.00	Hospi tal -Based Hospi ce	CAMERON HOSPICE	151561	99915	1	05/01/1997				14.
5.00	Hospital-Based Health Clinic - RHC	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	N	0	0	15.
6. 00	Hospital-Based Health Clinic - FQHC									16.
7.00	Hospital-Based (CMHC) I				1					17.
3. 00	Renal Dialysis				1					18.
9.00	Other				1					19.
						From:		To	:	
						1.00		2.0	00	
										-
	Cost Reporting Period (mm/dd/yyyy)					10/01/20		09/30/		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)									20. 21.
						10/01/20		09/30/	/2018	
	Type of Control (see instructions)				1.00	10/01/20			/2018	
. 00	Type of Control (see instructions)					10/01/20 2 2.00		09/30/	/2018	21.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it				1.00 N	10/01/20		09/30/	/2018	
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju	stment, in accordance wi	th 42 CFF			10/01/20 2 2.00		09/30/	/2018	21.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" for	stment, in accordance wi r yes or "N" for no. Is	th 42 CFF this			10/01/20 2 2.00		09/30/	/2018	21.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame	th 42 CFF this			10/01/20 2 2.00		09/30/	/2018	21.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" for facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" for	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no.	th 42 CFF this ndment	2	N	10/01/20 2.00 N		09/30/	/2018	21.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim ur	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment	th 42 CFF this ndment s for thi	s		10/01/20 2 2.00		09/30/	/2018	21.
2. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N"	th 42 CFF this ndment s for thi for no 1	s	N	10/01/20 2.00 N		09/30/	/2018	21.
2. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to	th 42 CFF this ndment s for thi for no 1 October 2	s for 1.	N	10/01/20 2.00 N		09/30/	/2018	21.
2. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion	th 42 CFF this ndment s for thi for no 1 October ~ of the c	s for 1.	N	10/01/20 2.00 N		09/30/	/2018	21.
2. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr	th 42 CFF this ndment s for thi for no 1 October of the c uctions)	s for 1. cost	N	10/01/20 2.00 N N		09/30/	/2018	21. 22. 22.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen	th 42 CFF this ndment s for thi for no 1 October of the c uctions) sated car	s for 1. cost	N	10/01/20 2.00 N		09/30/	/2018	21. 22. 22.
. 00 2. 00 2. 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "M reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost report	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in	th 42 CFF this ndment s for thi for no 1 October of the o uctions) sated car structior	s for 1. cost	N	10/01/20 2.00 N N		09/30/	/2018	21. 22. 22.
2. 00 2. 00 2. 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio	th 42 CFF this ndment s for thi for no 1 October of the c uctions) sated car struction n of the	s for 1. cost re ns)	N	10/01/20 2.00 N N		09/30/	/2018	21. 22. 22.
<u>1.00</u> 2.00 2.01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "M reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "M cost reporting period prior to Octob	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2,	th 42 CFF this ndment s for thi for no 1 October of the o uctions) sated can struction n of the "Y" for	s for 1. cost re ns) yes	N	10/01/20 2.00 N N		09/30/	/2018	21. 22. 22.
2. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2,	th 42 CFF this ndment s for thi for no 1 October of the o uctions) sated can struction n of the "Y" for	s for 1. cost re ns) yes	N	10/01/20 2.00 N N		09/30/	/2018	21. 22. 22.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octobe or "N" for no, for the portion of th October 1.	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period	th 42 CFF this ndment s for thi for no 1 October of the c uctions) sated car struction n of the "Y" for on or aft	s for 1. cost re ns) yes ter	N	10/01/20 2.00 N N		09/30/	/2018	21. 22. 22. 22.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the porti o er 1. Enter in column 2, e cost reporting period ic reclassification from	th 42 CFF this ndment s for thi for no 1 October 2 of the c uctions) sated car struction n of the "Y" for on or aft urban to	s for 1. cost re ns) yes ter	N	10/01/20 2.00 N N N		09/30,	/2018	21. 22. 22. 22.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to October or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati	th 42 CFF this ndment s for thi for no 1 October 7 of the c uctions) sated can struction n of the "Y" for on or aff urban to stical an	s for 1. cost re 1s) yes ter	N	10/01/20 2.00 N N N		09/30,	/2018	21. 22. 22. 22.
. 00 . 00 . 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or	th 42 CFF this ndment s for thi for no 1 October 7 of the c uctions) sated can struction n of the "Y" for on or aff urban to stical an "N" for r	s for 1. cost re ns) yes ter po reas no	N	10/01/20 2.00 N N N		09/30,	/2018	21. 22. 22. 22.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to October or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe	th 42 CFF this ndment s for thi for no 1 October 7 of the 0 uctions) sated can "Y" for on of the "Y" for urban to stical an "N" for r 1. Ente	s for 1. cost re ns) yes ter po reas no	N	10/01/20 2.00 N N N		09/30,	/2018	21.
. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph- rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th	th 42 CFF this ndment s for thi for no 1 October of the c uctions) sated car struction n of the "Y" for on or aff urban to stical ar "N" for r r 1. Ente e cost	s for 1. cost re ns) yes ter po reas no	N	10/01/20 2.00 N N N		09/30,	/2018	21. 22. 22. 22.
. 00 . 00 . 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportin in column 2, "Y" for yes or "N" for	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the porti o er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr	th 42 CFF this ndment s for thi for no 1 October 2 of the c uctions) sated car struction n of the "Y" for on or aff urban to stical ar "N" for r r 1. Ente e cost uctions)	s for 1. cost re ns) yes ter preas no er	N	10/01/20 2.00 N N N		09/30,	/2018	21. 22. 22. 22.
. 00 . 00 . 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	th 42 CFF this ndment s for no 1 October 7 of the 0 uctions) sated car struction n of the "Y" for on or aff urban to stical ar "N" for r r 1. Ente e cost uctions) 9 beds (a	s for 1. cost re ns) yes ter o reas no er	N	10/01/20 2.00 N N N		09/30,	/2018	21. 22. 22. 22.
2. 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period? Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	th 42 CFF this ndment s for no 1 October 7 of the 0 uctions) sated car struction n of the "Y" for on or aff urban to stical ar "N" for r r 1. Ente e cost uctions) 9 beds (a	s for 1. cost re ns) yes ter o reas no er	N	10/01/20 2.00 N N N		09/30,	/2018	21. 22. 22. 22.
2. 00 2. 01 2. 02 2. 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to October or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	th 42 CFF this ndment s for thi for no 1 October 7 of the o uctions) sated can "Y" for on or aff urban to stical an "N" for r r 1. Ente e cost uctions) 9 beds (a 3, "Y" for	s for 1. cost re ns) yes ter p reas no er	N	10/01/20 2.00 N N N		09/30,	/2018	21. 22. 22. 22.
. 00 2. 00 2. 01 2. 02 2. 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "M reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "M cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24	th 42 CFF this ndment s for thi for no 1 October 7 of the 0 uctions) sated can "Y" for on or aff urban to stical an "N" for r r 1. Ente e cost uctions) 9 beds (a 3, "Y" for and/or 25	s for 1. cost re ns) yes ter reas no er	N	10/01/20 2.00 N N N N		09/30,	/2018	21. 22. 22. 22. 22.
. 00 2. 00 2. 01 2. 02 2. 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of the October 1. Did this hospital receive a geograph- rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the porti o er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu	th 42 CFF this ndment s for no 1 October 2 of the c uctions) sated car struction n of the "Y" for on or aff urban to stical ar "N" for r 1. Ente e cost uctions) 9 beds (a 3, "Y" for and/or 25 s days, c	s for 1. cost re ns) yes ter preas no er as pr as pr 3	N	10/01/20 2.00 N N N N		09/30,	/2018	21. 22. 22. 22. 22.
. 00 . 00 . 01 . 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	stment, in accordance wi r yes or "N" for no. Is 412.106(c)(2)(Pickle ame r yes or "N" for no. compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portion er October 1. (see instr requires final uncompen port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	th 42 CFF this ndment s for no 1 October 7 of the 0 uctions) sated car struction n of the "Y" for on or aff urban to stical ar "N" for r r 1. Ente e cost uctions) 9 beds (a 3, "Y" for and/or 25 s days, o in this o	s for 1. cost re ns) yes ter preas no er as pr as pr 3	N	10/01/20 2.00 N N N N		09/30,	/2018	21 22 22 22 22 22

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		L	1/2017 0/2018	Part I Date/Ti 2/21/20	eet S-2 ime Pre 019 3:4	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	's Med	ither di cai d days	
4.00	If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	<u>6.00</u> 0	24.0
	in this provider is an TPPs hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0		0		0	U	24. 0
					Urban/Ru 1.0		Date of 2.		-
5. 00	Enter your standard geographic classification (not wa	age) status	at the beg	inning of t		2	۷.	0	26.0
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	r rural. age) status r "2" for ru	at the end ural. If ap	l of the cos		2			27.0
5.00	If this is a sole community hospital (SCH), enter the			CH status in		0			35.0
	effect in the cost reporting period.				Begi nn	i ng:	Endi	ng:	
	Entry and include heringing and and includes of COU at	tatua Cuba		24 6	1.0	0	2.	00	36.0
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.				0			37.0
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for								37.0
3. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.0
					Y/I 1.0		Y/ 2.		-
					I I. U	0			
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (íi), or the mileage	(iii)? Ent requiremen	er in colum its in	ne N		N		39. (
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t	), (İi), or the mileage ii)? Enter i n adjustmen per 1. Enter	(iii)? Ent requiremen n column 2 t? Enter "Y r "Y" for y	er in colum hts in ""Y" for ye " for yes o	ne N s r N				39. ( 40. (
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet f accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	), (İi), or the mileage ii)? Enter i n adjustmen per 1. Enter	(iii)? Ent requiremen n column 2 t? Enter "Y r "Y" for y	er in colum hts in ""Y" for ye " for yes o	ne N s r N	V	N XVIII	xi x	
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet f accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	), (İi), or the mileage ii)? Enter i n adjustmen per 1. Enter	(iii)? Ent requiremen n column 2 t? Enter "Y r "Y" for y	er in colum hts in ""Y" for ye " for yes o	ne N s r N		N	1	
. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	), (İi), or the mileage ii)? Enter i n adjustmen ber 1. Enter . (see instr	(iii)? Ent requiremen n column 2 t? Enter "Y c"Y" for y ructions)	rer in colum hts in ? "Y" for ye " for yes o res or "N" for	ne N S S or N	V	N XVIII	xi x	40.
. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet f accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	), (İi), or the mileage i))? Enter i ber 1. Enter . (see instr nt for disp	(iii)? Ent requiremen n column 2 t? Enter "Y "Y" for y ructions) roportionat	er in colum its in "Y" for yes res or "N" for e share in a nry circumst	me N s r N or accordance ances	V 1.00	N XVI I I 2. 00	XI X 3.00	
. 00 . 00 . 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet the accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excerp pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	), (ii), or the mileage ii)? Enter i ber 1. Enter cer 1. Enter (see instr (see instr nt for disp eption for d	(iii)? Ent requiremen n column 2 t? Enter "Y c "Y" for y ructions) roportionat extraordina i and Wkst	er in colum tts in "Y" for yes o res or "N" for e share in try circumst. . L-1, Pt.	me N n s or N accordance ances I through	V 1.00 N	N XVIII 2.00	XI X 3. 00	40.
. 00 . 00 . 00 . 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet f accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	), (ii), or the mileage ii)? Enter i n adjustmen ber 1. Enter . (see instr . (see instr . to for disp eption for disp t. L, Pt. I capital? En	(iii)? Ent requiremen n column 2 t? Enter "Y c "Y" for y ructions) roportionat extraordina il and Wkst	er in colum tts in "Y" for yes o res or "N" for e share in for try circumsta L-1, Pt.	me N n s r N or N accordance ances I through for no.	V 1.00 N N	N XVI I I 2. 00 N N	N XIX 3.00 N N	40. 45. 46.
. 00 . 00 . 00 . 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet is accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in	), (İi), or the mileage ii)? Enter i ber 1. Enter cor 1. Enter . (see instr cor dispr the for dispr	(iii)? Ent requiremen n column 2 t? Enter "Y ructions) roportionat extraordina i and Wkst nter "Y for Y" for yes	er in colum its in "Y" for yes o res or "N" fo e share in ury circumst . L-1, Pt. yes or "N" or "N" for	me N n s r N or N accordance ances I through for no. no.	V 1.00 N N N	N XVIII 2.00 N N N	V XIX 3.00 N N N	40. 45. 46. 47.
0. 00 6. 00 6. 00 7. 00 8. 00 8. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet is accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting pf GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N	), (İi), or the mileage ii)? Enter i be adjustmen ber 1. Enter . (see instr . Enter " approved GI beriod durin r yes or "N" th of this o Y", completo	(iii)? Ent requiremen n column 2 t? Enter "Y "Y" for y ructions) roportionat extraordina il and Wkst nter "Y for Y" for yes ME programs ng which re ' for no in cost report e Worksheet	er in colum its in "Y" for yes tes or "N" for e share in try circumst. L-1, Pt. yes or "N" or "N" for ? Enter "Y ssidents in column 1. ing period?	me N n N s N or N accordance ances I through for no. no. " for yes approved I f col umn 1 Enter "Y"	V 1.00 N N N N	N XVIII 2.00 N N N	V XIX 3.00 N N N	40. 45. 46. 47. 48.
5. 00 5. 00 5. 00 7. 00 7. 00 7. 00 8. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet is accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	), (ii), or the mileage ii)? Enter i n adjustmen ber 1. Enter (see instr (see instr to for disp eption for of t. L, Pt. II capital? En t? Enter " approved G period durin r yes or "N" th of this of (", completed ), if applic	(iii)? Ent requiremen n column 2 t? Enter "Y "Y" for y ructions) roportionat extraordina il and Wkst nter "Y for Y" for yes ME programs ng which re ' for no in cost report e Worksheet cable. or physicia	er in colum ts in "Y" for yes te share in te share in try circumst. L-1, Pt. yes or "N" or "N" for column 1. ing period? E-4. If co	me N n N s r N or N accordance ances I through for no. no. " for yes approved I f col umn 1 Enter "Y" I umn 2 i s	V 1.00 N N N N	N XVIII 2.00 N N N	V XIX 3.00 N N N	40. 45. 46. 47. 48. 56.

		MUNITY HOSPIT			u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TΑ	Provider CC		eriod: com 10/01/2017 o 09/30/2018		pared:
					2/21/2019 3:4	9 pm
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education	(NAHE)	costs for	N	2.00	0.00	60.00
any programs that meet the criteria under §413.85? (						
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00		61.00
<ul> <li>column 1. (see instructions)</li> <li>61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports</li> </ul>						61.01
ending and submitted before March 23, 2010. (see instructions)						
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						61.02
<ul> <li>ACA). (see instructions)</li> <li>61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determine compliance with the TEM toot. (see the second s</li></ul>						61.03
determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
<ul> <li>current cost reporting period. (see instructions).</li> <li>61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's</li> </ul>						61.05
<ul> <li>primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)</li> <li>61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary</li> </ul>						61.06
care or general surgery. (see instructions)	Pro	gram Name	Program Code	Unweighted IME	Unweighted	
				FTE Count	Direct GME FTE	
		1.00	2.00	3.00	Count 4.00	
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				0. OC		61. 10
<ul> <li>FTE unweighted count.</li> <li>61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,</li> </ul>				O. OC	0. 00	61. 20
the direct GME FTE unweighted count. Enter in column 4,						
		dmi ni etre 11			1.00	
<ul> <li>ACA Provisions Affecting the Health Resources and Ser</li> <li>62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct)</li> </ul>	trai ned			od for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	a Teachi gram. (s	<u>ee instructior</u>	. ,	your hospital	0.00	62. 01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this co	67. (see instru	ctions)	N	63.00
			Unweighted FTEs Nonprovider Site	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 year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is yes, or your facilit 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	ty train n-primar all non d non-pr n column	ed residents y care provider imary care 3 the ratio	0.00	0. OC	0. 000000	64.00
of (column 1 divided by (column 1 + column 2)). (see						

	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPL		A COMMUNITY HOSPIT	CN: 15-1315 Pe	eriod: com 10/01/2017	worksheet S-2 Part I	
				Tc		Date/Time Pre	pared:
		Program Name	Program Code	Unweighted	Unweighted	2/21/2019 3:4 Ratio (col. 3/	
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	-	1.00	2.00	3.00	4.00	5.00	-
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0.00	0.00	0. 000000	65.00
	divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te	2.00	2.00	-
	Section 5504 of the ACA Current	/ear FTF Residents in	Nonprovider Setting	1.00	2.00 er cost reporti	3.00	
	beginning on or after July 1, 20°	10			i obot i opoi ti	ng porrous	
66.00	Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonpro unweighted non-primary al. Enter in column 3	ovider settings. / care resident the ratio of	0.00 Unweighted FTEs Nonprovider Site		0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program 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			0.00	0.00	0. 000000	
	5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
	5, the ratio of (column 3 divided by (column 3 + column				1.00	0 2 00 3 00	
	5, the ratio of (column 3 divided by (column 3 + column	ps			1.00	0 2.00 3.00	-
70. 00	5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	/chiatric Facility (II	PF), or does it conta	ain an IPF subp		0 2.00 3.00	70.00
	5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Pf Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indice (see instructions)	ychiatric Facility (II the facility have an efore November 15, 200 umn 2: Did this facil & 412.424 (d)(1)(iii) cate which program yea	approved GME teachin 04? Enter "Y" for ye ity train residents (D)? Enter "Y" for ye	ng program in t es or "N" for n in a new teach es or "N" for n	rovider? N he most o. (see ing o.	0 2.00 3.00	
70. 00 71. 00 75. 00	5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Pf Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did recent cost report filed on or bé 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic	ychiatric Facility (II the facility have an efore November 15, 200 umn 2: Did this facil & 412.424 (d)(1)(iii) cate which program yea y PPS	approved GME teachin M? Enter "Y" for ye ity train residents (D)? Enter "Y" for ye ar began during this	ng program in t es or "N" for n in a new teach es or "N" for n cost reporting	rovider? N he most o. (see ing o.		70.0071.00

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 10/01/2017 To 09/30/2018 Part I Date/Time Prepared: 2/21/2019 3:49 pm 1.00 Long Term Care Hospital PPS 80.00 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. Ν 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. ٧ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90 00 ves or "N" for no in the applicable column.  $|I\,s\,$  this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 Ν Ν 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 Υ Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Υ C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation γ 98.02 v bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν 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 reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Y 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R Ν 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 Ν 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Respi ratory Physi cal Occupati onal Speech 1 00 2 00 4.00 3 00 109.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Υ therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00

 110.00
 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A
 N

 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.
 N

ealth Financial Systems CAMERON MEMORIAL COMMUNITY HOSPIT OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO		Period: From 10/01/ To 09/30/	2017	vof For Workshe Part I Date/Ti 2/21/20	et S-2 me Pre	2 epared:
		1.00		2. (	00	1
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	. N				111.00
			1.00	2.00	3.00	1
<ul> <li>Miscellaneous Cost Reporting Information</li> <li>15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no ir is yes, enter the method used (A, B, or E only) in column 2. If column 2 is either "93" percent for short term hospital or "98" percent for long ter psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.</li> <li>16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N"</li> </ul>	s "E", enter rm care (incl ne definition ' for no.	in column udes in CMS	N		0	115.00
17.00  s this facility legally-required to carry malpractice insurance? Enter "\ no.	2		Y			117.00
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 i claim-made. Enter 2 if the policy is occurrence.	f the policy	is	1			118.00
	Premi ums	Losse	5	Insur	ance	
	1.00	2.00		3. (	00	-
18.01 List amounts of malpractice premiums and paid losses:	204, 7		0			0118.01
		1.00		2.(	00	1
<ul> <li>18.02 Are mal practice premiums and paid losses reported in a cost center other 1 Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein.</li> <li>19.00 DO NOT USE THIS LINE</li> <li>20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provided and the second statement of the second s</li></ul>	ost centers vision in ACA	N N		N		118. 02 119. 00 120. 00
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for th Hold Harmless provision in ACA §3121 and applicable amendments? (see instr Enter in column 2, "Y" for yes or "N" for no.	ne Outpatient ructions)					101.0
21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	s charged to	Y				121.00
22.00 Does the cost report contain healthcare related taxes as defined in §19030 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information	(w)(3) of the r in column 2	N				122.00
25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certifin in column 1 and termination date, if applicable, in column 2.	fication date					126.00
27.00 If this is a Medicare certified heart transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2.						127.00
28.00 If this is a Medicare certified liver transplant center, enter the certifi in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certification of the certification o		n				128.00
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the cert						130. 00
date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the ce	ertification					131.00
date in column 1 and termination date, if applicable, in column 2. 32.00 f this is a Medicare certified islet transplant center, enter the certification date is column 2.	cation date					132.00
<ul> <li>in column 1 and termination date, if applicable, in column 2.</li> <li>33.00 If this is a Medicare certified other transplant center, enter the certifiin column 1 and termination date, if applicable, in column 2.</li> </ul>	cation date					133.00
34.00 If this is an organ procurement organization (OPO), enter the OPO number i and termination date, if applicable, in column 2.	n column 1					134.00
All Providers 40.00Are there any related organization or home office costs as defined in CMS		Y				140. 00

	CAMERON MEMORIAL X IDENTIFICATION DATA	Provi der CCN				u of Form CMS- Worksheet S- Part I Date/Time Pro 2/21/2019 3:-	2 epared:
1.00		00			3.00		
If this facility is part of a cha				name an	nd address	of the	
home office and enter the home of 41.00Name:	Contractor name and Contractor's Name:	contractor numbe	<u>Contrac</u>	tor's N	umbor:		
12.00 Street:	PO Box:		Contrac		ullber.		141.0
43. 00 Ci ty:	State:		Zip Code	a:			143.0
			1-1				1.121.2
						1.00	
44.00 Are provider based physicians' co	sts included in Worksheet	: A?				Y	144. C
					1 00	2.00	-
15.00 If costs for renal services are c	aimed on Wkst A line 7	A are the costs	for		1.00	2.00	145.0
inpatient services only? Enter "Y							145.0
no, does the dialysis facility in							
period? Enter "Y" for yes or "N"	for no in column 2.						
I6.00 Has the cost allocation methodolog	gy changed from the previ				N		146. (
Enter "Y" for yes or "N" for no i		15-2, chapter 40	D, §4020) I	f			
yes, enter the approval date (mm/	aa/yyyy) in column 2.						
						1.00	-
7.00 Was there a change in the statist	cal basis? Enter "Y" for	ves or "N" for i	10.			N 1.00	147.0
18.00 Was there a change in the order o						N	148. (
9.00 Was there a change to the simplif				r no.		N	149.
	<u> </u>	Part A	Part B		Title V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a prov							
or charges? Enter "Y" for yes or	"N" for no for each compo			<u>(See 4</u>			-
5.00 Hospi tal 6.00 Subprovi der – IPF		N	N N		N N	N N	155. 156.
7. 00 Subprovider – IRF		N	N		N	N N	150.
8. 00 SUBPROVI DER		IN I	IN IN		N		158.
59. 00 SNF		N	Ν		Ν	N	159.0
50.00 HOME HEALTH AGENCY		N	Ν		Ν	N	160. (
51. 00 CMHC			N		Ν	N	161. (
						1.00	_
Multicampus	move been to that bee		aaa in diff	arant C	064-2	N	1/5 /
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that has c	one or more campus	ses in dirr	erent C	BSAS?	N	165. (
	Name	County	State Z	ip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	1
6.00 fline 165 is yes, for each						0.0	0166. (
campus enter the name in column							
0, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in					1		
					1		
column 5 (see instructions)							
column 5 (see instructions)							
column 5 (see instructions)						1.00	
Health Information Technology (HI				nt Act			
Health Information Technology (HI 57.00 s this provider a meaningful use	under §1886(n)? Enter	"Y" for yes or "I	N" for no.			Y	
Health Information Technology (HI 57.00 Is this provider a meaningful use 88.00 If this provider is a CAH (line 10	r under §1886(n)? Enter D5 is "Y") and is a meani	"Y" for yes or "I ngful user (line	N" for no.		r the	Y	
Health Information Technology (HI 7.00 s this provider a meaningful use 8.00 f this provider is a CAH (line 1 reasonable cost incurred for the l	r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi	"Y" for yes or "I ngful user (line ons)	N" for no. 167 is "Y"	), ente		Y	0168.
Health Information Technology (HI 7.00Is this provider a meaningful use 8.00If this provider is a CAH (line 10 reasonable cost incurred for the 8.01If this provider is a CAH and is 10	r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi not a meaningful user, do	"Y" for yes or "I ngful user (line ons) bes this provider	V" for no. 167 is "Y" qualify fo	), ente r a har		Y	0168.
Heal th Information Technology (HI 77.00 s this provider a meaningful use 88.00 If this provider is a CAH (line 1 reasonable cost incurred for the 88.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi not a meaningful user, do ? Enter "Y" for yes or "N	"Y" for yes or "I ngful user (line ons) wes this provider I" for no. (see in	N" for no. 167 is "Y" qualify fo nstructions	), ente r a har )	dshi p	Y	0168. 168.
Heal th Information Technology (HI 77.00 s this provider a meaningful use 88.00 If this provider is a CAH (line 1 reasonable cost incurred for the 88.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	under §1886(n)? Enter 25 is "Y") and is a meani HT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "N user (line 167 is "Y") ar	"Y" for yes or "I ngful user (line ons) wes this provider I" for no. (see in	N" for no. 167 is "Y" qualify fo nstructions	), ente r a har )	dshi p	Y	0168. (
Heal th Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 1 reasonable cost incurred for the I 8.01 If this provider is a CAH and is exception under §413.70(a)(6)(i) 9.00 If this provider is a meaningful	under §1886(n)? Enter 25 is "Y") and is a meani HT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "N user (line 167 is "Y") ar	"Y" for yes or "I ngful user (line ons) wes this provider I" for no. (see in	N" for no. 167 is "Y" qualify fo nstructions	), ente r a har ) "N"),	dship enter the eginning	Y N O. O Endi ng	167. 0168. 168. 0169.
Heal th Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 8.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 9.00 If this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "N user (line 167 is "Y") ar ons)	"Y" for yes or "I ngful user (line ons) wes this provider " for no. (see in d is not a CAH (l	N" for no. 167 is "Y" qualify fo nstructions line 105 is	), ente r a har "N"), 	dship enter the eginning 1.00	Y N 0. 0 Endi ng 2. 00	0168.
Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "N user (line 167 is "Y") ar ons)	"Y" for yes or "I ngful user (line ons) wes this provider " for no. (see in d is not a CAH (l	N" for no. 167 is "Y" qualify fo nstructions line 105 is	), ente r a har "N"), 	dship enter the eginning	Y N O. O Endi ng	0168. (
Heal th Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the line 8.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 9.00 If this provider is a meaningful to transition factor. (see instruction)	r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "N user (line 167 is "Y") ar ons)	"Y" for yes or "I ngful user (line ons) wes this provider " for no. (see in d is not a CAH (l	N" for no. 167 is "Y" qualify fo nstructions line 105 is	), ente r a har "N"), 	dship enter the eginning 1.00	Y N 0. 0 Endi ng 2. 00	0168.
Heal th Information Technology (HI 77.00 Is this provider a meaningful use 88.00 If this provider is a CAH (line 10 reasonable cost incurred for the 88.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 99.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR 10	r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "N user (line 167 is "Y") ar ons)	"Y" for yes or "I ngful user (line ons) wes this provider " for no. (see in d is not a CAH (l	N" for no. 167 is "Y" qualify fo nstructions line 105 is	), ente r a har "N"), 	dship enter the eginning 1.00 /01/2017	Y N 0.0 Endi ng 2.00 09/30/2018	0168.
Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the I seception under \$413.70(a) (6) (ii) 59.00 If this provider is a meaningful i transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "N user (line 167 is "Y") ar ons) peginning date and ending	"Y" for yes or "I ngful user (line ons) bes this provider " for no. (see in d is not a CAH (l d date for the rep	N" for no. 167 is "Y" qualify fo nstructions ine 105 is	), ente r a har "N"), 	dship enter the eginning 1.00 //01/2017 1.00	Y N 0.0 Endi ng 2.00 09/30/2018 2.00	0168.0
Heal th Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the line 8.01 If this provider is a CAH and is in exception under §413.70(a) (6) (ii) 9.00 If this provider is a meaningful to transition factor. (see instruction 0.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy) 1.00 If line 167 is "Y", does this provider is a meaning the second	r under §1886(n)? Enter 25 is "Y") and is a meani HIT assets (see instructinot a meaningful user, dc 2 Enter "Y" for yes or "Nuser (line 167 is "Y") ar baser (line 167 is "Y") ar beginning date and ending vider have any days for i	"Y" for yes or "I ngful user (line ons) bes this provider " for no. (see in d is not a CAH (l date for the rep ndividuals enroll	N" for no. 167 is "Y" qualify fo nstructions ine 105 is porting	), ente r a har "N"), 	dship enter the eginning 1.00 /01/2017	Y N 0.0 Endi ng 2.00 09/30/2018 2.00	0168. 168. 0169. - 170.
Heal th Information Technology (HI 7.00 is this provider a meaningful use 8.00 if this provider is a CAH (line 1 reasonable cost incurred for the i 8.01 if this provider is a CAH and is exception under §413.70(a) (6) (ii) 9.00 if this provider is a meaningful transition factor. (see instruction 0.00 Enter in columns 1 and 2 the EHR i period respectively (mm/dd/yyyy)	r under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi not a meaningful user, dc ? Enter "Y" for yes or "N user (line 167 is "Y") ar ons) beginning date and ending vider have any days for i reported on Wkst. S-3, Pt	"Y" for yes or "I ngful user (line ons) bes this provider " for no. (see in d is not a CAH (l d date for the rep ndividuals enroll I, line 2, col.	N" for no. 167 is "Y" qualify fo nstructions ine 105 is porting led in . 6? Enter	), ente r a har ) "N"), <u>Be</u> 10	dship enter the eginning 1.00 //01/2017 1.00	Y N 0.0 Endi ng 2.00 09/30/2018 2.00	0168. 168. 0169.

	Financial Systems CAMERON MEMORIAL C		TAL CN: 15-1315	Period:	u of Form CMS Worksheet S-	
00111	AL AND NOSTITAL HEALTH GARE RELIMBORGEMENT QUESTIONNALIRE		. 10 1010	From 10/01/2017 To 09/30/2018	Part II	
				N/ /NI	2/21/2019 3:	<u>49 pm</u>
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	I for all NO re	esponses. Ente			
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
00	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions)			1.00
		· · ·	Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare F	Drogram2 If	1.00 N	2.00	3.00	2.00
00	yes, enter in column 2 the date of termination and in colum voluntary or "1" for involuntary.	5				2.00
00	Is the provider involved in business transactions, includir	ng management	Y			3.00
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)		N/ /NI	T	Data	_
			Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports		1100	2.00	0100	
00	Column 1: Were the financial statements prepared by a Cert	tified Public	Y	A	12/17/2018	4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" 1 or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
00	Are the cost report total expenses and total revenues diffe		N			5.00
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1.00	2.00	-
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.00
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.00
00	Were nursing school and/or allied health programs approved		d during the	N		8.00
00	cost reporting period? If yes, see instructions.			N		
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	0	cal education	N		9.00
. 00	Was an approved Intern and Resident GME program initiated of		the current	Ν		10.00
00	cost reporting period? If yes, see instructions.			N		11 00
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R IN an App	proved	N		11.00
					Y/N	
					1.00	
. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	tions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection p			ost reporting	N	13.00
	period? If yes, submit copy.					
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	ryes, see ins	structions.	N	14.00
5. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	ructions.	N	15.00
			rt A		tВ	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	12/04/2018	Y	12/04/2018	16.00
	instructions)					
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		Ν		17.00
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		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.					
7.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		19.00
		1	1			
	Report data for corrections of other PS&R Report information? If yes, see instructions.					

Health Financial Systems

CAMERON MEMORIAL COMMUNITY HOSPITAL	CAMERON	MEMORIAL	COMMUNI TY	HOSPI TAL
-------------------------------------	---------	----------	------------	-----------

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1315	Peri od:	Worksheet S	-2
				From 10/01/2017 To 09/30/2018	Date/Time P	repared:
		Deperi	ntion	V /N	2/21/2019 3	:49 pm
			iption D	Y/N 1.00	Y/N 3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		5	N N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)		1.00	
	Capital Related Cost		,			
	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 apprais	als made dur	ing the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	porting period?	Y	24.00
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repor	ting period?	lf yes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during 1 instructions.	the cost reporti	ng period? I	f yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th	ne cost reportin	ng period?lf	yes, submit	Ν	27.00
	copy. Interest Expense					_
28.00	Were new loans, mortgage agreements or letters of credit e	reporting	Y	28.00		
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	eserve Fund)	Y	29.00		
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	See	N	30.00		
	instructions.	-	-			
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	, see	N	31.00
	Purchased Services					
	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr	ructions.	0		Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	oplied pertainin	ig to competi	tive bidding? If	Y	33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a lf yes, see instructions.	arrangement with	provi der-ba	sed physi ci ans?	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ts with the	provi der-based	Y	35.00
	priver and during the cost reporting period. In yes, see i			Y/N	Date	
				1.00	2.00	
	Home Office Costs			•		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N		36.00 37.00
38 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38.00
	the provider? If yes, enter in column 2 the fiscal year er	nd of the home o	offi ce.			
	If line 36 is yes, did the provider render services to oth see instructions.		2	,		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	e home office?	lf 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 held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41.00
42.00	respectively. Enter the employer/company name of the cost report	BLUE & CO				42.00
+∠. UU	preparer.					42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00

Heal th	Financial Systems CAMERON MEMOR	IAL C	COMMUNITY HOSPITAL		In Lieu	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	E	Provider CCN: 15-1315		riod: om 10/01/2017	Worksheet S- Part II	2
				То		Date/Time Pr 2/21/2019 3:	
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	۱	SENI OR 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 co	ost					43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems CAMER TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RON MEMORIAL COM AL DATA	Provider CC		Period:	u of Form CMS-2 Worksheet S-3	∠05Z-1
				. 10 1010	From 10/01/2017 To 09/30/2018	Part I Date/Time Pre 2/21/2019 3:4	pared: 9 pm
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Avai I abl e 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8, 3		0	1. 0
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.0 3.0 4.0 5.0
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		23	8, 39	95 83, 592. 00	0	6.0 7.0
3.00 9.00 10.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	31.00	2	7:	30 3, 192. 00	0	8.0 9.0
<ol> <li>11.00</li> <li>12.00</li> <li>13.00</li> <li>14.00</li> <li>15.00</li> <li>16.00</li> <li>17.00</li> </ol>	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF	43. 00	25	9, 1:	25 86, 784. 00	0 0 0	11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0
8.00 9.00 1.00 2.00 3.00 4.00 4.10 5.00 6.00 6.25 7.00 8.00 9.00 0.00 1.00	SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambul ance Trips Employee discount days (see instruction) Employee discount days - IRF	101.00 116.00 30.00 88.00 89.00	0 25		0	0 0 0 0	18.0 19.0 20.0 21.0 22.0 23.0 24.0 24.0 25.0 26.0 26.0 26.0 27.0 28.0 29.0 30.0 31.0
2.00 2.01 3.00	Labor & delivery days - TKF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges		0		0		31. 32. 32. 33. 33.

		AL DATA	Provider CO		Period: From 10/01/2017 To 09/30/2018		pared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	1, 297	31	3, 48			1.
00	for the portion of LDP room available beds) HMO and other (see instructions)	442	309				2.
00	HMO IPF Subprovider	442	309 0				3.
00	HMO I RF Subprovi der	0	0				4
00	Hospital Adults & Peds. Swing Bed SNF	263	0		3		5
00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF	203	0				6
00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 560	31	3, 93			7
00	INTENSIVE CARE UNIT	51	23	13	3		8
00	CORONARY CARE UNIT						9
00	BURN INTENSIVE CARE UNIT						10
00	SURGICAL INTENSIVE CARE UNIT						11
00	OTHER SPECIAL CARE (SPECIFY)						12
00	NURSERY		0	46	9		13
00	Total (see instructions)	1, 611	54	4, 54	0 0.00	375.12	14
00	CAH visits	0	0		0		15
00	SUBPROVIDER - IPF						16
00	SUBPROVIDER - IRF						17
00	SUBPROVI DER						18
00	SKILLED NURSING FACILITY						19
00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY	753	654	5, 66	8 0.00	8.93	22
00	AMBULATORY SURGICAL CENTER (D. P.)						23
00	HOSPI CE	0	0		0 0.00	2.34	24
10	HOSPICE (non-distinct part)				0		24
00	CMHC - CMHC						25
00	RURAL HEALTH CLINIC	45	76				
25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
00	Total (sum of lines 14-26)				0.00	395.39	
00	Observation Bed Days		159	1, 18	6		28
00	Ambulance Trips	0					29
00	Employee discount days (see instruction)				0		30
00	Employee discount days - IRF				0		31
00	Labor & delivery days (see instructions)	0	5		5		32
. 01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						
. 00	LTCH non-covered days LTCH site neutral days and discharges	0					33

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	RON MEMORIAL COM AL DATA	Provider CC		Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part I Date/Time Pre 2/21/2019 3:4	pared:
	Full Time Equivalents		Di s	scharges		
Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
<ul> <li>Hospital Adults &amp; Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)</li> <li>HMO and other (see instructions)</li> <li>HMO IPF Subprovider</li> <li>HMO IRF Subprovider</li> <li>HMO HO IRF Subprovider</li> <li>HMO Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>Hospital Adults &amp; Peds. Swing Bed NF</li> <li>Total Adults and Peds. (exclude observation beds) (see instructions)</li> <li>O INTENSIVE CARE UNIT</li> <li>O CORONARY CARE UNIT</li> <li>O GURONARY CARE UNIT</li> <li>O SURGICAL INTENSIVE CARE UNIT</li> <li>O Total (see instructions)</li> <li>O NURSERY</li> <li>O Total (see instructions)</li> <li>O CAH visits</li> <li>O SUBPROVIDER - IPF</li> <li>O SUBPROVIDER - IPF</li> <li>O SUBPROVIDER - IRF</li> <li>O SUBPROVIDER - IRF</li> <li>O SUBPROVIDER</li> <li>INTENSING FACILITY</li> <li>O OTHER LONG TERM CARE</li> <li>O NURSING FACILITY</li> <li>O OTHER LONG TERM CARE</li> <li>O HOSPICE (non-distinct part)</li> <li>C MRL HEALTH AGENCY</li> <li>O RURAL HEALTH CLINIC</li> <li>FEDERALLY QUALIFIED HEALTH CENTER</li> <li>O SUBPROVI OR - INF</li> <li>O SUBPLE (non-distinct part)</li> <li>O CMHC - CMHC</li> <li>O RURAL HEALTH CLINIC</li> <li>FEDERALLY QUALIFIED HEALTH CENTER</li> <li>FO O Total (sum of lines 14-26)</li> <li>O Observation Bed Days</li> <li>O Ambulance Trips</li> <li>O Employee discount days (see instructions)</li> <li>Total ancillary labor &amp; delivery room outpatient days (see instructions)</li> </ul>	0.00 0.00 0.00 0.00 0.00 0.00	0	1	07 13 43 116 0 0 07 13		$\begin{array}{c} 1. \ 00\\ 3. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 13. \ 00\\ 20. \ 00\\ 22. \ 00\\ 24. \ 00\\ 24. \ 10\\ 25. \ 00\\ 24. \ 00\\ 24. \ 10\\ 25. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 26. \ 00\\ 26. \ 00\\ 26. \ 00\\ 26. \ 00\\ 26. \ 00\\ 27. \ 00\\ 30. \ 00\\ 31. \ 00\\ 32. \ 00\\ 32. \ 00\\ 32. \ 00\\ 32. \ 00\\ 32. \ 00\\ 33. \ 00$
33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges				0 0		33. 0 33. 0

		RON MEMORIAL COM				u of Form CMS-	
HOME I	IEALTH AGENCY STATI STI CAL DATA			CN: 15-1315 CCN: 15-7117	Period: From 10/01/2017 To 09/30/2018	Worksheet S-4 Date/Time Pre 2/21/2019 3:4	pared:
					Home Health	PPS	9 pili
					Agency I		
0.00						00	
0.00	County	Title V	Title XVIII	Title XIX	STEUBEN Other	Total	0.00
	L	1.00	2.00	3.00	4.00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA	0	C	b	0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	57.00	0.	00 0.00	0.00	
				Number of En	nployees (Full Tin	me Equivalent)	
		Enter the number	r of hours in	Staff	Contract	Total	
		your normal					
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0					
3.00 4.00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40.00	0. 0.			
5.00	Other Administrative Personnel			0.	00 0.00	0.00	5.00
6.00 7.00	Direct Nursing Service Nursing Supervisor			3. 0.			1
8.00	Physical Therapy Service			2.			1
9.00 10.00	Physical Therapy Supervisor Occupational Therapy Service			0. 0.		0. 00 0. 43	1
11.00	Occupational Therapy Supervisor			0.			1
12.00	Speech Pathol ogy Service			0.			1
13.00 14.00	Speech Pathology Supervisor Medical Social Service			0. 0.			
15.00	Medical Social Service Supervisor			0.			
16.00 17.00	Home Health Aide Home Health Aide Supervisor			1.			1
18.00	Other (specify)			0.			1
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				1		19.00
17.00	you provided services during the cost						
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			99915			20.00
20.00	during this cost reporting period (line 20 contains the first code).			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			20.00
			sodes			Tatal (asla	
		Without W Outliers	/ith Outliers	LUPA EDI SODE	es PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	242	C		29 5	276	21.00
22.00	Skilled Nursing Visit Charges	43, 351	C			49, 377	
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	352 72, 262	C		9 0 48 0	361 74, 110	
25.00	Occupational Therapy Visits	47	C		0 0	47	25.00
26.00 27.00	Occupational Therapy Visit Charges Speech Pathology Visits	9, 333 10			0 0	9, 333 10	1
28.00	Speech Pathology Visit Charges	1, 986	C	)	0 0	1, 986	28.00
29.00 30.00	Medical Social Service Visits Medical Social Service Visit Charges	3 740	C		0 0 0 0	3 740	
31.00	Home Health Aide Visits	56	C	)	0 0	56	31.00
32.00 33.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	2, 943 710	C		0 0 38 5	2, 943 753	
	29, and 31)		C				
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 130, 615	C	6,9	0 333 02 1, 305		1
36.00	30, 32, and 34) Total Number of Episodes (standard/non	49			11 1	61	
37.00	outlier) Total Number of Outlier Episodes		C	)	0	0	
38.00		2, 732	C	6	30 0		38.00

Heal th	Financial Systems CAME	RON MEMORIAL C	OMMUNI TY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 10/01/2017 To 09/30/2018		epared:
			•			2/21/2019 3:4	19 pm
					RHC I	Cost	
					1.	. 00	-
	Clinic Address and Identification						
1.00	Street		C	+.,	1500 W MAUMEE		1.00
				ty 00	<u>State</u> 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		ANGOLOA	00		46703	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for i		Award	C	3.00
					. 00	Date 2.00	
	Source of Federal Funds					2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00 7.00	Health Services for the Homeless (Section 340 Appalachian Regional Commission	U(d), PHS Act)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
10.00	Deep this facility answers as others than a h				1.00	2.00	10.00
10.00	Does this facility operate as other than a hory yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of d	other operation	ns in column	N		10.00
		Sur	nday	Мо	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1)		1	00.00	17.00	00.00	1 11 00
11.00				08:00	17:00	08:00	11.00
					1.00	2.00	
	Have you received an approval for an exception				N		12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report.	umn 1. lf yes,	enter in colur	nn 2 the	N	C	13.00
	numbers below.					0.01	
					ler name .00	CCN number 2.00	
14.00	RHC/FQHC name, CCN number					2.00	14.00
		Y/N	V	XVIII	XI X	Total Visits	
15.00		1.00	2.00	3.00	4.00	5.00	45.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
	(see instructions)						
				unty			
				00			
2.00	City, State, ZIP Code, County	Tuesday	STEUBEN	esday	Thu	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	08: 00	17:00	08: 00	17:00	11.00

Health Financial Systems CA	MERON MEMORIAL C	COMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1315	Peri od:	Worksheet S-8	
		Component	CCN: 15-8530	From 10/01/2017 To 09/30/2018	Data/Tima Dra	narad
		Component	UCN. 15-6550	10 09/30/2018	2/21/2019 3:4	
				RHC I	Cost	
	Fri	i 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

iospi t	AL-BASED HOSPICE IDENTIFICATION	I DATA		Provider Co Hospice CC		Period: From 10/01/2017 To 09/30/2018	Worksheet S-9 PARTS I THROU Date/Time Pre 2/21/2019 3:4	GH IV pared:
						Hospi ce I	2/21/2017 3.4	7 piii
		Unduplicated Days		· · · · ·				
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursing Facility	Facility		5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	DST REPORTING F	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
. 00	Hospice Continuous Home Care							1.0
2.00	Hospice Routine Home Care							2.0
. 00	Hospice Inpatient Respite Care							3.0
. 00	Hospice General Inpatient Care							4.0
5.00	Total Hospice Days							5.0
~~	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
. 00	Number of patients receiving							6.0
. 00	hospice care Total number of unduplicated							7.0
. 00	Continuous Care hours billable							/.(
	to Medicare							
. 00	Average Length of Stay (line 5							8.0
	/ line 6)							
9.00	Unduplicated census count							9.0
OTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
0 00	PART III - ENROLLMENT DAYS FOR	COST REPORTING	S PERIODS BEGIN	1				1 40 6
0.00	Hospice Continuous Home Care Hospice Routine Home Care			0		0 0	0	
1 00	THOSDICE ROUTINE HOME Care			244	18	30 1, 828	2, 252	11.0
						~ 7	10	10
12.00	Hospice Inpatient Respite Care Hospice General Inpatient Care			3		0 7 0 460	10 460	

7 15.00 450 16.00

14.00Total Hospice Days2471802,295PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 201515.00Hospice Inpatient Respite Care00716.00Hospice General Inpatient Care00450

Heal th	Financial Systems CAMERON MEMORIAL COMMUNI	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
		rovider CCN: 15-1	1315 Pe	eri od:	Worksheet S-1	
				om 10/01/2017		
			To	09/30/2018	Date/Time Pre 2/21/2019 3:4	
					2/21/2019 3.4	9 piii
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 202	column 8	3)	0. 388427	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				3, 834, 398	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementa		Medi cai c	1?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fro	m Medicaid			0	5.00
6.00	Medi cai d charges				15, 030, 416	6.00
7.00	Medicaid cost (line 1 times line 6)				5, 838, 219	7.00
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 minus sum	oflines	s 2 and 5; if	2, 003, 821	8.00
	< zero then enter zero)					-
0.00	Children's Health Insurance Program (CHIP) (see instructions for	each TThe)			0	0.00
9. 00 10. 00	Net revenue from stand-al one CHIP Stand-al one CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP (I	ing 11 minus lir	no 0∙if	< zero then	0	12.00
12.00	enter zero)		ie 7, 11	< Zero then	0	12.00
	Other state or local government indigent care program (see instr	uctions for each	ı line)			
13.00	Net revenue from state or local indigent care program (Not inclu				0	13.00
14.00	Charges for patients covered under state or local indigent care			lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for state or local indi	gent care progra	am (line	15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local	i ndi ger	it care program	ns (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fun	ding charity ou	r0		0	17.00
17.00	Government grants, appropriations or transfers for support of ho				0	17.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local			sum of lines	2, 003, 821	19.00
19.00	8, 12 and 16)	rnargent care pi		Sull OF TITIES	2,003,021	19.00
		Uni n	nsured	Insured	Total (col. 1	
			ients	patients	+ col. 2)	
		1.	. 00	2.00	3.00	
~~~~~	Uncompensated Care (see instructions for each line)		(50 (00	00.010	(00.550	00.00
20.00	Charity care charges and uninsured discounts for the entire faci	IITY	659, 639	20, 919	680, 558	20.00
21.00	(see instructions) Cost of patients approved for charity care and uninsured discound	tc (coo	256, 222	20, 919	277, 141	21.00
21.00	instructions)	LS (SEE	230, 222	20, 717	277, 141	21.00
22.00	Payments received from patients for amounts previously written o	ffas	0	0	0	22.00
22.00	charity care		Ũ	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		256, 222	20, 919	277, 141	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patient		length of	stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care p				_	
25.00	If line 24 is yes, enter the charges for patient days beyond the	indigent care p	program's	s length of	0	25.00
24 00	stay limit				/ / 00 70/	24 00
26.00	Total bad debt expense for the entire hospital complex (see inst		<b>a</b> a)		6, 689, 796	
27.00 27.01	Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (se		15)		593, 773 913, 498	
27.01	Non-Medicare bad debt expense (see instructions)	e instructions)			5, 776, 298	
28.00		( !+	ctions)			
	TLOST OF DOD-MEDICARE AND DOD-RELMDURSADLE MEDICARE DAD DEDT EXDE	nse (see instru				
30 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (see Enstruc	ctrons)		2, 563, 395 2, 840, 536	
30. 00 31. 00	Cost of uncompensated care (line 23 column 3 plus line 29)		ctrons)		2, 563, 395 2, 840, 536 4, 844, 357	30.00

Long         Dirth         Dirth <thd< th=""><th></th><th>Financial Systems CAME SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O</th><th>RON MEMORIAL COM F EXPENSES</th><th>MUNITY HOSPIT Provider C</th><th>CN: 15-1315 P</th><th>eriod:</th><th>u of Form CMS- Worksheet A</th><th>2552-10</th></thd<>		Financial Systems CAME SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	RON MEMORIAL COM F EXPENSES	MUNITY HOSPIT Provider C	CN: 15-1315 P	eriod:	u of Form CMS- Worksheet A	2552-10
Cost Center Description         Setaries (1.00)         Other (2.01)         Total (col. (2.01)         Red setar (1.00) (2.01)         Red setar (1.00) (2.01)         Red setar (1.00) (2.01)           1.00         2.00         3.00         4.00         5.00         1.00           0.0000 CAP HEL COST CENTERS (1.0000 CAP HEL COST CENTERS)         1.00         1.00         1.00         5.00         1.00           0.0000 CAP HEL COST CENTERS (1.0000 CAP HEL COST CENTERS)         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00						rom 10/01/2017 o 09/30/2018	Date/Time Pre	pared:
Image: 1         1.00         2.00         3.00         4.00         5.00           1.00         000000         Department of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of th		Cost Center Description	Sal ari es	Other			Reclassified Trial Balance (col. 3 +-	piii
1.00         DOTOD CAP KIL COSTS* MLPG & FLYT         6.113.844         6.113.844         6.113.844         6.123.844         6.123.844         6.123.844         6.123.844         6.123.844         6.123.844         6.123.844         6.123.844         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.705         7.206.7			1.00	2.00	3.00	4.00		
2.00         DONDIG LAP BIT LOSTS MUNIF FOUNP         1.866,085         1.866,085         1.866,085         2.981,291         4.109,312         4.109           5.00         DONDOL AP BIT LOSTS MUNIF FOUNP         6.177,79,440         7.223,242         11.003,183         3.00,467         11.342,477         5.00         7.00,709         0         7.50,709         4.00           0.00         DONDOL MUNITS ATTIVE & CENERAL         3.779,440         7.223,242         11.003,183         3.0487         11.342,477         5.00           0.00         DONDOL MUNISTER FLIN IN LIVIC T         63.779         743,3497         1.080,784         0         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,784         9.00         1.000,790,794         1.142,74         1.000,780,796         0.00         1.000,780,796         0.00,790,796         0.00,790,796         0.00,790,796         0.0				( 110 010	( 110 010	504 7/4	5 500 007	
4.00         000400         ENPLOYEE ERFERTS DEPARTMENT         0         7.566,709         4.00           7.00         00700         OPERATION PERATION STRUCTE         813,453         1.808,167         2.881,622         7.00           7.00         00700         OPERATION OF PLANT         813,453         1.808,167         2.881,622         7.00           00         00700         DEPART         SERVICE         66,297         3.44,831         7.353,333         3.00,887         1.985,784         9.00           00         00700         DEPART         SERVICE         660,992         3.44,631         7.353,333         -5.97,730         1.95,797         1.00           10.00         01000 DETERF         0         0         0         5.06         1.98,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757         1.95,757								
5.00         DODOD ADMINI NISTRATIVE & GENERAL         3.7.79, 940         7.223, 243         11.003, 183         30.497         11.433, 470         5.00           8.00         DDINGL LAMARY & LINIK SIRVICT         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3         3.3			О					
8.00         DOBOD LUMIDICY ALLINED SERVICE         0         33, 998         33, 998         33, 998         33, 998         49, 00           10.00         DIODOD DIELTAY         300, 702         344, 631         1, 385, 71, 600, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 1080, 784         0, 128, 984         10, 00         1, 1080, 784         0, 128, 984         1, 108, 744         0, 128, 984         1, 108, 744         0, 128, 984         1, 108, 128         1, 116, 118, 118         1, 116, 118, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 116, 118         1, 118         1, 118, 118         1, 118         1,			3, 779, 940					
9.00         00000 [NUSEFEEP ING         6-67, 207         41.3, 447         1.000, 71.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>								
10. 00 (1000) DE TARY       390. 702       344. 631       7.35. 733       -5.39. 736       195. 597       10. 00         11. 00       010300 LARES INC ADMINISTRATION       663. 052       41. 753       260. 758       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 186       508. 156       508. 156       518. 168       508. 156       508. 156       518. 168       508. 156			-					1
13. 00       01300       MURSI MG ADMI MI STRATT ON       000, 952       41, 753       650, 705       0       650, 705       13. 00         14. 00       01500       PHARLENTRAL SERVICE S & SUPPLY       174, 675       82, 909       27, 584       14. 00       13. 00       2, 969, 119       0       2, 969, 119       0       2, 969, 119       0       2, 969, 119       0       0, 900       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></th<>								1
14.00       CENTRAL SERVICES & SUPPLY       174, 675       82.009       257.584       0       257.584       0         16.00       01600/UFDICAL RECORDS & LIBRARY       448, 557       1.86.574       657.126       0       657.126       0       657.126       0       657.126       0       657.126       0       657.126       0       657.126       0       657.126       0       657.126       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			-	-	-			1
15.00         OISDO PHARMACY         444, 517         2, 464, 402         2, 965, 119         0         2, 666, 119         15.00           10.00         OISDO PHARMACY         466, 557         188, 574         6, 00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00         16.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
16. 00         01600         HEICCAL RECORDS & LIERARY         446, 552         188, 574         657, 126         0         677, 126         16. 00           10. 00         03000         03000         04001         14, 31, 571         3, 496, 285         510, 134         4, 006, 449         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         30. 00         50. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         60. 00         71. 74. 74. 74         72. 72. 74. 74. 74. 74. 74. 74. 74. 74. 74. 74								
INPATIENT ROUTINE SERVICE COST CENTERS								
31. 00       0100       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       11.00       114.224       114.224       11.00       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224       114.224 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>								
43. 00         0 (3300 NURSERY)         0         0         0         43. 962         43. 962         43. 962         43. 962         43. 962         43. 962         43. 962         43. 962         43. 962         43. 962         43. 962         43. 962         43. 962         44. 962         43. 962         45. 96         969, 555         -672. 605         316, 950         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         55. 96         56. 96         55. 96         56. 97         57. 37. 147         96. 39. 97         97. 37. 147         96. 39. 97         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         96. 39. 97         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 147         97. 37. 37. 147         97. 37. 37. 147         97. 37. 37. 147         97. 37. 37. 147         97. 37. 37. 37. 37. 37. 37. 37. 37. 37. 3								
ANCI LLARY SERVICE COST CONTERS								1
51. 00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         050.00         050.00         050.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00         051.00<		ANCILLARY SERVICE COST CENTERS			-			
52. 00         05200 DELLYERY PROM & LABOR ROOM         910.586         78.969         999.555         -672.605         316.950         52.00         46.00         0.2552.014         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         50.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         73.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70								
54. 00         05400 RADI LOCY-LI AGNOSTI C         1, 625, 686         926, 328         2, 52, 014         0         2, 552, 014         0         2, 552, 014         0         2, 734, 147         60, 00           60.00         06000 RESPIRATIONY THERAPY         40, 35         0, 97, 89         63, 97, 742         65, 00         065, 00         960, 742         01, 0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			-	-	-			
60. 00         60000         LABGRATORY         990. 893         1, 743, 254         2, 734, 147         0         2, 734, 147         0         60. 00         64.00           64.00         06400, RESPI RATORY THERAPY         44, 353         919, 578         976, 931         -176, 189         777, 742         65.00         6500         06500, RESPI RATORY THERAPY         895, 896         20, 747         916, 643         0         900, 203, 644         62.03, 644         65.00         6600, PHYSI CAL, THERAPY         895, 896         20, 747         916, 643         0         916, 643         66.00         900         6900         CARDIA C, REHAB         90, 070         84, 918         90, 772, 83, 390         69.00         72.00         702.00         702.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00				-				1
65. 00         06500         RESP LATORY THERAPY         44. 353         919, 578         963, 931         -1.76, 189         787, 742         65. 00           06         00         00600         PHYSICAL THERAPY         895, 896         20, 747         916, 643         0.         916, 643         0.         916, 643         0.         916, 643         0.         916, 643         0.         916, 643         0.         916, 643         0.         916, 643         0.         916, 643         0.         0.         916, 643         0.         916, 643         0.         916, 643         0.         916, 643         0.         916, 643         0.         0.         916, 010         0.         0.         916, 010         916, 010         916, 010         916, 010         916, 010         916, 010         916, 010         916, 010         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0.         0. <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
65.01         0 6601         9 55.896         0 747         916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.643         0 916.647         0 84.918         69.01         0 900.960         172.00         0 17000 MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         0         0 996.267         980.076         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00			0	0	0	0		
66. 00         00         06600         PHYSICAL THERAPY         995, 896         20, 747         916, 643         0         916, 643         66. 00         690         06900         CLUCTROCATION LOGY         0         380, 815         380, 815         -27, 425         353, 390         66. 00         720, 00         84, 918         0         84, 918         0         84, 918         0         84, 918         0         996, 267         998, 267         7998, 267         7998, 267         798, 267         720, 00         0         0         0         0         0         0         0         0         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         73. 00         83. 113, 71, 71         225, 743         76. 01         88. 00         80. 00         80. 00         80. 00         80. 00         80. 00         80. 00         80. 00         80. 00         80. 00         90. 01         90. 01         1, 613, 499         0. 0         1, 613, 342         1, 513, 499         0. 0         1, 513, 4			44, 353	919, 578	963, 931			
69:00         00         00         3300, 315         -27, 425         333, 390         69.00           00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00         00 <td< td=""><td></td><td></td><td>895 896</td><td>20 747</td><td>916 643</td><td></td><td></td><td>1</td></td<>			895 896	20 747	916 643			1
11.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         0         1,799,231         1,799,231         1,998,267         980,064         71.00           72.00         072000         MARCED CO PATIENTS         0         0         0         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         998,267         988,00         1,464,011         1,464,011         1,464,011         0         1,464,011         0         1,464,011         0         1,464,011         0         1,464,011         0         1,464,011         0         1,464,011         1,1464,011         0         1,034,94         90.00         0         0         0         0         1,513,499         90.01         1,513,499         90.01         1,513,499         90.01         1,010.00         0         0         0         0         0			0					
72.00         072.00         172.00         072.00         072.00         998.267         998.267         998.267         72.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00								1
73.00         073.00         DRUGS CHARGED TO PATLENTS         0         0         0         0         73.00         Comparing the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second			0					1
76:00       03202 (CHENI CAL DEPENDENCY       112,033       113,710       225,743       0       225,743       76.01         01       017PATI ENT SERVICE COST CENTERS       0       1,464,011       0       1,464,011       0       1,464,011       0       1,464,011       0       1,464,011       0       1,464,011       0       1,464,011       0       1,464,011       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			0	0	0			
OUTPATIENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         783, 146         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			112, 033	113, 710	225, 743	0	225, 743	1
88.00         00         08800         FURAL HEALTH CLINIC         783,146         42,471         825,677         0         825,677         88.00           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         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	76. 01		0	1, 464, 011	1, 464, 011	0	1, 464, 011	76.01
89:00         00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td>88 00</td> <td></td> <td>783 146</td> <td>42 471</td> <td>825 617</td> <td>0</td> <td>825 617</td> <td>88 00</td>	88 00		783 146	42 471	825 617	0	825 617	88 00
90.01         09001         CLI NI C- MCDONALD         481, 689         1, 031, 810         1, 513, 499         0         1, 513, 499         90.01           91.00         09100         EMERGENCY         1, 864, 778         283, 093         2, 147, 871         4, 235         2, 152, 106         91.00           07000         DESECIAL DURSABLE COST CENTERS								
91.00         09100         ENERGENCY         1,864,778         283,093         2,147,871         4,235         2,152,106         91.00           092.00         OBSERVATION BEDS (NON-DISTINCT PART         745,307         89,233         834,540         -156,714         677,826         111.00         101.00         677,826         113.00         11300         INTEREST EXPENSE         113.00         114.00         114.00         114.00         101.100         HORES COST CENTERS         113.00         0         0         0         0         0         113.00         113.00         114.00         114.00         114.00         114.00         114.00         114.00         144.00         0         0         0         0         113.00         113.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         104.01								1
92.00       05200       0BSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS       92.00         101.00       TOTHER REI MBURSABLE COST CENTERS       834,540       -156,714       677,826         113.00       INTERES EXPENSE       1,633,342       -1,633,342       -1,633,342       0       113.00         114.00       ITILIZATI ON REVIEW-SNF       0       0       0       0       114.00         114.00       ITILZATI ON REVIEW-SNF       0       0       0       0       114.00         116.00       ISBOTALS (SUM OF LINES 1 through 117)       19,674,481       41,312,417       60,986,898       275,610       61,262,508       118.00         118.00       SUBTOTALS (SUM OF CLINES 1 through 117)       19,674,481       41,312,417       60,986,898       275,610       61,262,508       118.00         190.00       IFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       194,00       0       0       0       194,01       194,02       194,02,07952       00       0       0       0       194,01       194,02       194,02       1953       ASSI TED LI VI NG/CAMERON WOODS       0       0       0       0       194,02       194,02       194,03       194,04       194,04       194,04								
OTHER         REI MBURSABLE COST CENTERS           101.00         10100   HOME         HEALTH         ACENCY         745, 307         89, 233         834, 540         -156, 714         677, 826           113.00         11300         INTEREST EXPENSE         1, 633, 342         -1, 633, 342         -1, 633, 342         0         113.00           114.00         11400         UTI LI ZATI ON REVI EW-SNF         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			1,004,770	203, 093	2, 147, 071	4,233	2, 152, 100	
SPECIAL PURPOSE COST CENTERS           113. 00         INTEREST EXPENSE         1, 633, 342         -1, 633, 342         0         113. 00           114. 00         ITILIZATION REVIEW-SNF         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<								
113.00       11300       INTEREST EXPENSE       1,633,342       -1,633,342       -1,633,342       0       113.00         114.00       11400       UTI LI ZATI ON REVI EW-SNF       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 </td <td>101.00</td> <td></td> <td>745, 307</td> <td>89, 233</td> <td>834, 540</td> <td>-156, 714</td> <td>677, 826</td> <td>101.00</td>	101.00		745, 307	89, 233	834, 540	-156, 714	677, 826	101.00
114.00         11400         UTI LI ZATI ON REVI EW-SNF         0         0         0         0         0         114.00           116.00         HOSPI CE         82,180         27,718         109,898         55,190         165,088         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         19,674,481         41,312,417         60,986,898         275,610         61,262,508         118.00           NONREI MBURSABLE COST CENTERS         0         0         0         0         0         190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         194.00         194.00         194.00         0         0         0         0         0         0         194.00         194.01         194.02         07951         DAYCARE-I NFANT/TODDLER         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td< td=""><td>113 00</td><td></td><td></td><td>1 633 342</td><td>1 633 342</td><td>-1 633 342</td><td>0</td><td>1113 00</td></td<>	113 00			1 633 342	1 633 342	-1 633 342	0	1113 00
116.00         11600         HOSPI CE         82, 180         27, 718         109, 898         55, 190         165, 088         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         19, 674, 481         41, 312, 417         60, 986, 898         275, 610         61, 262, 508         116.00           NONREL MBURSABLE COST CENTERS         0         0         0         0         190.00         1FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         194.00         0         0         0         0         194.00         194.00         0         0         0         0         194.02         194.02         07952         COMMUNI TY HEALTH         95, 303         7, 015         102, 318         0         102, 318         194.02         194.02         0         0         0         0         0         194.02         194.02         07952         COMMUNI TY HEALTH         95, 303         7, 015         102, 318         0         102, 318         194.02         194.04         07955         MARETING         122, 363         471, 062         593, 425         -644, 804         528, 621         194.06           194.06         07956         GUEST MEALS         0         0         0         0         0			0					
NONREI MBURSABLE COST CENTERS         Description         Description <thdescription< th="">         Description         <thdescri< td=""><td>116.00</td><td>11600 HOSPI CE</td><td></td><td></td><td></td><td></td><td>165, 088</td><td>116.00</td></thdescri<></thdescription<>	116.00	11600 HOSPI CE					165, 088	116.00
190.00       IFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       0       190.00         194.00       07950       DAYCARE-I NFANT/TODDLER       0       0       0       0       194.00         194.01       07951       MOB       0       0       0       0       0       194.00         194.02       07952       COMMUNI TY HEALTH       95,303       7,015       102,318       0       194.02         194.03       07954       ASSI STED LI VI NG/CAMERON WOODS       0       0       0       0       194.02         194.04       07954       EDUCATI ON       24,435       95,571       120,006       -70,174       49,832       194.04         194.05       07955       MARKETI NG       122,363       471,062       593,425       -64,804       528,621       194.05         194.06       07957       OUTSI DE LAUNDRY       0       0       0       0       0       194.07         194.08       07957       OUTSI DE LAUNDRY       0       0       0       0       0       0       194.07         194.08       07959       URGENT CARE       1,461,043       181,929       1,642,972       -185,518       1,457	118.00		19, 674, 481	41, 312, 417	60, 986, 898	275, 610	61, 262, 508	118.00
194.00       07950       DAYCARE - I NFANT/TODDLER       0       0       0       0       194.00         194.01       07951       MOB       0       0       0       0       0       0       194.01         194.02       07952       COMMUNI TY HEALTH       95,303       7,015       102,318       0       102,318       194.02         194.03       07953       ASSI STED LI VI NG/CAMERON WOODS       0       0       0       0       194.03         194.04       07954       EDUCATI ON       24,435       95,571       120,006       -70,174       49,832       194.04         194.05       07955       MARKETI NG       122,363       471,062       593,425       -64,804       528,621       194.06         194.06       07956       GUEST MEALS       0       0       0       0       194.06         194.09       07957       OUTSI DE LAUNDRY       0       0       0       0       194.07         194.09       07958       CANCER CENTER       0       0       0       0       0       0       194.09         194.10       07660       RHC       0       0       0       0       0       0       194.0	190 00		0	0	0	0	0	190 00
194. 02       07952       COMMUNI TY HEALTH       95, 303       7, 015       102, 318       0       102, 318       194. 02         194. 03       07953       ASSI STED LI VI NG/CAMERON WOODS       0       0       0       0       194. 03         194. 04       07954       EDUCATI ON       24, 435       95, 571       120, 006       -70, 174       49, 832       194. 04         194. 05       07955       MARKETI NG       122, 363       471, 062       593, 425       -64, 804       528, 621       194. 05         194. 06       07956       GUEST MEALS       0       0       0       0       0       194. 05         194. 07       07957       OUTSI DE LAUNDRY       0       0       0       0       194. 05         194. 09       07958       CANCER CENTER       0       0       0       0       194. 07         194. 09       07959       URGENT CARE       1, 461, 043       181, 929       1, 642, 972       -185, 518       1, 457, 454       194. 09         194. 10       07960       RHC       0       0       0       0       194. 10         194. 11       07961       0BGYN       896, 774       119, 075       1, 015, 849			-		-	0		
194. 03       07953       ASSI STED LI VI NG/CAMERON WOODS       0       0       0       194. 03         194. 04       07954       EDUCATI ON       24, 435       95, 571       120, 006       -70, 174       49, 832       194. 04         194. 05       07955       MARKETI NG       122, 363       471, 062       593, 425       -64, 804       528, 621       194. 05         194. 06       07956       GUEST MEALS       0       0       0       194. 05         194. 07       07957       OUTSI DE LAUNDRY       0       0       0       0       194. 08         194. 09       07958       CANCER CENTER       0       0       0       0       194. 08         194. 09       07959       URGENT CARE       1, 461, 043       181, 929       1, 642, 972       -185, 518       1, 457, 454       194. 09         194. 10       07960       RHC       0       0       0       0       194. 10         194. 10       07960       RHC       0       0       0       0       194. 10         194. 11       07960       RHC       0       0       0       0       194. 10         194. 12       07962       TRI NE STUDENT HEALTH			0	•	0	0		
194. 04       07954       EDUCATI ON       24, 435       95, 571       120, 006       -70, 174       49, 832       194. 04         194. 05       07955       MARKETI NG       122, 363       471, 062       593, 425       -64, 804       528, 621       194. 05         194. 06       07956       GUEST MEALS       0       0       0       31, 548       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. 09       07959       URGENT CARE       1, 461, 043       181, 929       1, 642, 972       -185, 518       1, 457, 454       194. 09         194. 10       07960       RHC       0       0       0       0       0       194. 10         194. 11       07960       RHC       0       0       0       194. 10       194. 10         194. 12       07962       TRI NE STUDENT HEALTH       79, 332       1, 279       80, 611       194. 12         194. 12       07963       OCCUPATI ONAL HEALTH       220, 630       148, 037       368, 667       0			95, 303	7, 015				
194.05       07955       MARKETING       122,363       471,062       593,425       -64,804       528,621       194.05         194.06       07956       GUEST MEALS       0       0       0       31,548       31,548       194.06         194.07       07957       OUTSI DE LAUNDRY       0       0       0       0       194.07         194.08       07958       CANCER CENTER       0       0       0       0       194.08         194.09       07959       URGENT CARE       1,461,043       181,929       1,642,972       -185,518       1,457,454       194.09         194.10       07960       RHC       0       0       0       0       194.10         194.11       07961       D8GNN       896,774       119,075       1,015,849       0       1,015,849       194.11         194.12       07962       TRINE STUDENT HEALTH       79,332       1,279       80,611       0       80,611       194.12         194.14       07964       IMUNI ZATI ON CLINIC       59,442       1,151       60,593       0       60,593       194.14         194.15       07965       FOUNDATI ON       54,255       225       54,480       13,338			24 435	0 95 571	-	-		
194.07       07957       OUTSI DE LAUNDRY       0       0       0       194.07         194.08       07958       CANCER CENTER       0       0       0       0       194.08         194.09       07959       URGENT CARE       1, 461, 043       181, 929       1, 642, 972       -185, 518       1, 457, 454       194.09         194.10       07960       RHC       0       0       0       0       194.10         194.11       07960       RHC       0       0       0       0       194.10         194.12       07961       0BGYN       896,774       119,075       1,015,849       0       1,015,849       194.11         194.12       07962       TRI NE STUDENT HEALTH       79,332       1,279       80,611       0       80,611       194.12         194.13       07964       IMUNI ZATI ON CLI NIC       59,442       1,151       60,593       0       60,593       194.14         194.15       07965       FOUNDATI ON       54,255       225       54,480       13,338       67,818       194.15								
194.08       07958       CANCER CENTER       0       0       0       0       194.08         194.09       07959       URGENT CARE       1, 461, 043       181, 929       1, 642, 972       -185, 518       1, 457, 454       194.09         194.10       07960       RHC       0       0       0       0       0       194.10         194.10       07960       RHC       0       0       0       0       194.10         194.11       07961       DBGYN       896,774       119,075       1,015,849       0       1,015,849       194.11         194.12       07962       TRI NE STUDENT HEALTH       79,332       1,279       80,611       0       806,71 194.13         194.13       07963       OCCUPATI ONAL HEALTH       220,630       148,037       368,667       0       368,667 194.13         194.14       07964       IMMUNI ZATI ON CLI NIC       59,442       1,151       60,593       0       60,593 194.14         194.15       07965       FOUNDATI ON       54,255       225       54,480       13,338       67,818       194.15			0	0	0	31, 548		
194.09       07959       URGENT CARE       1,461,043       181,929       1,642,972       -185,518       1,457,454       194.09         194.10       07960       RHC       0       0       0       0       194.10         194.11       07960       RHC       0       0       0       0       194.10         194.11       07960       RHC       896,774       119,075       1,015,849       0       1,015,849       194.11         194.12       07962       TRI NE STUDENT HEALTH       79,332       1,279       80,611       0       866,611       194.12         194.13       07963       OCUPATI ONAL HEALTH       220,630       148,037       368,667       0       368,667       194.13         194.14       07964       IMUNI ZATI ON CLI NIC       59,442       1,151       60,593       0       60,593       194.14         194.15       07965       FOUNDATI ON       54,255       225       54,480       13,338       67,818       194.15			0	0	0	0		
194. 1007960RHC000194. 10194. 11079610BGYN896, 774119, 0751, 015, 84901, 015, 849194. 11194. 1207962TRI NE STUDENT HEALTH79, 3321, 27980, 611080, 611194. 12194. 13079630CCUPATI ONAL HEALTH220, 630148, 037368, 6670368, 667194. 13194. 1407964IMMUNI ZATI ON CLI NI C59, 4421, 15160, 593060, 593194. 14194. 1507965FOUNDATI ON54, 25522554, 48013, 33867, 818194. 15			1 461 043	U 181 929	0 1 642 972	0 -185 518		
194. 11 194. 12 079610BGYN896, 774119, 0751, 015, 84901, 015, 849194. 11194. 12 194. 1207962TRI NE STUDENT HEALTH79, 3321, 27980, 611080, 611194. 12194. 13 194. 13079630CCUPATI ONAL HEALTH220, 630148, 037368, 6670368, 667194. 13194. 14 194. 1507964IMMUNI ZATI ON CLI NI C59, 4421, 15160, 593060, 593194. 14194. 15 194. 1507965FOUNDATI ON54, 25522554, 48013, 33867, 818194. 15			0	0	0	0		
194. 1307963OCCUPATI ONAL HEALTH220, 630148, 037368, 6670368, 667194. 13194. 1407964I MMUNI ZATI ON CLI NI C59, 4421, 15160, 593060, 593194. 14194. 1507965FOUNDATI ON54, 25522554, 48013, 33867, 818194. 15	194.11	07961 OBGYN					1, 015, 849	194.11
194. 1407964I MMUNI ZATI ON CLI NI C59, 4421, 15160, 593060, 593194. 14194. 1507965FOUNDATI ON54, 25522554, 48013, 33867, 818194. 15								
194. 15         07965         FOUNDATION         54, 255         225         54, 480         13, 338         67, 818         194. 15								
	194.15	07965 FOUNDATI ON					67, 818	194. 15
	200.00	TOTAL (SUM OF LINES 118 through 199)	22, 688, 058	42, 337, 761	65, 025, 819	0	65, 025, 819	200. 00

CLASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-1315	Period: From 10/01/2017	Worksheet A
					To 09/30/2018	Date/Time Prepar 2/21/2019 3:49 p
	Cost Center Description	Adjustments	Net Expenses		- <b>I</b>	
		(See A-8) 6.00	For Allocation 7.00			
GF	ENERAL SERVICE COST CENTERS	0.00	7.00			
	0100 CAP REL COSTS-BLDG & FIXT	-878, 373	4, 643, 714			· · · · · · · · · · · · · · · · · · ·
	0200 CAP REL COSTS-MVBLE EQUIP	-170, 156				
	0400 EMPLOYEE BENEFITS DEPARTMENT	-474,091				
	0500 ADMI NI STRATI VE & GENERAL	-1, 971, 062				
	0700 OPERATION OF PLANT	-3, 300				
	0800 LAUNDRY & LINEN SERVICE	0	33, 998			
	0900 HOUSEKEEPI NG	0	1, 080, 784			
	1000 DI ETARY	-12, 250				10
00 0'	1100 CAFETERI A	-255, 757	252, 431			1
00 0'	1300 NURSING ADMINISTRATION	0	650, 705			1
00 0	1400 CENTRAL SERVICES & SUPPLY	0	257, 584			1
	1500 PHARMACY	-60, 897	2, 908, 222			1
	1600 MEDI CAL RECORDS & LI BRARY	-283	656, 843			1
	NPATIENT ROUTINE SERVICE COST CENTERS	I				
	3000 ADULTS & PEDIATRICS	-1, 139, 301	2, 867, 168			30
	3100 I NTENSI VE CARE UNI T	0				3
1	4300 NURSERY	0	43, 962			4
	NCILLARY SERVICE COST CENTERS					
	5000 OPERATING ROOM	-556, 838	1, 408, 786			50
	5100 RECOVERY ROOM	0	619, 174			5
	5200 DELIVERY ROOM & LABOR ROOM	0	316, 950			5
00 09	5400 RADI OLOGY-DI AGNOSTI C	0	2, 552, 014			5
00 00	6000 LABORATORY	-7, 312	2, 726, 835			61
00 00	6400 INTRAVENOUS THERAPY	0	0			6
00 00	6500 RESPI RATORY THERAPY	0	787, 742			6
01 00	6501 SLEEP LAB	0	203, 614			6
00 00	6600 PHYSI CAL THERAPY	-215	916, 428			6
00 00	6900 ELECTROCARDI OLOGY	0	353, 390			6
01 00	6901 CARDI AC REHAB	0	84, 918			6
00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	800, 964			7
00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0	998, 267			7
00 0	7300 DRUGS CHARGED TO PATIENTS	0	0			7
00 03	3020 CHEMI CAL DEPENDENCY	0	225, 743			7
01 03	3480 ONCOLOGY	0	1, 464, 011			7
οι	UTPATIENT SERVICE COST CENTERS					
00 00	8800 RURAL HEALTH CLINIC	0	825, 617			8
00 08	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			8
00 00	9000 CLINIC	0	173, 944			90
01 09	9001 CLINIC- MCDONALD	-1, 235, 391	278, 108			90
00 00	9100 EMERGENCY	0	2, 152, 106			9
00 00	9200 OBSERVATION BEDS (NON-DISTINCT PART					93
01	THER REIMBURSABLE COST CENTERS					
. 00 10	0100 HOME HEALTH AGENCY	0	677, 826			10
	PECIAL PURPOSE COST CENTERS					
	1300 INTEREST EXPENSE	0	0			11:
	1400 UTI LI ZATI ON REVI EW-SNF	0	0			11.
	1600 HOSPI CE	0	165, 088			110
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-6, 765, 226	54, 497, 282			11;
NC	ONREIMBURSABLE COST CENTERS					
0. 00 19	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190
. 00 01	7950 DAYCARE-I NFANT/TODDLER	0	0			19
	7951 MOB	0	0			19
	7952 COMMUNI TY HEALTH	0	102, 318			19
	7953 ASSISTED LIVING/CAMERON WOODS	0	0			19
	7954 EDUCATI ON	0	49, 832			19
. 05 07	7955 MARKETI NG	0	528, 621			19
. 06 07	7956 GUEST MEALS	0	31, 548			19
. 07 07	7957 OUTSI DE LAUNDRY	0	0			194
	7958 CANCER CENTER	0	o			19
	7959 URGENT CARE	0	1, 457, 454			19-
	7960 RHC	0	o			19-
	7961 OBGYN	0	1, 015, 849			19
	7962 TRINE STUDENT HEALTH	0	80, 611			19
	7963 OCCUPATI ONAL HEALTH	0	368, 667			19
	7964 I MMUNI ZATI ON CLINIC	0	60, 593			19
	7965 FOUNDATION	0	67, 818			19
	TOTAL (SUM OF LINES 118 through 199)	-6, 765, 226				200

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

# CAMERON MEMORIAL COMMUNITY HOSPITAL In Provider CCN: 15-1315 Period:

In Lieu of Form CMS-2552-10 Worksheet A-6

					 From 10/01/201 To 09/30/201	
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00 A - LABOR AND DELIVERY	3.00	4.00	5.00	 	
1	A - LABOR AND DELIVERY ADULTS & PEDIATRICS	30.00	574, 579	49, 829		1
	NURSERY	43.00	40, 454	49, 829 3, 508		
	EMERGENCY	91.00	3, 897	338		
			618, 930	53, 675		
	B - PROPERTY INSURANCE	L				
	CAP REL COSTS-BLDG & FIXT	1.00	0	88, 413		1
	0		0	88, 413		
	C – CAFETERIA					
	CAFETERIA	11.00	270, 014	238, 174		
	GUEST_MEALS	<u> </u>	16, 762	1 <u>4, 7</u> 86		
			286, 776	252, 960		
	D - INTEREST EXPENSE	1.00	0	1 50/ 70/		
	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 586, 786		-
	CAP REL COSTS-MVBLE EQUI P	2.00 5.00	0	16, 362		
	ADMI NI STRATI VE & GENERAL		0	<u>30, 194</u> 1, 633, 342		
	E - DEPRECIATION EXPENSE		0	1,033,342		
1	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 276, 936		
				2, 276, 936		
	F - ICU			2,270,930		
	I NTENSI VE CARE UNI T	31.00	67, 454	46, 770		
			67,454	46, 770		
	G - ADVERTISING COST		07,101	10, 110		
	ADMI NI STRATI VE & GENERAL	5.00	19, 656	61, 962		
	0		19, 656	61, 962		
	H - PROPERTY TAX					
	CAP REL COSTS-BLDG & FIXT	1.00	0	9, 976		
	0		0	9, 976		
	I - EDUCATION COSTS					
	ADMI NI STRATI VE & GENERAL	5.00	24, 435	45, 739		
	0		24, 435	45, 739		
	J - SLEEP LAB	(5.04)		000 (44		
	SLEEP LAB	65.01	0	203, 614		
			<u>0</u>	0 203, 614		
	L - PUBLIC RELATIONS		U	203, 014		
	MARKETING	194.05	0	16, 814		
			<u>0</u>	16, 814		
	M - HOME HEALTH SALARY		Ч	10, 014		
	HOME HEALTH AGENCY	101.00	8, 130	0		
			8, 130	0		
	N - RECOVERY ROOM	I		- 1		
	RECOVERY ROOM	51.00	619, 174	0		
	0		619, 174	0		
	0 - IMPLANTABLE DEVICES		·			
	IMPL. DEV. CHARGED TO	72.00	0	998, 267		
	PATI ENTS					
	0		0	998, 267	 	
	P - HOME HEALTH ADMIN	T				
	ADMI NI STRATI VE & GENERAL		101, 524	0		
			101, 524	0		
	Q - URGENT CARE	E ool	105 540			
	ADMI NI STRATI VE & GENERAL		185, 518	0		
			185, 518	0		
	R - HOSPICE RECLASS	11/ 00	(2, 200	~		
1	HOSPICE	1 <u>16.</u> 00	63, 320	0		
	U S - FOUNDATION RECLASS		63, 320	0		
	FOUNDATION RECLASS	194.15	13, 338	0		
		174.10	13, 330	0		1
	TOTALS		13, 338			

ECLAS	Financial Systems SIFICATIONS		RON MEMORIAL CO		CCN: 15-1315	Period: From 10/01/2017 To 09/30/2018	u of Form CM Worksheet A Date/Time P 2/21/2019 3	-6 repared:
		Decreases					272172017 0	
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A - LABOR AND DELIVERY				1	-1		_
. 00	DELIVERY ROOM & LABOR ROOM	52.00	618, 930	53, 675		0		1.00
. 00		0.00	0	0		0		2.00
. 00			618, 930	53,675		o		3.00
	B - PROPERTY INSURANCE		010, 930	55, 675				
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	88, 413	1	2		1.0
. 00				88, 413		-		1.0
	C – CAFETERIA	I						
. 00	DI ETARY	10.00	286, 776	252, 960		0		1.0
. 00		0.00	0	0		o		2.0
	0		286, 776	252, 960				
	D - INTEREST EXPENSE				1			
. 00	INTEREST EXPENSE	113.00	0	1, 633, 342		9		1.0
. 00		0.00	0	0		0		2.0
. 00			0	0		o		3.0
	E - DEPRECIATION EXPENSE		0	1, 633, 342				
. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	2, 276, 936		9		1.00
. 00			o	2, 276, 936		2		1.00
	F - ICU		0	2,270,730				
. 00	ADULTS & PEDIATRICS	30.00	67, 454	46, 770		0		1.00
	0		67, 454	46, 770		-		
	G - ADVERTISING COST							
. 00	MARKETI NG	194.05	19, 656	61, 962		0		1.00
	0		19, 656	61, 962				
	H – PROPERTY TAX				1			
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>9, 9</u> 76		3		1.00
			0	9, 976				_
00	I - EDUCATION COSTS	104.04	24 425	45 720		0		1.0
. 00	EDUCATION	<u> </u>	<u>24, 435</u> 24, 435	4 <u>5, 7</u> 39 45, 739		Q		1.0
	J - SLEEP LAB		24, 433	45,757				
. 00	RESPI RATORY THERAPY	65.00	0	176, 189		0		1.0
. 00	ELECTROCARDI OLOGY	69.00	Ő	27, 425		o		2.0
				203, 614		-		
	L - PUBLIC RELATIONS							
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	16, 814		0		1.00
	0		0	16, 814				
	M - HOME HEALTH SALARY				1			
. 00	HOSPICE	1 <u>16.</u> 00	<u> </u>	0 0		Q		1.0
			8, 130	0				
00	N - RECOVERY ROOM	50.00	619, 174			0		1.0
. 00	OPERATING ROOM		619, 174	0		9		1.0
	0 - IMPLANTABLE DEVICES		019, 174	0				
. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	998, 267		0		1.0
	PATI ENT	, 00	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	0	+	0	998, 267		1		
	P - HOME HEALTH ADMIN			· · · · ·				
. 00	HOME_HEALTH_AGENCY	101.00	101, 524	0		0		1.0
	0		101, 524	0				
	Q – URGENT CARE				1			
. 00	URGENT CARE	1 <u>94.</u> 09	185, 518	0	<u> </u>	이		1.0
			185, 518	0				
00	R - HOSPICE RECLASS	101.00	(0.000		1	0		
. 00	HOME HEALTH AGENCY	1 <u>01.</u> 00	63, 320	0	<u> </u>	<u>o</u>		1.0
	S - FOUNDATION RECLASS		63, 320	0	1			-
. 00	ADMI NI STRATI VE & GENERAL	5.00	13, 338	0		0		1.0
00	TOTALS		13, 338	0 ō	<u> </u>	Ť		1.0
	Grand Total: Decreases		2, 008, 255	5, 688, 468				500.0

## TOTALS 500.00 Grand Total : Decreases Τ

Health Financial S	Systems		
RECONCILIATION OF	CAPI TAL	COSTS	CENTERS

					From 10/01/2017 To 09/30/2018		pared: 9 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 317, 868	145, 000		0 145, 000	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	56, 766, 732	206, 078		0 206, 078	0	3.00
4.00	Building Improvements	20, 000	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	18, 884, 224	811, 320		0 811, 320	374, 854	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76, 988, 824	1, 162, 398		0 1, 162, 398	374, 854	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	76, 988, 824	1, 162, 398		0 1, 162, 398	374, 854	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 462, 868	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	56, 972, 810	0				3.00
4.00	Building Improvements	20, 000	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	19, 320, 690	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	77, 776, 368	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	77, 776, 368	0				10.00

Heal th	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1315	Peri od:	Worksheet A-7		
					From 10/01/2017 To 09/30/2018	Part II	norod.	
					To 09/30/2018	Date/Time Pre 2/21/2019 3:4	pareu. 9 pm	
	SUMMARY OF CAPITAL							
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
					instructions)	instructions)		
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	6, 113, 848			0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 866, 085	5	0 0	0	2.00	
3.00	Total (sum of lines 1-2)	6, 113, 848	1, 866, 085	5	0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description		Total (1) (sum	1				
		Capi tal -Rel ate						
		d Costs (see	through 14)					
		instructions)		_				
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 113, 848				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 866, 085				2.00	
3.00	Total (sum of lines 1-2)	0	7, 979, 933	3			3.00	

		RON MEMORIAL CO				u of Form CMS-2	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Peri od:	Worksheet A-7	
					From 10/01/2017 To 09/30/2018	Part III Date/Time Prep	arod
					10 09/30/2018	2/21/2019 3:49	
		COM	PUTATION OF RAT	FI OS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		-	1			
1.00	CAP REL COSTS-BLDG & FIXT	58, 435, 678		58, 435, 67		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19, 340, 691	0	19, 340, 69		0	2.00
3.00	Total (sum of lines 1-2)	77, 776, 369		77, 776, 36			3.00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Rel ate			Louse	
			d Costs	through 7)			
		6,00	7.00	8.00	9.00	10,00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	<u> </u>				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1	0 5, 392, 006	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 2, 115, 511	1, 882, 447	2.00
3.00	Total (sum of lines 1-2)	0	0		0 7, 507, 517	1, 882, 447	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
					) Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)	thi ough (1)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	-846, 681	88, 413	9, 97	6 0	4, 643, 714	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-8, 731			0 0	3, 989, 227	2.00
3.00	Total (sum of lines 1-2)	-855, 412			-	8, 632, 941	3.00
0.00		000, 112	00,110	1 , , ,		5, 502, 711	0.00

	Financial Systems MENTS TO EXPENSES	CAMER	RON MEMORIAL C	OMMUNITY HOSPITAL Provider CCN: 15-1315	In Lie Period:	u of Form CMS-2 Worksheet A-8	
					From 10/01/2017 To 09/30/2018	Date/Time Pre	pared:
				Expense Classification	on Worksheet A	2/21/2019 3:49	9 pm
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	A		CAP REL COSTS-BLDG & FIXT	1.00		1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	А	-8, 731	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	А	-16, 111	ADMI NI STRATI VE & GENERAL	5.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time				0.00		4.00
	discounts (chapter 8)		c.				
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	В	-11, 614	CAP REL COSTS-MVBLE EQUIP	2.00	9	6. 00
7.00	Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00		
10. 00	Provider-based physician adjustment	A-8-2	-2, 709, 166			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-637, 638			0	12.00
13.00	Laundry and linen service		C		0.00		13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-236, 941	CAFETERI A	11.00 0.00		14.00 15.00
16.00	and others Sale of medical and surgical		0		0.00		
16.00	supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than	В	-60, 897	PHARMACY	15.00	0	17.00
18.00	patients Sale of medical records and	В	- 283	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
	abstracts	D					
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines	В	-16 256	CAFETERI A	11.00	0	20.00
	Income from imposition of	5	0		0.00		
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
23.00	therapy costs in excess of	A-0-3	0	RESFIRATORT THERAFT	03.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		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
28.00	Non-physician Anesthetist			*** Cost Center Deleted **			28.00
	Physicians' assistant Adjustment for occupational	A A-8-3		CLINIC- MCDONALD *** Cost Center Deleted **	* 90.01 * 67.00		29.00 30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	*** Cost Center Deleted **	* 68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest	А	-18, 814	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	LOBBYING EXPENSES	А	-4, 638	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal th	Financial Systems	CAME	RON MEMORIAL CO	OMMUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 10/01/2017 To 09/30/2018	Date/Time Pre	
				Expense Classification or	Workchoot A	2/21/2019 3:4	9 pm
				To/From Which the Amount is			
				I Allourt I's	to be Aujusteu		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	EMPLOYEE CHRISTMAS PARTY	A	-11, 447	ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33.02	PHYSICIAN RECRUITMENT	A	-127, 445	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MEALS ON WHEELS	В	-12, 250	DI ETARY	10.00	0	33.03
33.04	RENTAL INCOME OFFSET - CANCER	В	-31, 692	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
	CENTER						
33.05	ATM SURCHARGE REVENUE	В	-455	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	OP EDUCATION	В	-1, 050	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.06
33.07	DIETICIAN CONSULTATIONS	В	-2, 560	CAFETERIA	11.00	0	33.07
33.08	PHYSICIAN INCOME GUARANTEE	A	9, 194	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	HAF EXPENSE	В	-1, 789, 860	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CLIMB PROGRAM REVENUE	В	-215	PHYSICAL THERAPY	66.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49)		-6, 765, 226				50.00
	(Transfer to Worksheet A,						
		1					

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	CAMERON MEMORIAL	CAMERON MEMORIAL COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1315	Period:	Worksheet A-8	-1		
OFFICE	COSTS			From 10/01/2017 To 09/30/2018				
	Line 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 ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED			
	HOME OFFICE COSTS:							
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	473, 041	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	2.00	CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	467, 743	598, 740	4.00		
5.00	0		0	467, 743	1, 105, 381	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			
			i dano				
		Ownershi p		Ownershi p			
1.00	2.00	3.00	4,00	5,00			
 B INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							
IN INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE			4		

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.

rerinbur					
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.

Health Financial Systems	CAMERON MEMORIAL COMM	CAMERON MEMORIAL COMMUNITY HOSPITAL			
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1315	From 10/01/2017	Worksheet A-8-1 Date/Time Prepared: 2/21/2019 3:49 nm	

			2/21/2019 3:4	49 pili
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-473, 041	0		1.00
2.00	-30, 300	0		2.00
3.00	-3, 300	0		3.00
4.00	-130, 997	9		4.00
5.00	-637, 638			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

nas nu	n been posteu to worksheet A,	condining i and/or 2, the amount arrowable should be rifdicated in condinin 4 of this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	5.		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED 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 7.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
8. 00 9. 00 10. 00 <u>100. 00</u>	100.00

(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.

 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.

Director, officer, administrator, or key person of related organization or relative of such person has financial interest in F. provi der.

Heal th Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

### CAMERON MEMORIAL COMMUNITY HOSPITAL Provider CCN: 15-1315 Period:

In Lieu of Form CMS-2552-10 Worksheet A-8-2

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (		Period:	Worksheet A-8	8-2
						From 10/01/2017 To 09/30/2018	Date/Time Pre	
							2/21/2019 3:4	9 pm
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
	1 00	2.00	2.00	4.00	E 00	( 00	Hours	
1.00	1.00	2.00	3.00	4.00	5.00	6.00	7.00	1 00
1.00		LABORATORY	13, 521	7, 312	6, 209		0	1.00
2.00		ADULTS & PEDIATRICS	996, 485	951, 961	44, 524		0	2.00
3.00		OPERATI NG ROOM	556, 838	556, 838	C	-	0	3.00
4.00		ADULTS & PEDIATRICS	187, 340	187, 340		°	0	4.00
5.00		CLINIC- MCDONALD	1, 005, 715	1, 005, 715	C	0	0	5.00
6.00	0.00		0	0	C	0	0	6.00
7.00	0.00		0	0	C	0	0	7.00
8.00	0.00		0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			2, 759, 899	2, 709, 166	50, 733		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		I denti fi er			Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		LABORATORY	0	0	0		0	1.00
2.00		ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00		OPERATI NG ROOM	0	0	0	-	0	3.00
4.00		ADULTS & PEDIATRICS	0	0	0		0	4.00
5.00		CLINIC- MCDONALD	0	0	0	-	0	5.00
6.00	0.00		0	0			0	6.00
7.00	0.00		0	0		-	0	7.00
8.00	0.00		0	0		°	0	7.00 8.00
			0	0		0	-	
9.00	0.00		0	0	L L	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	C		0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		ldentifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	44.00	17.00	10.00		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		LABORATORY	0	0				1.00
2.00		ADULTS & PEDIATRICS	0	0	-			2.00
3.00		OPERATING ROOM	0	0	-			3.00
4.00		ADULTS & PEDIATRICS	0	0	C	187, 340		4.00
5.00		CLINIC- MCDONALD	0	0	C	1, 005, 715		5.00
6.00	0.00		0	0	C	0		6.00
7.00	0.00		0	0	C	0		7.00
8.00	0.00		0	0	C	0		8.00
9.00	0.00		0	0	C	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00	51.00		0	0	-	-		200.00
	I	1	, s	0			I I	

	Financial Systems CAME WABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	RON MEMORIAL CO FURNISHED BY	MMUNI TY HOSPI TA Provi der CC	N: 15-1315 Pe	riod: om 10/01/2017	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Prep 2/21/2019 3:4 Cost	-3 pared:
					-	1.00	
1 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	c) (coo i potruct	tione)			F.2	1 00
1.00 2.00	Line 1 multiplied by 15 hours per week	s) (see mistruct	LI ONS)			52 780	1.00 2.00
3.00	Number of unduplicated days in which supervision			•		365	3.00
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		on provider sit	e but neither	supervi sor	0	4.00
5.00	Number of unduplicated offsite visits - supe	rvisors or thera				0	5.00
6.00	Number of unduplicated offsite visits - therassistant and on which supervisor and/or the					0	6.00
	instructions)		5				
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					3.25 0.00	7.00 8.00
		Supervi sors 1.00	Therapists	Assistants	Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	2, 505. 80	2.00 21,597.25	3.00 0.00	4.00	0.00	9.00
10.00	AHSEA (see instructions)	64.62	64.62	0.00	0.00	0.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	32. 31	32.31	0.00			11.00
	one-half of column 3, line 10)						10.00
12. 00 12. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0	0			12. 00 12. 01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)		I				13.01
						1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	. line 10)				161, 925	14.00
15.00	Therapists (column 2, line 9 times column 2,	line 10)				1, 395, 614	15.00
16.00 17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		atory therapy	or lines 14-16	for all	0 1, 557, 539	16.00 17.00
17.00	others)		atory therapy			1,007,007	
18.00 19.00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					0	18.00 19.00
20.00	Total allowance amount (sum of lines 17-19 f	or respiratory t				1, 557, 539	
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
01 00	the amount from line 20. Otherwise complete					0.00	01 00
21.00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,			I OF COLUMNS I	and 2, Tine 9	0.00	21.00
22.00 23.00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (line 2 time	es line 21)			0 1, 557, 539	22.00 23.00
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLON	VANCE AND TRAVEL	EXPENSE COMPL	TATION - PROVI	DER SITE	1, 557, 559	23.00
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					11, 793	24 00
24.00	Assistants (line 4 times column 3, line 11)					0	24.00 25.00
26.00	Subtotal (line 24 for respiratory therapy or					11, 793	
27.00	Standard travel expense (line 7 times line 3 others)	for respiratory	y therapy or su	m of lines 3 a	nd 4 for all	1, 186	27.00
28.00	Total standard travel allowance and standard	travel expense	at the provide	er site (sum of	lines 26 and	12, 979	28.00
	27) Optional Travel Allowance and Optional Travel	Expense					
29.00	Therapists (column 2, line 10 times the sum		d 2, line 12 )			0	29.00
20 00			0				
30. 00 31. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or		9 and 30 for al	l others)		0	30.00 31.00
	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	sum of lines 29			r sum of	-	30.00
31.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	sum of lines 29 s 1 and 2, line	13 for respira		r sum of	0	30. 00 31. 00
31.00 32.00 33.00 34.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave	sum of lines 29 s 1 and 2, line l expense (line l expense (sum o	13 for respira 28) of lines 27 and	tory therapy o	r sum of	0 0 0 0	30.00 31.00 32.00 33.00 34.00
31.00 32.00 33.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave	sum of lines 2 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	13 for respira 28) of lines 27 and of lines 31 and	tory therapy o   31)   32)		0 0 0 0 0	30. 00 31. 00 32. 00 33. 00
31.00 32.00 33.00 34.00 35.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense	sum of lines 2 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	13 for respira 28) of lines 27 and of lines 31 and	tory therapy o   31)   32)		0 0 0 0 VI DER SI TE	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
31.00 32.00 33.00 34.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	sum of lines 2 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	13 for respira 28) of lines 27 and of lines 31 and	tory therapy o   31)   32)		0 0 0 0 0	30.00 31.00 32.00 33.00 34.00
31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	sum of lines 2 s 1 and 2, line l expense (line l expense (sum of ANCE AND TRAVEL	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	tory therapy o   31)   32)		0 0 0 VI DER SI TE 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
31.00 32.00 33.00 34.00 35.00 36.00 37.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	sum of lines 2 s 1 and 2, line l expense (line expense (sum of ANCE AND TRAVEL m of lines 5 and	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	tory therapy o   31)   32)		0 0 0 <u>0</u> <u>0</u> <u>0</u> <u>0</u> 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.1	sum of lines 2 s 1 and 2, line l expense (line expense (sum of expense (sum of ANCE AND TRAVEL m of lines 5 and Expense D1 times column	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	tory therapy o   31)   32)		0 0 0 VI DER SI TE 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	sum of lines 2 s 1 and 2, line l expense (line expense (sum of expense (sum of ANCE AND TRAVEL m of lines 5 and Expense D1 times column	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	tory therapy o   31)   32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 37. 00 38. 00 39. 00 40. 00 41. 00
31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	sum of lines 2 s 1 and 2, line l expense (line l expense (sum of expense (sum of ANCE AND TRAVEL m of lines 5 and Expense O1 times column n 3, line 10)	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT d 6) 2, line 10)	tory therapy o   31)   32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, d Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	sum of lines 2 s 1 and 2, line l expense (line l expense (sum of ANCE AND TRAVEL m of lines 5 and Expense D1 times column n 3, line 10) m of columns 1-3	13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT 4 6) 2, line 10) 3, line 13.01)	I 31) I 32) ATION - SERVIC	ES OUTSI DE PRO	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00

Therapy         Therapy           5.00         Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)         0.45.00           6.00         Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)         0.45.00           7.00         Wertime hours worked during reporting         1.114.50         0.00         0.00         1.114.50         4.00           9         PART V - OVERTIME COMPUTATION         1.114.50         0.00         0.00         0.00         1.114.50         4.00           9         Overtime hours worked during reporting         1.114.50         0.00         0.00         0.00         1.114.50         4.00           0.00         Overtime hours worked overtime (including base and overtime)         108.028.49         0.00         0.00         0.00         48.00           0.00         Overtime hours by category         100.00         0.00         0.00         0.00         100.00           0.00         Overtime hours by category         100.00         0.00         0.00         0.00         2.080.00         50.00           0.00         Overtime each column on line 47         108.028         0.00         0.00         0.00         2.080.00         50.00         50.00         50.00         50.	)UTSI D	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	URNI SHED BY	Provider CC	CN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet A-8 Parts I-VI Date/Time Pre 2/21/2019 3:4	pared:
0.00         Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)         00         45.00           0.00         Optional travel allowance and optional travel expense (sum of lines 34 and 42 - see instructions)         0.45.00           0.00         Descriptional travel allowance and optional travel expense (sum of lines 34 and 42 - see instructions)         0.45.00           1.00         2.00         3.00         4.00         5.00           0.00         Overtine hours worked our ing reporting comparison of the standard standard travel allowance and enter zero in each complete lines 48-53 and enter zero in each colum of lines 56.0         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00						Respi ratory Therapy	Cost	
0.00         Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)         00         45.00           0.00         Optional travel allowance and optional travel expense (sum of lines 34 and 42 - see instructions)         0.45.00           0.00         Descriptional travel allowance and optional travel expense (sum of lines 34 and 42 - see instructions)         0.45.00           1.00         2.00         3.00         4.00         5.00           0.00         Overtine hours worked our ing reporting comparison of the standard standard travel allowance and enter zero in each complete lines 48-53 and enter zero in each colum of lines 56.0         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00							1 00	
Incerptist         Assistants         Al des         Trainees         Total           PART V - OVERTIME COMPUTATION         1.00         2.00         3.00         4.00         5.00           Do Overtime hours worked during reporting period (1 r column 5, line 47, lis zero or complete lines 48-55 and enter zero in each column of line 56)         0.00         0.00         0.00         0.00         0.00         0.00         47.00           0.00 Overtime inters (ase instructions)         96.93         0.00         0.00         0.00         0.00         48.00           0.00 Overtime orbits of the 47 lines 31 ine 47.1         106.02.49         0.00         0.00         0.00         0.00         0.00         49.00           0.00 Overtime orbits of method use on line 47         100.00         0.00         0.00         0.00         100.00         0.00         0.00         100.00         50.00           0.00 Overtime cost line the durant colum on no line 47         100.00         0.00         0.00         0.00         2.080.00         0.00         0.00         2.080.00         52.00           0.00 Overtime cost line that colum on no line 47         1.00         0.00         0.00         0.00         52.00           0.00 Overtime cost line transition         1.00         0.00         0.00         0.00	15.00	Optional travel allowance and standard travel	expense (sum o	of lines 39 an	d 42 - see in	istructions)		45.00
PART V - OVERTIME COMPUTATION         1.00         2.00         3.00         4.00         5.00           7.00         OverTime hours worked during reporting period (If colums, 11 ine 47, is zero or expuil to ar greater than 2,080, do not complete lines 455 and enter zero) in each setual to ar greater than 2,080, do not complete lines 455 and enter zero or expuil to ar greater than 2,080, do not complete lines 455 and enter zero)         0.00         0.00         0.00         1,114.50           8.00         Overtime rate (size instructions)         96.93         0.00         0.00         0.00         44.00           0.00         Total overtime (including base and overtime of the hours in acch colum on line 47         90         0.00         0.00         0.00         100.00         50.00           0.01         All costing of providers' standard work year or one full time engloyee times the percentages on line 67) (see instructions)         2,080.00         0.00         0.00         0.00         52.00           0.01         All costing of overtime and report year of on of Coll cost (inter the lesser of line 47 or lines 31 ind stine (line 51 times line 104.00         10.00         0.00         53.00           0.02         Overtime all evence (line 51 mins line 55 is respiratory theragy and columns 1 through 3 for all others.)         1.00         0         55.00           0.03         Overtime all evence (line 54 mins 21)         36.000         0         <	16.00	Optional travel allowance and optional travel						46.00
PART V - OVERTIME COMPUTATION         Image: Computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation of the computation								
period (if column 5, line 47, is zero`or equal to or greater than 2,080, do not complete lines 48-85 and enter zero in each column of line 50.         96.93         0.00         0.00         0.00         48.00           8.00         Overtime (rate (see instructions)         96.93         0.00         0.00         0.00         0.00           8.00         Overtime (rate (see instructions)         96.93         0.00         0.00         0.00         0.00           0.00         Total overtime end overtime         108.028.49         0.00         0.00         0.00         0.00           0.00         Percentage of overtime hours by category (divide the hours in each column 5, line 47)         100.00         0.00         0.00         0.00         0.00         50.00           0.01         Allocation of provider's standard work year (divide the hours y categoris monthe divide of the percentages on line 50) (cee instructions)         0.00         0.00         0.00         52.00           2.00         All usted hourly staffill advamace (see instructions)         Solution of provider's standard work year (see instructions)         0.00         0.00         0.00         52.00           3.00         Overtime cost (enter the lesser of 108,028         0.00         0.00         0.00         55.00           5.00         Portion of overtime already included in hourly couputation at the ARS		PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
9.00       Total overtime (including base and overtime)       108,028,49       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00	7.00	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, 114. 50	0.00	0. C	0.00	1, 114. 50	47. OC
allowance) (multiply line 47 times line 48)	8.00		96. 93	0.00	0. C	0.00		48.00
CALCULATION OF LIMIT         Constrained of overtime hours by category         100.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00	9.00		108, 028. 49	0.00	0. C	0.00		49.00
0.00       Percentage of overtime hours by category (divide the hours in each column on line 47)       100.00       0.00       0.00       0.00       100.00       50.00         1 (divide the hours in each column on line 47)       100.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       2,080.00       51.00         1 (ine 47)       100.00       0.00       0.00       0.00       0.00       0.00       0.00       2,080.00       51.00         Detremination of overtime constructions)       Detremination of overtime constructions)       134.410       0       0       0       52.00         3.00       Overtime cost (enter the lesser of low of using the sthe percentages on line 53 (not of overtime already included in hourly computation of the AHSEA (nult ip)       72.019       0       0       0       55.00         5.00       Portion of overtime already included in hourly computation of the AHSEA (nult ip)       72.019       0       0       0       36,009       55.00         6.00       Overtime allowance (line 54 minus line 55 - in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3       1.557.539       57.00       57.00       58.00         7.00       Salary equivalency amount (from line 23)       1.557.539       59.00       59.00       59.00					<u> </u>			-
1.00       All ocation of provider's standard work year for one full time employee times the percentages on line 50) (see instructions)       0.00       0.00       0.00       0.00       2.080.00       51.00         DETERMINATION OF OVERTIME ALLOWANCE       0.00       0.00       0.00       0.00       0.00       52.00         2.00       Adjusted hourly salary equival ency amount (see instructions)       64.62       0.00       0.00       0.00       53.00         3.00       Overtime cost (enter the lesser of line 53)       108.028       0       0       0       54.00         5.00       Portion of overtime already included in hourly computation at the AHEA (multiply line 47 times line 52)       36,009       0       0       0       55.00         0.00       Overtime allowance (line 54 minus line 55 - 36,009       0       0       0       36,009       56.00         0.00       Overtime allowance ond expense - provider site (from line 33, 34, or 35))       1,557,539       57.00       58.00         0.00       Dertal allowance and expense - provider site (from line 33, 34, or 35))       1,557,539       57.00       58.00       58.00         0.00       Guard allowance (from column 5, line 56)       0       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00 <td>50.00</td> <td>Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,</td> <td>100. 00</td> <td>0.00</td> <td>0. C</td> <td>0.00</td> <td>100. 00</td> <td>50.00</td>	50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	100. 00	0.00	0. C	0.00	100. 00	50.00
2.00       Adjusted hourly salary equivalency amount (see instructions)       64.62       0.00       0.00       0.00       0.00       52.00         3.00       Overtime cost limitation (line 51 times line 52)       134.410       0       0       0       0       0       53.00         4.00       Maximum overtime cost (enter the lesser of 108.028       0       0       0       0       0       54.00         5.00       Portion of overtime already included in hourly computation at the ARSEA (multiply line 47 times line 52)       72.019       0       0       0       0       55.00         6.00       Overtime allowance (line 54 minus line 55 - 16 regative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3       36,009       0       0       0       36,009       55.00         7.00       Salary equivalency amount (from line 23)       1.00       1.00       1.00       59.00       58.00       58.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00       59.00	1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2, 080. 00	0.00	0. C	0.00	2, 080. 00	51.00
sign instructions)       imession	2 00		64 62	0.00	0.0			52 00
4.00       Maximum overtime cost (enter the lesser of lines 30)       108,028       0       0       0       54.00         5.00       Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times ine 52)       72,019       0       0       0       0       55.00         6.00       Overtime allowance (line 54 minus line 55 - 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.)       36,009       0       0       0       36,009       55.00         Note that the the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)       1.00       1.00       1.00         Note that the allowance and expense - provider site (from lines 33, 34, or 35))       1,557,539       57.00         0.00 Fravel allowance and expense - offsite services (from lines 44, 45, or 46)       0       0       0       0       0       64.00       64.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65.00       65		(see instructions)						53.00
5.00       Portion of overtime al ready included in hourly computation at the AHSEA (multiply line 47 times line 52)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td>4.00</td> <td>Maximum overtime cost (enter the lesser of</td> <td>108, 028</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td>54. OC</td>	4.00	Maximum overtime cost (enter the lesser of	108, 028	0		0 0		54. OC
6.00Overtime allowance (line 54 minus line 55 - 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.)36,0090036,00956.00 <b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b> 1.00Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT1.00Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT00Over the allowance and expense - provider site (from lines 33, 34, or 35))00Over time allowance and expense - Offsite services (from lines 44, 45, or 46)000000000000000000000000000000000								

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 10/01/2017 o 09/30/2018	Worksheet B Part I Date/Time Pre	pared:
				LATED COSTS		2/21/2019 3:4	9 pm
			CAPITAL KEI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost Allocation			BENEFI TS DEPARTMENT		
		(from Wkst A			DELYNYTHEIT		
		<u>col.7)</u> 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	4, 643, 714	4, 643, 714				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	3, 989, 227	00.0(4	3, 989, 227			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	7, 032, 618 9, 372, 608	23, 961 410, 829				4.00 5.00
7.00	00700 OPERATION OF PLANT	2, 678, 322	417, 408				1
8.00	00800 LAUNDRY & LINEN SERVICE	33, 998	43, 130			107, 055	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 080, 784 183, 347	19, 250 159, 279			1, 321, 427 485, 549	9.00 10.00
11.00	01100 CAFETERI A	252, 431	80, 614				1
13.00	01300 NURSING ADMINISTRATION	650, 705	33, 139	22, 995			1
14.00	01400 CENTRAL SERVICES & SUPPLY	257, 584	126, 546				
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	2, 908, 222 656, 843	46, 907 0				1
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	0007010	, i i i i i i i i i i i i i i i i i i i		110/0/0	001/111	10100
30.00	03000 ADULTS & PEDIATRICS	2, 867, 168	656, 084				30.00
31.00 43.00	03100 INTENSIVE CARE UNIT 04300 NURSERY	114, 224 43, 962	47, 922 17, 057				1
43.00	ANCI LLARY SERVICE COST CENTERS	43, 702	17,037	11,030	12,012	03,407	43.00
50.00	05000 OPERATI NG ROOM	1, 408, 786	441, 450				
51.00	05100 RECOVERY ROOM	619, 174	288, 628				
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	316, 950 2, 552, 014	137, 390 335, 250				
60.00	06000 LABORATORY	2, 726, 835	112, 657				60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	-	0	64.00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	787, 742 203, 614	54, 623 0			894, 094 276, 883	
66.00	06600 PHYSI CAL THERAPY	916, 428	244, 889				
69.00	06900 ELECTROCARDI OLOGY	353, 390	5, 807	4, 030	0	363, 227	69.00
69.01	06901 CARDI AC REHAB	84, 918	31, 352				1
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	800, 964 998, 267	0	0	0	800, 964 998, 267	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 CHEMI CAL DEPENDENCY	225, 743	0	0	34, 927	260, 670	
76.01	03480 ONCOLOGY OUTPATI ENT SERVI CE COST CENTERS	1, 464, 011	450, 791	312, 801	0	2, 227, 603	76.01
88.00	08800 RURAL HEALTH CLINIC	825, 617	0	123, 683	244, 153	1, 193, 453	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90. 00 90. 01	09000 CLINIC 09001 CLINIC- MCDONALD	173, 944 278, 108	19, 981 0	13, 865 117, 991		251, 860 546, 270	
	09100 EMERGENCY	2, 152, 106	387, 599				1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
101 00	OTHER REIMBURSABLE COST CENTERS	677, 826	0	41, 397	183, 499	902, 722	101 00
101.00	SPECIAL PURPOSE COST CENTERS	077, 820	0	41, 397	103, 499	902, 722	101.00
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF	1/5 000	0	0.400	42.024	21/ 20/	114.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	165, 088 54, 497, 282	4, 592, 543	8, 482 3, 749, 271			
	NONREI MBURSABLE COST CENTERS	011177202				00,020,011	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 555				190.00
	07950 DAYCARE-INFANT/TODDLER 07951 MOB	0	0	0			194.00 194.01
	07952 COMMUNI TY HEALTH	102, 318	0	0	-		
194.03	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194. 03
	07954 EDUCATI ON 07955 MARKETI NG	49,832	0	0	0		194.04
	07955 GUEST MEALS	528, 621 31, 548	27, 616 0	19, 163 0	32, 020 5, 226		194.05
194.07	07957 OUTSI DE LAUNDRY	0	0	0	0	0	194. 07
	07958 CANCER CENTER	0	0	0	0		194.08
	07959 URGENT CARE 07960 RHC	1, 457, 454	0	177, 169	397, 656 0		194.09 194.10
	07961 0BGYN	1, 015, 849	0	0	279, 577	1, 295, 426	
	07962 TRI NE STUDENT HEALTH	80, 611	0	0	24, 732		1
	07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC	368, 667 60, 593	0	23, 869 3, 410			194. 13 194. 14
	07965 FOUNDATION	67, 818	0	0			194. 14
200.00	Cross Foot Adjustments					0	200. 00
201.00	Negative Cost Centers		0	0	0	0	201.00

Health Financial Sy	ystems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lieu of Form CMS-2552-10			
COST ALLOCATION -	GENERAL SERVICE COSTS		Provider C	F	Period: From 10/01/2017 To 09/30/2018		pared: 9 pm	
			CAPI TAL REI	LATED COSTS				
Cost C	Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal		
		0	1.00	2.00	4.00	4A		
202.00 TOTAL	(sum lines 118 through 201)	58, 260, 593	4, 643, 714	3, 989, 227	7, 073, 205	58, 260, 593	202.00	

Heal th Financial	Systems	
COCT ALLOCATION		

In Lieu of Form CMS-2552-10

Heal th	Financial Systems CAME	ERON MEMORIAL CO	OMMUNITY HOSPIT	FAL	In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 10/01/2017 o 09/30/2018	Worksheet B Part I Date/Time Pre 2/21/2019 3:4	pared: 9 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1	1				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11 440 445					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	11, 442, 645	4 (15 00)				5.00
7.00	00700 OPERATION OF PLANT	906, 470	4, 615, 326				7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	26, 165	42, 745				8.00 9.00
9.00 10.00	01000 DI ETARY	322, 966 118, 672	19, 078 157, 858		1, 709, 793 16, 800	779, 290	
11.00	01100 CAFETERI A	115, 644	79, 895		46, 073	0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	219, 156			40, 073	0	1
14.00	01400 CENTRAL SERVICES & SUPPLY	128, 655			12, 473	0	1
15.00	01500 PHARMACY	767, 128			16, 291	0	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	203, 863	44, 556		0,2,1	0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	200,000	11,000	<u> </u>		Ŭ	10.00
30, 00	03000 ADULTS & PEDIATRICS	1, 168, 347	650, 230	34, 857	481, 605	750, 643	30.00
31.00	03100 I NTENSI VE CARE UNI T	52, 897	47, 494	1, 853	9, 927	28, 647	31.00
43.00	04300 NURSERY	20, 889			102, 328	0	1
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	591, 749	437, 512	25, 509	125, 237	0	50.00
51.00	05100 RECOVERY ROOM	318, 001	286, 053	0	81, 964	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	156, 567	136, 164	2, 490	25, 200	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	886, 394	332, 259	14, 927	128, 801	0	54.00
60.00	06000 LABORATORY	788, 600	111, 652	577	78, 146	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	218, 523	54, 136		16, 800	0	65.00
65.01	06501 SLEEP LAB	67,672	104, 649			0	65.01
66.00	06600 PHYSI CAL THERAPY	393, 629	242, 704			0	
69.00	06900 ELECTROCARDI OLOGY	88, 775	5, 756		0	0	
69.01	06901 CARDI AC REHAB	39, 514	31, 073	0	0	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	195, 761	0	0	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	243, 983	0	0	0	0	
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY	63, 710		0	0	0	73.00
76.00	03480 ONCOLOGY	544, 442	446, 769		0	0	
70.01	OUTPATIENT SERVICE COST CENTERS	544, 442	440,707	0	0	0	/0.01
88.00	08800 RURAL HEALTH CLINIC	291, 688	176, 655	1, 719	53, 709	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	271,000	0	0	00,707	0	
90.00	09000 CLINIC	61, 556	19, 803	l o	0	0	1
90.01	09001 CLINIC- MCDONALD	133, 512	168, 525		144, 074	0	90.01
91.00	09100 EMERGENCY	828, 841	384, 141	30, 062	239, 529	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	220, 632	59, 126	51	13, 236	0	101.00
	SPECIAL PURPOSE COST CENTERS		1	1			
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF	50.000					114.00
		52, 889			0		116.00
118.00		10, 237, 290	4, 272, 602	175, 965	1, 681, 284	779, 290	1118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 752	23, 345	0	0	0	190.00
	07950 DAYCARE-I NFANT/TODDLER	9,752	23, 340		0		190.00
	07951 MOB	0	0		0		194.00
	07952 COMMUNI TY HEALTH	32, 269			0		194.01
	07953 ASSI STED LI VI NG/CAMERON WOODS	0		0	0		194.03
	07954 EDUCATI ON	12, 179		0	0		194.04
	07955 MARKETI NG	148, 458	27, 370	0	0		194.05
	07956 GUEST MEALS	8, 988	0	Ö	0		194.06
	07957 OUTSI DE LAUNDRY	0	0	0	0	0	194.07
	07958 CANCER CENTER	0	0	0	0		194.08
	07959 URGENT CARE	496, 703	253, 048	0	28, 509		194.09
	07960 RHC	0	0	0	0		194.10
	07961 OBGYN	316, 611	0	0	0		194.11
	07962 TRINE STUDENT HEALTH	25, 747	0	0	0		194. 12
	07963 OCCUPATI ONAL HEALTH	112, 750		0	0		194.13
	07964 IMMUNIZATION CLINIC	20, 172	4, 870	0	0		194.14
	07965 FOUNDATI ON	21, 726	0	0	0	0	194. 15
200.00							200.00
201.00	8	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	11, 442, 645	4, 615, 326	175, 965	1, 709, 793	779, 290	202.00

OST A	Financial         Systems         CAME           LLOCATION         -         GENERAL         SERVICE         COSTS		OMMUNITY HOSPIT Provider CC	CN: 15-1315	Peri od:	u of Form CMS- Worksheet B	
					From 10/01/2017 To 09/30/2018		pared
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	2/21/2019 3: 4 MEDI CAL	9 pm
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16. 00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
. 00	00100 CAP REL COSTS-BLDG & FIXT						1. C
. 00	00200 CAP REL COSTS-MVBLE EQUI P						2.0
. 00 . 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. C
. 00	00700 OPERATION OF PLANT						7.0
. 00	00800 LAUNDRY & LINEN SERVICE						8.0
. 00	00900 HOUSEKEEPI NG						9. (
0.00	01000 DI ETARY	745 005					10.0
1.00 3.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	715, 905 24, 392					11.0
	01400 CENTRAL SERVICES & SUPPLY	15, 106		808, 04	.8		14.0
	01500 PHARMACY	17, 460		4, 74			15.0
6.00	01600 MEDICAL RECORDS & LIBRARY	37, 177	0	6	0 0	1, 119, 770	16.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	454.0/4	504.000	07.47		0,400	
0.00 1.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	151, 061 4, 293		27, 67 93		9, 480 684	1
	04300 NURSERY	1, 717			0 0		
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	46, 718		83, 69			
1.00	05100 RECOVERY ROOM	29, 513			0 0		
2.00 1.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	12, 371 77, 216		10, 24 8, 01		0 205, 377	52. 54.
), 00	06000 LABORATORY	64, 305		216, 78		337,056	
1.00	06400 I NTRAVENOUS THERAPY	0			0 0	0	
5.00	06500 RESPI RATORY THERAPY	1, 208	0	6, 47	8 0	29, 341	
. 01	06501 SLEEP LAB	0	-		0 0	0	
b. 00 9. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	46, 781	_	2, 24 70		101, 617 50, 942	
7.00 9.01	06901 CARDI AC REHAB	3, 880	u u u u u u u u u u u u u u u u u u u	42		26, 958	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,000		170, 83		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	212, 91	7 0	0	72. (
	07300 DRUGS CHARGED TO PATIENTS	0	, s		0 3, 990, 842	0	73. (
	03020 CHEMI CAL DEPENDENCY	6, 774			3 0	1, 374	
6. 01	03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	0	I	5 0	0	76. (
8.00	08800 RURAL HEALTH CLINIC	0	0	1, 54	1 0	0	88. (
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.
0. 00	09000 CLI NI C	8, 237		4, 53		35, 946	
). 01 I. 00	09001 CLINIC- MCDONALD 09100 EMERGENCY	22, 580 97, 093		2,62		35, 464 128, 416	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	97,093	324, 463	36, 31	0 0	128, 410	91. 92.
	OTHER REIMBURSABLE COST CENTERS		11				/2.
	10100 HOME HEALTH AGENCY	28, 400	0	1, 75	7 0	0	101.
	SPECIAL PURPOSE COST CENTERS	1	1 1				1
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						113. 114.
	11600 HOSPICE	7, 442	0	10	0	0	114.
8.00		703, 724		792, 72			
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0		190.
	07950 DAYCARE-I NFANT/TODDLER	0	0		0 0		194.
	07951 MOB 07952 COMMUNITY HEALTH	4, 071	0	30	0 0		194. 194.
	07953 ASSI STED LI VI NG/CAMERON WOODS	0	0		0 0		194.
	07954 EDUCATI ON	0	0		0 0		194.
	07955 MARKETI NG	6, 329		12	0 0		194.
	07956 GUEST MEALS	1, 781			0 0		194.
	07957 OUTSI DE LAUNDRY 07958 CANCER CENTER	0	0		0 0		194. 194.
	07959 URGENT CARE			10, 92			194.
	07960 RHC	0	0	10, 72	0 0		194.
4.11	07961 OBGYN	0	o	2, 77	4 0	31, 431	194.
	07962 TRINE STUDENT HEALTH	0	0	25	2 0		194.
	07963 OCCUPATIONAL HEALTH	0	0	75			194.
	07964 IMMUNIZATION CLINIC	0	0	20	0 0		194. 194.
/4.15 )0.00	07965 FOUNDATION Cross Foot Adjustments	0			0	0	200.
		0	0		0 0	n	200.
01.00					Ŭ	, v	

SI ALLOCA	TION - GENERAL SERVICE COSTS		Provider C	CN: 15-1315	Period: From 10/01/201	Worksheet B 7 Part I
						8 Date/Time Prepare
	Cost Center Description	Subtotal	Intern &	Total		2/21/2019 3:49 pm
			Residents Cost			
			& Post			
			Stepdown Adjustments			
	-	24.00	25.00	26.00		
GENER	AL SERVICE COST CENTERS		1			
	CAP REL COSTS-BLDG & FIXT					1.
1	CAP REL COSTS-MVBLE EQUI P					2.
	EMPLOYEE BENEFITS DEPARTMENT					4.
	ADMINISTRATIVE & GENERAL					5.
1	LAUNDRY & LINEN SERVICE					8.
	HOUSEKEEPING					9.
	DIETARY					10.
00 01100	CAFETERIA					11.
00 01300	NURSING ADMINISTRATION					13.
	CENTRAL SERVICES & SUPPLY					14.
	PHARMACY					15.
	MEDICAL RECORDS & LIBRARY					
	I ENT ROUTI NE SERVI CE COST CENTERS	0 550 000			000	20
	ADULTS & PEDIATRICS	8, 559, 090 377, 455				30. 31.
	NURSERY	243, 075		243,		43.
	LARY SERVICE COST CENTERS	210,070		210,	0/0	10.
	OPERATING ROOM	3, 909, 645	(	3, 909,	645	50.
	RECOVERY ROOM	2, 115, 259	0	2, 115, 1	259	51.
	DELIVERY ROOM & LABOR ROOM	1, 025, 023		1, 025,		52.
1	RADI OLOGY-DI AGNOSTI C	5, 279, 706		5, 279,		54.
1	LABORATORY	4, 823, 701	(	4, 823,		60.
1	INTRAVENOUS THERAPY		(	1 220	0	64.
	RESPI RATORY THERAPY SLEEP LAB	1, 220, 656 474, 071		0 1, 220, 0 474,		65. 65.
1	PHYSICAL THERAPY	2, 467, 521				66.
	ELECTROCARDI OLOGY	509, 405		509,		69.
	CARDI AC REHAB	263, 517		263,		69.
00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 167, 560	0	1, 167,	560	71.
00 07200	IMPL. DEV. CHARGED TO PATIENTS	1, 455, 167	(	1, 455,	167	72.
	DRUGS CHARGED TO PATIENTS	3, 990, 842		3, 990,	842	73.
		332, 611				76.
	ONCOLOGY	3, 218, 829	(	3, 218,	829	
	RURAL HEALTH CLINIC	1, 718, 765		1, 718,	765	88.
	FEDERALLY QUALIFIED HEALTH CENTER	0			0	89.
	CLINIC	409, 472	(	409,	472	90.
01 09001	CLINIC- MCDONALD	1, 055, 186	0	1, 055,	186	90.
	EMERGENCY	5, 460, 088	0	5, 460, 9	088	91.
	OBSERVATION BEDS (NON-DISTINCT PART					92.
	REIMBURSABLE COST CENTERS			1 005		
	AL PURPOSE COST CENTERS	1, 225, 924		1, 225,	924	101.
	INTEREST EXPENSE		1	1		113.
	UTILIZATION REVIEW-SNF					114.
. 00 11600	HOSPI CE	288, 949		288,	949	116.
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	51, 591, 517				118.
	I MBURSABLE COST CENTERS		1		207	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72, 997		72,		190.
I. 00 07950 I. 01 07951	DAYCARE-INFANT/TODDLER	0 101, 800		101	0	194. 194.
	COMMUNITY HEALTH	168, 676		) 101, ) 168,		194. 194.
	ASSISTED LIVING/CAMERON WOODS	100, 070 N		)	0	194.
	EDUCATI ON	62, 011		62,	011	194.
	MARKETING	789, 697		789,		194.
	GUEST MEALS	47, 543	(	47,	543	194.
	OUTSI DE LAUNDRY	0	(	)	0	194.
	CANCER CENTER	0	(		0	194.
	URGENT CARE	2, 821, 459	(	2, 821,	459	194.
1007960		0			0	194.
1. 11 07961		1, 646, 242		1, 646, 1		194. 194.
	2 TRI NE STUDENT HEALTH 3 OCCUPATI ONAL HEALTH	131, 342 608, 911		) 131, 608,		194.
	IMMUNIZATION CLINIC	107, 781		107,		194.
	FOUNDATION	110, 617		110,		194.
). 00	Cross Foot Adjustments	0			0	200.
. 00	Negative Cost Centers	0			0	200.
	TOTAL (sum lines 118 through 201)	58, 260, 593		58, 260,	1	202.

	Financial Systems CAME TION OF CAPITAL RELATED COSTS	RON MEMORIAL CO	OMMUNITY HOSPI Provider C	CN: 15-1315 P	eriod: rom 10/01/2017	u of Form CMS-2 Worksheet B Part II Date/Time Pre 2/21/2019 3:4	pared:
			CAPI TAL REI	LATED COSTS		272172019 3.4	7 pili
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	23, 961	16, 626	40, 587	40, 587	4.00
5.00	00500 ADMINI STRATI VE & GENERAL	0	410, 829		792, 531	7, 330	
7.00	00700 OPERATION OF PLANT	0	417, 408	359, 524	776, 932	1, 455	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	43, 130		73, 057	0	8.00
9.00	00900 HOUSEKEEPING	0	19, 250		32, 607	1, 194	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	159, 279			186 483	10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON		80, 614 33, 139			483 1, 089	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	126, 546			312	14.00
15.00	01500 PHARMACY	0	46, 907			867	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		31, 196	838	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	i	1				
30.00	03000 ADULTS & PEDI ATRI CS	0				4, 601	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	47, 922			121	31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	17, 057	11, 836	28, 893	72	43.00
50, 00	05000 OPERATI NG ROOM	0	441, 450	306, 320	747, 770	1, 518	50.00
51.00	05100 RECOVERY ROOM	0	288, 628		488, 905	1, 108	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	137, 390		232, 724	522	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	335, 250	232, 628	567, 878	2, 908	54.00
60.00	06000 LABORATORY	0	112, 657	78, 172	190, 829	1, 773	
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	54, 623		92, 525	79 0	65.00 65.01
66.00	06600 PHYSI CAL THERAPY	0	244, 889	73, 269 169, 927	73, 269 414, 816	1, 603	
69.00	06900 ELECTROCARDI OLOGY	0	5, 807	4, 030	9, 837	1, 003	69.00
69.01	06901 CARDI AC REHAB	0	31, 352	21, 755	53, 107	136	
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	200	
76.01	03480 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	0	450, 791	312, 801	763, 592	0	76.01
88.00	08800 RURAL HEALTH CLINIC	0	0	123, 683	123, 683	1, 401	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLI NI C	0	19, 981	13, 865	33, 846	253	90.00
90. 01	09001 CLINIC- MCDONALD	0	0	117, 991	117, 991	862	
	09100 EMERGENCY	0	387, 599	268, 952	656, 551		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92.00
101 00	10100 HOME HEALTH AGENCY	0	0	41, 397	41, 397	1 053	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0		11,077	11,077	1,000	101.00
113.00	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11600 HOSPI CE	0		8, 482			116.00
118.00		0	4, 592, 543	3, 749, 271	8, 341, 814	35, 553	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 555	16, 345	39, 900	0	190.00
	07950 DAYCARE-I NFANT/TODDLER	0	23, 333	10, 343	37, 900		194.00
	07951 MOB	0	0	0	0		194.01
194.02	07952 COMMUNI TY HEALTH	0	0	0	0	170	194.02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
	07954 EDUCATI ON	0	0	0	0		194.04
	07955 MARKETING	0	27, 616				194.05
	07956 GUEST MEALS	0		0	0		194.06 194.07
	07957 OUTSI DE LAUNDRY 07958 CANCER CENTER	0		0	0		194.07
	07959 URGENT CARE	0		-	177, 169		194.08
	07960 RHC	0	0	0	0		194.10
	07961 OBGYN	0	0	0	0	1, 604	194. 11
	07962 TRINE STUDENT HEALTH	0	0	0	0		194. 12
	07963 OCCUPATIONAL HEALTH	0	0	23, 869			194.13
	07964 IMMUNIZATION CLINIC	0	0	3, 410	3, 410		194.14
194.15 200.00	07965 FOUNDATION Cross Foot Adjustments	0	0	0	0	121	194. 15 200. 00
200.00			0	n	0	0	200.00
202.00		0	4, 643, 714	3, 989, 227	8, 632, 941		
					. · · · · ·		

Heal th	Fina	nci	al	Syste	ems		
		OF	C A		DEL	ATED	0

Heal th	Financial Systems CAME	ERON MEMORIAL CO	OMMUNITY HOSPIT	TAL	In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 10/01/2017 o 09/30/2018	Worksheet B Part II	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		I	1			
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	799, 861					5.00
7.00	00700 OPERATION OF PLANT	63, 362	841, 749				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 829	7, 796	82, 682			8.00
9.00	00900 HOUSEKEEPI NG	22, 575	3, 480	21, 766	81, 622		9.00
10.00	01000 DI ETARY	8, 295	28, 790	193	802	308, 068	10.00
11.00	01100 CAFETERI A	8, 083	14, 571	531	2, 199	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	15, 319	5, 990	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 993	22, 874	0	595	0	14.00
15.00	01500 PHARMACY	53, 622	8, 479	0	778	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	14, 250	8, 126	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	81, 692	118, 587	16, 378	22, 989	296, 743	30.00
31.00	03100 I NTENSI VE CARE UNI T	3, 697	8,662		474	11, 325	31.00
43.00	04300 NURSERY	1,460	3, 083			0	1
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	41, 363	79, 794	11, 986	5, 979	0	50.00
51.00	05100 RECOVERY ROOM	22, 228	52, 171			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 944	24, 834			0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	61, 959	60, 598			0	1
60.00	06000 LABORATORY	55, 123	20, 363		3, 731	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	03,123	20, 303	0	3, 731	0	1
65.00	06500 RESPIRATORY THERAPY	15, 275	9, 873		802	0	
65.00	06501 SLEEP LAB	4, 730	19, 086			0	1
66.00	06600 PHYSI CAL THERAPY	27, 515	44, 265			0	
69.00	06900 ELECTROCARDI OLOGY	6, 205	1, 050			0	1
69.00 69.01	06901 CARDI AC REHAB				0	0	
		2,762	5, 667	0	0	0	1
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	13, 684		0	0	-	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	17,054	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
76.00	03020 CHEMI CAL DEPENDENCY	4, 453	01 402	0	-	0	
76. 01	O3480 ONCOLOGY	38, 056	81, 482	0	0	0	76.01
00.00	OUTPATIENT SERVICE COST CENTERS	20, 200	22.010	000	2.544	0	00.00
88.00	08800 RURAL HEALTH CLINIC	20, 389	32, 219			0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	4, 303	3, 612		0	0	
90.01	09001 CLINIC- MCDONALD	9, 332	30, 736			0	
91.00	09100 EMERGENCY	57, 936	70, 060	14, 126	11, 435	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	45 400	10 704		(00)		101 00
101.00	10100 HOME HEALTH AGENCY	15, 422	10, 784	24	632	0	101.00
440.00	SPECIAL PURPOSE COST CENTERS	1	[	1			110.00
	11300 I NTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
		3, 697	2, 210		0		116.00
118.00		715, 607	779, 242	82, 682	80, 261	308, 068	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	682	4, 258				190.00
	07950 DAYCARE-I NFANT/TODDLER	0	0	0	-		194.00
	07951 MOB	0	0	0	0		194.01
	07952 COMMUNITY HEALTH	2, 256	0	0	0		194.02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.03
	07954 EDUCATI ON	851	0	0	0		194.04
	07955 MARKETI NG	10, 377	4, 992	0	0		194.05
	07956 GUEST MEALS	628	0	0	0		194.06
	07957 OUTSI DE LAUNDRY	0	0	0	0		194.07
	07958 CANCER CENTER	0	0	0	0		194.08
	07959 URGENT CARE	34, 719	46, 151	0	1, 361		194.09
194.10	07960 RHC	0	0	0	0	0	194.10
194.11	07961 OBGYN	22, 131	0	0	0	0	194.11
194.12	07962 TRINE STUDENT HEALTH	1,800	0	0	0	0	194.12
194.13	07963 OCCUPATIONAL HEALTH	7, 881	6, 218	0	0	0	194.13
	07964 IMMUNIZATION CLINIC	1, 410			0		194.14
	07965 FOUNDATI ON	1, 519	0	0	0		194.15
200.00							200.00
201.00	3	0	0	0	0	0	201.00
202.00		799, 861	841, 749	82, 682	81, 622		
		•		•			•

	Financial Systems         CAME           TION OF CAPITAL RELATED COSTS         CAME	RON MEMORIAL CC	Provider CC	N: 15-1315 Pe	riod: om 10/01/2017	u of Form CMS-2 Worksheet B Part II	
				To		Date/Time Pre 2/21/2019 3:4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	<u> </u>
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
00	GENERAL SERVICE COST CENTERS						1 1 0
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. C 2. C
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
00	00500 ADMI NI STRATI VE & GENERAL						5.0
00	00700 OPERATION OF PLANT						7.0
00	00800 LAUNDRY & LINEN SERVICE						8.0
00	00900 HOUSEKEEPI NG						9.0
. 00	01000 DI ETARY						10.0
. 00	01100 CAFETERI A	162, 419					11. C
8. 00	01300 NURSING ADMINISTRATION	5, 534	84, 066				13.0
	01400 CENTRAL SERVICES & SUPPLY	3, 427	0	250, 557			14. C
5.00	01500 PHARMACY	3, 961	0	1, 471	148, 633		15. C
b. 00	01600 MEDI CAL RECORDS & LI BRARY	8, 434	0	19	0	62, 863	16. C
0. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	34, 271	36, 182	8, 581	0	532	30. 0
. 00	03100 I NTENSI VE CARE UNI T	974	1, 025	290	0	38	31.0
. 00 3. 00	04300 NURSERY	390	411	270	0	110	43.0
	ANCILLARY SERVICE COST CENTERS	,		-	-1		
0. 00	05000 OPERATI NG ROOM	10, 599	11, 190	25, 951	0	1, 230	50.0
. 00	05100 RECOVERY ROOM	6, 696	7, 067	0	0	0	51.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	2, 807	2, 966	3, 177	0	0	52.0
1.00	05400 RADI OLOGY-DI AGNOSTI C	17, 518	0	2, 486	0	11, 530	54.0
0.00		14, 589	0	67, 217	0	18, 923	60.0
. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 274	0	0 2, 009	0	0 1, 647	64.0 65.0
5. 01	06501 SLEEP LAB	2/4	0	2,009	0	1, 047	65.0
. 00	06600 PHYSI CAL THERAPY	10, 613	0	696	0	5, 705	66.0
. 00	06900 ELECTROCARDI OLOGY	0	0	219	0	2,860	69.0
9. 01	06901 CARDI AC REHAB	880	0	131	0	1, 513	69.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	52, 973	0	0	71.0
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	66, 021	0	0	72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	148, 633	0	73.0
5.00	03020 CHEMI CAL DEPENDENCY	1, 537	0	26	0	77	76.0
5. 01	03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	U	4	0	0	76. C
8.00	08800 RURAL HEALTH CLINIC	0	0	478	0	0	88. 0
7.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.0
0. 00	09000 CLI NI C	1, 869	1, 973	1, 407	0	2, 018	90.0
0. 01	09001 CLINIC- MCDONALD	5, 123	0	812	0	1, 991	90.0
I. 00	09100 EMERGENCY	22, 028	23, 252	11, 259	0	7, 209	91.0
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.0
	OTHER REIMBURSABLE COST CENTERS	( 110		E 4 E	0		101
01.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	6, 443	0	545	0	0	101. (
3 00	11300 INTEREST EXPENSE						113. (
	11400 UTI LI ZATI ON REVI EW-SNF						114. 0
	11600 HOSPI CE	1, 688	0	33	0	0	116. (
8.00		159, 655	84, 066	245, 805	148, 633	55, 383	118. (
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. (
	07950 DAYCARE-INFANT/TODDLER 07951 MOB	0	0	0	0		194. (
	07951 MOB 07952 COMMUNITY HEALTH	924	0	95	0	5, 715	194. ( 194. (
	07953 ASSISTED LIVING/CAMERON WOODS	924	0	95	0		194. (
	07954 EDUCATI ON	0	0	0	0		194. (
	07955 MARKETI NG	1, 436	0	37	0		194. (
	07956 GUEST MEALS	404	0	0	Ō		194. (
	07957 OUTSI DE LAUNDRY	0	0	0	0		194. (
	07958 CANCER CENTER	0	0	0	0		194. (
	07959 URGENT CARE	0	0	3, 386	0		194. (
	07960 RHC	0	0	0	0		194.
	07961 OBGYN	0	0	860 79	0	1, 765	
	07962 TRINE STUDENT HEALTH 07963 OCCUPATI ONAL HEALTH	0	0	78 233	0		194. <sup>-</sup> 194. <sup>-</sup>
	07964 IMMUNIZATION CLINIC		0	233	0		194. 194. 1
	07965 FOUNDATION	0	0	0	0		194. <sup>-</sup>
			J.	Ũ	Ŭ		200. 0
00.00			1				
00.00 01.00 02.00	Negative Cost Centers	0	0	0	0 148, 633	0 62, 863	201. C

Heal th	Fina	nci	al S	yste	ems		
	TLON	OF	CADI	TAI	DEL	ATED	

## CAMERON MEMORIAL COMMUNITY HOSPITAL

| ALLOCATION OF CAPITAL RELATED COSTS         Provider CON: 15131         Provider CON: 15131         Provider T0/0/2011<br>From 10/0/2012         Worksheet 8<br>From 10/0/2012           Cest Center Description         Subtotal         Interm 6<br>(Secidents Cost<br>24.00         Total<br>Subtotal         Interm 6<br>(Secidents Cost<br>25.00         Total<br>Subtotal         Interm 6<br>(Secidents Cost<br>25.00         Worksheet 8<br>(Secidents Cost<br>22.1/2019 3:<br>22.1/2019 552-10                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Cost Center Description         Subtotal         Intern & Response Construction         Total Response           6 Physics         24.00         25.00         26.00           00 100 CAP REL COSTS-BLIG & FIXT         24.00         25.00         26.00           00 100 CAP REL COSTS-BLIG & FIXT         1.00         0.00 CORPAREL COSTS-BLIG & FIXT         1.01           00 100 CAP REL COSTS-BLIG & FIXT         1.01         0.000 COMPAREL COSTS-BLIG & FIXT         1.01           00 100 CAP REL COSTS-BLIG & FIXT         1.01         0.000 COMPAREL COSTS-BLIG & FIXT         1.01           10 00 100 COMPARED COSTS CENTERS         1.01         0.000 COMPARED COSTS & SUPPLY         1.01           10 00 100 COMPARED ROTHING IN TRATION         1.731, 491         0         1.731, 491           11.00         0.000 COMPARED ROTHING IN TRATION         1.08, 652         0         1.08, 652           10.00         0.000 COMPLATING IN TRATION         1.08, 652         0         1.08, 652           10.00         0.000 COMPLICATING INTERSIVE COST CENTERS         0         0.000 COMPLICATING INTERSIVE COST CENTERS         0           10.00         0.000 COMPLICATING INTERSIVE COST CENTERS         0         0         2.20, 20           10.00         0.000 COMPLICATING INTERSIVE COST CENTERS         0         0 <t< th=""><th>pared:<br/>9 pm</th></t<>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | pared:<br>9 pm                                                                                    |
| OPENERAL SERVICE COST CATERS           100         00100 (AP REL COST-SUBGE & FIXT)           2.00         00200 (AP REL COST-SUBGE & FIXT)           2.01         00200 (APR REL COST-SUBGE & FIXT)           2.01         00200 (APR REL COST-SUBGE & FIXT)           2.01         00200 (ADRIN & FIXTATIVE & GENERAL           2.01         0000 (ADRIN & FIXTATIVE & GENERAL           2.01         0000 (ADRIN & FIXTATIVE & GENERAL           2.01         0000 (ADRIN & FIXTATIVE & GENERAL           2.00         01100 (ATRIN & FIXTATIVE & GENERAL           2.00         01100 (ATRIN & FIXTATIVE & GENERAL           2.00         01100 (ATRIN & FIXTATIVE & GENERAL           3.00         0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |
| 1:00 0100 CAP FEL COSTS BLDG & FIXT 00400 EMPLOYE BALEFITS DEPARTMENT 00400 EMPLOYE BALEFITS DEPARTMENT 00400 EMPLOYE BALEFITS DEPARTMENT 000700 OPERATION OF PLANT 8 GENERAL 00700 OPERATION OF PLANT 8 GENERAL 00700 OPERATION OF PLANT 8 GENERAL 000700 OPERATION OF PLANT 8 GENERAL 000700 OPERATION OF PLANT 8 GENERAL 0000000 CAFFTERIA 0000000 DI ETAPY NG 000000 CAFFTERIA 0000000 CAFFTERIA 0000000 CAFFTERIA 0000000 CAFFTERIA 00000000 CAFFTERIA 00000000 CAFFTERIA 00000000 CAFFTERIA 00000000 CAFFTERIA 00000000 CAFFTERIA 000000000000000000000000000000000000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |
| 2. 00         00200 CAP REL COSTS-INVELE COULP           4.00         04000 DEHUCYCE ENCRENTS DEPARTMENT           5. 00         0500 ADMINISTRATIVE & GENERAL.           7. 00         07000 DEHAUTAG DENGENTS DEPARTMENT           8. 00         00600 LAURORY & LINEN SERVICE           9. 00         00700 DITENSIVE CARAGE           9. 00         00700 DITENSIVE CARAGE           9. 00         00700 DITENSIVE CARAGE           9. 00         00700 DITENSIVE CARE AL RECORDS & LIBRARY           10. 00         01000 CHITENSI VE CARE UNIT           10. 00         01000 ADULTS & PEDIATRICS           11. 00         01000 THENSIVE CARE UNIT           10. 00         05000 APECOMENT NS ROOM           10. 00         05000 APECOMENT NG ROOM           10. 00         05000 APECOMENT NG ROOM           10. 00         05200 DELIVERY NOUA & LABOR ROOM           10. 00         05200 DELIVERY NOUA & LABOR ROOM           10. 00 STOO APECOMENT NG ROOM         132, 200           10. 00 STOO APENDATING ROOM         132, 200           10. 00 STOO APECOMENT NG ROOM         132, 200           10. 00 STOO APECOMENT NG ROOM         132, 200           10. 00 STOO APECOMENT NG ROOM         132, 200           10. 00 STOO APECOMENT NG ROOM         132, 200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                   |
| 11:00       03100[INTERSIVE CARE UNIT       108,652       0       108,652         AND 01LLAPY SERVICE COST CENTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1.00<br>2.00<br>4.00<br>5.00<br>7.00<br>8.00<br>9.00<br>10.00<br>11.00<br>13.00<br>14.00<br>15.00 |
| 43.00     04300 NURSERY     43.093     0     43.093       ANCILLARY SERVICE COST CENTERS     937,380     0     937,380       50.00     05000 REPERATING ROOM     920,347     0     280,347       51.00     05000 REDURERY ROOM     220,347     0     280,347       51.00     05000 REDURERY ROOM     220,347     0     280,347       51.00     05000 REDURATORY ROOM     220,347     0     272,819       64.00     06400 INTRAVENOUS THERAPY     122,520     0     122,520       65.01     06500 RESPIRATORY THERAPY     122,520     0     122,520       66.01     06600 PHYSICAL THERAPY     10,165     0     10,165       67.00     0     0     0     0     0       67.00     00 OROO RESPIRATORY THERAPY     10,165     0     10,171       68.00     06900 RESPIRATORY THERAPY     20,171     0,171     0,171       69.00     00 OROO RESPIRATORY     83,075     0     64,657       71.00     07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS     148,633     0     148,633       72.00     07200 INPL. DEV. CHARGED TO PATIENTS     148,633     0     483,134       00 Oroo 0     0     0     0     0       70.01     03480 OROLOGY<                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 30.00                                                                                             |
| ANOLLIARY SERVICE COST CENTERS         Image: Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of                                                                                                                                                                                                                                                                | 31.00<br>43.00                                                                                    |
| 50.00     05000     005000     005200     0197, 380     097, 380       51.00     05100     05100     05200     0100     05000       52.00     05200     0ELIVERY ROOM     8 LABOR ROOM     280, 347     0       54.00     05400     RADIOLOCY-DIAGNOSTIC     738, 040     0     738, 040       0.00     06000     LABORATORY     372, 819     0     372, 819     0       64.00     06400     INTRAVENOUS THERAPY     0     0     0     0       65.00     06500 RESPI RATORY THERAPY     122, 520     0     122, 520       65.01     06500 RESPI RATORY THERAPY     0     0     0       66.00     06600 PHYSI CAL THERAPY     122, 520     0     122, 520       67.01     06301 CAEDIA CREBAB     99, 099     0     99, 099       69.00     06900 ELECTROCARDI OLOGY     20, 171     0     20, 171       69.01     06900 ELECTROCARDI OLOGY     20, 171     0     64, 196       71.00     07100 MEDI CAL, SUPPLIES CHARGED TO PATI ENTS     148, 633     0     148, 633       70.00     0320 CHEM CAL DEPENDENCY     6, 293     0     6, 293       70.00     03000 RUBAL CHARGED TO PATI ENTS     148, 633     148, 633       70.00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | +3.00                                                                                             |
| 60.00         06000         LABORATORY         372, 819         0         372, 819           64.00         06400         INTRAVENOUS THERAPY         0         0         0           65.01         06501         RESPI RATORY THERAPY         122, 520         0         122, 520           65.01         06501         SLEEP LAB         99, 099         0         99, 099           64.00         06600         PHS1 C.A. THERAPY         510, 165         0         510, 165           69.00         06900         ELCTROCARDI OLOGY         20, 171         0         20, 171           69.01         OARDI CAL SUPPLIES CHARGED TO PATI ENTS         83, 075         0         83, 075           70.00         07100         MPL. DEV. CHARGED TO PATI ENTS         148, 633         0         148, 633           70.00         03480         ONCOLOGY         883, 134         0         883, 134           0171 FINT SERVICE COST CENTERS         0         0         0         0           90.00         0800         RURAL HEALTH CLINIC         181, 542         0         0           90.01         03480         MCADLALY OUALIFIED HEALTH CENTER         0         0         0           90.01         09000 <td>50.00<br/>51.00<br/>52.00</td>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 50.00<br>51.00<br>52.00                                                                           |
| 64.00         06400         INTRAVENOUS THERAPY         0         0           65.00         06500         RESPIRATORY THERAPY         122,520         0           66.01         06501         SLEEP LAB         99,099         0         99,099           66.00         06600         PLST CACATDI LAC THERAPY         510,165         0         510,165           67.00         06900         ELECTROCARDI OLOGY         20,171         0         22,171           69.01         06900         ELECTROCARDI OLOGY         20,171         0         20,171           69.01         06900         ELECTROCARDI OLOGY         20,171         0         20,171           69.01         06900         ELECTROCARDI OLOGY         20,171         0         20,171           60.0100         MEDICAL CHARGED TO PATIENTS         83,075         0         83,075           72.00         07200         INUS. CHARGED TO PATIENTS         148,633         0         148,633           74.00         07300         DRUCS. CHARGED TO PATIENTS         883,134         0         883,134           0         04300         NCOLOCY         883,134         0         883,134           0         049,281         0         4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 54.00<br>60.00                                                                                    |
| 65.00         06500         RESPI RATORY THERAPY         122,520         0           65.01         06500         SLEP LAB         99,099         0         99,099           66.00         06600         PHYSI CAL THERAPY         510,165         0         510,165           69.00         06400         CRECKOCARDIOLOGY         20,171         0         20,171           69.01         OROPOL CREIAB         64,196         0         64,196           71.00         01700         MEDI CAL SUPPLIES CHARGED TO PATIENTS         83,075         0         63,075           73.00         07300         DRUL. DEV. CHARGED TO PATIENTS         148,633         0         148,633           76.00         03202         CHEMI CAL DEPENDENCY         6,293         0         6,293           76.10         03400         ONCOLOCY         883,134         0         883,134           0UTPATIENT SERVICE COST CENTERS         181,542         0         181,542         0           80.00         08900         FEDERALY OUALIFIED HEALTH CENTER         0         0         0           90.01         09001         CLINIC         MCDONALD         174,731         0         174,731           90.01         OSPOOT CENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 64.00                                                                                             |
| 65.01         06501         SLEEP LAB         99,099         0         99,099           66.00         06600         PHYSI CAL THERAPY         510,165         0         510,165           69.00         06900         ELECTROCARDI OLOGY         20,171         0         20,171           69.01         06901         CARDI AC REHAB         64,196         0         66,657           71.00         07100         MEIC AL SUPPLIES CHARGED TO PATIENTS         83,075         0         83,075           73.00         07300         DRUGS CHARGED TO PATIENTS         148,633         0         148,633           76.00         30302         CHEM CAL DEPENDENCY         6,293         0         6,293           76.01         03480         0000LOGY         883,134         0         883,134           0017PATIENT SERVICE COST CENTERS         0         0         0         0           80.00         08800         REALY UALI FIED HEALTH CENTER         0         174,731         0         174,731           90.10         09001         CLINIC         MERCENCY         877,199         0         877,199           90.00         09000         CLINIC         NON         76,300         76,300         76,30                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 65.00                                                                                             |
| 66.00       06000       PHYSI CAL THERAPY       510, 165       0         69.00       06900       ELCTROCARDI OLOGY       20, 171       0       20, 171         69.01       06901       CARDI AC REHAB       64, 196       0       64, 196         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       66, 657       0       66, 657         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       83, 075       0       83, 075         73.00       07300       DRUSC CHARGED TO PATI ENTS       148, 633       0       6, 293         76.01       03480       ONCOLOGY       883, 134       0       883, 134         00TPATT ENT SERVICE COST CENTERS       0       0       0       0         88.00       08800       RURAL HEALTH CLINIC       181, 542       0       181, 542         90.00       09000       CLINIC       49, 281       0       49, 281         90.01       09000       CLINIC       877, 199       0       877, 199         91.00       09100       EKERGENCY       76, 300       76, 300       76, 300         92.00       09200 OBSERVATI ON BEDS (NON-DI STI NCT PART       0       174, 731       0       174, 731 <td>65.01</td>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 65.01                                                                                             |
| 69.01       06901       CARDIAC REHAB       64, 196       0       64, 196         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       66, 657       0       66, 657         72.00       07100       DEV. CHARGED TO PATIENTS       83, 075       0       83, 075         73.00       07300       DRUGS CHARGED TO PATIENTS       148, 633       0       148, 633         76.00       03200       CHEMICAL DEPENDENCY       6, 293       0       6, 293         76.01       03480       ONCOLOGY       883, 134       0       883, 134         0UTPATIENT SERVICE COST CENTERS       0       181, 542       0       0       0         90.00       08900       RURAL HEALTH CLINIC       181, 542       0       0       0       0         90.01       08900       RURAL MEALTH CONTER       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 66.00                                                                                             |
| 71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       66, 657       0       66, 657         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       83, 075       0       83, 075         73.00       07300       DRUGS CHARGED TO PATI ENTS       148, 633       0       148, 633         76.01       03400       OX300 DRUGAL DEPENDENCY       6, 293       0       6, 293         76.01       03480       ONCOLOGY       883, 134       0       883, 134         0       01741 ENT SERVICE COST CENTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 69.00                                                                                             |
| 72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       83,075       0       83,075         73.00       07300       DRUGS CHARGED TO PATIENTS       148,633       0       148,633         76.00       03020       CHEMI CAL DEPENDENCY       883,134       0       883,134         00       03480       ONCOLOGY       883,134       0       883,134         00       017ATIENT SERVICE COST CENTERS       0       181,542       0       181,542         80.0       08800       RRAL HEALTH CLINIC       181,542       0       0       0         90.00       09000       CLINIC       49,281       0       49,281         90.01       09001       CLINIC - MCDONALD       174,731       0       174,731         91.00       09000       EMERGENCY       877,199       0       877,199         92.00       09200       DESERVATION BEDS (NON-DISTINCT PART       0       76,300       76,300         011000       HOME HEALTH AGENCY       76,300       0       76,300       877,199         91.100       11400       UTI LIZATION REVIEW-SNF       16,356       16,356       16,356         113.00       INTERST EXPERDISE       16,356       16,356 <t< td=""><td>69.01</td></t<>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 69.01                                                                                             |
| 73.00       O7300       DRUGS CHARGED TO PATIENTS       148,633       0       148,633         76.00       O3202       CHEM CAL DEPENDENCY       6,293       0       6,293         76.01       O3480       ONCOLOGY       883,134       0       883,134         0UTPATIENT SERVICE COST CENTERS       0       0       883,134       0         0UTPATIENT SERVICE COST CENTERS       0       0       0       0         90.00       OB800       RURAL HEALTH CLINIC       181,542       0       181,542         90.00       09000       CLINIC       49,281       0       49,281         90.01       09001       CLINIC - MCDONALD       174,731       0       174,731         91.00       09001       EMERGENCY       877,199       0       877,199         92.00       09200       0SERVATION BEDS (NON-DI STINCT PART       0       0       76,300       76,300         91.10.01       INTEREST EXPENSE       113.00       INTEREST EXPENSE       114.00       1400       1400       11400       11400       11400       16,356       0       16,356         113.00       INTEREST EXPENSE       16,356       0       16,356       16,356       16,356                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 71.00                                                                                             |
| 76.00       03020       CHEMI CAL DEPENDENCY       6, 293       0       6, 293         76.01       03480       ONCOLOGY       883, 134       0       883, 134         OUTPATI ENT SERVICE COST CENTERS       0       181, 542       0       181, 542         88.00       08800       RURAL HEALTH CLINIC       181, 542       0       49, 281         90.01       09000       CLINIC       49, 281       0       49, 281         90.01       09010       EMERGENCY       877, 199       0       877, 199         92.00       09200       DESERVATION BEDS (NON-DISTINCT PART       0       0       76, 300       76, 300         011.00       1000HOME       HEALTH AGENCY       76, 300       0       76, 300       76, 300         92.00       09200       ITHA GENCY       76, 300       0       76, 300       76, 300         101.00       10100 HOME       HEALTH AGENCY       76, 300       0       76, 300       76, 300         113.00       I1300       ITAGON REVIEWSNF       16, 356       0       16, 356         114.00       11400       UTI LI ZATI ON REVIEWSNF       16, 356       0       8, 173, 662         100.00       190000       GIFT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 72.00                                                                                             |
| 76. 01         03480         0NCOLOGY         883, 134         0         883, 134           OUTPATIENT SERVICE COST CENTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 73.00                                                                                             |
| OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         181,542         0         181,542           99.00         09000         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0           90.01         09000         CLINIC         49,281         0         49,281           90.01         09010         CLINIC - MCDONALD         174,731         0         174,731           91.00         09200         DBSERVATION BEDS (NON-DISTINCT PART         0         0         0           0         00         00         0         76,300         0         76,300           0         10100         HOME HEALTH AGENCY         76,300         0         76,300           SPECIAL PURPOSE COST CENTERS         10.00         10400 UTI LIZATION REVIEW-SNF         1         1           114.00         11400         HILZATION REVIEW-SNF         1         6.356         0         16,356           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         8,173,662         0         8,173,662           190.00         IFT, FLOWER, COFFEE SHOP & CANTEEN         44,840         0         0         0           194.00         07950         DAYCARE-INFANT/TODDLER <td>76.00</td>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 76.00                                                                                             |
| 88.00       08800       RURAL HEALTH CLINIC       181,542       0       181,542         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0         90.00       09000       CLINIC       49,281       0       49,281         90.10       09001       CLINIC       MCDONALD       174,731       0       174,731         91.00       09100       EMERGENCY       877,199       0       877,199         92.00       09200 (DSERVATION BEDS (NON-DISTINCT PART       0       76,300       0       76,300         0       1101.00       IOME HEALTH AGENCY       76,300       0       76,300       76,300         SPECIAL PURPOSE COST CENTERS         113.00       ITTRERST EXPENSE       16,356       0       16,356         114.00       ITA0V UTI LIZATI ON REVIEW-SNF       16,356       0       8,173,662         100.00       19000 GIT, FLOWER, COFFEE SHOP & CANTEEN       44,840       0       44,840         190.00       174, F31,500       5,715       0       5,715         194.00       07950       DAYCARE - I NFANT/TODDLER       5,715       0       5,715         194.02       07952       COMUNITY HEALTH <td< td=""><td>76.01</td></td<>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 76.01                                                                                             |
| 89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0         90.00       09000       CLINIC       49,281       0       49,281         90.01       09001       CLINIC- MCDONALD       174,731       0       174,731         91.00       09100       EMERGENCY       877,199       0       877,199         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       877,199       0         0THER       REI MBURSABLE COST CENTERS       0       76,300       0       76,300         10100       HOME HEALTH AGENCY       76,300       0       76,300       0         113.00       INTEREST EXPENSE       16,356       0       16,356         114.00       11400       UTILIZATION REVIEW-SNF       16,356       0       8,173,662         114.00       11400       GIFT, FLOWER, COFFEE SHOP & CANTEEN       44,840       0       44,840         190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       44,840       0       44,840         194.01       07950       DAYCARE-INFANT/TODDLER       5,715       0       5,715         194.02       07952       COMMUNITY HEALTH       5,715       0       5,715                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 88.00                                                                                             |
| 90. 00       09000       CLINIC       49, 281       0       49, 281         90. 01       09001       CLINIC- MCDONALD       174, 731       0       174, 731         91. 00       09100       EMERGENCY       877, 199       0       877, 199         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0       877, 199       0         0THER REIMBURSABLE COST CENTERS       0       76, 300       0       76, 300         OTHER REIMBURSABLE COST CENTERS         101. 00       10100       HOME HEALTH AGENCY       76, 300       0       76, 300         SPECIAL PURPOSE COST CENTERS         113. 00       11400       UTI LIZATION REVIEW-SNF       16, 356       0       16, 356         114. 00       11400       UTI LIZATION REVIEW-SNF       16, 356       0       8, 173, 662         NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         190. 00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       44, 840       0       44, 840         194. 00       07950       DAYCARE-I NFANT/TODDLER       0       0       0       0         194. 02       07951       MOB       5, 715       0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 89.00                                                                                             |
| 90.01       09001       CLI NI C - MCDONALD       174, 731       0       174, 731         91.00       09100       EMERGENCY       877, 199       0       877, 199         92.00       0BSERVATI ON BEDS (NON-DI STI NCT PART       0       877, 199       0         0THER REI MBURSABLE COST CENTERS       0       76, 300       0       76, 300         101.00       HOME HEALTH AGENCY       76, 300       0       76, 300         SPECIAL PURPOSE COST CENTERS       113.00       INTEREST EXPENSE       114.00       11400       UTI LI ZATI ON REVI EW-SNF         114.00       11400       UTI LI ZATI ON REVI EW-SNF       16, 356       0       16, 356         116.00       10600       HOSPI CE       16, 356       0       16, 356         118.00       SUBTOTALS (SUM OF LI NES 1 through 117)       8, 173, 662       0       8, 173, 662         NONREI MBURSABLE COST CENTERS       190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       44, 840       0       44, 840         194.00       07950       DAYCARE - I NFANT/TODDLER       0       0       0       0         194.01       07951       MOB       5, 715       0       5, 715       0       3, 445         194.02       07951<                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 90.00                                                                                             |
| 92.00         OBSERVATI ON BEDS (NON-DI STINCT PART         0           OTHER REIMBURSABLE COST CENTERS         OTHER REIMBURSABLE COST CENTERS           101.00         10100         HOME HEALTH AGENCY         76, 300         0         76, 300           SPECIAL PURPOSE COST CENTERS         SPECIAL PURPOSE COST CENTERS         Image: Cost Centers         Image: Cost Centers         Image: Cost Centers           113.00         11300         INTEREST EXPENSE         Image: Cost Centers         Image: Cost Centers </td <td>90.01</td>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 90.01                                                                                             |
| OTHER         REI MBURSABLE         COST         CENTERS           101.00         10100         HOME         HEALTH         AGENCY         76, 300         0         76, 300           SPECIAL         PURPOSE         COST         CENTERS         113.00         INTEREST         EXPENSE         113.00         11300         INTEREST         EXPENSE         114.00         114.00         UTI LI ZATI ON REVIEW-SNF         16, 356         0         16, 356         16, 356         16, 356         16, 356         16, 356         16, 356         18.00         SUBTOTALS         SUBTOTALS         SUM OF LINES 1 through 117)         8, 173, 662         0         8, 173, 662         0         17, 362         0         8, 173, 662         0         14, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         144, 840         0         140, 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 91.00                                                                                             |
| 101.00         HOME         HEALTH         AGENCY         76,300         0         76,300           SPECIAL PURPOSE COST CENTERS           SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           114.00         ITILIZATION REVIEW-SNF           116.00         HOSPICE         16,356         0         16,356           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         8,173,662         0         8,173,662           NONREI MBURSABLE COST CENTERS           190.00           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         44,840         0         44,840         0           194.00         07950         DAYCARE - I NFANT/TODDLER         0         0         0         0         0         10         10         10         10         10         10         10         10         13,445         0         3,445         14         14,840         0         0         0         0         0         10         10         10         10         10         10         10         10         10         10         10         10         10         10         10 <td>92.00</td>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 92.00                                                                                             |
| SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           114.00         UTI LI ZATI ON REVIEW-SNF           116.00         11600           116.00         11600           SUBTOTALS (SUM OF LI NES 1 through 117)         8, 173, 662           NONREI MBURSABLE COST CENTERS           190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN           194.00         07950           DAYCARE -I NFANT/TODDLER         0           194.01         07952           COMMUNI TY HEALTH         3, 445           194.02         07952           COMMUNI TY HEALTH         3, 445           194.03         07953           ASI STED LI VI NG/CAMERON WOODS         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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |
| 113.00       11300       INTEREST EXPENSE       11300       INTEREST EXPENSE         114.00       11400       UTI LI ZATI ON REVI EW-SNF       16,356       0         116.00       11600       HOSPI CE       16,356       0         118.00       SUBTOTALS (SUM OF LI NES 1 through 117)       8,173,662       0       8,173,662         NONREI MBURSABLE COST CENTERS         190.00       19400       GI FT, FLOWER, COFFEE SHOP & CANTEEN       44,840       0       44,840         194.00       07950       DAYCARE-I NFANT/TODDLER       0       0       0         194.01       07952       COMMUNI TY HEALTH       3,445       0       3,445         194.02       07952       COMMUNI TY HEALTH       3,445       0       0         194.04       07954       EDUCATI ON       851       0       851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 101.00                                                                                            |
| 114.00       11400       UTI LI ZATI ON REVIEW-SNF       16,356         116.00       11600       HOSPI CE       16,356         118.00       SUBTOTALS (SUM OF LI NES 1 through 117)       8,173,662       0         NONREI MBURSABLE COST CENTERS         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       44,840       0         194.00       07950       DAYCARE-I NFANT/TODDLER       0       0         194.01       07952       COMMUNI TY HEALTH       3,445       0       3,445         194.02       07952       COMMUNI TY HEALTH       3,445       0       0       0         194.04       07954       EDUCATI ON       851       0       851       0       851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 112 00                                                                                            |
| 116.00         HOSPI CE         16, 356         0         16, 356           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         8, 173, 662         0         8, 173, 662           NONREI MBURSABLE         COST CENTERS         44, 840         0         44, 840           190.00         19750         DAYCARE-I NFANT/TODDLER         0         0         0           194.01         07950         DAYCARE-I NFANT/TODDLER         5, 715         0         5, 715           194.02         07952         COMMUNI TY HEALTH         3, 445         0         3, 445           194.03         07953         ASSI STED LI VI NG/CAMERON WOODS         0         0         0           194.04         07954         EDUCATI ON         851         0         851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 113.00<br>114.00                                                                                  |
| 118.00         SUBTOTALS (SUM OF LINES 1 through 117)         8, 173, 662         0         8, 173, 662           NONREI MBURSABLE COST CENTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 116.00                                                                                            |
| NONREI MBURSABLE         COST         CENTERS           190. 00         GI FT,         FLOWER,         COFFEE         SHOP         A           194. 00         07950         DAYCARE-I NFANT/TODDLER         0         0         0           194. 01         07951         MOB         5,715         0         5,715           194. 02         07952         COMMUNI TY         HEALTH         3,445         0         3,445           194. 03         07953         ASSI STED         LI VI NG/CAMERON         WOODS         0         0           194. 04         07954         EDUCATI ON         851         0         851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 118.00                                                                                            |
| 190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       44,840       0       44,840         194.00       07950       DAYCARE-I NFANT/TODDLER       0       0       0         194.01       07951       MOB       5,715       0       5,715         194.02       07952       COMMUNI TY HEALTH       3,445       0       3,445         194.03       07953       ASSI STED LI VI NG/CAMERON WOODS       0       0         194.04       07954       EDUCATI ON       851       0       851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |
| 194.01       07951       MOB       5,715       0       5,715         194.02       07952       COMMUNI TY HEALTH       3,445       0       3,445         194.03       07953       ASSI STED LI VI NG/CAMERON WOODS       0       0       0         194.04       07954       EDUCATI ON       851       0       851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 190.00                                                                                            |
| 194. 02     07952     COMMUNI TY     HEALTH     3, 445     0     3, 445       194. 03     07953     ASSI STED LI VI NG/CAMERON WOODS     0     0     0       194. 04     07954     EDUCATI ON     851     0     851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 194.00                                                                                            |
| 194. 03         07953         ASSI STED         LI VI NG/CAMERON         WOODS         0         0           194. 04         07954         EDUCATI ON         851         0         851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 194.01                                                                                            |
| 194. 04 07954 EDUCATI ON 851 0 851                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 194.02                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 194.03                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 194.04                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 194.05                                                                                            |
| 194. 06 07956 GUEST MEALS 1, 062 0 1, 062<br>194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 194.06<br>194.07                                                                                  |
| 194. 08 07958 CANCER CENTER 0 0 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 194.07                                                                                            |
| 194. 09 07959 URGENT CARE 265, 068 0 265, 068                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 194.09                                                                                            |
| 194.10[07960] RHC 0 0 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 194.10                                                                                            |
| 194. 11 07961 OBGYN 26, 360 0 26, 360                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 194.11                                                                                            |
| 194. 12 07962 TRI NE STUDENT HEALTH 2, 020 0 2, 020                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 194.12                                                                                            |
| 194. 13 07963 OCCUPATI ONAL HEALTH 38, 596 0 38, 596                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 194. 13                                                                                           |
| 194. 14 07964 I MMUNI ZATI ON CLI NI C 5, 877 0 5, 877                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 194.14                                                                                            |
| 194. 15 07965 FOUNDATI ON 1, 640 0 1, 640                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 194. 15                                                                                           |
| 200.00   Cross Foot Adjustments   0   0   0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 200.00                                                                                            |
| 201.00         Negative Cost Centers         0         0         0           202.00         TOTAL (sum lines 118 through 201)         8,632,941         0         8,632,941                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 201.00                                                                                            |
| 202.00   TOTAL (sum lines 118 through 201)   8,632,941  0  8,632,941                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 202.00                                                                                            |

		RON MEMORIAL CO				u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider CO	F	Period: From 10/01/2017 To 09/30/2018	Worksheet B-1 Date/Time Pre 2/21/2019 3:4	pared:
		CAPI TAL REL	ATED COSTS			272172017 0.1	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	JA	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	114, 344			1		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	111,011	141, 561				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	590		22, 688, 058	3		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	10, 116				46, 817, 948	
7.00	00700 OPERATION OF PLANT	10, 278				3, 708, 856	
8.00	00800 LAUNDRY & LINEN SERVICE	1,062				107, 055	
9.00	00900 HOUSEKEEPI NG	474			0	1, 321, 427	
10.00	01000 DI ETARY	3, 922				485, 549	
11.00	01100 CAFETERI A	1, 985				473, 162	
13.00	01300 NURSI NG ADMI NI STRATI ON	816				896, 685	
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 116				526, 397	
15.00	01500 PHARMACY	1, 155				3, 138, 730	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0				834, 114	
	INPATIENT ROUTINE SERVICE COST CENTERS	·				·	
30.00	03000 ADULTS & PEDIATRICS	16, 155	16, 155	2, 571, 839	9 0	4, 780, 297	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 180	1, 180	67, 454	1 0	216, 428	31.00
43.00	04300 NURSERY	420	420	40, 454	1 0	85, 467	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	10, 870				_,,	
51.00	05100 RECOVERY ROOM	7, 107				1, 301, 112	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 383				640, 600	
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 255				3, 626, 714	
60.00	06000 LABORATORY	2,774	2, 774	990, 893	s 0	3, 226, 584	
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	
65.00	06500 RESPI RATORY THERAPY	1, 345	1, 345		s 0	894, 094	
65. 01	06501 SLEEP LAB	0	2, 600		0	276, 883	
66.00	06600 PHYSI CAL THERAPY	6, 030			0	1, 610, 548	
69.00	06900 ELECTROCARDI OLOGY	143	143		0	363, 227	
69. 01	06901 CARDI AC REHAB	772	772	75, 848	3 O	161, 671	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	800, 964	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	998, 267	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
76.00	03020 CHEMI CAL DEPENDENCY	0	0	112, 033		260, 670	
76. 01	03480 ONCOLOGY	11, 100	11, 100	C	0 0	2, 227, 603	76.01
00 00	OUTPATIENT SERVICE COST CENTERS		4 200	702 14/		1 100 450	
88.00	08800 RURAL HEALTH CLINIC	0	4, 389	783, 146	5 O	.,	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 492	402	1/1 240		0 251, 860	
	09001 CLINIC MCDONALD	492	492			546, 270	
	09100 EMERGENCY	9, 544	.,				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 344	7, 344	1,000,075	, U	3, 371, 233	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101 00	10100 HOME HEALTH AGENCY	0	1, 469	588, 593	3 0	902, 722	101 00
101.00	SPECIAL PURPOSE COST CENTERS	0	1, 107	000,070	<u> </u>	702,722	101.00
113.00	11300 I NTEREST EXPENSE				1		113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11600 HOSPI CE	0	301	137, 370	0 0	216, 396	
118.00		113, 084					
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	580	580	C	) 0	39, 900	190. 00
	07950 DAYCARE-I NFANT/TODDLER	0	0	C	) 0	0	194.00
194.01	07951 MOB	0	0	C	) 0	0	194.01
	07952 COMMUNI TY HEALTH	0	0	95, 303	s  0	132, 030	194.02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0	C	) o		194.03
	07954 EDUCATI ON	0	0	C	) o	49, 832	194.04
	07955 MARKETI NG	680	680	102, 707	'  ol	607, 420	
	07956 GUEST MEALS	0	0	16, 762	2  O	36, 774	
	07957 OUTSI DE LAUNDRY	0	0	C	) o		194.07
	07958 CANCER CENTER	0	0	C	) O		194. 08
01 00	07959 URGENT CARE	0	6, 287	1, 275, 525	o از	2, 032, 279	
	07960 RHC	0	0	C	) o		194.10
94.10				896, 774		1, 295, 426	
94.10 94.11	07961 OBGYN	0	0				1101 10
194. 10 194. 11 194. 12	07961 OBGYN 07962 TRI NE STUDENT HEALTH	0	0	79, 332		105, 343	
194. 10 194. 11 194. 12 194. 13	07961 OBGYN 07962 TRI NE STUDENT HEALTH 07963 OCCUPATI ONAL HEALTH	0 0 0	0 847	220, 630	0 0	461, 319	194.13
194. 10 194. 11 194. 12 194. 13 194. 14	07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC	0 0 0	0 847 121	220, 630 59, 442	0 0 2 0	461, 319 82, 535	194. 13 194. 14
194. 10 194. 11 194. 12 194. 13 194. 13 194. 14	07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC 07965 FOUNDATION	0 0 0 0		220, 630	0 0 2 0	461, 319	194. 13 194. 14 194. 15
194. 10 194. 11 194. 12 194. 13 194. 14	07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC 07965 FOUNDATION Cross Foot Adjustments	0 0 0 0		220, 630 59, 442	0 0 2 0	461, 319 82, 535 88, 891	194. 13 194. 14

Heal th I	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lieu of Form CMS-2552-10			
COST AL	LOCATION - STATISTICAL BASIS	Provider CCN: 15-1315			Period:	Worksheet B-1		
					From 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4		
		CAPI TAL REL	ATED COSTS					
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)		
		1.00	2.00	4.00	5A	5.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 643, 714	3, 989, 227	7, 073, 20	5	11, 442, 645	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	40. 611785	28. 180269	0. 31175	9	0. 244407	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			40, 58	7	799, 861	204.00	
205.00	Unit cost multiplier (Wkst. B, Part			0. 00178	9	0. 017084	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	

COST A	Financial Systems CAME LLOCATION - STATISTICAL BASIS	RON MEMORIAL CO	Provi der CC	N: 15-1315 P	eriod: rom 10/01/2017	u of Form CMS-2 Worksheet B-1	
				T.		Date/Time Pre 2/21/2019 3:4	
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	
	r	7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1					1.00
2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00	00200 CAP REL COSTS-MUBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	114, 668 1, 062 474 3, 922 1, 985	78, 722 20, 723 184 506	6, 717 66 181	14, 989 0	22, 511	2.00 4.00 5.00 7.00 8.00 9.00 10.00
	01300 NURSING ADMINISTRATION	816	0	0	0	767	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	3, 116 1, 155	0	49 64		475 549	
	01600 MEDICAL RECORDS & LIBRARY	1, 107	0	04	0	1, 169	1
	INPATIENT ROUTINE SERVICE COST CENTERS	T	-		-		
30.00	03000 ADULTS & PEDIATRICS	16, 155	15, 594	1, 892		4, 750	
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	1, 180 420	829 3, 608	39 402		135 54	
101 00	ANCI LLARY SERVI CE COST CENTERS	120		102		01	
50.00	05000 OPERATING ROOM	10, 870	11, 412	492		1, 469	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	7, 107	0 1, 114	322 99	0	928 389	
52.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 255	6, 678	506		2, 428	1
60.00	06000 LABORATORY	2,774	258	307	0	2, 022	
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0	0	
65. 00 65. 01	06501 SLEEP LAB	1, 345 2, 600	34 876	66 90		38 0	1
66.00	06600 PHYSI CAL THERAPY	6, 030	1, 707	260		1, 471	1
69.00	06900 ELECTROCARDI OLOGY	143	0	0	0	0	
	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	772	0	0	0	122 0	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0 11, 100	0	0	0	213 0	
70.01	OUTPATIENT SERVICE COST CENTERS	11,100	0	0	0	0	70.01
88.00	08800 RURAL HEALTH CLINIC	4, 389	769	211	0	0	
89.00 90.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C	0 492	0	0	0	0 259	
90.00 90.01	09001 CLINIC- MCDONALD	4, 187	958	566	-	710	
	09100 EMERGENCY	9, 544	13, 449	941	0	3, 053	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	1, 469	23	52	0	893	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	301	0	0	0	234	114.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	106, 153	78, 722	6, 605	14, 989		118.00
100.00	NONREI MBURSABLE COST CENTERS	580					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					()	1100 00
194 00	07950 DAYCARE - I NEANT/TODDLER		0	0			190.00 194.00
194.01	07950 DAYCARE-INFANT/TODDLER 07951 MOB	0	0	0		0	190.00 194.00 194.01
194.01 194.02	07951 MOB 07952 COMMUNI TY HEALTH		-	0 0 0	0	0 0 128	194. 00 194. 01 194. 02
194. 01 194. 02 194. 03	07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS		-	0 0 0 0	0	0 0 128 0	194. 00 194. 01 194. 02 194. 03
194.01 194.02 194.03 194.04	07951 MOB 07952 COMMUNI TY HEALTH		-	0 0 0	0 0 0 0	0 0 128 0 0	194. 00 194. 01 194. 02
194.01 194.02 194.03 194.04 194.05 194.06	07951 MOB 07952 COMMUNI TY HEALTH 07953 ASSI STED LI VI NG/CAMERON WOODS 07954 EDUCATI ON 07955 MARKETI NG 07956 GUEST MEALS	0 0 0 0 0	-	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 128 0 0 199 56	194.00 194.01 194.02 194.03 194.04 194.05 194.06
194.01 194.02 194.03 194.04 194.05 194.06 194.07	07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY	0 0 0 0 0	-	0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	0 0 128 0 199 56 0	194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08	07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER	0 0 0 680 0 0 0 0	-	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 128 0 0 199 56 0 0	194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10	07951 MOB 07952 COMMUNI TY HEALTH 07953 ASSI STED LI VI NG/CAMERON WOODS 07954 EDUCATI ON 07955 MARKETI NG 07956 GUEST MEALS 07957 OUTSI DE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC	0 0 0 0 0	-	0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 128 0 0 199 56 0 0 0 0 0	$\begin{array}{c} 194.\ 00\\ 194.\ 01\\ 194.\ 02\\ 194.\ 03\\ 194.\ 04\\ 194.\ 05\\ 194.\ 06\\ 194.\ 07\\ 194.\ 08\\ 194.\ 09\\ 194.\ 10\\ \end{array}$
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11	07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07950 URGENT CARE 07960 RHC 07961 OBGYN	0 0 0 680 0 0 0 0	-	0 0 0 0 0 0 0 0 0 0 0 0 0 112		0 0 128 0 0 199 56 0 0 0 0 0 0 0 0	$\begin{array}{c} 194.\ 00\\ 194.\ 01\\ 194.\ 02\\ 194.\ 03\\ 194.\ 04\\ 194.\ 05\\ 194.\ 06\\ 194.\ 07\\ 194.\ 08\\ 194.\ 09\\ 194.\ 10\\ 194.\ 11\\ \end{array}$
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12	07951 MOB 07952 COMMUNI TY HEALTH 07953 ASSI STED LI VI NG/CAMERON WOODS 07954 EDUCATI ON 07955 MARKETI NG 07956 GUEST MEALS 07957 OUTSI DE LAUNDRY 07958 CANCER CENTER 07959 URCENT CARE 07960 RHC 07961 OBGYN 07962 TRI NE STUDENT HEALTH	0 0 0 680 0 0 6, 287 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-	0 0 0 0 0 0 0 0 0 0 0 0 0 112		0 0 128 0 0 199 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 194.\ 00\\ 194.\ 01\\ 194.\ 02\\ 194.\ 03\\ 194.\ 04\\ 194.\ 05\\ 194.\ 06\\ 194.\ 07\\ 194.\ 08\\ 194.\ 09\\ 194.\ 10\\ 194.\ 11\\ 194.\ 12\\ \end{array}$
194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14	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 07950 RHC 07960 RHC 07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC	0 0 0 680 0 0 0 0	-	0 0 0 0 0 0 0 0 0 0 0 0 0 112		0 0 128 0 199 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194.00 194.01 194.02 194.03 194.04 194.06 194.06 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14
194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14 194.15	07951 MOB 07952 COMMUNI TY HEALTH 07953 ASSI STED LI VI NG/CAMERON WOODS 07954 EDUCATI ON 07955 MARKETI NG 07955 GUEST MEALS 07957 OUTSI DE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC 07961 OBGYN 07962 TRI NE STUDENT HEALTH 07963 OCCUPATI ONAL HEALTH 07964 IMMUNI ZATI ON CLI NI C 07965 FOUNDATI ON	0 0 0 680 0 0 6, 287 0 6, 287 0 0 847	-	0 0 0 0 0 0 0 0 0 0 0 0 0 112		0 0 128 0 199 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 12 194. 14 194. 15
194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14 194.15 200.00	07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07955 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 Cross Foot Adjustments	0 0 0 680 0 0 6, 287 0 6, 287 0 0 847	-	0 0 0 0 0 0 0 0 0 0 0 0 0 112		0 0 128 0 199 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13 194. 14 194. 15 200. 00
194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14	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 Cross Foot Adjustments Negative Cost Centers	0 0 0 680 0 0 6, 287 0 6, 287 0 0 847	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 0 112		0 0 128 0 199 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.09 194.09 194.10 194.11 194.12 194.13 194.14 194.13 200.00 201.00
194.01 194.02 194.03 194.04 194.05 194.06 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14 194.15 200.00 201.00	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 Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	0 0 0 680 0 0 0 6,287 0 0 0 0 847 121 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 0 112 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 0 128 0 0 199 56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13 194. 14 194. 15 200. 00 201. 00

Health F	inancial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider C		Period: From 10/01/2017	Worksheet B-1	
					o 09/30/2018	Date/Time Pre 2/21/2019 3:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(FTES)	
		(SQUARE FEET)	(POUNDS OF	SERVIC)			
			LAUNDR)				
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B,	841, 749	82, 682	81, 62	2 308, 068	162, 419	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	7. 340749	1. 050304	12. 151550	20. 552939	7. 215095	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)						

					rom 10/01/2017	
					o 09/30/2018	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	2/21/2019 3:49 pm
		(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	LI BRARY (TI ME SPENT)	
		HR) 13.00	REQUIS.) 14.00	15.00	16.00	
	ERAL SERVICE COST CENTERS	· · · · · · ·				
	00 CAP REL COSTS-BLDG & FIXT 00 CAP REL COSTS-MVBLE EQUIP					1.0
. 00 004	OO EMPLOYEE BENEFITS DEPARTMENT					4.
	00 ADMINISTRATIVE & GENERAL					5.
	OO OPERATION OF PLANT					7.
	00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING					8.0
	00 DI ETARY					10.
	00 CAFETERI A					11.
	OO NURSI NG ADMI NI STRATI ON	229, 570	2 700 540			13.
	00 CENTRAL SERVI CES & SUPPLY 00 PHARMACY	0	3, 788, 540 22, 245	100		14.0
	00 MEDICAL RECORDS & LIBRARY	0	22, 243	C		
	ATIENT ROUTINE SERVICE COST CENTERS					
	00 ADULTS & PEDIATRICS	98, 808	129, 741	C		
	00 I NTENSI VE CARE UNI T	2,798	4, 386	C		
	00 NURSERY I LLARY SERVI CE COST CENTERS	1, 123	0	C	1, 167	43.0
	00 OPERATI NG ROOM	30, 558	392, 394	C	13, 012	50.
	OO RECOVERY ROOM	19, 299	0	C	-	51.
	00 DELIVERY ROOM & LABOR ROOM	8, 099	48, 040	C	-	52.
	00 RADI OLOGY-DI AGNOSTI C	0	37, 591	C		54.0
	00 LABORATORY 00 I NTRAVENOUS THERAPY	0	1, 016, 375			60.0
	00 RESPI RATORY THERAPY	0	30, 374	C	-	
	01 SLEEP LAB	0	0	C		65.
	00 PHYSI CAL THERAPY	0	10, 522	C		66.
		0	3, 306	C	00/210	69.
	01 CARDIAC REHAB 00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 976 800, 964			69.0
	00 IMPL. DEV. CHARGED TO PATIENTS	0	998, 267	C	-	72.
	00 DRUGS CHARGED TO PATIENTS	0	0	100	-	73.
	20 CHEMI CAL DEPENDENCY	0	388	C		
	80 ONCOLOGY	0	68	C	0 0	76.
	PATIENT SERVICE COST CENTERS	0	7, 223	C	0	88.0
	00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	-	89.
	OO CLINIC	5, 388	21, 278	C		90.
	01 CLINIC- MCDONALD	0	12, 283	C		90.
	00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART	63, 497	170, 239	C	76, 237	91.0
	ER REIMBURSABLE COST CENTERS	I				72.0
	OO HOME HEALTH AGENCY	0	8, 239	C	0 0	101.
	CIAL PURPOSE COST CENTERS	1				
	00 INTEREST EXPENSE 00 UTILIZATION REVIEW-SNF					113.0
	00 HOSPI CE	0	501	C	0	114.
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	229, 570	3, 716, 680	100	-	118.
	REI MBURSABLE COST CENTERS	1			1	
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C		
94.00079 94.01079	50 DAYCARE-INFANT/TODDLER	0	0	C	0 0 60, 436	194. ( 194. (
	51 MOB 52 COMMUNI TY HEALTH	0	1, 435		00,430	194.
	53 ASSISTED LIVING/CAMERON WOODS	0	0	C	0	194.
94.04079	54 EDUCATI ON	0	0	C	0 0	194.
	55 MARKETING	0	564	C	0	194.
	956 GUEST MEALS 957 OUTSI DE LAUNDRY	0	0		0	194. ( 194. (
	57 COTSTDE LAUNDRY 58 CANCER CENTER	0	0	( ) ( )		194.
	59 URGENT CARE	0	51, 197	C	0	194.
94. 10 079		0	0	C	0 0	194.
94.11079		0	13,008	C	18, 660	194.
	62 TRINE STUDENT HEALTH	0	1, 180 3, 521	0	0	194.
	63 OCCUPATIONAL HEALTH 64 IMMUNIZATION CLINIC		3, 521 955			194. 194.
	65 FOUNDATION	0	700 0	( ) ( )		194.
00.00	Cross Foot Adjustments		Ŭ		0	200.
	Negative Cost Centers					201.
01.00 02.00	Cost to be allocated (per Wkst. B,	1, 173, 077	808, 048	3, 990, 842	1, 119, 770	202.0

Heal th	Financial Systems CAME	RON MEMORIAL CO	RON MEMORIAL COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
COST A	COST ALLOCATION - STATISTICAL BASIS		Provider CC	Provider CCN: 15-1315		Worksheet B-1		
					rom 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL			
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &			
			SUPPLY	REQUIS.)	LI BRARY			
		(DIRECT NRSING	(COSTED		(TIME SPENT)			
		HR)	REQUIS.)					
		13.00	14.00	15.00	16.00			
203.00	Unit cost multiplier (Wkst. B, Part I)	5. 109888	0. 213287	39, 908. 42000	1. 684430		203.00	
204.00	Cost to be allocated (per Wkst. B,	84, 066	250, 557	148, 633	62, 863		204.00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 366189	0. 066136	1, 486. 330000	0. 094563		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)							

## CAMERON MEMORIAL COMMUNITY HOSPITAL

	ERUN MEMORIAL C				U OI FOI III CMS-	2002-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Pre 2/21/2019 3:4	epared:
		Ti ti o	XVIII	Hospi tal	Cost	Pill
				Costs	CUSI	
Cast Canton Decarintian	Tatal Coat	Therapy Limit	Tatal Casta	RCE	Tatal Casta	
Cost Center Description	Total Cost (from Wkst. B,		Total Costs		Total Costs	
	Part I, col.	Adj .		Di sal I owance		
	<u>26)</u> 1.00	2.00	2.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 550 000		0 550 00		0	200.00
30. 00 03000 ADULTS & PEDIATRICS	8, 559, 090		8, 559, 09		0	
31.00 03100 INTENSIVE CARE UNIT	377, 455		377, 45		0	
43. 00 04300 NURSERY	243, 075		243, 07	5 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS		1	I	-		-
50. 00 05000 OPERATI NG ROOM	3, 909, 645		3, 909, 64		0	
51.00 05100 RECOVERY ROOM	2, 115, 259		2, 115, 25		0	1 0 0
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 025, 023		1, 025, 02	3 0	0	52.0
54.00 05400 RADI OLOGY-DI AGNOSTI C	5, 279, 706		5, 279, 70	6 0	0	54.0
50. 00 06000 LABORATORY	4, 823, 701		4, 823, 70	1 0	0	60.0
54.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.0
55. 00 06500 RESPI RATORY THERAPY	1, 220, 656	0	1, 220, 65	6 0	0	65.0
65. 01 06501 SLEEP LAB	474,071		474,07		0	
66. 00 06600 PHYSI CAL THERAPY	2, 467, 521		2, 467, 52		0	
69. 00 06900 ELECTROCARDI OLOGY	509, 405		509, 40		0	
69. 01 06901 CARDI AC REHAB	263, 517		263, 51		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 167, 560		1, 167, 56		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 455, 167				0	
			1, 455, 16		-	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 990, 842		3, 990, 84		0	
76. 00 03020 CHEMI CAL DEPENDENCY	332, 611		332, 61		0	
76. 01 03480 ONCOLOGY	3, 218, 829		3, 218, 82	9 0	0	76.0
OUTPATIENT SERVICE COST CENTERS		1	1			
38.00 08800 RURAL HEALTH CLINIC	1, 718, 765		1, 718, 76	5 0	0	
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
90. 00 09000 CLINIC	409, 472		409, 47	2 0	0	90.0
PO. 01 09001 CLINIC- MCDONALD	1, 055, 186		1, 055, 18	6 0	0	90. C
P1. 00 09100 EMERGENCY	5, 460, 088		5, 460, 08	8 0	0	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2,051,057		2, 051, 05	7	0	92.0
OTHER REIMBURSABLE COST CENTERS			•			
101.00 10100 HOME HEALTH AGENCY	1, 225, 924		1, 225, 92	4	0	101.0
SPECIAL PURPOSE COST CENTERS		1	.,,	·		1
113. 00 11300 I NTEREST EXPENSE						113. 0
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.0
116. 00 11600 HOSPI CE	288, 949		288, 94	0	0	116.0
200.00 Subtotal (see instructions)	53, 642, 574					200. 0
						200.0
201.00 Less Observation Beds	2,051,057		2, 051, 05			
202.00  Total (see instructions)	51, 591, 517	0	51, 591, 51	7 0	0	202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Pre 2/21/2019 3:4	pared: 9 pm
			XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	8, 078, 369		8, 078, 30	59		30.00
1.00 03100 INTENSIVE CARE UNIT	279, 300		279, 30	00		31.0
3. 00 04300 NURSERY	473,000		473, 00	00		43.0
ANCI LLARY SERVI CE COST CENTERS						
0.00 05000 OPERATING ROOM	2, 850, 047	13, 148, 567	15, 998, 6	0. 244374	0.00000	50.0
1.00 05100 RECOVERY ROOM	653, 580	2, 675, 623	3, 329, 20	0. 635365	0.00000	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	931, 107	306, 145	1, 237, 2	52 0. 828467	0.00000	52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 801, 282	29, 383, 058	31, 184, 34	40 0. 169306	0.00000	54.0
0. 00 06000 LABORATORY	1, 858, 196	13, 282, 176	15, 140, 3	0. 318599	0.00000	60.0
4.00 06400 INTRAVENOUS THERAPY	0	0		0 0.000000	0.00000	64.0
5. 00 06500 RESPI RATORY THERAPY	1, 762, 316	945, 954	2, 708, 2	0. 450714	0.00000	65.0
5. 01 06501 SLEEP LAB	0	1, 212, 570	1, 212, 5	0. 390964	0.00000	65.0
6. 00 06600 PHYSI CAL THERAPY	758, 912	4, 017, 987	4, 776, 89	99 0. 516553	0.00000	66.0
9. 00 06900 ELECTROCARDI OLOGY	282, 853	1, 870, 658	2, 153, 51	0. 236546	0.00000	69.0
9. 01 06901 CARDI AC REHAB	11, 396	465, 258	476, 65	54 O. 552848	0.00000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	614, 224	1, 945, 381	2, 559, 60	0. 456149	0.00000	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	963, 397	899, 198			0.00000	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	1, 763, 017	8, 751, 921	10, 514, 93	38 0. 379540	0.00000	73.0
6. 00 03020 CHEMI CAL DEPENDENCY	0	113, 133			0.000000	
6. 01 03480 ONCOLOGY	0	9, 193, 010	9, 193, 01	0. 350139	0.00000	76.0
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	0	1, 091, 982	1, 091, 98			88.0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.0
0. 00 09000 CLINIC	40	622, 038	622, 0		0.00000	
0. 01 09001 CLINIC- MCDONALD	0	156, 084	156, 08	6. 760373	0.00000	90.0
1.00 09100 EMERGENCY	559, 498	15, 995, 023	16, 554, 52	0. 329825	0.00000	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	61, 426	1, 649, 837	1, 711, 20	53 1. 198563	0.00000	92.0
OTHER REIMBURSABLE COST CENTERS						
01.00 10100 HOME HEALTH AGENCY	0	1, 079, 725	1, 079, 72	25		101.0
SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
13.00 11300 INTEREST EXPENSE						113.0
14.00 11400 UTI LI ZATI ON REVI EW-SNF						114. C
16. 00 11600 H0SPI CE	0	314, 449	314, 44	49		116. 0
00.00 Subtotal (see instructions)	23, 701, 960	109, 119, 777	132, 821, 73	37		200. 0
01.00 Less Observation Beds						201. 0
02.00 Total (see instructions)	23, 701, 960	109, 119, 777	132, 821, 73	37		202.0

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Pre 2/21/2019 3:4	pared:
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS	· · · ·				1
50. 00 05000 OPERATI NG 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 INTRAVENOUS 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 0NC0L0GY	0. 000000				76.01
OUTPATIENT SERVICE COST CENTERS	0.000000				70.01
88. 00 08800 RURAL HEALTH CLINIC					88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 CLINIC- MCDONALD	0. 000000				90.00
91. 00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000				92.00
101. 00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					101.00
113. 00 11300 I NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
116. 00/11600/H0SPI CE					114.00
					200.00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)					202.00

## CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10

COMPUT	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Pre 2/21/2019 3:4	pared: 9 pm
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 559, 090		8, 559, 09	0 0	8, 559, 090	30.00
31.00	03100 I NTENSI VE CARE UNI T	377, 455		377, 45		377, 455	
43.00	04300 NURSERY	243, 075		243, 07		243, 075	
101.00	ANCI LLARY SERVICE COST CENTERS	210/010		210/07	<u> </u>	210/070	101.00
50.00	05000 OPERATI NG ROOM	3, 909, 645		3, 909, 64	5 0	3, 909, 645	50.00
51.00	05100 RECOVERY ROOM	2, 115, 259		2, 115, 25		2, 115, 259	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 025, 023		1, 025, 02		1, 025, 023	
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 279, 706		5, 279, 70		5, 279, 706	
60.00	06000 LABORATORY	4, 823, 701		4, 823, 70		4, 823, 701	
64.00	06400 I NTRAVENOUS THERAPY	4, 023, 701			0 0	4, 023, 701	
65.00	06500 RESPI RATORY THERAPY	1, 220, 656				1, 220, 656	
65.01	06501 SLEEP LAB	474,071		474, 07		474, 071	
66.00	06600 PHYSI CAL THERAPY	2, 467, 521		2, 467, 52		2, 467, 521	
69.00	06900 ELECTROCARDI OLOGY	509, 405	0	509, 40		509, 405	
69.00	06901 CARDI AC REHAB	263, 517		263, 51		263, 517	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 167, 560		1, 167, 56		1, 167, 560	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 455, 167		1, 455, 16		1, 455, 167	
72.00	07300 DRUGS CHARGED TO PATIENTS	3, 990, 842		3, 990, 84		3, 990, 842	
76.00	03020 CHEMI CAL DEPENDENCY	332, 611		332, 61		3, 990, 842	
	03480 ONCOLOGY					3, 218, 829	
76. 01	OUTPATIENT SERVICE COST CENTERS	3, 218, 829		3, 218, 82	9 0	3, 218, 829	76.01
88.00	08800 RURAL HEALTH CLINIC	1, 718, 765		1, 718, 76	5 0	1, 718, 765	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	1, /18, /03			0 0	1, 710, 705	
90.00	09000 CLINIC	409, 472		409, 47	0	409, 472	
90.00 90.01	09001 CLINIC- MCDONALD	1, 055, 186				1, 055, 186	
90.01 91.00	09100 EMERGENCY	5, 460, 088		1,055,18			
91.00				5, 460, 08		5, 460, 088	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 051, 057		2,051,05	1	2, 051, 057	92.00
101 00	OTHER REIMBURSABLE COST CENTERS	1 225 024		1 225 02	4	1 225 024	101 00
101.00		1, 225, 924		1, 225, 92	.4	1, 225, 924	101.00
110.00	SPECIAL PURPOSE COST CENTERS	1		1			112 00
	11400 UTI LI ZATI ON REVI EW-SNF						113.00
		200 040		200.04	0	200 040	114.00
	11600 HOSPI CE	288, 949		288, 94		288, 949	
200.00		53, 642, 574					
201.00		2,051,057		2,051,05		2, 051, 057	
202.00	Total (see instructions)	51, 591, 517	0	51, 591, 51	7 0	51, 591, 517	202.00

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Pre 2/21/2019 3:4	pared: 9 pm
		Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	8, 078, 369		8, 078, 30	69		30.00
1.00 03100 INTENSIVE CARE UNIT	279, 300		279, 30	00		31.00
3. 00 04300 NURSERY	473, 000		473, 00	00		43.00
ANCI LLARY SERVI CE COST CENTERS						
0.00 05000 OPERATING ROOM	2, 850, 047	13, 148, 567	15, 998, 61	0. 244374	0.000000	50.00
1.00 05100 RECOVERY ROOM	653, 580	2, 675, 623	3, 329, 20	0. 635365	0.000000	51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	931, 107	306, 145	1, 237, 2	52 0. 828467	0.000000	52.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 801, 282	29, 383, 058	31, 184, 34	40 0. 169306	0.000000	54.00
0. 00 06000 LABORATORY	1, 858, 196	13, 282, 176	15, 140, 3	0. 318599	0.000000	60.0
4.00 06400 INTRAVENOUS THERAPY	0	0		0 0.000000	0.000000	64.0
5. 00 06500 RESPI RATORY THERAPY	1, 762, 316	945, 954	2, 708, 2	70 0. 450714	0.000000	65.0
5. 01 06501 SLEEP LAB	0	1, 212, 570	1, 212, 5	0. 390964	0.000000	65. 0 <sup>4</sup>
6. 00 06600 PHYSI CAL THERAPY	758, 912	4, 017, 987	4, 776, 89	99 0. 516553	0.000000	66.00
9. 00 06900 ELECTROCARDI OLOGY	282, 853	1, 870, 658	2, 153, 5 <sup>-</sup>	0. 236546	0.000000	69.0
9. 01 06901 CARDI AC REHAB	11, 396	465, 258	476, 6	54 0. 552848	0.000000	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	614, 224	1, 945, 381	2, 559, 60	0. 456149	0.000000	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	963, 397	899, 198	1, 862, 59	95 0. 781258	0.000000	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	1, 763, 017	8, 751, 921	10, 514, 93	38 0. 379540	0.000000	73.0
6. 00 03020 CHEMI CAL DEPENDENCY	0	113, 133	113, 13	2. 940000	0.000000	76.0
6. 01 03480 ONCOLOGY	0	9, 193, 010	9, 193, 0 <sup>-</sup>	0. 350139	0.000000	76.0
OUTPATIENT SERVICE COST CENTERS						
8.00 08800 RURAL HEALTH CLINIC	0	1, 091, 982	1, 091, 98	32 1.573987	0.000000	88.0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0.000000	
0. 00 09000 CLINIC	40	622, 038	622, 0	78 0. 658233	0.000000	90.0
0.01 09001 CLINIC- MCDONALD	0	156, 084	156, 08	6. 760373	0.000000	90.0
1.00 09100 EMERGENCY	559, 498	15, 995, 023	16, 554, 52	0. 329825	0.000000	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	61, 426	1, 649, 837	1, 711, 20	63 1. 198563	0.000000	92.0
OTHER REIMBURSABLE COST CENTERS						
01.00 10100 HOME HEALTH AGENCY	0	1, 079, 725	1, 079, 72	25		101.0
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113.0
14.00 11400 UTI LI ZATI ON REVI EW-SNF						114.0
16. 00 11600 H0SPI CE	0	314, 449	314, 44	49		116.0
00.00 Subtotal (see instructions)	23, 701, 960	109, 119, 777	132, 821, 73	37		200.0
01.00 Less Observation Beds						201.0
02.00 Total (see instructions)	23, 701, 960	109, 119, 777	132, 821, 73	37		202.0

	WERON WEWORTAL COW		111 LIE		2-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepare 2/21/2019 3:49 pm	ed:
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	0. 00
31. 00 03100 I NTENSI VE CARE UNI T				31	1.00
43. 00 04300 NURSERY				43	3. 00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 244374			50	0. 00
51.00 05100 RECOVERY ROOM	0. 635365			51	1.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 828467			52	2.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 169306			54	4.00
60. 00 06000 LABORATORY	0. 318599			60	0. 00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			64	4.00
65. 00 06500 RESPI RATORY THERAPY	0. 450714			65	5.00
65.01 06501 SLEEP LAB	0. 390964			65	5. 01
66. 00 06600 PHYSI CAL THERAPY	0. 516553			66	5.00
69. 00 06900 ELECTROCARDI OLOGY	0. 236546			69	9. 00
69. 01 06901 CARDI AC REHAB	0. 552848			69	9. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 456149			71	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 781258			72	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 379540			73	3.00
76. 00 03020 CHEMI CAL DEPENDENCY	2.940000			76	5.00
76. 01 03480 ONCOLOGY	0. 350139			76	5. 01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	1. 573987			88	3. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89	9.00
90. 00 09000 CLINIC	0. 658233			90	0. 00
90. 01 09001 CLINIC- MCDONALD	6. 760373			90	D. 01
91. 00 09100 EMERGENCY	0. 329825			91	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 198563			92	2.00
OTHER REIMBURSABLE COST CENTERS					
101.0010100 HOME HEALTH AGENCY				101	1.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					3.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					4.00
116. 00 11600 HOSPI CE					5.00
200.00 Subtotal (see instructions)					0. 00
201.00 Less Observation Beds					1.00
202.00  Total (see instructions)				202	2.00

	ERON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider C	CN: 15-1315	Period:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 10/01/2017 To 09/30/2018	Part II Date/Time Pre	narod
				10 09/30/2016	2/21/2019 3:4	9 nm
		Ti tl	e XIX	Hospi tal	PPS	, bii
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
'	(Wkst. B, Part	(Wkst. B, Part		al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	3, 909, 645				-	
51.00 05100 RECOVERY ROOM	2, 115, 259				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 025, 023				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 279, 706				0	54.00
60. 00 06000 LABORATORY	4, 823, 701	372, 819	4, 450, 8		0	60.00
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 220, 656				0	65.00
65. 01 06501 SLEEP LAB	474, 071				0	65.01
66. 00 06600 PHYSI CAL THERAPY	2, 467, 521				0	66.00
69. 00 06900 ELECTROCARDI OLOGY	509, 405				0	69.00
69. 01 06901 CARDI AC REHAB	263, 517				0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 167, 560				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 455, 167				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 990, 842				0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	332, 611				0	76.00
76. 01 03480 0NC0L0GY	3, 218, 829	883, 134	2, 335, 6	95 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	1, 718, 765					
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	409, 472				0	90.00
90. 01 09001 CLINIC- MCDONALD	1, 055, 186				0	90.01
91.00 09100 EMERGENCY	5, 460, 088				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 051, 057	415, 021	1, 636, 0	36 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					-	
101.00 10100 HOME HEALTH AGENCY	1, 225, 924	76, 300	1, 149, 6	24 0	0	101.00
SPECIAL PURPOSE COST CENTERS	1		1			
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF	200.040	1/ 05/	070 5			114.00
116.00 11600 HOSPI CE	288, 949					116.00
200.00 Subtotal (sum of lines 50 thru 199)	44, 462, 954					200.00
201.00 Less Observation Beds	2,051,057					201.00
202.00  Total (line 200 minus line 201)	42, 411, 897	6, 290, 026	36, 121, 8	71 0	0	202.00

Health Financial Systems CAM	ERON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	eu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provider C	CN: 15-1315	Peri od:	Worksheet C
REDUCTIONS FOR MEDICAID ONLY				From 10/01/2017	Part II
				To 09/30/2018	Date/Time Prepared: 2/21/2019 3:49 pm
		Ti +1	e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges			113
Cost Center Description		(Worksheet C,			
	Operating Cost				
	Reduction	8)	/ col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	3, 909, 645	15, 998, 614	0. 2443	74	50.00
51.00 05100 RECOVERY ROOM	2, 115, 259	3, 329, 203	0. 6353	65	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 025, 023	1, 237, 252	0. 8284	67	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 279, 706	31, 184, 340	0. 1693	06	54.00
60. 00 06000 LABORATORY	4, 823, 701	15, 140, 372	0. 3185	99	60.00
64.00 06400 INTRAVENOUS THERAPY	0	C	0.0000	00	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 220, 656	2, 708, 270	0. 4507	14	65.00
65. 01 06501 SLEEP LAB	474,071	1, 212, 570	0. 3909	64	65.01
66. 00 06600 PHYSI CAL THERAPY	2, 467, 521	4, 776, 899	0. 5165	53	66.00
69. 00 06900 ELECTROCARDI OLOGY	509, 405	2, 153, 511	0. 2365	46	69.00
69. 01 06901 CARDI AC REHAB	263, 517	476, 654	0. 5528	48	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 167, 560	2, 559, 605	0. 4561	49	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 455, 167	1, 862, 595	0. 7812	58	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 990, 842	10, 514, 938	0. 3795	40	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	332, 611	113, 133	2.9400	00	76.00
76. 01 03480 ONCOLOGY	3, 218, 829	9, 193, 010	0. 3501	39	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	1, 718, 765	1, 091, 982			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C			89.00
90. 00 09000 CLINIC	409, 472	622, 078			90.00
90. 01 09001 CLINIC- MCDONALD	1, 055, 186	156, 084			90.01
91. 00 09100 EMERGENCY	5, 460, 088				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 051, 057	1, 711, 263	1. 1985	63	92.00
OTHER REIMBURSABLE COST CENTERS			1		
101.00 10100 HOME HEALTH AGENCY	1, 225, 924	1, 079, 725	1. 1354	04	101.00
SPECIAL PURPOSE COST CENTERS	1		1		
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
116.00 11600 HOSPI CE	288, 949			06	116.00
200.00 Subtotal (sum of lines 50 thru 199)	44, 462, 954	123, 991, 068			200.00
201.00 Less Observation Beds	2, 051, 057				201.00
202.00  Total (line 200 minus line 201)	42, 411, 897	123, 991, 068	1	I	202.00

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	Provider CCN: 15-1315		Worksheet D Part II Date/Time Pre 2/21/2019 3:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	-		- 1		
50.00 05000 OPERATI NG ROOM	937, 380					
51.00 05100 RECOVERY ROOM	582,088	3, 329, 203	0. 17484			
52.00 05200 DELIVERY ROOM & LABOR ROOM	280, 347	1, 237, 252	0. 22658			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	738, 040	31, 184, 340	0. 02366	612, 029	14, 485	54.00
60. 00 06000 LABORATORY	372, 819	15, 140, 372	0. 02462	631, 696	15, 555	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	122, 520	2, 708, 270	0. 04523	664, 471	30, 060	65.00
65.01 06501 SLEEP LAB	99, 099	1, 212, 570	0. 08172	26 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	510, 165	4, 776, 899	0. 10679	98 196, 607	20, 997	66.00
69. 00 06900 ELECTROCARDI OLOGY	20, 171	2, 153, 511	0.00936	233, 531	2, 187	69.00
69. 01 06901 CARDI AC REHAB	64, 196	476, 654	0. 13468	989	133	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 657	2, 559, 605	0. 02604	447, 350	11, 650	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	83, 075	1, 862, 595	0. 04460	353, 031	15, 746	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	148, 633	10, 514, 938	0. 01413	593, 116	8, 384	73.00
76.00 03020 CHEMI CAL DEPENDENCY	6, 293	113, 133	0. 05562	25 0	0	76.00
76. 01 03480 ONCOLOGY	883, 134	9, 193, 010	0. 09606	6 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	181, 542	1, 091, 982	0. 16625	i0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
90. 00 09000 CLINIC	49, 281	622, 078	0. 07922	20 39	3	90.00
90. 01 09001 CLINIC- MCDONALD	174, 731	156, 084	1. 11946	0 8	0	90.01
91.00 09100 EMERGENCY	877, 199	16, 554, 521	0. 05298	16, 536	876	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	415, 021	1, 711, 263	0. 24252	47, 468	11, 512	92.00
200.00   Total (lines 50 through 199)	6, 612, 391			4, 869, 675	214, 680	200. 00

Heal th	Financial Systems C/	AMERON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY S H COSTS	SERVICE OTHER PASS			Period: From 10/01/2017 To 09/30/2018		pared: 9 pm
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C		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	C		o o	0 0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		o o	0 0	54.00
60, 00	06000 LABORATORY	0	C		o o	0	60,00
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
65.01	06501 SLEEP LAB	0	0		0 0	0	65.01
	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
	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
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	03020 CHEMI CAL DEPENDENCY	0	0		0 0		76.00
	03480 ONCOLOGY	0	0		0 0	0	76.01
/ 0/ 0/	OUTPATIENT SERVICE COST CENTERS				<u> </u>		, 01 01
88 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		89.00
	09000 CLINIC	0	0		0 0	0	
90.01	09001 CLINIC- MCDONALD	0	0				90.01
	09100 EMERGENCY	0	0		0 0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		ő	0	
200.00		0	0		0 0		200.00
200.00		1 0	0	1	-1 0		

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 10/01/2017 To 09/30/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1 1		1			
50.00 OPERATING ROOM	0	0		0 15, 998, 614		
51.00 05100 RECOVERY ROOM	0	0		3, 329, 203		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 237, 252		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		31, 184, 340		
60. 00 06000 LABORATORY	0	0		0 15, 140, 372		
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		2, 708, 270	0.000000	
65.01 06501 SLEEP LAB	0	0		0 1, 212, 570		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 776, 899		
69. 00 06900 ELECTROCARDI OLOGY	0	0		2, 153, 511	0. 000000	
69. 01 06901 CARDI AC REHAB	0	0		0 476, 654		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 559, 605		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 862, 595	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 514, 938	0.00000	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0	0		0 113, 133	0.00000	76.00
76. 01 03480 ONCOLOGY	0	0		9, 193, 010	0.00000	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 1, 091, 982	0.00000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.00000	89.00
90. 00 09000 CLI NI C	0	0		0 622, 078	0.00000	90.00
90. 01 09001 CLINIC- MCDONALD	0	0		0 156, 084	0.00000	90.01
91. 00 09100 EMERGENCY	0	0		0 16, 554, 521	0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 1, 711, 263	0.00000	92.00
200.00 Total (lines 50 through 199)	0	0		0 122, 596, 894		200. 00

Health Financial Systems CAME	ERON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CC		Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Pre 2/21/2019 3:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS				- F		
50. 00 05000 OPERATI NG ROOM	0. 000000	900, 640		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	167, 912		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	4, 260		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	612, 029		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	631, 696		0 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	664, 471		0 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	196, 607		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	233, 531		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	989		0 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	447, 350		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	353, 031		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	593, 116		0 0	0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0. 000000	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90. 00 09000 CLINIC	0. 000000	39		0 0	0	90.00
90. 01 09001 CLINIC- MCDONALD	0. 000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 000000	16, 536		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	47, 468		0 0	0	92.00
200.00 Total (lines 50 through 199)		4, 869, 675		0 0	0	200. 00

		RON MEMORIAL CO				u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
					From 10/01/2017 To 09/30/2018		nared
					10 077 307 2010	2/21/2019 3:4	9 pm
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	0. 244374	0	3, 305, 69	0	0	50.00
	O RECOVERY ROOM	0. 244374	0	3, 305, 69		0	
	O DELIVERY ROOM & LABOR ROOM	0. 828467	0	498, 22		0	1
	0 RADIOLOGY-DIAGNOSTIC	0. 828467	0	7, 253, 50	0	0	
	0 LABORATORY	0. 318599	0	3, 478, 51		0	
	0 INTRAVENOUS THERAPY	0. 318399	0	3, 476, 31	0 0	0	
	0 RESPI RATORY THERAPY	0. 450714	0	532, 24	1 0	0	
	1 SLEEP LAB	0. 390964	0	16, 34		0	
	0 PHYSI CAL THERAPY	0. 516553	0	1, 217, 63		0	
	0 ELECTROCARDI OLOGY	0. 236546	0	594, 93		0	
	1 CARDI AC REHAB	0. 552848	0	146, 95		0	
	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 456149	0	360, 41		0	1
	O I MPL. DEV. CHARGED TO PATIENTS	0. 781258	0	274, 15		0	1
	O DRUGS CHARGED TO PATIENTS	0. 379540	0	3, 255, 39		0	1
	O CHEMI CAL DEPENDENCY	2. 940000	0	67, 32		0	
	0 ONCOLOGY	0. 350139	0	3, 726, 66		0	
	ATIENT SERVICE COST CENTERS	0. 330137	0	3,720,00	0	0	/0.01
	ORURAL HEALTH CLINIC	0, 000000				0	88.00
	O FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
	O CLINIC	0. 658233	0	292, 36	5 0	0	
	1 CLINIC- MCDONALD	6. 760373	0	88, 06		0	
	0 EMERGENCY	0. 329825	0	3, 414, 60		0	
	0 OBSERVATION BEDS (NON-DISTINCT PART	1. 198563	0	975, 15		0	
200.00	Subtotal (see instructions)		0	29, 498, 17		0	200.00
201.00	Less PBP Clinic Lab. Services-Program		0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0	0	201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	0	29, 498, 17	4 13, 614	0	202.00

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST		CN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Pro 2/21/2019 3:	epared: 49 pm
			e XVIII	Hospi tal	Cost	_
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)	4			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
io. 00 05000 OPERATING ROOM	807, 825	C	1			50.0
1. 00 05100 RECOVERY ROOM	316, 552					51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	310, 552					52.0
	0	-				
64. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	1, 228, 063		1			54.0 60.0
	1, 108, 250					
4. 00 06400 I NTRAVENOUS THERAPY	0	C				64.0
5. 00 06500 RESPIRATORY THERAPY	239, 888					65.0
5.01 06501 SLEEP LAB	6, 388		1			65.0
6. 00 06600 PHYSI CAL THERAPY	628, 975	C				66.0
9.00 06900 ELECTROCARDI OLOGY	140, 728					69.0
9. 01 06901 CARDI AC REHAB	81, 245					69.0
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	164, 401	C				71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	214, 186					72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	1, 235, 551		1			73.0
6. 00 03020 CHEMI CAL DEPENDENCY	197, 944		1			76.0
6. 01 03480 0NC0L0GY	1, 304, 851	C				76.0
OUTPATIENT SERVICE COST CENTERS	-		1			
88.00 08800 RURAL HEALTH CLINIC	0	C C	•			88.0
99.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	102.11	C				89.0
0.00 09000 CLINIC	192, 444		1			90.0
0. 01 09001 CLINIC- MCDONALD	595, 373		•			90.0
11.00 09100 EMERGENCY	1, 126, 220					91.0
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 168, 782					92.0
200.00 Subtotal (see instructions)	10, 757, 666	5, 737				200.0
201.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges	10 757 ///	F 707	.			
02.00 Net Charges (line 200 - line 201)	10, 757, 666	5, 737	T			202.0

APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST         Provider CN: 15-1315         Period: From 10/01/2017         Worksheet D Part V           Component CON: 15-2315         Title XVIII         Swing Beds - SNF         Cost           Cost Center Description         Cost to Charge         PPS Reimbursed Ratio From Worksheet D, Part I, col. 9         Cost         Cost         Cost           NACILLARY SERVICE COST CENTERS         Cost Cost Center Description         Cost Cost Cost Cost Center Description         Cost Cost Cost Cost Cost Center Description         Cost Cost Cost Cost Cost Center Description         Cost Cost Cost Cost Cost Cost Cost Cost	Heal th Fina	ncial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lie	eu of Form CMS-	2552-10
Component CCN: 15-Z315         To         09/30/2018         Date/Time Prepared: 2/21/2019 3: 49 pm           Title XVIII         Swing Beds - SNF         Cost           Cost Center Description         Cost to Charge         Cost         Cost         Reimbursed         Cost         Subject To         Subject To           Part I, col. 9         Part I, col. 9         Part I, col. 9         Part I, col. 9         Services (see inst.)         Services (see inst.)         Subject To         Subject To         Subject To         Subject To         Subject To         Secvices (see inst.)         Secvices (see inst	APPORTI ONME	INT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1315			
ANCI LLARY SERVICE COST CENTERS         Cost Cost Center Description         Cost to Charges         Cost Cost Reimbursed Services Not Subject To Ded. & Coins.         PS Services (see inst.)         Cost Subject To Ded. & Coins.         Services Not Subject To Ded. & Coins.         Services Not Subject To Ded. & Coins.         Source inst.)         Source in				Component (	CON: 15 7215			narod:
Ancitized Services         Cost Center Description         Cost to Charges Cost to Charges         Cost Cost Ratio From Worksheet C, Part I, col. 9         Cost PS Reimbursed Services (see inst.)         Cost Reimbursed Subject To Ded. & Coins.         PS Services (see inst.)         Cost (see inst.)         PS Services (see inst.)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000         0ERATING ROOM         0.244374         0         0         0         0         5.00           51.00         05100 RECOVERY ROOM         0.244374         0         0         0         0         51.00           52.00         05200 DELIVERY ROOM & LABOR ROOM         0.828467         0         0         0         0         52.00           64.00         06400 INTRAVENUS THERAPY         0.318599         0         0         0         0         66.00           65.01         0.5000 DELIVERY RORD & LABOR ROOM         0.23653         0         0         0         0         66.00           64.00         06400 INTRAVENUS THERAPY         0.318599         0         0         0         0         66.00           65.01         06501 SLEEP LAB         0         309904         0         0				Component (	JUN. 10-2010	10 09/30/2018		
Cost Center Description         Cost Center Description         Cost Cost Centrege         Cost Cost Cost         Cost Cost         Cost Cost         Cost Cost         Cost Cost         Cost Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost         Cost          Cost								

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CC Component C		Period: From 10/01/2017 To 09/30/2018	
		Title	XVIII	Swing Beds - SNI	
	Co	sts			
Cost Center Description	Cost	Cost			
·	Reimbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6.00	7.00			
ANCI LLARY SERVI CE COST CENTERS					
0. 00 05000 OPERATI NG ROOM	C				50.
1.00 05100 RECOVERY ROOM	C	0 0			51.
2.00 05200 DELIVERY ROOM & LABOR ROOM	C	0 0			52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0 0			54.
0. 00 06000 LABORATORY	C	0 0			60.
4. 00 06400 INTRAVENOUS THERAPY	C	0 0			64.
5. 00 06500 RESPI RATORY THERAPY	C	0 0			65.
5.01 06501 SLEEP LAB	C	0 0			65.
6. 00 06600 PHYSI CAL THERAPY	C	0 0			66.
9. 00 06900 ELECTROCARDI OLOGY	C	0 0			69.
9. 01 06901 CARDI AC REHAB	C	0 0			69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0 0			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0 0			72.
3.00 07300 DRUGS CHARGED TO PATIENTS	C	0 0			73.
6. 00 03020 CHEMI CAL DEPENDENCY	C	0 0			76.
6. 01 03480 ONCOLOGY	C	0 0			76.
OUTPATIENT SERVICE COST CENTERS	-				
B. OO 08800 RURAL HEALTH CLINIC	C	0 0			88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0 0			89.
D. 00 09000 CLINIC	C	0 0			90.
D. 01 09001 CLINIC- MCDONALD	C	0 0			90.
1.00 09100 EMERGENCY	C	0 0			91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	0 0			92.
00.00 Subtotal (see instructions)	C	0 0			200.
01.00 Less PBP Clinic Lab. Services-Program	C				201.
Only Charges					
02.00 Net Charges (line 200 - line 201)	C	0			202.

Health Financial Systems CAM	ERON MEMORIAL COMMUNITY HOSPITAL			In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2017		
				To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
		Ti tl	e XIX	Hospi tal	PPS	<sup>7</sup> piii
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost		í í	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 731, 891	98, 054	1, 633, 83	7 4, 669	349.93	30.00
31.00 INTENSIVE CARE UNIT	108, 652		108, 65	2 133	816.93	31.00
43.00 NURSERY	43, 093		43, 09	3 469	91.88	43.00
200.00 Total (lines 30 through 199)	1, 883, 636		1, 785, 58	2 5, 271		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days					
		Capital Cost				
		(col. 5 x col.				
		6)	4			
	6.00	7.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.1	10.040				0.00
30. 00 ADULTS & PEDIATRICS	31		•			30.00
31. 00 INTENSIVE CARE UNIT	23	18, 789	(			31.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	54	29, 637	1			200. 00

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		Provider CCN: 15-1315		Worksheet D Part II Date/Time Pre 2/21/2019 3:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	r	-				
50.00 ODERATING ROOM	937, 380					
51.00 05100 RECOVERY ROOM	582, 088	3, 329, 203	0. 17484	3 5, 237	916	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	280, 347	1, 237, 252	0. 22658	38 7, 461	1, 691	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	738, 040					
60. 00 06000 LABORATORY	372, 819	15, 140, 372	0. 02462	14, 889	367	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	122, 520	2, 708, 270	0. 04523	39 14, 121	639	65.00
65.01 06501 SLEEP LAB	99, 099	1, 212, 570	0. 08172	26 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	510, 165	4, 776, 899	0. 10679	6, 081	649	66.00
69. 00 06900 ELECTROCARDI OLOGY	20, 171	2, 153, 511	0.00936	1, 064	10	69.00
69. 01 06901 CARDI AC REHAB	64, 196	476, 654	0. 13468	91	12	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	66, 657	2, 559, 605	0. 02604	12, 641	329	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	83, 075	1, 862, 595	0. 04460	02 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	148, 633	10, 514, 938	0. 01413	14, 126	200	73.00
76.00 03020 CHEMI CAL DEPENDENCY	6, 293	113, 133	0. 05562	25 0	0	76.00
76. 01 03480 ONCOLOGY	883, 134	9, 193, 010	0. 09606	6 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	181, 542	1, 091, 982	0. 16625	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000	0 0	0	89.00
90. 00 09000 CLINIC	49, 281	622, 078	0. 07922	20 0	0	90.00
90. 01 09001 CLINIC- MCDONALD	174, 731	156, 084	1. 11946	0 8	0	90.01
91.00 09100 EMERGENCY	877, 199	16, 554, 521	0. 05298	4, 483	238	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	415, 021					92.00
200.00   Total (lines 50 through 199)	6, 612, 391			124, 860	8, 525	200. 00

Health Financial Systems	CAMERON MEMORIAL COMM	MUNITY HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	OTHER PASS THROUGH COSTS		<u> </u>	Period: From 10/01/2017 Fo 09/30/2018	Date/Time Pre 2/21/2019 3:4	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments	-	Post-Stepdown Adjustments	Cost	All Other Medical Education Cost	
		1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTE       30.00     03000       ADULTS & PEDIATRICS       31.00     03100       INTENSIVE CARE UNIT       43.00     04300       NURSERY       200.00     Total (lines 30 through 199)		000000000000000000000000000000000000000			0 0 0	31.00
Cost Center Description	Adjustment (s Amount (see 1 instructions) mi	Total Costs sum of cols. through 3, inus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTE       30.00     03000       ADULTS & PEDIATRICS       31.00     03100       INTENSIVE CARE UNIT       43.00     04300       NURSERY       200.00     Total (lines 30 through 199)	CRS 0	0 0 0	4, 66 13 46 5, 27	3 0.00 9 0.00	23 0	31.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00			-		
INPATI ENT ROUTI NE SERVI CE COST CENTE           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           43. 00         04300         NURSERY           200. 00         Total (lines 30 through 199)	RS 0 0 0 0 0					30.00 31.00 43.00 200.00

Heal th	lealth Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu o						2552-10
	I ONMENT OF I NPATI ENT/OUTPATI ENT ANCI LLARY H COSTS	SERVICE OTHER PASS		<u> </u>	Period: From 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4	pared: 9 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown	-	Post-Stepdown		
		Cost	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 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		o o	0	65.00
65.01	06501 SLEEP LAB	0	0		o o	0	65.01
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	06901 CARDI AC REHAB	0	0		0 0	0	69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	03020 CHEMI CAL DEPENDENCY	0	0		0	0	76.00
	03480 ONCOLOGY	0	0		0	0	76.01
/0/01	OUTPATIENT SERVICE COST CENTERS				<u> </u>		10101
88 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
	09000 CLINIC	0	0			0	90.00
	09001 CLINIC- MCDONALD	0	0			0	90.01
	09100 EMERGENCY	0	0		n n	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		) )	0	92.00
200.00		0	0		- - -		200.00
200.00			0	1	- -	1 0	200.00

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 10/01/2017 To 09/30/2018		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	r		-	T		
50.00 O5000 OPERATI NG ROOM	0	0		0 15, 998, 614		
51.00 05100 RECOVERY ROOM	0	C		3, 329, 203	0.00000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 1, 237, 252	0.00000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		31, 184, 340	0.00000	
60. 00 06000 LABORATORY	0	C		0 15, 140, 372	0.00000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	C		0 0	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		2, 708, 270	0.000000	65.00
65. 01 06501 SLEEP LAB	0	0		0 1, 212, 570	0.000000	65.01
66. 00 06600 PHYSI CAL THERAPY	0	0		4, 776, 899	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		2, 153, 511	0.000000	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 476, 654	0. 000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		2, 559, 605	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 862, 595	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 10, 514, 938	0.000000	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0	C		0 113, 133	0.000000	76.00
76. 01 03480 ONCOLOGY	0	C	)	9, 193, 010	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	C		0 1, 091, 982	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	)	0 0	0.000000	89.00
90. 00 09000 CLINIC	0	C		622, 078	0.000000	90.00
90. 01 09001 CLINIC- MCDONALD	0	C		156, 084	0.000000	90.01
91.00 09100 EMERGENCY	0	C		16, 554, 521	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0 1, 711, 263		
200.00 Total (lines 50 through 199)	0	C		0 122, 596, 894		200.00
			•			•

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PASS			Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Pre 2/21/2019 3:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS				1		
50. 00 05000 OPERATI NG ROOM	0. 000000	22, 836		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	5, 237		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	7, 461		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	14, 433		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	14, 889		0 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	14, 121		0 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66.00 06600 PHYSI CAL THERAPY	0. 000000	6, 081		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 064		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	91		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	12, 641		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	14, 126		0 0	0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0. 000000	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	76.01
OUTPATIENT 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 CLINIC- MCDONALD	0, 000000	0		0 0	0	90, 01
91.00 09100 EMERGENCY	0, 000000	4, 483		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 000000	7, 397		0 0	0	92.00
200.00 Total (lines 50 through 199)		124, 860		0 0	-	200.00
	· · ·	.,	1	-		

## CAMERON MEMORIAL COMMUNITY HOSPITAL

	Financial Systems CAMERON MEMORIAL COMM			u of Form CMS-2			
MPUL	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1315	Period: From 10/01/2017	Worksheet D-1			
			To 09/30/2018	Date/Time Pre			
		Title XVIII	Hospi tal	2/21/2019 3:4 Cost	9 pr		
	Cost Center Description		nospi tai	031			
				1.00			
	PART I - ALL PROVIDER COMPONENTS				4		
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s oveluding nowhern)		5, 124	1 1		
00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			4, 669			
00	Private room days (excluding swing-bed and observation bed day		rivate room davs.	4,007			
	do not complete this line.						
00	Semi-private room days (excluding swing-bed and observation be	3, 483					
00	Total swing-bed SNF type inpatient days (including private roo	0	5				
00	reporting period Total swing-bed SNF type inpatient days (including private roo	263	6				
	reporting period (if calendar year, enter 0 on this line)	un days, arter becember	ST OF the cost	205			
00	Total swing-bed NF type inpatient days (including private room	m days) through Decembe	r 31 of the cost	192	7		
	reporting period						
00	Total swing-bed NF type inpatient days (including private room	31 of the cost	0	8			
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	a swing-bed and	1, 297	9		
50	newborn days)		g swillig bed and	1,277	′		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10		
	through December 31 of the cost reporting period (see instruction						
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	263	11				
.00	Swing-bed NF type inpatient days applicable to titles V or XIX		te room days)	0	12		
	through December 31 of the cost reporting period	<b>3 ( 1 ( 1 ) ( 1 )</b>					
. 00	Swing-bed NF type inpatient days applicable to titles V or XLX			0	13		
00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter 0 on this li	ne)	0	11		
	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0			
	Nursery days (title V or XIX only)			0			
	SWING BED ADJUSTMENT						
00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 (	of the cost		17		
00	reporting period		++		10		
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es alter becember 31 01	the cost		18		
. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 o	f the cost	155.02	19		
	reporting period	-					
. 00	Medicaid rate for swing-bed NF services applicable to services	155.02	20				
. 00	reporting period Total general inpatient routine service cost (see instructions	e)		8, 559, 090	21		
. 00	Swing-bed cost applicable to SNF type services through December		ting period (line	0, 337, 070			
	5 x line 17)		510 00 0				
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23		
. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 21 of the cost report	ing pariod (line	29, 764	24		
. 00	7 x line 19)	i si ui the cost report	ing period (inte	29,704	24		
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25		
	x line 20)			101 501			
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(lino 21 minus lino 26)		484, 591 8, 074, 499			
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	(The 21 minus the 20)		0, 074, 499	2'		
00	General inpatient routine service charges (excluding swing-bed	d and observation bed c	harges)	0	28		
	Private room charges (excluding swing-bed charges)		-	0	29		
	Semi -private room charges (excluding swing-bed charges)			0	30		
	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0.000000			
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00			
	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instru	ctions)	0.00			
00	Average per diem private room cost differential (line 34 x line 31)						
	Private room cost differential adjustment (line 3 x line 35)			0	36		
. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost d	ifferential (line	8,074,499	37		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1		
00	Adjusted general inpatient routine service cost per diem (see			1, 729. 38	38		
	Program general inpatient routine service cost (line 9 x line			2, 243, 006			
	Medically necessary private room cost applicable to the Progra			0			
. UU	Total Program general inpatient routine service cost (line 39	+ iine 40)		2, 243, 006	41		

		RON MEMORIAL CO				u of Form CMS-2	2552-10		
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Pre	pared:		
			T: +1 /	e XVIII	lloonital	2/21/2019 3: 4	9 pm		
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	Cost Program Cost			
		Inpatient Cost		Diem (col. 1	÷	(col. 3 x col.			
		1.00	2.00	col. 2) 3.00	4.00	4)			
42.00	NURSERY (title V & XIX only)	0	(				42.00		
42.00	Intensive Care Type Inpatient Hospital Units		102	2 0 2 0 2 0	1 51	144 720	42.00		
	INTENSIVE CARE UNIT CORONARY CARE UNIT	377, 455	133	3 2, 838. 0	1 51	144, 739	43.00 44.00		
	BURN INTENSIVE CARE UNIT						45.00		
	SURGI CAL I NTENSI VE CARE UNI T						46.00		
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00		
	·					1.00			
48.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			anc)		1, 859, 367 4, 247, 112	48.00 49.00		
49.00	PASS THROUGH COST ADJUSTMENTS					4, 247, 112	49.00		
50.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00		
51.00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	atient ancillar	y services (fr	rom Wkst. D, s	um of Parts II	0	51.00		
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00		
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	5 1	lated, non-phy	ysician anesth	etist, and	0	53.00		
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00		
55.00	Target amount per discharge					0.00			
	Target amount (line 54 x line 55)					0	56.00		
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	57.00 58.00		
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996, ι	updated and co	mpounded by the	-			
(0.00	market basket	aget report up	datad by the m	norkat bookat		0.00	(0.00		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60.00 61.00		
	which operating costs (line 53) are less that	n expected cost							
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00		
	Allowable Inpatient cost plus incentive payment (see instructions)						63.00		
( 1 00	PROGRAM INPATIENT ROUTINE SWING BED COST	0	( 1 00						
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ng period (see	0	64.00					
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the c	cost reporting	period (See	454, 827	65.00		
66.00	Total Medicare swing-bed SNF inpatient routi	454, 827	66.00						
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	0	67.00						
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00		
	(line 13 x line 20)				ring period				
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00		
	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service o	cost (line 37)			70.00		
71.00 72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00 72.00		
	Medically necessary private room cost applic		(line 14 x li	ne 35)			73.00		
74.00	Total Program general inpatient routine serv	•					74.00		
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	Vorksheet B, P	art II, column		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 Aggregate charges to beneficiaries for exces		78.00 79.00						
80.00	Total Program routine service costs for comp		80. 00 81. 00						
81.00									
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)								
84.00	Program inpatient ancillary services (see instructions) 84								
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85.00 86.00		
00.00	PART IV - COMPUTATION OF OBSERVATION BED PAS					I	00.00		
87.00	Total observation bed days (see instructions						87.00		
88.00 89.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		rine∠)			1, 729. 39 2, 051, 057			
200						_,,,			

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNI TY HOSPI T	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 10/01/2017	Worksheet D-1	
				To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 731, 891	8, 559, 090	0. 20234	5 2, 051, 057	415, 021	90.00
91.00 Nursing School cost	0	8, 559, 090	0.00000	2, 051, 057	0	91.00
92.00 Allied health cost	0	8, 559, 090	0.00000	2, 051, 057	0	92.00
93.00 All other Medical Education	0	8, 559, 090	0.00000	2, 051, 057	0	93.00

## CAMERON MEMORIAL COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

2.00       Inpattent days (including any case and observation bed days)       4.660       2.00         00       Private room days (excluding asying-bed and observation bed days)       17 you have only private room days, and the cost reporting period (if calendar year, enter 0 on this line)       3.0         00       Total simple-de SNF type inpattent days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       2.00         10       Total simple-de SNF type inpattent days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       7.00         0.00       Total simple-de SNF type inpattent days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0.00         0.01       Simple-de SNF type inpattent days applicable to the Program (excluding saving-bed and news)       0.00         0.00       Simple-de SNF type inpattent days applicable to the Program (excluding private room days)       0.00         0.01       Simple-de SNF type inpattent days applicable to the Program (excluding private room days)       0.00         0.01       Simple-de SNF type inpattent days applicable to the Program (excluding saving-bed days)       0.00         0.02       Simple-de SNF type inpattent days applicable to the Program (excluding saving-bed days)       0.00         0.03       Simple-de SNF type inpattent days applicable to the Program (excluding	Heal th	Financial Systems CAMERON MEMORIAL COMM	IUNI TY HOSPI TAL	In Lie	u of Form CMS-2	<u>2552-1</u> 0
Cost Center Description         1.00           PMI1 is ALL SPRONDER COMPONENTS         1.00           Implified days (including private room days, and swing-bed days, excluding neeborn)         5.12 1 0           Implified days (including private room days, and swing-bed days, excluding neeborn)         5.12 1 0           0         Implified days (including private room days, actualing swing-bed and observation bed days)         6.60 2 0           0         Ford and region of the cost regorting period (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including p				From 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4	pared:
DACT         I ALL PROVIDER COMPORENTS         1.00           100         Implified DAYS         Implified DAYS         1.00           100         Implified DAYS         1.00         5.124         1.00           100         Implified DAYS         1.00         5.124         1.00           100         Department Days         0.00         5.124         1.00           100         Department Days         0.00         0.00         0.00         0.00           100         Department Days         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00			Title XIX	Hospi tal	PPS	
PART I - ALL PROVIES COMPONENTS           INPART I THAN DAYS         Institut days (including private room days, excluding sering-bed days, excluding sering-bed days).         1.1           1.00         Inpattent days (including private room days, excluding sering-bed days).         1.2         1.0           0.01         Inpattent days (including private room days, excluding sering-bed days).         1.2         1.0           0.01         Sami-private room days (including private room days).         1.7         9.0           0.02         Sami-private room days (including private room days).         1.7         9.0           0.01         Sami-private room days (including private room days).         1.7         9.0           0.01         Total sering-bed M type inpattent days (including private room days) after December 31 of the cost reporting period.         0.0         0.0           0.02         Total sering-bed M type inpattent days (including private room days) after December 31 of the cost reporting period.         0.0         0.0           0.03         Sami-g-bed SN type inpattent days (including private room days).         0.0         0.0         0.0           0.04         Sami-g-bed SN type inpattent days (including private room days).         0.0         0.0         0.0           0.05         Sami-g-bed SN type inpattent days (including private room days).         0.0         0.0         0.0		Cost Center Description			1 00	
Impart INF         Description         Description         String          String         Stri		PART L - ALL PROVIDER COMPONENTS			1.00	
100       Inpatient days (including private room days. excluding newborn)       5,124       1.00         00       Inpatient days (including private room days. excluding swing-bed and newborn days).       9,000       9,000         00       Swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including						1
0.00       Private room days (excluding swing-bed and observation bed days). If you have only private room days.       0       3.483       4.00         1.00       Seel-private room days (excluding swing-bed and observation bed days)       3.483       4.00         1.00       Total swing-bed SF type inpatient days (including private room days) through December 31 of the cost       5.00         0.00       Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost       10.00         0.00       Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost       10.00         0.00       Total swing-bed SF type inpatient days applicable to tile XVII only (including private room days)       0.00         0.01       Total swing-bed SF type inpatient days applicable to tile XVII only (including private room days)       0.00         0.01       Total swing-bed SF type inpatient days applicable to tile XVII only (including private room days)       0.00         0.02       Swing-bed SF type inpatient days applicable to tile SV or XX only (including private room days)       0.10         1.00       Swing-bed SF type inpatient days applicable to tile SV or XX only (including private room days)       0.10         1.00       Swing-bed SF type inpatient days applicable to tiles V or XIX only (including swing-bed days)       0.10         1.00       Swing-bed SF type inpatient days applicable to tiles V or XIX onl	1.00		s, excluding newborn)		5, 124	1.00
4.00       Seen - private room days (excluding swing-bed and observation bed days) through December 31 of the cost reporting period.       3, 443       4.00       5.00         0       Total swing-bed SK type inpatient days (including private room days) through December 31 of the cost reporting period.       5.00       7.00         0       Total swing-bed KF type inpatient days (including private room days) through December 31 of the cost reporting period.       7.00         0       Total swing-bed KF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) (including private room days) and the private room days) through December 31 of the cost reporting period (including private room days) (including private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days) and the private room days applicable to titles V or XIX and y (including private room days) and the private room days applicable to the services through December 31 of the cost reporting period (incleader year, enter 0 on this line)       11.00         12.00       Swing-bed KF type inpatient days applicable to titles V or XIX and y (including private room days) and the private room days) and the private room days)       13.00         13.00       Swing-bed KF type inpatient days applicable to se	2.00 3.00	Private room days (excluding swing-bed and observation bed day		rivate room days,		
0.00       Total swing-bed SWF type inpatient days (including private room days) after becember 31 of the cost reporting period.       262.6       0.00         0.00       Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period.       192       7.00         0.00       Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period.       192       7.00         0.00       Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and readorm days).       10.00         0.01       Swing-bed SWF type inpatient days applicable to the Program (excluding private room days) after December 31 of the cost reporting period (see instructions).       10.00         1.00       Swing-bed SWF type inpatient days applicable to the Program (excluding private room days) through DWF bype inpatient days applicable to the Program (excluding private room days)       11.00         1.10       Swing-bed WF type inpatient days applicable to the Program (excluding private room days)       11.00         1.10       Swing-bed DWF type inpatient days applicable to the Program (excluding private room days)       11.00         1.10       Swing-bed DWF type inpatient days applicable to the Program (excluding swing-bed days)       11.00         1.10       Medicare rate for swing-bud SWF services applicable to services after December 31 of the cost reporting period.       11.00         1.10       Medicare rate for swin	4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		4.00 5.00
1.00       Total swing-bed WF type inpatient days (including private room days) through December 31 of the cost reporting period (inclaiding private room days) after December 31 of the cost reporting period (inclaiding private room days applicable to the Program (excluding sning-bed and 31 0.00       8.00         1.00       Total inpatient days including private room days applicable to the Program (excluding sning-bed and 31 0.00       9.00         1.00       Sning-bed SWF type inpatient days applicable to the title XVII only (including private room days) after December 31 of the cost reporting period (see instructions)       01.00         1.00       Swing-bed SWF type inpatient days applicable to the YI tes V or XIX only (including private room days)       01.00         1.00       Swing-bed WF type inpatient days applicable to the YI tes V or XIX only (including private room days)       01.00         1.00       Swing-bed WF type inpatient days applicable to the Program (excluding sning-bed days)       01.00         1.00       Swing-bed WF type inpatient days applicable to the Program (excluding sning-bed days)       01.00         1.00       Numsery days (title V or XIX only)       01.00         1.00       Numsery days (title V or XIX only)       01.00         1.00       Numsery days (title V or XIX only)       01.00         1.00       Numsery days (title V or XIX only)       01.00         1.00       Numsery days (title V or XIX only)       01.00         1.00 <td>6.00</td> <td>Total swing-bed SNF type inpatient days (including private ro</td> <td>om days) after December</td> <td>31 of the cost</td> <td>263</td> <td>6.00</td>	6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	263	6.00
0.00       Total saving-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days)       0.01       0.01         0.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newdorm days)       0.01       0.01         0.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after toom days)       0.01       0.00         0.00       Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after toom days)       0       1.00         0.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0       1.00         1.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0       1.00         1.00       Medicatly necessary private room days applicable to the Program (excluding swing-bed days)       0       1.00         1.00       Medicatly necessary private room days applicable to services through December 31 of the cost reporting period       0       1.00         1.00       Medicatl arst for swing-bed NF services applicable to services after December 31 of the cost reporting period       18.00         1.00       Medicatl arst for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6       2.00         1.00	7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	7 31 of the cost	192	7.00
newborn days)       01.0         00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)       01.00         10.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)       01.00         10.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       01.00         10.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       01.00         10.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       01.00         10.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       01.00         10.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       01.00         11.00       Wedicatly necessary private room days applicable to services through December 31 of the cost       10.00         10.00       Medicate rate for Swing-bed SNF services applicable to services fitre December 31 of the cost       15.02         10.00       Medicate rate for Swing-bed SNF type services applicable to services fitre December 31 of the cost       15.02         10.00       Swing-bed cost applicable to SNF type services after December 31 of the cost       15.02       20.00         10.00       Swing-bed cost applicable to	8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8.00
through December' 31 of the cost reporting period (see instructions)       11.00         Do Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after       0         10.00       Swing-bed KT type inpatient days applicable to title SV XIX only (including private room days)       0         11.00       Swing-bed KT type inpatient days applicable to title SV or XIX only (including private room days)       0         12.00       Swing-bed KT type inpatient days applicable to title SV or XIX only (including swing-bed days)       0       13.00         13.00       Maing-bed KT type inpatient days applicable to title SV or XIX only (including swing-bed days)       0       14.00         14.00       Medical IP 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)       0       0       16.00         10.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       15.00       10.00         10.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       15.00       10.00         20.00       Swing-bed cost applicable to SNF type services through December 31 of the cost       15.00       20.00         21.00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 0 x iln	9.00		o the Program (excluding	g swing-bed and	31	9.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)         Image: 100 SWing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         12.00           100 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         13.00           101 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)         0         14.00           101 Model II y necessary private room days applicable to the Program (excluding swing-bed days)         0         14.00           101 Model II y necessary private room days applicable to services through December 31 of the cost         15.00         16.00           101 Model Care rate for swing-bed SNF services applicable to services after December 31 of the cost         15.02         19.00           101 Model Care rate for swing-bed NF services applicable to services after December 31 of the cost         15.02         20.00           110 Model Care rate for swing-bed NF services applicable to services after December 31 of the cost         15.02         20.00           120 Model Care rate for swing-bed NF services applicable to services after December 31 of the cost         15.02         20.00           120 Model Care rate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)         20.00         20.00           21.00 Model Care rate for swing-bed NF type services through December 31 of the cost reporting period (l	10. 00	through December 31 of the cost reporting period (see instruc	tions)	3 /	-	
through December 31 of the cost reporting period       13.00         100       Swing-bed NF type inpatient disys applicable to titles V or XIX only (including swing-bed days)       0       13.00         100       Medical IV necessary private room days applicable to the to the Program (excluding swing-bed days)       0       14.00         100       Medical IV necessary private room days applicable to services through December 31 of the cost       0       14.00         100       Net reporting period       18.00       18.00       18.00       18.00         100       Medical rate for swing-bed SNF services applicable to services through December 31 of the cost       17.00       18.00         110.00       Medical rate for swing-bed SNF services applicable to services through December 31 of the cost       15.00       18.00         110.00       Medical rate for swing-bed NF services applicable to services after December 31 of the cost       15.02       19.00         12.00       Medical rate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 18)       8.559.090       21.00         12.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       22.00       22.00         12.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)       20.00       20.00       20.00	11.00	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	5,		
after December'31 of the cost reporting period (if calendar year, enter O on this line)       0       0         14.00 Medical ly 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)       0       0       0         16.00 Nursery days (title V or XIX only)       0       0       0       0         17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00       18.00         18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       18.00         19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       18.02       00         10.00 Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)       8.559.090       21.00         22.00 Swing-bed cost applicable to SF type services after December 31 of the cost reporting period (line 6 x line 18)       23.00       8.559.090       23.00         23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       24.00       24.00       24.00       24.00       27.00       28.00       28.00       28.00       28.00       28.00       28.00       30.07.499       30.00       30.00       30.00		through December 31 of the cost reporting period		•		
15.00       Total nursery days (title V or XIX only)       469       15.00         15.00       Nursery days (title V or XIX only)       0       0         16.00       Nursery days (title V or XIX only)       0       0         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period       17.00       18.00         18.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       18.00         19.00       Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       155.02       20.02         10.00       Medicard rate for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)       8,559.090       21.00         11.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       8,559.090       21.00         12.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)       22.02         13.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       25.00         14.00       Swing-bed cost (see instructions)       484.591       26.00         15.00       Swing-bed cost (see instructions)       484.591		after December 31 of the cost reporting period (if calendar y	ear, enter O on this lin	ne)	_	
6.00       Nursery days <sup>2</sup> (title V or XIX only)       0       16.00         SWIN BE DADUSTMENT       0       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         19.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       155.02         10.00       Medicare cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       8.559,000         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       23.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)       0         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0         26.00       Soling-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)       0         27.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period			all (excluding swing-bed	uays)		
SWING BED ADJUSTMENT         Image: Construct on the service of the services applicable to services through December 31 of the cost         Image: Construct on the service of the services applicable to services through December 31 of the cost         Image: Construct on the service of the cost         Image: Construct on the service of the cost         Image: Construct on the service of the cost         Image: Construct on the service of the cost         Image: Construct on the service of the cost         Image: Construct on the service of the cost         Image: Construct on the service of the cost         Image: Construct on the service of the cost         Image: Construct on the service on the service on the cost         Image: Construct on the service on the cost         Image: Construct on the service on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         Image: Construct on the cost         I		5 5 ( 5)				
reporting period reporting period reporting period reporting period reporting period reporting period reporting period reporting period Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period (line feedback services applicable to SNF type services applicable to services after December 31 of the cost reporting period (line 5 x line 17) (and be applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) (box services applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17) (box services after December 31 of the cost reporting period (line 7 x line 18) (box services applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19) (box services after December 31 of the cost reporting period (line 7 x line 19) (box services after December 31 of the cost reporting period (line 8 x line 20) (box services after December 31 of the cost reporting period (line 8 x line 20) (box services after December 31 of the cost reporting period (line 8 x line 20) (box services after December 31 of the cost reporting period (line 8 x line 20) (box services after December 31 of the cost reporting period (line 8 x line 20) (box service cost net of swing-bed cost (line 21 minus line 20) (box services after 20 to 10 tal swing-bed cost (see instructions) (box service cost (line 21 minus line 20) (box service cost net of swing-bed charges) (box service cost charges (excluding swing-bed charges) (box service cost differential (line 3 + line 3) (box service cost differential (line 3 + line 3) (box service cost differential di s + line 3) (box service cost differential di s + line 3) (box service cost differential di s + line 3) (box service cost differential di s + line 3) (box service cost differential di s + line 3) (box service cost differential di s + line 3) (box service cost differential di s + line 3) (box service cost differential di s + line 3) (box serv						
reporting period1119.00Medicaid artefor swing-bed NF services applicable to services through December 31 of the cost155.0219.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost155.0210.00Total general inpatient routine service cost (see instructions)8.559,09012.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 58.559,09012.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6023.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8026.00Total swing-bed cost (see instructions)484,59126.0026.00Total swing-bed cost (see instructions)484,59126.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)8.074,49927.00General inpatient routine service cost/charge ratio (line 27 + line 28)00.0020.00Semi-private room charges (excluding swing-bed charges)00020.01General inpatient routine service cost the of swing-bed cost and private room cost differential (line 32 minus line 33) (see instructions)0.00020.00Average per diem private room cost differential (line 34 x line 31)00	17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 d	of the cost		17.00
reporting period20.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period155.0220.0020.00Total general inpatient routine service cost (see instructions)8,559,09021.0022.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)023.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 19)29.76424.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 20)29.76424.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)025.0026.00Total swing-bed cost (see instructions)484,59126.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)8.074,49927.0028.00General inpatient routine service cost/charge ratio (line 27 + line 28)00.00000031.0030.00Average periot room charges (excluding swing-bed charges)00.0032.0031.00Average periot room charge differential (line 32 minus line 33) (see instructions)0.0032.0031.00Average per diem private room charge differential (line 32 minus line 33)0.0033.0032.00Average per diem private room charge differential (line 32 minus line 33)0.0033.0033.00Average per diem private room cost at offferential	18.00		es after December 31 of	the cost	-	18.00
reporting period21.00Total general inpatient routine service cost (see instructions)8,559,09022.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)026.00Total swing-bed cost (see instructions)484,59126.00Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)8,074,49927.00Private room charges (excluding swing-bed charges)028.00General inpatient routine service cost/charge ratio (line 27 + line 28)020.01General inpatient routine service cost/charge ratio (line 30 + line 3)0.00020.02Average per diem private room charge differential (line 34 x line 31)0.0020.03Average per diem private room cost differential (line 34 x line 31)0.0020.04Private room cost differential adjustment (line 34 x line 35)020.05Private room cost differential (line 34 x line 38)020.06Private room cost BEPORE PASS THROUGH COST ADJUSTMENTS20.07Program general inpatient routine servi	19. 00		s through December 31 of	f the cost	155.02	19.00
22.00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       0       22.00         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 18)       0       0         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       0       29,764         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       29,764         26.00       Total swing-bed cost (see instructions)       484,591       0       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       8,074,499       27.00         28.00       Private room charges (excluding swing-bed charges)       0       0       29.00         30.00       Semi-private room charges (excluding swing-bed charges)       0       0       0       0.00         31.00       Average perivate room charges (excluding swing-bed charges)       0       0       0       0.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		reporting period		the cost		
23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0       23.00         24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)       24.00       25.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       25.00         26.00       Total swing-bed cost (see instructions)       8,074,499       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       8,074,499       27.00         27.00       General inpatient routine service charges (excluding swing-bed charges)       0       28.00         28.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.00         29.00       Average private room per diem charge (line 29 + line 3)       0.000000       31.00         30.00       Average per diem private room charge differential (line 32 minus line 33)(see instructions)       0.00       32.00         31.00       Average per diem private room cost differential (line 34 x line 31)       0.00       36.00       37.00         32.00       Average per diem private room cost differential (line 34 x line 31)       0.00       36.00       37.00         35.00       Average per	21. 00 22. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		
24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)       29,764       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
25. 00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)25. 0026. 00Total swing-bed cost (see instructions)484,59126. 00Total swing-bed cost (see instructions)484,59127. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)8,074,49927. 01General inpatient routine service charges (excluding swing-bed and observation bed charges)028. 00Private room charges (excluding swing-bed charges)030. 00Semi-private room charges (excluding swing-bed charges)031. 00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031. 00Average per diem private room cost differential (line 30 + line 3)0.0032. 00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0.0033. 00Average per diem private room cost differential (line 3 x line 35)036. 00Private room cost differential adjustment (line 3 x line 35)037. 00General inpatient routine service cost per diem of swing-bed cost and private room cost differential (line 3 x line 35)037. 00Adgusted general inpatient routine service cost per diem (see instructions)1,729.3938. 00Adjusted general inpatient routine service cost (line 9 x line 38)1,729.3938. 00Adjusted general inpatient routine service cost (line 9 x line 38)53,61140. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)1,729.39	24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	29, 764	24.00
27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)8,074,49927.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28.00General inpatient routine service charges (excluding swing-bed charges)028.0028.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)029.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 30 + line 3)0.0032.00Average semi-private room cost differential (line 34 x line 31)0.0033.0034.00Average per diem private room cost differential (line 3 x line 35)0.0035.0035.00Private room cost differential adjustment (line 3 x line 35)0.0035.0037.00Private room cost differential observations)0.0035.0037.00Private room cost differential observations)0.0035.0037.00Private room cost differential adjustment (line 3 x line 35)036.0037.00Private room cost differential adjustment (line 3 x line 35)038.0038.00Adjusted general inpatient routine service cost per diem (see instructions)1,729.3938.00Adjusted general inpatient routine service cost (line 9 x line 38)53.61140.00Medically necessary private room cost applicable to the Program (line 14 x line 35)53.601	25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000032.00Average private room per diem charge (line 29 + line 3)0.0033.00Average semi-private room per diem charge (line 30 + line 4)0.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0035.00Average per diem private room cost differential (line 3 x line 35)037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)36.0037.00PART 11 - HOSPI TAL AND SUBPROVI DERS ONLY0.01PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS1, 729.3938.00Adj usted general inpatient routine service cost (line 9 x line 38)53, 61139.00Program general inpatient routine service cost (line 9 x line 38)53, 61140.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	26. 00 27. 00		(line 21 minus line 26)			
29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average per diem private room per diem charge (line 30 + line 4)0.0033.0034.00Average per diem private room cost differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 074, 49937.0027 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY0.0135.0078.00Program general inpatient routine service cost per diem (see instructions)1, 729.3938.0039.00Program general inpatient routine service cost per diem (see instructions)53, 61139.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00						
30.00       Semi-private room charges (excluding swing-bed charges)       0       30.00         31.00       General inpatient routine service cost/charge ratio (line 27 ÷ line 28)       0.000000       31.00         32.00       Average private room per diem charge (line 29 ÷ line 3)       0.00       32.00         33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       32.00         34.00       Average per diem private room cost differential (line 32 minus line 33) (see instructions)       0.00       32.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.00         35.00       Average per diem private room cost differential (line 3 x line 35)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0.30.00       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8,074,499       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       9       38.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1,729.39       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,729.39       38.00         39.00       Program general inpatient routi			d and observation bed ch	narges)		
31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.00         32.00       Average private room per diem charge (line 29 + line 3)       0.00       32.00         33.00       Average semi-private room per diem charge (line 30 + line 4)       0.00       33.00         34.00       Average per diem private room cost differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, x line 35)       0       36.00         37.00       PART II - HOSPITAL AND SUBPROVIDERS ONLY       8,074,499       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       1,729.39       38.00         78.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,729.39       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       53,611       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00						
32.00       Average private room per diem charge (line 29 + line 3)       0.00       32.00         33.00       Average semi-private room per diem charge (line 30 + line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 074, 499       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       38.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 729.39       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 729.39       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       53, 611       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	30.00		÷line 28)			
33.00       Average semi-private room per diem charge (line 30 + line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 074, 499       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 729.39         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       53, 611         39.00       Program general inpatient routine service cost applicable to the Program (line 14 x line 35)       0       40.00	32.00					
34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0       0         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8,074,499)       37.00       36.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       8.074,499       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1,729.39       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,729.39       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       53,611       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	33.00					
36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 7 minus line 36)       0       37.00         27 minus line 36)       PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       0       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       1, 729.39       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1, 729.39       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       53, 611       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	34.00
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8,074,499 27 minus line 36)       37.00         PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       1,729.39       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       53,611       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	35.00		ne 31)			
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)       1,729.39       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       53,611       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	36. 00 37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		36.00 37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38. 00Adjusted general inpatient routine service cost per diem (see instructions)1,729.3938.0039. 00Program general inpatient routine service cost (line 9 x line 38)53,61139.0040. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00						1
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,729.3938.0039.00Program general inpatient routine service cost (line 9 x line 38)53,61139.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			USTMENTS			
39.00Program general inpatient routine service cost (line 9 x line 38)53,61139.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	38.00				1, 729. 39	38.00
	39.00					
		3 31 11 0	, , ,			1

)MPU I	ATION OF INPATIENT OPERATING COST		Provider CC	F	Period: From 10/01/2017 To 09/30/2018		
					10 0973072018	2/21/2019 3:4	
	Cost Center Description	Total	Ti tl o Total		Hospital	PPS	
	cost center bescription	Total Inpatient Costl		Average Per Diem (col 1 d	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	243, 075	469	518.28	8 0	0	42
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	377, 455	133	2, 838. 01	1 23	65, 274	43
. 00	CORONARY CARE UNI T	377,433	100	2,000.0	23	05,274	44
. 00	BURN I NTENSI VE CARE UNI T						45
. 00	SURGI CAL INTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	Line 200)			53, 557	7 48
. 00	Total Program inpatient costs (sum of lines 4			ns)		172, 442	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sum	of Parts I and	29, 637	7 50
. 00	) Pass through costs applicable to Program inc	tiont ancillar	, sorvicos (fr	om Wkst D si	um of Parts II	8, 525	5 51
. 00	Pass through costs applicable to Program inpa and IV)		Services (III	JII WKSL D, SL		0, 525	
2. 00	Total Program excludable cost (sum of lines !					38, 162	2 52
. 00	Total Program inpatient operating cost exclud		ated, non-phys	sician anesthe	etist, and	134, 280	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00	Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	56
. 00	Difference between adjusted inpatient operati	ng cost and tar	rget amount (li	ine 56 minus l	ine 53)	0	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	borting period e	enaing 1996, u	sdated and com	ipounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, upo	dated by the ma	arket basket		0.00	0 60
. 00	If line 53/54 is less than the lower of lines				the amount by	0	61
	which operating costs (line 53) are less than		s (lines 54 x d	50), or 1% of	the target		
2. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	nber 31 of the	cost reportir	ng period (See	0	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	to often Decembe	n 21 of the o	oot ronarting	partial (Cas		
. 00	instructions) (title XVIII only)	is after Decembe	er 31 of the co	ost reporting	period (See	0	) 65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line é	54 plus line 6	5)(title XVIII	only). For	0	66
	CAH (see instructions)						
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 of	f the cost rep	porting period	0	67
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after De	combor 21 of	the cost repor	sting poriod	C	68
. 00	(line 13 x line 20)		cember 31 01	the cost repor	ting period		
. 00	Total title V or XIX swing-bed NF inpatient n	routine costs (I	ine 67 + line	68)		0	69 (
	PART III - SKILLED NURSING FACILITY, OTHER NU						
. 00	Skilled nursing facility/other nursing facili	2					70
. 00 . 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ne /u ÷ line .	<u> </u>			71
. 00	Medically necessary private room cost application		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)				74
. 00	Capital -related cost allocated to inpatient i	routine service	costs (from We	orksheet B, Pa	art II, column		75
. 00	26, line 45) Por diam capital related costs (line 75 - lin	2)					76
. 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	,	ovider record	s)			79
00	Total Program routine service costs for compa		ost limitation	(line 78 minu	us line 79)		80
00	Inpatient routine service cost per diem limit						81
00 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82
. 00	Program inpatient ancillary services (see ins		· /				84
. 00	Utilization review - physician compensation		ıs)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
						1 104	- 07
. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			1, 186 1, 729. 39	

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNI TY HOSPI T	AL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
				From 10/01/2017 To 09/30/2018		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 731, 891	8, 559, 090	0. 20234	5 2, 051, 057	415, 021	90.00
91.00 Nursing School cost	0	8, 559, 090	0.00000	2, 051, 057	0	91.00
92.00 Allied health cost	0	8, 559, 090	0.00000	2, 051, 057	0	92.00
93.00 All other Medical Education	0	8, 559, 090	0.00000	2, 051, 057	0	93.00

Health Financial Systems CAMERON MEMORIAL COMM	UNITY HOSPIT	ΓAL	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Pre 2/21/2019 3:4	epared:
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 937, 104		30.00
31. 00 03100 I NTENSI VE CARE UNI T			107, 100		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2443			
51.00 05100 RECOVERY ROOM		0. 6353			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 8284			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1693			
60. 00 06000 LABORATORY		0. 3185		201, 258	
64. 00 06400 INTRAVENOUS THERAPY		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 4507		299, 486	
65. 01 06501 SLEEP LAB		0. 3909	64 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 5165	53 196, 607	101, 558	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2365	46 233, 531	55, 241	69.00
69. 01 06901 CARDI AC REHAB		0. 5528	48 989	547	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4561	49 447, 350	204, 058	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7812	58 353, 031	275, 808	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3795	40 593, 116	225, 111	73.00
76. 00 03020 CHEMI CAL DEPENDENCY		2.9400	00 0	0	76.00
76. 01 03480 ONCOLOGY		0. 3501	39 0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		0. 6582	33 39	26	90.00
90. 01 09001 CLI NI C- MCDONALD		6. 7603	73 0	0	90.01
91. 00 09100 EMERGENCY		0. 3298	25 16, 536	5, 454	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 1985	63 47, 468	56, 893	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 869, 675	1, 859, 367	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	5 (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			4, 869, 675		202.00

Health Financial Systems CAMERON MEMORIAL COMMUN	NITY HOSPI	TAL	In Lie	eu of Form CMS-:	2552-10
	Provider C	CN: 15-1315	Peri od:	Worksheet D-3	
	· ·		From 10/01/2017		
	Component	CCN: 15-Z315	To 09/30/2018	Date/Time Pre 2/21/2019 3:4	pared:
	Ti †l e	e XVIII	Swing Beds - SNI		7 piii
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
		j i i i i i i i i i i i i i i i i i i i	Charges	(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			C		30.00
31. 00 03100 I NTENSI VE CARE UNI T			C		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2443	74 C	0	50.00
51.00 05100 RECOVERY ROOM		0. 6353	65 C	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 8284	67 C	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1693	06 15, 100	2, 557	54.00
60. 00 06000 LABORATORY		0. 3185		6, 150	
64. 00 06400 I NTRAVENOUS THERAPY		0.0000		Ŭ	
65. 00 06500 RESPI RATORY THERAPY		0. 4507		15, 631	
65.01 06501 SLEEP LAB		0. 3909		0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 5165			66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2365		287	
69. 01 06901 CARDI AC REHAB		0. 5528		Ŭ	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4561			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7812		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3795			
76. 00 03020 CHEMI CAL DEPENDENCY		2.9400			
76. 01 03480 ONCOLOGY		0. 3501	39 C	0	76.01
OUTPATIENT SERVICE COST CENTERS				1	
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC		0. 6582		0	90.00
90. 01 09001 CLI NI C- MCDONALD		6. 7603		0	90.01
91.00 09100 EMERGENCY		0. 3298		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 1985			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			300, 150		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		C		201.00
202.00 Net charges (line 200 minus line 201)			300, 150	1	202.00

Health Financial Systems CAMERON MEMORIAL C				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1315	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Pre 2/21/2019 3:4	pared:
	Ti †I	e XIX	Hospi tal	PPS	9 pili
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		J	Charges	(col. 1 x col.	
			ů – Č	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			45, 016		30.00
31. 00 03100 I NTENSI VE CARE UNI T			2, 238		31.00
43. 00 04300 NURSERY			3, 790		43.00
ANCI LLARY SERVI CE COST CENTERS				-	
50. 00 05000 OPERATI NG ROOM		0. 2443			
51.00 05100 RECOVERY ROOM		0. 6353			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 8284		6, 181	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1693			
60. 00 06000 LABORATORY		0. 3185		4, 744	
64.00 06400 INTRAVENOUS THERAPY		0.0000			
65. 00 06500 RESPI RATORY THERAPY		0. 4507		6, 365	
65. 01 06501 SLEEP LAB		0. 3909		0	
66. 00 06600 PHYSI CAL THERAPY		0. 5165			
69. 00 06900 ELECTROCARDI OLOGY		0. 2365			
69. 01 06901 CARDI AC REHAB		0. 55284		50	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4561		5, 766	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7812		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3795			
76. 00 03020 CHEMI CAL DEPENDENCY		2.9400			
76. 01 03480 ONCOLOGY		0. 3501	39 0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		1.5739		-	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		e e e e e e e e e e e e e e e e e e e	
90. 00 09000 CLINIC		0.6582		0	
90. 01 09001 CLINIC- MCDONALD		6.7603		0	
91. 00 09100 EMERGENCY		0. 3298			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 1985			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			124, 860		200.00
201.00 Less PBP Clinic Laboratory Services-Program only char	rges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	124, 860		202.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT PI	TY HOSPITAL rovider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet E	
			From 10/01/2017 To 09/30/2018		
		Title XVIII	Hospi tal	2/21/2019 3:4 Cost	9 pm
			nooprtai		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			10, 763, 403	1 1.
00	Medical and other services reimbursed under OPPS (see instructio	ns)		0	
00	OPPS payments			0	
00	Outlier payment (see instructions)			0	
01	Outlier reconciliation amount (see instructions)	ono)		0	
00 00	Enter the hospital specific payment to cost ratio (see instructi Line 2 times line 5	ons)		0.000	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9
0. 00	Organ acquisitions			0	10
. 00	Total cost (sum of lines 1 and 10) (see instructions)			10, 763, 403	11
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
2.00	Ancillary service charges			0	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	13
	Total reasonable charges (sum of lines 12 and 13)			0	14
	Customary charges				
	Aggregate amount actually collected from patients liable for pay			0	
5.00	Amounts that would have been realized from patients liable for p	ayment for services o	n a chargebasis	0	16
7.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17
7.00 3.00	Total customary charges (see instructions)			0.000000	18
7.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19
	instructions)				
0. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20
	instructions)			40.074.007	0.1
1.00 2.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			10, 871, 037 0	
	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	
	COMPUTATION OF REIMBÜRSEMENT SETTLEMENT				
5.00	Deductibles and coinsurance amounts (for CAH, see instructions)			65, 443	
5.00	Deductibles and Coinsurance amounts relating to amount on line 2	•		5, 190, 769	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	IS THE SUM OF LINES 22	and 23] (see	5, 614, 825	27
3. 00	Direct graduate medical education payments (from Wkst. E-4, line	9 50)		0	28
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29
0. 00	Subtotal (sum of lines 27 through 29)			5, 614, 825	30
	Primary payer payments			4, 616	
2.00	Subtotal (line 30 minus line 31)	١		5, 610, 209	32
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES Composite rate ESRD (from Wkst. 1-5, line 11)			0	33
	Allowable bad debts (see instructions)			853, 402	
5.00	Adjusted reimbursable bad debts (see instructions)			554, 711	
5.00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		632, 211	36
7.00	Subtotal (see instructions)			6, 164, 920	
	MSP-LCC reconciliation amount from PS&R			0	38
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50 9.97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39
9.98	Partial or full credits received from manufacturers for replaced	l devices (see instruc	tions)	0	39
9.99	RECOVERY OF ACCELERATED DEPRECIATION	(212 / 1021 40	/	0	39
0. 00	Subtotal (see instructions)			6, 164, 920	
	Sequestration adjustment (see instructions)			123, 298	
. 02	Demonstration payment adjustment amount after sequestration			0	
	Interim payments Tentative settlement (for contractors use only)			6, 688, 755	
2.00 3.00	Balance due provider/program (see instructions)			0 -647, 133	
. 00 . 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2	chapter 1.	-047, 133	
	§115. 2		- p		
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	1 92
2.00 3.00	Time Value of Money (see instructions)			0	

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1315	Period: From 10/01/2017 To 09/30/2018		pared
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		3, 680, 80	00	6, 552, 555 0	1. 0 2. 0 3. 0
	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					
01	ADJUSTMENTS TO PROVIDER			0 04/20/2018	136, 200	3.0
02				0	0	3.0
03				0	0	3.
04				0	0	3. 3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0 136, 200	3. 3.
77	3. 50-3. 98)			0	130, 200	5.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 680, 80	00	6, 688, 755	4.
	TO BE COMPLETED BY CONTRACTOR					
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					5.
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
	Provider to Program					-
50 51	TENTATI VE TO PROGRAM			0	0	5. 5.
52				0	0	5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
D1	SETTLEMENT TO PROVIDER		68, 59	95	0	6.
02	SETTLEMENT TO PROGRAM			0	647, 133	
00	Total Medicare program liability (see instructions)		3, 749, 39		6, 041, 622	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	(	)	1.00	2.00	8.

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1315	Period: From 10/01/201	Worksheet E-1 7 Part I	1
		Component	CCN: 15-Z315	To 09/30/201	8 Date/Time Pre 2/21/2019 3:4	
		Title	e XVIII	Swing Beds - SI		
		Inpatier	t Part A	Pa	art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	-
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		611, 38	30	C	) 1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		•			
01	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03				0	0	
04				0	0	
05	Dravidar to Dragram			0	0	) 3.
50	Provider to Program ADJUSTMENTS TO PROGRAM		1	0		) 3.
50 51	ADJUSTIMENTS TO FROGRAM			0		-
52				0		-
53				0	0	
54				0	0	) 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	) 3.
	3. 50-3. 98)				_	
00	Total interim payments (sum of lines 1, 2, and 3.99)		611, 38	30	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
~ 1	Program to Provider		1			
01 02	TENTATI VE TO PROVIDER			0		
02				0		
	Provider to Program		1	-1		
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	) 5
00	5.50-5.98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM		23, 05	0		
00	Total Medicare program liability (see instructions)		588, 32			
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			C	1.00	2.00	

Heal th	Financial Systems CAMERON MEMORIAL COMM	IUNI TY HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL/	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Peri od:	Worksheet E-1	
			From 10/01/2017 To 09/30/2018		norod.
			10 09/30/2018	Date/Time Pre 2/21/2019 3:4	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
-	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
	Total hospital discharges as defined in AARA §4102 from Wkst.		e 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				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)		32.00

LCULA		Provider CCN: 15-1315	Period: From 10/01/2017	Worksheet E-2	
		Component CCN: 15-Z315	To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		450.275	0	1 1
	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		459, 375	0	1.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of Wkst D	141, 613	0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst		141,013	0	J 3.
0	Per diem cost for interns and residents not in approved teaching			0.00	4
	instructions)				
	Program days		263	0	
	Interns and residents not in approved teaching program (see ins			0	
	Utilization review - physician compensation - SNF optional meth	nod only	0	_	7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		600, 988	0	
	Primary payer payments (see instructions)		600, 988	0	
	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applica	able to physician	000, 988	0	
00	professional services)	able to physiciali	0	0	''
00	Subtotal (line 10 minus line 11)		600, 988	0	12
	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	658	0	
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14	4)	600, 330	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)				16
55	Rural community hospital demonstration project (§410A Demonstra	ation) payment	0		16
99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	0	0	18
00	Total (see instructions)		600, 330	0	19
01	Sequestration adjustment (see instructions)		12, 007	0	19
	Demonstration payment adjustment amount after sequestration)		0	0	
	Interim payments		611, 380	0	
	Tentative settlement (for contractor use only) Release due provider(program (line 10 minus lines 10.01, 20, es	ad 01)	22.057	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, am Protested amounts (nonallowable cost report items) in accordance		-23, 057 0	0	
00	chapter 1, §115.2	Le with CMS Pub. 15-2,	0	0	23
	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment	I		
0. 00	Is this the first year of the current 5-year demonstration peri				200
ļ	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
. 00	Medicare swing-bed SNF inpatient routine service costs (from Wi	kst. D-1, Pt. II, line			201
00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	What D 2 col 2 lin			202
	200 (title XVIII swing-bed SNF))	WKST. D-3, COL. 3, TH			202
	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in f	irst year of the curre	nt 5-year demonst	ration	
	period)				
	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 tir				206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse Program reimbursement under the S410A Demonstration (see instru				207
	Program reimbursement under the §410A Demonstration (see instru Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,		1		207 208
	and 3)	Sol. I, Sum OF FITTES	'		200
9. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruct	tions)			209
	Reserved for future use	/			210
	Comparision of PPS versus Cost Reimbursement				1
	Total adjustment to Medicare swing-bed SNF PPS payment (line 20	09 plus line 210) (see			215

ALCUL.	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Peri od:	Worksheet E-3	
			From 10/01/2017 To 09/30/2018	Part V Date/Time Pre 2/21/2019 3:4	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR ME	DICARE PART A SERVICES - COS	ST RELMBURSEMENT	1.00	
00	Inpatient services		in nermoonoement	4, 247, 112	1 1
00	Nursing and Allied Health Managed Care payment (see ins	structions)		0	
00	Organ acquisition	· · · · · · · · · · · · · · · · · · ·		0	3
00	Subtotal (sum of lines 1 through 3)			4, 247, 112	4
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instructi	ons)		4, 289, 583	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
~~	Reasonabl e charges				Ι.
00	Routi ne servi ce charges			0	
00 00	Ancillary service charges Organ acquisition charges, net of revenue			0	
	Total reasonable charges			0	1 1
. 00	Customary charges			0	- ''
. 00	Aggregate amount actually collected from patients liabl	e for payment for services or	a charge basis	0	111
	Amounts that would have been realized from patients lia			0	
	had such payment been made in accordance with 42 CFR 4	1 5		-	
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (compl	ete only if line 14 exceeds l	ine 6) (see	0	15
	instructions)				
. 00	Excess of reasonable cost over customary charges (compl	ete only if line 6 exceeds li	ne 14) (see	0	16
00	instructions)	· · · · · · · · · · · · · · · · · · ·		0	1-
. 00	Cost of physicians' services in a teaching hospital (see COMPUTATION OF REIMBURSEMENT SETTLEMENT	ee Instructions)		0	17
. 00	Direct graduate medical education payments (from Works)	peet E_4 line 49)		0	1 18
	Cost of covered services (sum of lines 6, 17 and 18)			4, 289, 583	
	Deductibles (exclude professional component)			502, 732	
	Excess reasonable cost (from line 16)			0	
	Subtotal (line 19 minus line 20 and 21)			3, 786, 851	2
. 00	Coinsurance			0	
. 00	Subtotal (line 22 minus line 23)			3, 786, 851	24
. 00	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		60, 096	25
	Adjusted reimbursable bad debts (see instructions)			39, 062	
	Allowable bad debts for dual eligible beneficiaries (se	ee instructions)		29, 315	
	Subtotal (sum of lines 24 and 25, or line 26)			3, 825, 913	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see insti			0	
	Demonstration payment adjustment amount before sequest	ration		0	1 - 1
	Subtotal (see instructions)			3, 825, 913	
	Sequestration adjustment (see instructions)	ati an		76, 518	
	Demonstration payment adjustment amount after sequestra	ation		2 680 800	
	Interim payments Tentative settlement (for contractor use only)			3, 680, 800 0	
	Balance due provider/program (line 30 minus lines 30.0)	1  30  02  31  and  32)		68, 595	
3.00					

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2017	Worksheet E-3 Part VII	
			To 09/30/2018		pare 9 pr
		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpati ent	
	· · · · · · · · · · · · · · · · · · ·		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR >	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient hospital/SNF/NF services		0		
	Medical and other services		0	0	
	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		0	0	
	Inpatient primary payer payments		0	0	1
	Outpatient primary payer payments		0	0	6
	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				1
) oc	Routi ne servi ce charges		51, 044		] 8
	Ancillary service charges		124, 860	0	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0		1
	Total reasonable charges (sum of lines 8 through 11)		175, 904	0	12
	CUSTOMARY CHARGES			0	1 1 1
00	Amount actually collected from patients liable for payment fo basis	r services on a charge	0	0	13
00	Amounts that would have been realized from patients liable fo	r navment for services (	on O	0	14
00	a charge basis had such payment been made in accordance with			0	''
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15
	Total customary charges (see instructions)		175, 904	0	
00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	175, 904	0	17
	line 4) (see instructions)	5			
00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lir	ne O	0	18
	16) (see instructions)			_	
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst		0	0	
	Cost of covered services (enter the lesser of line 4 or line PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		0	0	2'
	Other than outlier payments		0	0	22
	Outlier payments		0	0	
	Program capital payments		0	Ŭ	24
00	Capital exception payments (see instructions)		0		2
	Routine and Ancillary service other pass through costs		0	0	26
00	Subtotal (sum of lines 22 through 26)		0	0	2
00	Customary charges (title V or XIX PPS covered services only)		0	0	28
	Titles V or XIX (sum of lines 21 and 27)		0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)	、 、	0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	)	0	0	
	Deducti bl es		0	0	
	Coinsurance Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/	0	0	
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40
	Interim payments		87, 239	0	4
	Balance due provider/program (line 40 minus line 41)		-87, 239	0	42
00	Protested amounts (nonallowable cost report items) in accorda	nco with CMS Dub 15 0	0	0	43

	SHEET (If you are nonproprietary and do not maintain	Provider C		Period: From 10/01/2017	Worksheet G	
ina-typi il y)	e accounting records, complete the General Fund column			To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
		General Fund	Specific Purpose Fund	Endowment Fund		
CU	JRRENT ASSETS	1.00	2.00	3.00	4.00	
	ash on hand in banks	2, 857, 852		0 0	0	1 1
	emporary investments	2,037,032		0 0	0	
	otes receivable	0		0 0	0	
	ccounts receivable	9, 809, 507		0 0	0	
01 00	ther receivable	510, 372		0 0	0	5
IA OC	llowances for uncollectible notes and accounts receivable	0		0 0	0	6
00 Ir	nventory	1, 745, 446		0 0	0	7
	repaid expenses	911, 631		0 0	0	8
	ther current assets	66, 635		0 0	0	9
	ue from other funds	0		0 0	0	10
	otal current assets (sum of lines 1-10)	15, 901, 443		0 0	0	11
	XED ASSETS	1 4(2 0(0		0 0	0	1 1 -
	and and improvements	1, 462, 868		0 0		
	ccumul ated depreciation	0		0 0	0	14
	uildings	56, 959, 487			0	15
	ccumulated depreciation	-17, 089, 344		0 0	0	16
	easehold improvements	Ω		0 0	0	17
	ccumul ated depreciation	0		0 0	0	18
	ixed equipment	0		0 0	0	19
	ccumulated depreciation	0		0 0	0	20
. 00 Au	utomobiles and trucks	0	1	0 0	0	21
. 00 🛛 Ac	ccumulated depreciation	0		0 0	0	22
	ajor movable equipment	19, 354, 015		0 0	0	23
	ccumulated depreciation	-13, 345, 940		0 0	0	24
	inor equipment depreciable	0		0 0	0	25
	ccumulated depreciation	0		0 0	0	26
	IT designated Assets	0		0 0	0	27
	ccumulated depreciation	0		0 0	0	28
	inor equipment-nondepreciable	47 241 004		0 0 0 0	0	29
	otal fixed assets (sum of lines 12-29) THER ASSETS	47, 341, 086		0 0	0	1 30
	nvestments	23, 745, 888		0 0	0	31
	eposits on leases	20,710,000		0 0	0	32
	ue from owners/officers	0		0 0	0	33
	ther assets	982, 036		o o	0	
. 00 To	otal other assets (sum of lines 31-34)	24, 727, 924		0 0	0	35
. 00 To	otal assets (sum of lines 11, 30, and 35)	87, 970, 453		0 0	0	36
CU	JRRENT LIABILITIES					
	ccounts payable	1, 733, 527		0 0	0	37
	alaries, wages, and fees payable	2, 087, 779		0 0	0	38
	ayroll taxes payable	0		0 0	0	
	otes and loans payable (short term)	1, 063, 107		0 0	0	
	eferred income	0		0 0	0	
	ccelerated payments	0				42
	ue to other funds	0 107		0 0	0	
	ther current liabilities	600, 127		0 0 0 0		
	otal current liabilities (sum of lines 37 thru 44) DNG TERM LIABILITIES	5, 484, 540		0 0	0	45
	ortgage payable			0 0	0	46
	otes payable			0 0	0	
	nsecured Loans	0		0 0	0	
	ther long term liabilities	43, 936, 093		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	43, 936, 093		0 0		
	otal liabilities (sum of lines 45 and 50)	49, 420, 633		0 0	0	51
CA	API TAL ACCOUNTS				•	1
00 Ge	eneral fund balance	38, 549, 820				52
	pecific purpose fund			0		53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
	ant fund balance - invested in plant				0	
	lant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion	20 540 000		0	_	
	otal fund balances (sum of lines 52 thru 58)	38, 549, 820		0 0	0	
JU 110	otal liabilities and fund balances (sum of lines 51 and	87, 970, 453	1	0 0	0	60

Heal th	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL		In Lie	u of Form CMS-:	2552-10
STATEN	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1315	Peri From To	od: n 10/01/2017 09/30/2018	Worksheet G-1 Date/Time Pre 2/21/2019 3:4	pared:
		General	Fund	Speci al	Purpo	ose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		39, 714, 106 -1, 164, 286 38, 549, 820 0 38, 549, 820 0 38, 549, 820 0 38, 549, 820			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	13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund				
1 00		6.00	7.00	8.00				1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	000	0 0 0 0 0		0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

	Financial Systems CAMERON MEMORIAL COMM			In Lie	u of Form CMS-2	2552-10
STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC		Period: From 10/01/2017 To 09/30/2018	Worksheet G-2 Parts I & II Date/Time Pre 2/21/2019 3:4	pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
	PART I – PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					1
1.00	Hospi tal		8, 551, 36	9	8, 551, 369	1.00
2.00	SUBPROVIDER - IPF		0,001,00		0,001,007	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	
7.00	SKILLED NURSING FACILITY					7.00
8.00 9.00	NURSING FACILITY OTHER LONG TERM CARE					8.00 9.00
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		8, 551, 36	.0	8, 551, 369	
10.00	Intensive Care Type Inpatient Hospital Services		0, 331, 30	7	0, 331, 307	10.00
11.00	INTENSIVE CARE UNIT		279, 30	0	279, 300	11.00
12.00	CORONARY CARE UNI T		,	-	,	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	279, 30	0	279, 300	16.00
17 00	11-15)		0 000 //	0	0 000 //0	17 00
17.00 18.00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	)	8, 830, 66 14, 100, 32		8, 830, 669 102, 460, 965	
19.00	Outpatient services		620, 92		19, 043, 944	
20,00	RURAL HEALTH CLINIC			0 1, 091, 982	1, 091, 982	1
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	1
22.00	HOME HEALTH AGENCY			1, 079, 725	1, 079, 725	
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE			0 314, 449	314, 449	
27.00	PROFESSIONAL FEES		1, 919, 80		4, 163, 251	
27.01 28.00	OTHER REVENUE Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkat	319, 91 25, 791, 64		5, 414, 287 142, 399, 272	
28.00	G-3, line 1)	to wkst.	25, 791, 64	.3 116, 607, 629	142, 399, 272	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			65, 025, 819		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00 33.00				0		32.00 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 to Wkst. G-3, line 4)	2)(transfer		65, 025, 819		43.00

Heal th	Financial Systems CAMERON MEMORIAL COM	MUNITY HOSPITAL	Inlie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1315	Peri od:	Worksheet G-3	
			From 10/01/2017		
			To 09/30/2018	Date/Time Prep	
	· · · · · · · · · · · · · · · · · · ·			2/21/2019 3:40	y pm
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		142, 399, 272	1.00
2.00	Less contractual allowances and discounts on patients' accour			80, 744, 360	2.00
3.00	Net patient revenues (line 1 minus line 2)			61, 654, 912	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		65, 025, 819	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-3, 370, 907	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 servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to other 1	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts Tuition (fees, sale of textbooks, uniforms, etc.)			0	18.00 19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
20.00	Rental of vending machines			0	20.00
21.00	Rental of hospital space			0	21.00
22.00	Governmental appropriations			0	22.00
24.00	OTHER INCOME			1, 292, 242	24.00
24.01	CONTRI BUTI ONS			165, 020	
24.02	LOSS ON DI SPOSAL OF PROPERTY			-47, 499	
24.03	CONTRIBUTION TO FOUNDATION			0	24.03
24.04	CHANGE IN ASSETS FOUNDATION			0	24.04
24.05	INVESTMENT INCOME			784, 129	24.05
24.06	OP REVENUE, GROUPED TO OTHER			12, 729	24.06
25.00	Total other income (sum of lines 6-24)			2, 206, 621	25.00
	Total (line 5 plus line 25)			-1, 164, 286	
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1, 164, 286	29.00

	Financial Systems SIS OF HOSPITAL-BASED HOME HEALT		RON MEMORIAL CO	Provider C	CN: 15-1315	Period:	u of Form CMS-2 Worksheet H	2002-
				HHA CCN:		From 10/01/2017 To 09/30/2018	Date/Time Pre	pared
					-		2/21/2019 3:4	9 pm
						Home Health Agency I	PPS	
		Sal ari es	Employee Benefits	Transportati on	Contracted/Pu chased	r Other Costs	Total (sum of cols. 1 thru	
			Denerrits	(see instructions)			5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			0	1	0	0	1.
	Fixtures			Ū			-	
00	Capital Related – Movable Equipment			0		0	0	2.
00	Plant Operation & Maintenance	0	0	0		o o	0	3.
00	Transportation	0	0	0		0 0	0	
00	Administrative and General HHA REIMBURSABLE SERVICES	193, 504	0	0	36, 69	1 30, 168	260, 363	5.
00	Skilled Nursing Care	272, 945	0	22, 375		0 0	295, 320	6.
00	Physical Therapy	166, 427	0	0		0 0	166, 427	
00 00	Occupational Therapy Speech Pathology	36, 819 3, 157	0	0		0 0 0 0	36, 819 3, 157	
00	Medi cal Soci al Servi ces	24, 651	0	0		0 0	24, 651	
00	Home Health Aide	47, 803	0	0		0 0	47, 803	11.
00	Supplies (see instructions)	0	0	0		0 0	0	1
00 00	Drugs DME	0	0	0 0		0 0 0 0	0	
	HHA NONREI MBURSABLE SERVI CES		0		1			1 '
00	Home Dialysis Aide Services	0	0	0		0 0	0	
00 00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0 0 0	0	
00	Clinic	0	0	0		0 0	0	
00	Health Promotion Activities	0	0	0		0 0	0	19
00	Day Care Program	0	0	0		0 0	0	20
00 00	Home Delivered Meals Program Homemaker Service	0	0	0			0	21.
00	All Others (specify)	0	0	0		0 0	0	
50	Tel emedi ci ne	0	0	0		0 0	0	
00	Total (sum of lines 1-23)	745, 306 Recl assi fi cati		22,375 Adjustments	36,69 Net Expenses		834, 540	24.
		on	Trial Balance	Auj us tilientis	for Allocatio			
			(col. 6 +		(col. 8 + col			
		7.00	<u>col.7)</u> 8.00	9.00	9) 10.00	_		-
	GENERAL SERVICE COST CENTERS				1			
00	Capital Related - Bldg. & Fixtures	0	0	0		0		1.
00	Capital Related - Movable	0	0	0		0		2.
	Equi pment							
00	Plant Operation & Maintenance	0	0	0		0		3.
00 00	Transportation Administrative and General	0 -108, 137	0 152, 226	0 0		0		4. 5.
	HHA REIMBURSABLE SERVICES							
00	Skilled Nursing Care	-39, 315		0				6.
)0 )0	Physical Therapy Occupational Therapy	-129 -42	166, 298 36, 777	0				7. 8.
00	Speech Pathol ogy	-42	3, 157	0				9.
	Medical Social Services	-2, 796	21, 855	0				10.
	Home Health Aide	-6, 295	41, 508	0				11.
00	Cumpling (and instruction )		0	0 0		0		12. 13.
00 00	Supplies (see instructions)	0	0			S.		14.
00 00 00	Supplies (see instructions) Drugs DME	0	0	0		0		
00 00 00 00	Drugs DME HHA NONREI MBURSABLE SERVI CES	0	0	0				
00 00 00 00	Drugs DME HHA NONREI MBURSABLE SERVI CES Home Di al ysi s Ai de Servi ces	0	0	0		0		15.
00 00 00 00	Drugs DME HHA NONREI MBURSABLE SERVI CES Home Di al ysi s Ai de Servi ces Respi ratory Therapy	0	0	0				15. 16.
00 00 00 00	Drugs DME HHA NONREI MBURSABLE SERVI CES Home Di al ysi s Ai de Servi ces	0	0 0 0	0 0 0		0		15 16 17
00 00 00 00 00 00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0		15. 16. 17. 18. 19.
00 00 00 00 00 00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0	0 0 0 0 0	0 0 0 0 0		0 0 0 0 0 0		15. 16. 17. 18. 19. 20.
00 00 00 00 00 00 00 00 00 00	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	0				0 0 0 0 0 0 0		15. 16. 17. 18. 19. 20. 21.
00 00 00 00 00 00 00 00 00 00 00 00 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0		15. 16. 17. 18. 19. 20. 21. 22. 23.
00 00 00 00 00 00 00 00 00 00 00 00 50	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)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0		15. 16. 17. 18. 19. 20. 21. 22.

	Financial Systems		RON MEMORIAL CO				u of Form CMS-2	
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider CO	CN: 15-1315	Period: From 10/01/2017	Worksheet H-1 Part I	
				HHA CCN:	15-7117	To 09/30/2018	Date/Time Pre 2/21/2019 3:4	pared:
						Home Health	PPS	7 pili
			Capital Rela	atad Casta		Agency I		
			Capital Rela					
		Net Expenses	BIdgs &	Movabl e	Plant	Transportati on		
		for Cost Allocation	Fixtures	Equi pment	Operation & Maintenance		(cols. 0-4)	
		(from Wkst. H,			Marintenance			
		col . 10)						
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	4A. 00	-
1.00	Capital Related - Bldg. &	0	0				0	1.00
2 00	Fixtures			0			0	2 00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	0	3.00
4.00	Transportation	0	0	0		0 0	450.00/	4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	152, 226	0	0		0 0	152, 226	5.00
6.00	Skilled Nursing Care	256, 005	0	0		0 0	256, 005	6.00
7.00	Physical Therapy	166, 298	0	0		0 0	166, 298	
8.00 9.00	Occupational Therapy Speech Pathology	36, 777 3, 157	0	0		0 0	36, 777 3, 157	
9.00 10.00	Medical Social Services	21, 855	0	0		0 0	21,855	
11.00	Home Health Aide	41, 508	0	0		0 0	41, 508	
12.00	Supplies (see instructions)	0	0	0		0 0	0	
13.00 14.00	Drugs DME	0	0	0		0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	Ő	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	0	1
23. 50	Tel emedi ci ne	0	0	0		0 0	0	20.00
24.00	Total (sum of lines 1-23)	677,826 Administrative		0		0 0	677, 826	24.00
		& General	4A + 5)					
		5.00	6.00					
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
1.00	Fixtures							1.00
2.00	Capital Related - Movable							2.00
3.00	Equipment Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	152, 226						5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	74, 145	330, 150					6.00
7.00	Physical Therapy	48, 164	214, 462					7.00
8.00	Occupational Therapy	10, 651	47, 428					8.00
9.00	Speech Pathology	914	4,071					9.00
10.00 11.00	Medical Social Services Home Health Aide	6, 330 12, 022	28, 185 53, 530					10.00
12.00	Supplies (see instructions)	0	00,000					12.00
13.00	Drugs	0	0					13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00 18.00
	Clinic	0	0					18.00
18.00	Health Promotion Activities							
18. 00 19. 00	Health Promotion Activities Day Care Program	0	0					20.00
18.00 19.00 20.00 21.00	Day Care Program Home Delivered Meals Program	0	0 0					21.00
18.00 19.00 20.00 21.00 22.00	Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0	0 0 0					20.00 21.00 22.00 23.00
18.00 19.00 20.00 21.00	Day Care Program Home Delivered Meals Program	0	0 0					21.00

	LLOCATION - HHA STATISTICAL BAS	il S		Provider C HHA CCN:	CN: 15-1315 15-7117	Period: From 10/01/2017 To 09/30/2018		pared:
						Home Health Agency I	PPS	·
		Capital Rel	ated Costs					
		BI dgs & Fi xtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	Transportati (MI LEAGE)	onReconciliation	Admi ni strati ve & General (ACCUM. COST)	-
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS				1			
1.00 2.00	Capital Related - Bldg. & Fixtures Capital Related - Movable	0	0			0		1.00
2.00	Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	C		0		3.00
4.00	Transportation (see	0	0	C	)	0		4.00
5.00	instructions) Administrative and General	0	0	C		0 -152, 226	525, 600	5.00
	HHA REIMBURSABLE SERVICES	-	-	-	1	-		
6.00	Skilled Nursing Care	0	0	0		0 0	256,005	
7.00 8.00	Physical Therapy Occupational Therapy	0	0				166, 298 36, 777	
9.00	Speech Pathol ogy		0				3, 157	
10.00	Medical Social Services	0	0	0		0 0	21, 855	
11.00	Home Health Aide	0	0	C C		0 0	41,508	
12.00	Supplies (see instructions)	0	0	C	)	0 0	0	12.00
13.00	Drugs	0	0	C	)	0	0	13.00
14.00	DME	0	0	0		0 0	0	14.00
45 00	HHA NONREI MBURSABLE SERVI CES				1			1 4 5 . 0.0
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy Private Duty Nursing	0	0			0 0	0	16.00
17.00 18.00	Clinic	0	0			0 0	0	17.00 18.00
19.00	Health Promotion Activities		0			0 0		19.00
20.00	Day Care Program		0	0				20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	C C		0 0	0	22.00
23.00	All Others (specify)	0	0	C C		0 0	0	23.00
23.50	Tel emedi ci ne	0	0	C		0 0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	C	)	0 -152, 226	525, 600	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	C		0	152, 226	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 289623	26.00

	n Financial Systems			MMUNITY HOSPIT			u of Form CMS-2	
ALLOC	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider CC	CN: 15-1315 15-7117	Period: From 10/01/2017 To 09/30/2018	Worksheet H-2 Part I Date/Time Pre	
						Home Health	2/21/2019 3:4 PPS	
			CAPITAL REL	ATED COSTS		Agency I		
			CAPITAL REL	LATED COSTS				
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	2.00	4. 00	4A	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 330, 150 214, 462 47, 428 4, 071 28, 185 53, 530 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		41, 397 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	183, 49 183, 49	$ \begin{smallmatrix} 0 & 330, 150 \\ 0 & 214, 462 \\ 0 & 47, 428 \\ 0 & 4, 071 \\ 0 & 28, 185 \\ 0 & 53, 530 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & 0 \\ 0 & $	80, 691 52, 416 11, 592 995 6, 889	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ \end{array}$
	column 26, line 1, rounded to 6 decimal places. Cost Center Description	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		7.00	8.00	9.00	10.00	11.00	13.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	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)	59, 126 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13, 236 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0       28,400         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       28,400		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE C	OSTS TO HHA COST CEN	NTERS	Provider CC	CN: 15-1315 15-7117	Period: From 10/01/2017 To 09/30/2018	2/21/2019 3:4	pared:
					Home Health Agency I	PPS	
Cost Center Descrip	ti on CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
	14.00	15.00	16.00	24.00	25.00	26.00	
<ol> <li>1.00 Administrative and General</li> <li>2.00 Skilled Nursing Care</li> <li>3.00 Physical Therapy</li> <li>4.00 Occupational Therapy</li> <li>5.00 Speech Pathology</li> <li>6.00 Medical Social Services</li> <li>7.00 Home Health Aide</li> <li>8.00 Supplies (see instruction</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialysis Aide Servi</li> <li>12.00 Respiratory Therapy</li> <li>13.00 Private Duty Nursing</li> <li>14.00 Clinic</li> <li>15.00 Health Promotion Activit</li> <li>16.00 Home Delivered Meals Program</li> <li>17.00 Home Delivered Meals Program</li> <li>18.00 Homemaker Service</li> <li>19.00 All Others (specify)</li> <li>19.50 Telemedicine</li> <li>20.00 Total (sum of lines 1-19)</li> <li>21.00 Unit Cost Multiplier: co</li> <li>26, line 1 divided by the of column 26, line 20, on an an an an an an an an an an an an an</li></ol>	rs) (() ces (() gram (() () () () (2) 1,75 umn e sum hus ed to			410, 8 266, 8 59, 0 5, 0 35, 0 66, 6	41       0         78       0         20       0         66       0         74       0         13       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 19.00 19.00
Cost Center Descrip	A&G (see Part	Costs					
1 00 Administrative and Conor	27.00	28.00					1.0
<ol> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>O Skilled Nursing Care</li> <li>O Ccupational Therapy</li> <li>O Speech Pathology</li> <li>Medical Social Services</li> <li>Medical Social Services</li> <li>O Home Health Aide</li> <li>Supplies (see instruction</li> <li>O Drugs</li> <li>O DME</li> <li>O Home Dialysis Aide Servi</li> <li>O Respiratory Therapy</li> <li>O Health Promotion Activit</li> <li>O Alt Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Service</li> <li>O Unit Cost Multiplier: co</li> <li>I ine 1 divided by the of column 26, line 10, round</li> </ol>	es (() () (2) 382, 432 () (2) 382 () (2) 382, 432 () (2) 382 ()	387, 878           85, 779           7, 363           2, 50, 976           2, 96, 815           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0           0, 0					$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 21. \ 00\\ 21. \ 00\\ 21. \ 00\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ri od:	Perio	In Lieu of Form CMS-2 Worksheet H-2	
om 10/01/2017 09/30/2018	From To		
Home Health Agency I			
Agency I			
& GENERAL	8	RAL PLANT	
5.00		0 7.00	
224, 896	0		1.00
330, 150	0		2.00
214, 462	0		3.00
47, 428	0		4.00 5.00
4, 071 28, 185	0		6.00
53, 530	0		7.00
0	0		8.00
0	0	0 0	9.00
0	0	0 0	10.00
0	0	0 0	11.00
0	0		12.00
0	0	° °	13.00
0	0	° °	14.00
0	0	° °	15.00
0	0	0 0	16.00 17.00
0	0		18.00
0	0	0 0	19.00
0	0	0 0	19.50
902, 722	-	02, 722 1, 469	20.00
220, 632			21.00
0.244407			22.00
NURSI NG DMI NI STRATI ON DI RECT NRSI NG	ADM	RATION SERVICES & SUPPLY	
HR)		REQUIS.)	
13.00	93		1 00
0	73 0		1.00 2.00
0	0		3.00
0	0		4.00
0	0	0 0	5.00
0	0	0 0	6.00
0	0	-	7.00
0	0		8.00
0	0		9.00
0	0		10. 0 11. 0
0	0		12.0
0	0		13.0
Ő	0	-	14.0
0	0		15.0
0	0	0 0	16.00
0	0	0 0	17.00
0	0	0 0	18.0
0	0		19.0
=			19.5
-			
-			
	0 0 93 00 12	0.	1

Heal th	Financial Systems	CAME	RON MEMORIAL COMM	IUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICAL	Provider CCN: 15-1315	Peri od:	Worksheet H-2	
BASI S				HHA CCN: 15-7117	From 10/01/2017 To 09/30/2018	Part II Date/Time Pre	nared
					10 07/30/2010	2/21/2019 3:4	9 pm
					Home Health	PPS	
					Agency I		
	Cost Center Description	PHARMACY	MEDI CAL				
		(COSTED REQUIS.)	RECORDS & LI BRARY				
		KEQUIS.)	(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	Physical 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 14.00	Private Duty Nursing Clinic	0	0				13.00 14.00
14.00	Health Promotion Activities	0	0				14.00 15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program		0				10.00
18.00	Homemaker Service	0	0				18.00
19.00		0	0				19.00
19.50	Tel emedi ci ne	0	o				19.50
	Total (sum of lines 1-19)	0	o				20.00
	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	MMUNITY HOSPIT	TAL	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	īS.		Provider C	CN: 15-1315	Peri od:	Worksheet H-3	
				HHA CCN:	15-7117	From 10/01/2017 To 09/30/2018	Part I Date/Time Pre 2/21/2019 3:49	pared: 9 pm
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.		Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	ROGRAM COST, A	GGREGATE OF TH	E PROGRAM LIN	NITATION COST, OF	2	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	597, 113		597, 1	13 2,040	292. 70	1.00
2.00	Physical Therapy	3.00		0				•
3.00	Occupational Therapy	4.00	85, 779	0	85, 7	79 349	245. 79	3.00
4.00	Speech Pathology	5.00		0	1 1 1 0 0			•
5.00	Medical Social Services	6.00			50, 97		1, 108. 17	
6.00 7.00	Home Health Aide Total (sum of lines 1-6)	7.00	96, 815 1, 225, 924	0	96, 8 <sup>-</sup> 1, 225, 92		105. 12	6.00 7.00
7.00			1, 223, 724	0	Program Visit			7.00
					Pa	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1			
					Deducti bl es Coi nsurance			
	1	0	1.00	2.00	3.00	4.00	5.00	
0.00	Limitation Cost Computation		00015	0		7.		
8.00 9.00	Skilled Nursing Care Physical Therapy		99915 99915	0				8.00 9.00
10.00	Occupational Therapy		99915	0		17		10.00
11.00	Speech Pathology		99915	0		10		11.00
12.00	Medical Social Services		99915	0	)	3		12.00
13.00	Home Health Aide		99915	0		56		13.00
14.00		Freeze Wheet 11 0		0 Charact	75		Datia (aal 2	14.00
	Cost Center Description	From Wkst. H-2 Part I, col.	facility costs (from Wkst.		Total HHA Costs (cols.	U U	Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	. cor. +)	
				Part II)				
	Supplies and Drugs Cast Comput		1.00	2.00	3.00	4.00	5.00	
15.00	Supplies and Drugs Cost Computa Cost of Medical Supplies	8.00	0	0		0 0	0. 000000	15 00
16.00		9.00		0		0 0	0. 000000	
			Program Visits		Cost of	-		
					Servi ces			
	Cast Contor Description	Part A	Par Not Subject to		Part A	Part B Not Subject to	Subject to	
	Cost Center Description	Part A	Deductibles &	Deductibles &	Parta	Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	ROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIN	NITATION COST, OF	2	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							-
1.00	Skilled Nursing Care	0	276			0 80, 785		1.00
2.00	Physical Therapy	0	361			0 61, 984		2.00
3.00	Occupational Therapy	0	47			0 11, 552		3.00
4.00	Speech Pathol ogy	0	10			0 1, 389		4.00
5.00	Medical Social Services	0	3			0 3, 325		5.00
6.00 7.00	Home Health Aide Total (sum of lines 1–6)	0	56 753			0 5, 887 0 164, 922		6.00 7.00
	Cost Center Description	0	/53			104, 922		7.00
7.00			7.00	8.00	9.00	10.00	11.00	
7.00		6.00	7.00					1
	Limitation Cost Computation	6.00	7.00		1			0.00
8.00	Limitation Cost Computation Skilled Nursing Care	6.00	7.00					8.00
8. 00 9. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy	6.00	7.00					9.00
8.00	Limitation Cost Computation Skilled Nursing Care	6.00	7.00					
8. 00 9. 00 10. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	6.00						9.00 10.00
8.00 9.00 10.00 11.00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	6.00						9.00 10.00 11.00

Heal th	Financial Systems	CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	- AL	In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-1315	Peri od:	Worksheet H-3	
					45 7447	From 10/01/2017	Part I	
				HHA CCN:	15-7117	To 09/30/2018	Date/Time Pre 2/21/2019 3:4	pared: 9 nm
				Title	XVIII	Home Health	PPS	<u>, bui</u>
						Agency I		
		Prog	ram Covered Cha	irges	Cost of			
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &		Part A	Not Subject to Deductibles &	Subject to Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6,00	7.00	8.00	9,00	10.00	11.00	
	Supplies and Drugs Cost Comput		7.00	0.00	7.00	10.00	11.00	
15.00	Cost of Medical Supplies		0	0		0 0	0	15.00
	Cost of Drugs		240			0		
	Cost Center Description	Total Program						
		Cost (sum of						
		cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
	BENEFICIARY COST LIMITATION							
1 00	Cost Per Visit Computation	00.705						1 00
1.00 2.00	Skilled Nursing Care Physical Therapy	80, 785 61, 984						1.00 2.00
2.00	Occupational Therapy	11, 552						3.00
4.00	Speech Pathol ogy	1, 389						4.00
5.00	Medi cal Soci al Servi ces	3, 325						5.00
6.00	Home Heal th Aide	5, 887						6.00
7.00	Total (sum of lines 1-6)	164, 922						7.00
	Cost Center Description							
		12.00						1
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathol ogy							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8–13)	I						14.00

Heal th Fi	inancial Systems	CAME	RON MEMORIAL CO	MMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
APPORTI 0	NMENT OF PATIENT SERVICE COST	S		Provider C	CN: 15-1315	Period: From 10/01/2017	Worksheet H-3 Part II	
				HHA CCN:	15-7117	To 09/30/2018		
				Titl€	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Rati o	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3.00	4.00		
PA	ART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00 PI	hysical Therapy	66.00	0. 516553	C	)	0 col. 2, line 2	. 00	1.00
2.00 00	ccupational Therapy							2.00
3.00 S	peech Pathology							3.00
4.00 Co	ost of Medical Supplies	71.00	0. 456149	C	)	0 col. 2, line 1	5.00	4.00
5.00 C	ost of Drugs	73.00	0. 379540	C		Ocol. 2, line 1	6. 00	5.00

	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-1315	Peri		Worksheet H-4	
		HHA CCN:	15-7117	To	m 10/01/2017 09/30/2018	Part I-II Date/Time Pre 2/21/2019 3:4	
		Title	XVIII	H	ome Health Agency I	PPS	
			Devet A	N -	Par		
			Part A	De		Deductibles &	
			1.00	(	2.00	Coi nsurance 3.00	<u> </u>
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGES			2.00	3.00	
00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0	0	0	1 1
00	Total charges			0	240	0	
00	Customary Charges Amount actually collected from patients liable for payment for	r servi ces		0	0	0	3
	on a charge basis (from your records)						
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0	0	0	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	000	0.000000	0.000000	
00 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	complete		0	240 240	0	
	only if line 6 exceeds line 1)						
00	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0	0	0	8
00	Primary payer amounts			0	0	0	9
					Part A Servi ces	Part B Services	
					1.00	2.00	
. 00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)				0	0	1 10
	Total PPS Reimbursement - Full Episodes without Outliers				0	131, 380	
. 00 . 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				0	0 5, 294	
. 00	Total PPS Reimbursement - PEP Episodes				0	3, 294	
. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers				0	0	
. 00	Total PPS Outlier Reimbursement - PEP Episodes				0	0	
. 00	Total Other Payments				0	0	
. 00 . 00	DME Payments Oxygen Payments				0	0	
	Prosthetic and Orthotic Payments				0	0	
	Part B deductibles billed to Medicare patients (exclude coinsu	urance)				0	2
	Subtotal (sum of lines 10 thru 20 minus line 21)				0	137, 034	
	Excess reasonable cost (from line 8)				0	0	
	Subtotal (line 22 minus line 23)				0	137, 034 0	
. 00 . 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				0	137, 034	
	Reimbursable bad debts (from your records)				Ŭ	137,034	27
	Reimbursable bad debts for dual eligible beneficiaries (see in	nstructions)					28
	Total costs - current cost reporting period (line 26 plus line				0	137, 034	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	0	
. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			0	0	
. 99	Demonstration payment adjustment amount before sequestration				0	0	
. 00	Subtotal (see instructions)				0	137, 034 2, 742	
01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration				0	2, 742	
	bemonstration payment aujustment amount arter sequestration				0	134, 292	
. 02	Interim payments (see instructions)				(1)		1 5 4
1.02 2.00	Interim payments (see instructions) Tentative settlement (for contractor use only)				0		
3. 00	Interim payments (see instructions) Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, a	and 33)			0	134, 292 0 0	33

	GIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider CC	CN: 15-1315		eriod:	Worksheet H-5	
PRC	OGRAM BENEFICIARIES	HHA CCN:	15-7117	Fi   Ti	rom 10/01/2017 o 09/30/2018	Date/Time Prep 2/21/2019 3:49	arec
					Home Health Agency I	PPS	/ piii
		I npati en	t Part A			t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00	-	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		134, 292 0	1. 2.
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.
)1				0		0	3.
)2				0		0	3.
)3				0		0	3
)4 )5				0		0	3 3
Э	Provider to Program			0		0	3
0				0		0	3
1				0		0	3
2				0		0	3
3				0		0	3
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	3 3
7	3. 50-3. 98)			0		0	5
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		134, 292	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						5
0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						С
1	Program to Provider			0		0	5
)2				0		0	5
3				0		0	5
	Provider to Program						
0				0		0	5 5
1 2				0		0	5 5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on						6
11	the cost report. (1) SETTLEMENT TO PROVIDER			~			,
)1 )2	SETTLEMENT TO PROVIDER			0		0	6
0	Total Medicare program liability (see instructions)			0		134, 292	7
				-	Contractor	NPR Date	
					Number	(Mo/Day/Yr)	
)0	Name of Contractor	C	)		1.00	2.00	8

IALYSI S	S OF HOSPITAL-BASED HOSPICE COSTS		Provider C Hospice CC	F	eriod: rom 10/01/2017 o 09/30/2018	Worksheet 0 Date/Time Pre	pare
					Hospi ce I	2/21/2019 3:4	9 pm
		SALARI ES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	ENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT*			0	0	0	1 1.
	CAP REL COSTS-DEDG & TTXT		(		0	0	
	EMPLOYEE BENEFITS DEPARTMENT*	0	(		0	0	
	ADMINISTRATIVE & GENERAL*	14, 744	3, 201	17, 945	0	17, 945	
	PLANT OPERATION & MAINTENANCE*	0	C	0 0	0	0	
DO L	AUNDRY & LINEN SERVICE*	0	C	0 0	0	0	6
DO  F	HOUSEKEEPING*	0	C	0 0	0	0	7
00 0	DI ETARY*	0	C	0 0	0	0	8
70 OC	NURSI NG ADMI NI STRATI ON*	0	C	0 0	0	0	9
.00 🖡	ROUTI NE MEDI CAL SUPPLI ES*	0	C	0 0	0	0	10
00 N	MEDICAL RECORDS*	0	C	0 0	0	0	11
	STAFF TRANSPORTATI ON*	0	21, 794		0	21, 794	
	/OLUNTEER SERVICE COORDINATION*	1, 589	C	1, 589	0	1, 589	
	PHARMACY*	0	C	0	0	0	
	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	(	0	0	0	
1	OTHER GENERAL SERVICE*	0	C	0	0	0	16
	PATIENT/RESIDENTIAL CARE SERVICES						17
	I RECT PATIENT CARE SERVICE COST CENTERS		2 722	2,723	0	2, 723	25
	PHYSICIAN SERVICES**	0	2, 723		0	2,723	
	NURSE PRACTITIONER**	0			0	0	
	REGI STERED NURSE**	95, 376		95, 376	0	95, 376	
	_PN/LVN**	,3,3,0	(	0	0	0	
	PHYSICAL THERAPY**	129	C	129	o	129	
	OCCUPATIONAL THERAPY**	42	C	42	0	42	
00 5	SPEECH/LANGUAGE PATHOLOGY**	0	C	0 0	0	0	32
00 N	MEDICAL SOCIAL SERVICES**	17, 512	C	17, 512	0	17, 512	33
00 5	SPI RI TUAL COUNSELI NG**	1, 683	C	1, 683	0	1, 683	34
	DI ETARY COUNSELI NG**	0	C	0 0	0	0	35
	COUNSELING - OTHER**	0	C	0 0	0	0	
	HOSPICE AIDE & HOMEMAKER SERVICES**	6, 295	C	6, 295	0	6, 295	
	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	
	PATIENT TRANSPORTATION**	0	(	0	0	0	
	MAGING SERVICES**	0	(	0	0	0	
	LABS & DI AGNOSTI CS** /IEDI CAL_SUPPLI ES-NON-ROUTI NE**	0	(		0	0	
	DRUGS CHARGED TO PATIENTS**	0			0	0	
	DUTPATI ENT SERVI CES**	0			0	0	
	PALLIATIVE RADIATION THERAPY**	0	(		0	0	
	PALLIATIVE CHEMOTHERAPY**	0	(	0	0	0	
	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	C	0	o	0	
	ONREIMBURSABLE COST CENTERS	- <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u> - <u>-</u>					
	BEREAVEMENT PROGRAM *	0	C	0 0	0	0	60
1	/OLUNTEER PROGRAM *	0	C	0	0	0	61
	FUNDRAI SI NG*	0	C	0	0	0	62
00  +	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	C	0	0	0	63
	PALLIATIVE CARE PROGRAM*	0	C	0	0	0	
	OTHER PHYSICIAN SERVICES*	0	C	0	0	0	
	RESIDENTIAL CARE*	0	C	0	0	0	
	ADVERTI SI NG*	0	C	0	0	0	
	FELEHEALTH/TELEMONI TORI NG*	0	C	0	0	0	
	THRI FT STORE*	0	C	0	0	0	
	NURSING FACILITY ROOM & BOARD*	0	C	0	0	0	
	OTHER NONREIMBURSABLE (SPECIFY)*	0	)		0	0	
). UOFT	FOTAL	137, 370	27, 718	165, 088	0	165, 088	1100

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

	Financial Systems CA SIS OF HOSPITAL-BASED HOSPICE COSTS	AMERON MEMORIAL CO	Provi der CCN:		Peri od:	u of Form CMS Worksheet O	
			Hospi ce CCN:	15-1561	From 10/01/2017 To 09/30/2018	Date/Time P	
					Hospi ce I	2/21/2019 3	:49 pn
		ADJUSTMENTS	TOTAL (col. 5		1.0001.001		
		6.00	± col. 6) 7.00				
	GENERAL SERVICE COST CENTERS	6.00	7.00				_
00	CAP REL COSTS-BLDG & FIXT*	0	0				1
00	CAP REL COSTS-MVBLE EQUIP*	0	0				2
00	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3
00	ADMINI STRATI VE & GENERAL*	0	17, 945				4
00	PLANT OPERATION & MAINTENANCE*	0	0				5
00	LAUNDRY & LINEN SERVICE*	0	0				6
00	HOUSEKEEPI NG*	0	0				7
00	DI ETARY*	0	0				8
00	NURSING ADMINISTRATION*	0	0				9
0. 00	ROUTINE MEDICAL SUPPLIES*	0	0				10
. 00	MEDI CAL RECORDS*	0	0				11
2.00	STAFF TRANSPORTATION*	0	21, 794				12
3. 00	VOLUNTEER SERVICE COORDINATION*	0	1, 589				13
1.00	PHARMACY*	0	0				14
5.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0				15
6. 00	OTHER GENERAL SERVICE*	0	o				16
. 00	PATI ENT/RESI DENTI AL CARE SERVI CES						17
	DIRECT PATIENT CARE SERVICE COST CENTERS		· · · · · ·				
5.00	INPATIENT CARE-CONTRACTED**	0	2, 723				25
. 00	PHYSI CLAN SERVI CES**	0	0				26
. 00	NURSE PRACTITIONER**	0	0				27
3. 00	REGI STERED NURSE**	0	95, 376				28
9.00	LPN/LVN**	0	0				29
0. 00	PHYSI CAL THERAPY**	0	129				30
I. 00	OCCUPATIONAL THERAPY**	0	42				31
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
3.00	MEDICAL SOCIAL SERVICES**	0	17, 512				33
1.00	SPIRITUAL COUNSELING**	0	1, 683				34
5.00	DI ETARY COUNSELI NG**	0	0				35
5.00	COUNSELING - OTHER**	0	0				36
. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	6, 295				37
3. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0				38
9.00	PATIENT TRANSPORTATION**	0	0				39
0. 00	I MAGI NG SERVI CES**	0	0				40
. 00	LABS & DI AGNOSTI CS**	0	0				41
. 00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0				42
2.50	DRUGS CHARGED TO PATI ENTS**	0	0				42
3.00	OUTPATI ENT SERVICES**	0	0				43
. 00	PALLIATIVE RADIATION THERAPY**	0	0				44
5.00	PALLIATIVE CHEMOTHERAPY**	0	0				45
6. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46
	NONREI MBURSABLE COST CENTERS						
. 00		0					60
. 00	VOLUNTEER PROGRAM *	0	0				61
. 00	FUNDRAI SI NG*	0	0				62
. 00		0	0				63
. 00	PALLIATIVE CARE PROGRAM*	0	0				64
	OTHER PHYSICIAN SERVICES*	0	0				65
. 00		0	0				66
	ADVERTI SI NG*	0	0				67
. 00		0	0				68
. 00		0	0				69
0. 00		0	0				70
I. 00	OTHER NONREI MBURSABLE (SPECI FY)*	0	0				71
10 00	TOTAL	0	165, 088				100

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

NALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP	ICE ROUTINE HOME	Provider (	CN: 15-1315	Peri od:	Worksheet 0-2	
ARE		Hospi ce CC	CN: 15-1561	From 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
			_	Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (co 1 + col. 2)		SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 INPATIENT CARE-CONTRACTED						25.00
26. 00 PHYSI CI AN SERVI CES	0	(	D	0 0	0	
27.00 NURSE PRACTITIONER	0	(	D	0 0	0	27.00
28. 00 REGI STERED NURSE	78, 908	(	78,9	08 0	78, 908	28.00
29.00 LPN/LVN	0	(	D	0 0	0	29.00
30. 00 PHYSI CAL THERAPY	107	(		07 0	107	30.00
31. 00 OCCUPATI ONAL THERAPY	35	(	C	35 0	35	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	(	C	0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	14, 489	(	0 14,4	89 0	14, 489	33.00
34. 00 SPI RI TUAL COUNSELI NG	1, 393	(	0 1,3	93 0	1, 393	34.00
35. 00 DI ETARY COUNSELI NG	0	(	D	0 0	0	35.00
36.00 COUNSELING - OTHER	0	(	D	0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	5, 208	(	5, 2	08 0	5, 208	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	(	D	0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0	(	D	0 0	0	39.00
0.00 I MAGI NG SERVI CES	0	(	D	0 0	0	40.00
1.00 LABS & DIAGNOSTICS	0	(	D	0 0	0	41.00
2.00 MEDICAL SUPPLIES-NON-ROUTINE	0	(	D	0 0	0	42.00
2.50 DRUGS CHARGED TO PATIENTS	0	(	D	0 0	0	42.50
3.00 OUTPATI ENT SERVICES	0	(	D	0 0	0	43.00
4.00 PALLIATIVE RADIATION THERAPY	0	(	D	0 0	0	44.00
5. 00 PALLIATIVE CHEMOTHERAPY	0	(	D	0 0	0	45.00
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	(	b	0 0	0	46.00
00.00 TOTAL *	100, 140	(	100, 1	40 0	100, 140	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6,00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	78, 908		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSI CAL THERAPY	0	107		30.00
31.00	OCCUPATIONAL THERAPY	0	35		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	14, 489		33.00
34.00	SPI RI TUAL COUNSELI NG	0	1, 393		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	5, 208		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 MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	100, 140	10	00.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51.			

Health Financial Systems	CAME	RON MEMORIAL CON	MUNI TY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSP	PICE COSTS FOR HOSPIC	E INPATIENT	Provider C	CN: 15-1315	Peri od:	Worksheet 0-3	
RESPITE CARE			Hospi ce CC	N: 15-1561	From 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
				_	Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (co		SUBTOTAL	
				1 + col. 2)			
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERV							
25.00 INPATIENT CARE-CONTRACTE	D		58	3	58 0	58	
26.00 PHYSI CI AN SERVI CES		0	(	)	0 0	0	20.00
27.00 NURSE PRACTITIONER		0	(	D	0 0	0	27.00
28.00 REGI STERED NURSE		350	(	) 3	50 0	350	
29.00 LPN/LVN		0	(	D	0 0	0	
30. 00 PHYSI CAL THERAPY		0	(	D	0 0	0	
31.00 OCCUPATIONAL THERAPY		0	(	D	0 0	0	
32.00 SPEECH/LANGUAGE PATHOLOG	βY	0	(	D	0 0	0	02.00
33.00 MEDICAL SOCIAL SERVICES		64	(	D	64 0	64	33.00
34.00 SPI RI TUAL COUNSELI NG		6	(	D	6 0	6	34.00
35.00 DI ETARY COUNSELI NG		0	(		0 0	0	35.00
36.00 COUNSELING - OTHER		0	(		0 0	0	
37.00 HOSPICE AIDE & HOMEMAKER		23	(		23 0	23	
38.00 DURABLE MEDICAL EQUIPMEN	IT/OXYGEN	0	(		0 0	0	00.00
39.00 PATIENT TRANSPORTATION		0	(		0 0	0	39.00
40.00 I MAGI NG SERVI CES		0	(		0 0	0	10100
41.00 LABS & DIAGNOSTICS		0	(		0 0	0	1 11 00
42.00 MEDI CAL SUPPLI ES-NON-ROL		0	(		0 0	0	
42.50 DRUGS CHARGED TO PATIENT	S	0	(	D	0 0	0	
43.00 OUTPATIENT SERVICES		0	(		0 0	0	10100
44.00 PALLIATIVE RADIATION THE	RAPY	0	(	D	0 0	0	44.00
45.00 PALLI ATI VE CHEMOTHERAPY		0	(	D	0 0	0	45.00
46.00 OTHER PATIENT CARE SERVI	CES (SPECI FY)	0	(	ן ע	0 0	0	101.00
100.00 TOTAL *		443	58	3 5	01 0	501	100.00

 40.00
 OTAL \*
 443

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DI RECT PATIENT CARE SERVICE COST CENTERS	1	1	4
25.00		0	58	25.00
26.00		0	0	26.00
27.00		0	0	27.00
28.00		0	350	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	64	33.00
34.00	SPI RI TUAL COUNSELI NG	0	6	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	23	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 MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
	O TOTAL *	0	501	100.00
* Tra	nsfer the amount in column 7 to Wkst. 0-5, col	umn 1. line 52.		

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10							
ANALYSI S OF HOSPI TAL-BASED HOSPI CE COSTS FOR HOSPI CE GENERAL			Provider CO		Peri od:	Worksheet 0-4	
I NPATI	ENT CARE		Hospi ce CCN		From 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col 1 + col. 2)	. RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		2, 665	2, 66	5 0	2, 665	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	16, 118	0	16, 11	18 0	16, 118	28.00
29.00	LPN/LVN	0	0		0 0	0	29.00
30.00	PHYSI CAL THERAPY	22	0	2	22 0	22	30.00
31.00	OCCUPATIONAL THERAPY	7	0		7 0	7	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	2, 959	0	2, 95	59 0	2, 959	33.00
34.00	SPI RI TUAL COUNSELI NG	284	0	28	34 0	284	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	1,064	0	1, 06	64 0	1, 064	37.00
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 MAGI NG SERVI CES	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 SERVICES	0	0		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00	TOTAL *	20, 454	2, 665	23, 11	0 0	23, 119	100.00

46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 100. 00 TOTAL \* 20, 454 \* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
		6,00	<u>± col. 6)</u> 7.00	-	
	DIRECT PATIENT CARE SERVICE COST CENTERS	6.00	7.00		
25.00	INPATIENT CARE-CONTRACTED		2.445		25.00
	PHYSICIAN SERVICES		2, 665		
26.00 27.00	NURSE PRACTITIONER		0		26.00
			1( 110		
28.00	REGI STERED NURSE	0	16, 118		28.00
29.00		0	0		29.00
30.00	PHYSI CAL THERAPY	0	22		30.00
31.00	OCCUPATIONAL THERAPY	0	/		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDI CAL SOCI AL SERVI CES	0	2, 959		33.00
34.00	SPI RI TUAL COUNSELI NG	0	284		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	1, 064		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 MAGI NG SERVI CES	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 SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	100.00 TOTAL *		23, 119		100.00
* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.					

Heal th	Financial Systems CAMERON MEMORIAL COM	MUNITY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
		Provider C	CN: 15-1315	Period:	Worksheet 0-5	
EXPENS	EXPENSES FOR ALLOCATION			rom 10/01/2017		
		Hospi ce CC	N: 15-1561	Го 09/30/2018		
				Hospi ce I	2/21/2019 3:4	9 pili
	Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
	bescriptions		EXPENSES (see		(sum of cols.	
			i nstructi ons)		1 + 2)	
				WKST B PART I	1 2)	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS			-		
1.00	CAP REL COSTS-BLDG & FIXT		(	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		(	8, 482	8, 482	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		(	42, 826		3.00
4.00	ADMINI STRATI VE & GENERAL		17, 94	60, 331	78, 276	4.00
5.00	PLANT OPERATION & MAINTENANCE			12, 115	12, 115	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPING			0	0	7.00
8.00	DIETARY		(	0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON		(		0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			107	107	10.00
11.00	MEDICAL RECORDS			0 0	0	11.00
12.00	STAFF TRANSPORTATION		21, 79		21, 794	12.00
13.00	VOLUNTEER SERVI CE COORDI NATI ON		1, 589		1, 589	13.00
14.00	PHARMACY			0 0	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
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0		17.00
	LEVEL OF CARE			-	-	
50, 00	HOSPICE CONTINUOUS HOME CARE		(		0	50.00
51.00	HOSPICE ROUTINE HOME CARE		100, 140		100, 140	51.00
52,00	HOSPICE INPATIENT RESPITE CARE		50		501	52.00
53.00	HOSPI CE GENERAL I NPATI ENT CARE		23, 110		23, 119	53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		(	)	0	60.00
61.00	VOLUNTEER PROGRAM			D	0	61.00
62.00	FUNDRAI SI NG			D	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			D	0	63.00
64.00	PALLIATIVE CARE PROGRAM			D	0	64.00
65.00	OTHER PHYSI CLAN SERVI CES			D	0	65.00
66.00	RESIDENTIAL CARE		(	D	0	66.00
67.00	ADVERTI SI NG		(	D	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			D	0	68.00
69.00	THRIFT STORE		(	D	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			D	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			D	0	71.00
99.00	NEGATI VE COST CENTER		(		0	99.00
100.00			165, 088	3 123, 861	288, 949	100.00

	Financial Systems CA LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-1315 N: 15-1561	Pe Fr To	riod: om 10/01/2017 09/30/2018 Hospice I	Worksheet 0-6 Part I Date/Time Pre 2/21/2019 3:4	pared: 9 pm
	Descriptions	TOTAL EXPENSESC	FIX	EQUI P	LE	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS			1				
1.00	CAP REL COSTS-BLDG & FIXT	0	C					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8, 482		8, 4				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	42, 826	0		0	42, 826		3.00
4.00	ADMI NI STRATI VE & GENERAL	78, 276	0		0	0	78, 276	4.00
5.00	PLANT OPERATION & MAINTENANCE	12, 115	0		0	0	12, 115	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0	0	0	6.00
7.00	HOUSEKEEPING	0	0		0	0	0	7.00
8.00		0	0		0	0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	107	0		0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	107	U		0	0	107	10.00
11.00	MEDICAL RECORDS	21 704	0		0	0	0	11.00
12.00	STAFF TRANSPORTATION	21, 794	0		0	0	21, 794	
13.00 14.00	VOLUNTEER SERVICE COORDINATION PHARMACY	1, 589	0		0	0	1, 589	13.00
14.00	PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	0	0	14.00 15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	0	0	17.00
17.00	LEVEL OF CARE		0	1	0		0	17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	100, 140				35, 432	135, 572	
52.00	HOSPICE INPATIENT RESPITE CARE	501	C	1	80	157	838	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	23, 119	0			7, 237	38, 658	
	NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	C		0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	)	0	0	0	61.00
62.00	FUNDRAI SI NG	0	0	)	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	)	0	0	0	65.00
66.00	RESI DENTI AL CARE	0	C		0	0	0	66.00
67.00	ADVERTI SI NG	0	C		0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	0	68.00
69.00	THRI FT STORE	0	C		0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	C		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	C		0	0		99.00
100 00	TOTAL	288, 949	0	8,4	182	42, 826	288, 949	1100 00

COST A	LLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL	_ SERVICE COSTS	Provider C Hospice CC				Worksheet O Part I Date/Time P 2/21/2019 3	rep	
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &		Hospi ce I HOUSEKEEPI NG	DI ETARY		
		& GENERAL	OPERATI ON & MAI NTENANCE	LINEN SERVI	CE				
		4.00	5.00	6.00		7.00	8.00		
	GENERAL SERVICE COST CENTERS			·					
1.00	CAP REL COSTS-BLDG & FIXT								1.00
2.00	CAP REL COSTS-MVBLE EQUIP								2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT								3.00
4.00	ADMI NI STRATI VE & GENERAL	78, 276							4.00
5.00	PLANT OPERATION & MAINTENANCE	4, 501	16, 616	,					5.00
6.00	LAUNDRY & LINEN SERVICE	0	C		0				6.00
7.00	HOUSEKEEPING	0	C			0			7.00
8.00	DIETARY	0	C			0		0	8.00
9.00	NURSING ADMINISTRATION	0	0			0			9,00
10.00	ROUTINE MEDICAL SUPPLIES	40	0			0			10.00
11.00	MEDI CAL RECORDS	0	0			0			11.00
12.00	STAFF TRANSPORTATION	8,098	0			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	590	0			0			13.00
14.00	PHARMACY	0	0			0			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0			15.00
16.00	OTHER GENERAL SERVICE	0	C C			0			16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0			0			17.00
	LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0							50.00
51.00	HOSPICE ROUTINE HOME CARE	50, 373							51.00
52.00	HOSPICE INPATIENT RESPITE CARE	311	354		0	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	14, 363	16, 262		0	0		0	53.00
00.00	NONREI MBURSABLE COST CENTERS		10,202					-	00.00
60.00	BEREAVEMENT PROGRAM	0	C			0			60.00
61.00	VOLUNTEER PROGRAM	0	0			0			61.00
62.00	FUNDRALSING	0	0			0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0			63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0			64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0			0			65.00
66.00	RESI DENTI AL CARE	0	0		0	0		0	66.00
67.00	ADVERTI SI NG	0	0		Ŭ	0		Ĭ	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0				0			68.00
69.00	THRI FT STORE	0	0			0			69.00
70.00	NURSING FACILITY ROOM & BOARD		Ŭ			Ŭ			70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0	C		0	0		0	70.00
99.00	NEGATI VE COST CENTER	0	0		0	0		0	99.00
, ,. 00	HEORITIE OUDI CENTER			1	0	0		~	//. 00

	Descriptions		Provider CCN: 15-1315 Hospice CCN: 15-1561		From 10/01/2017 To 09/30/2018	B Date/Time Pre	
	Descriptions					2/21/2019 3:4	9 pm
		NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	Hospi ce I STAFF TRANSPORTATI OI	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS				I		
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	0					9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	147				10.00
11.00	MEDICAL RECORDS	0			0		11.00
12.00	STAFF TRANSPORTATION	0			29, 89		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			(	_,	13.00
14.00 15.00	PHARMACY PHYSI CLAN ADMINI STRATI VE SERVI CES	0					14.00 15.00
15.00 16.00	OTHER GENERAL SERVICE	0					16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0					17.00
17.00	LEVEL OF CARE						17.00
50, 00	HOSPICE CONTINUOUS HOME CARE	0	0		0 (	0 0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	121		0 24, 73	-	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1		0 110		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	25		0 5,05		53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			(	0 0	60.00
61.00	VOLUNTEER PROGRAM	0			(	0 0	61.00
62.00	FUNDRAI SI NG	0			(	0 0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			(	0 0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			(	0 0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			(	0 0	65.00
66.00	RESIDENTIAL 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	THRIFT STORE	0			(	0 0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	~			0	71.00
99.00 100.00	NEGATI VE COST CENTER	0	0 147		0 29,892	0	99.00 100.00

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provider C Hospice CC	CN: 15-1315 N: 15-1561	Period: From 10/01/2017 To 09/30/2018	Worksheet 0-6 Part I Date/Time Pre 2/21/2019 3:4	epared:
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI VE SERVI CES	OTHER GENERA SERVI CE	Hospi ce I AL PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		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	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						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 15.00							14.00
16.00	PHYSI CI AN ADMINI STRATI VE SERVI CES OTHER GENERAL SERVI CE				0		15.00 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
17.00	LEVEL OF CARE				0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	(		1	0	(	50.00
51.00	HOSPICE ROUTINE HOME CARE	(			0	212, 600	
52.00	HOSPICE INPATIENT RESPITE CARE				0 0	1, 622	
53.00	HOSPICE GENERAL INPATIENT CARE				0 0	74, 727	
	NONREI MBURSABLE COST CENTERS		-1 -				
60.00	BEREAVEMENT PROGRAM	(			0	C	60.00
61.00	VOLUNTEER PROGRAM	(			0	C	61.00
62.00	FUNDRAI SI NG	(			0	C	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	(			0	C	63.00
64.00	PALLIATIVE CARE PROGRAM	(			0	C	64.00
65.00	OTHER PHYSICIAN SERVICES	(			0	C	65.00
66.00	RESI DENTI AL CARE	(	) C	)	0 0	C	66.00
67.00	ADVERTI SI NG	(			0	C	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	(			0	C	68.00
69.00	THRI FT STORE	(			0	C	
	NURSING FACILITY ROOM & BOARD					C	
71.00	OTHER NONREIMBURSABLE (SPECIFY)	(	) C		0 0	C	
99.00	NEGATIVE COST CENTER	(	) C		0 0	C	
100.00	IOTAL	(	) C		0 0	288, 949	100.00

Heal th	Financial Systems	CAMERO	N MEMORIAL CON	MUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GEN	NERAL SERVI	CE COSTS	Provider CC	CN: 15-1315	Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S					From 10/01/2017	Part II	
				Hospi ce CCN	l: 15-1561	To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
-						Hospi ce I	2/21/201/ 3.4	7 pm
	Cost Center Descriptions	CA	P REL BLDG & C	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	· · · · · · · · · · · · · · · · · · ·		FLX	EQUI P	BENEFITS		& GENERAL	
		(5	SQUARE FEET) (	DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
			í ľ	·	(GROSS		COSTS)	
					SALARI ES)			
			1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT		0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP			7, 812				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		0	0	42, 82	25		3.00
4.00	ADMINISTRATIVE & GENERAL		0	0		0 -78, 276	210, 673	4.00
5.00	PLANT OPERATION & MAINTENANCE		0	0		0 0	12, 115	5.00
6.00	LAUNDRY & LINEN SERVICE		0	0		0 0	0	6.00
7.00	HOUSEKEEPING		0	0		0 0	0	7.00
8.00	DI ETARY		0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION		0	0		0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES		0	0		0 0	107	10.00
11.00	MEDI CAL RECORDS		0	0		0 0	0	11.00
12.00	STAFF TRANSPORTATION		0	0		0 0	21, 794	12.00
13.00	VOLUNTEER SERVICE COORDINATION		0	0		0 0	1, 589	13.00
14.00	PHARMACY		0	0		0 0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES		0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE		0	0		0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	0	17.00
	LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE				35, 43		135, 572	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		0	166		57 0	838	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		0	7, 646	7, 23	37 0	38, 658	53.00
	NONREI MBURSABLE COST CENTERS			1		1		
60.00	BEREAVEMENT PROGRAM		0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM		0	0		0 0	0	61.00
62.00	FUNDRAI SI NG		0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM		0	0		0 0	0	64.00
65.00	OTHER PHYSI CLAN SERVI CES		0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE		0	0		0 0	0	66.00
67.00	ADVERTI SI NG		0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0	0		0 0	0	68.00
69.00	THRI FT STORE		0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	~	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)		0	0		0 0	0	71.00
99.00	NEGATIVE COST CENTER	Dort 1)		0 400	40.0			99.00 100.00
	COST TO BE ALLOCATED (per Wkst. 0-6, UNIT COST MULTIPLIER	rait I)	0.000000	8, 482 1. 085765	42, 82 1.00002		78, 276 0. 371552	
101.00	UNIT COST MULTIPLIER		0.000000	1. 000/00	1.00002	20	0.3/1552	101.00

Heal th	Financial Systems C/	MERON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL TICAL BASIS	SERVICE COSTS	Provider C Hospice CC		Period: From 10/01/2017 To 09/30/2018	Date/Time Pre	pared:
						2/21/2019 3:4	9 pm
	Cast Conton Deceriptions						
	Cost Center Descriptions	PLANT OPERATION &	LAUNDRY &	HOUSEKEEPI NO		NURSI NG	
		MAINTENANCE	LINEN SERVICE (IN-FACILITY	(SQUARE FEET	DAYS)	ADMI NI STRATI ON	
		(SQUARE FEET)	DAYS)		DATS)	(DIRECT NURS.	
		(SCOARE TEET)	DATS)			HRS. )	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS			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	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	17, 794					5.00
6.00	LAUNDRY & LINEN SERVICE	0	l c				6.00
7.00	HOUSEKEEPING	0			0		7.00
8.00	DI ETARY	0			0 0		8.00
9.00	NURSING ADMINISTRATION	0			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17.00
	LEVEL OF CARE		•				
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	379	c c		0 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	17, 415	C	)	0 0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	C	)	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	C		0 0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part				0 0	-	100.00
101.00	UNIT COST MULTIPLIER	0. 933798	0. 000000	0.0000	0. 000000	0. 000000	101.00

OOCT A			MMUNI TY HOSPI			u of Form CMS-	
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S TICAL BASIS	SERVICE COSTS	Provider C		Period: From 10/01/2017 To 09/30/2018	Worksheet 0-6 Part II Date/Time Pre 2/21/2019 3:4	epared:
	Cost Center Descriptions	ROUTINE	MEDI CAL	STAFF	Hospi ce I VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI	ON SERVICE	(CHARGES)	
			(PATIENT DAYS)		COORDI NATI ON		
		(PATIENT DAYS)		(MI LEAGE)	(HOURS OF SERVICE)		
		10.00	11.00	12.00	13.00	14.00	
	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	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	2, 722					10.00
11.00	MEDI CAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			32, 0			12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 2, 334		13.00
14.00	PHARMACY				0 0	C	
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES				0 0	C	
16.00	OTHER GENERAL SERVICE				0 0	C	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.00
50.00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	0	0		0 0	C	50.00
50.00	HOSPICE CONTINUOUS HOME CARE	2, 252	0		-	C	
51.00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	2, 252	0		18 1, 931	C	
52.00 53.00	HOSPICE THPATTENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	460	0			C	
55.00	NONREI MBURSABLE COST CENTERS	400	0	J, 4	J7 J74	L. L.	53.00
60.00	BEREAVEMENT PROGRAM				0 0	C	60.00
61.00	VOLUNTEER PROGRAM				0 0	C	1
62.00	FUNDRAI SI NG				0 0	C	1
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	C	
64.00	PALLIATIVE CARE PROGRAM				0 0	C	1
65.00	OTHER PHYSICIAN SERVICES				0 0	C	
66.00	RESI DENTI AL CARE				0 0	C	
67.00	ADVERTI SI NG				0 0	C	67.00
68.00	TELEHEALTH/TELEMONI TORI NG				0 0	C	68.00
69.00	THRI FT STORE				0 0	C	
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0 0	C	71.00
99.00	NEGATI VE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I	) 147	0	29, 8	92 2, 179	C	100.00
	UNIT COST MULTIPLIER	0. 054004	0.00000	0. 9338	92 0. 933590		101.00

	2	RON MEMORIAL CO				u of Form CMS	
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-1315	Period: From 10/01/2017	Worksheet 0-	6
STATI S	TICAL BASIS		Hospi ce CC	N: 15-1561	To 09/30/2018	Part II Date/Time Pr	epared.
			110001100 001	10 1001	10 07/00/2010	2/21/2019 3:	
					Hospi ce I		_
	Cost Center Descriptions		OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASI S)	(IN-FACILIT	Y		
		15.00	16.00	DAYS) 17.00			
	GENERAL SERVICE COST CENTERS	15.00	10.00	17.00			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						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						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15.00
16.00	OTHER GENERAL SERVICE		0				16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0		53.00
	NONREI MBURSABLE COST CENTERS	· · · · · ·					
60.00	BEREAVEMENT PROGRAM		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
64.00	PALLIATIVE CARE PROGRAM		0				64.00
65.00	OTHER PHYSI CI AN SERVI CES		0				65.00
66.00	RESI DENTI AL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRIFT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD		~		0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
99.00	NEGATIVE COST CENTER		0		0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	0		100.00
101.00	UNIT GOST MULTIFLIER	0.000000	0.000000	0.0000			101.00

Heal th	Financial Systems CA	AMERON MEMORIAL CON	MUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SI	ERVICE COSTS BY	Provider CC	N: 15-1315	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospice CCN	l: 15-1561	From 10/01/2017 To 09/30/2018	Date/Time Prep 2/21/2019 3:49	pared: 9 pm
					Hospi ce I	272172017 011	, bii
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C Part I, Col. 9 line	ost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00 2.00 3.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	66. 00 67. 00 68. 00	0. 516553		0 0	0	1.00 2.00 3.00
3.00 4.00 5.00	DRUGS CHARGED TO PATIENTS DURABLE MEDICAL EQUIP-RENTED	73.00	0. 379540		0 0	0	3.00 4.00 5.00
6.00	LABORATORY	60.00	0. 318599		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0. 456149		0 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00					9.00
10.00	CHEMI CAL DEPENDENCY	76.00	2. 940000		0 0	0	10.00
10. 01	ONCOLOGY	76. 01	0. 350139		0 0	0	
11.00	Totals (sum of lines 1–11)						11.00
		Charges by LOC (from Provider Records)		Shared Servi	ice Costs by LOC		
	Cost Center Descriptions		CHC (col 1 x	HRHC (col 1	xHIRC (col. 1 x	HGLP (col 1 x	
			col . 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS	· · · · ·					
1.00	PHYSI CAL THERAPY	0	0		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATI ENTS	0	0		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED				-		5. OC
6.00	LABORATORY	0	0		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00 9.00
9.00 10.00	RADI OLOGY-THERAPEUTI C CHEMI CAL DEPENDENCY		_		0 0	0	
10.00	ONCOLOGY	0	0		0 0	0	10.00
	Totals (sum of lines 1-11)	0	0		0 0	°,	11.00
11.00		1	U U		9	U	11.00

Heal th	Financial Systems CAMERON MEMORIA	L COMMUNITY HOSI	PI TAL			In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provi der	CCN: 15-	-1315	Peri	od: n 10/01/2017	Worksheet 0-8	
		Hospi ce	CCN: 15	5-1561	То	09/30/2018	Date/Time Prep 2/21/2019 3:49	
					ł	Hospi ce I		
				E XVIII		TITLE XIX	TOTAL	
				DI CARE		MEDI CAI D		
	1		· ·	1.00		2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE							
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wks	st. 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	e, line 10)			0	0		4.00
5.00	Program cost (line 3 times line 4)				0	0		5.00
	HOSPICE ROUTINE HOME CARE					T		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst	st. 0-7, col. 7,					212, 600	6.00
	line 11)						0.050	7
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)						2, 252	7.00
8.00	Total average cost per diem (line 6 divided by line 7)						94.40	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropria	te, line 11)		24		180		9.00
10.00	Program cost (line 8 times line 9)			23, 03	34	16, 992		10.00
	HOSPICE INPATIENT RESPITE CARE							
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst	st. 0-7, col. 8,					1, 622	11.00
	line 11)						10	
	Total unduplicated days (Wkst. S-9, col. 4, line 12)	<u>`</u>						12.00
13.00	Total average cost per diem (line 11 divided by line 12)						162.20	
14.00	Unduplicated program days (Wkst. S-9, col. as appropriated)	te, line 12)			3	0		14.00
15.00	Program cost (line 13 times line 14)			48	37	0		15.00
	HOSPICE GENERAL INPATIENT CARE						7.4 707	
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wks	st. 0-7, col. 9,					74, 727	16.00
47.00	line 11)							47.00
	Total unduplicated days (Wkst. S-9, col. 4, line 13)	、 、					460	
18.00	Total average cost per diem (line 16 divided by line 17)				~	0	162.45	
19.00	Unduplicated program days (Wkst. S-9, col. as appropria:	te, line 13)			0	0		19.00
20.00	Program cost (line 18 times line 19)				U	0		20.00
21 00	TOTAL HOSPICE CARE					I	200 040	21 00
	Total cost (sum of line 1 + line 6 + line 11 + line 16)						288, 949	
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)							22.00
23.00	Average cost per diem (line 21 divided by line 22)		I.				106.15	23.00

	Financial Systems CAMER IS OF HOSPITAL-BASED RHC/FQHC COSTS	RON MEMORIAL CO	Provi der C		Peri od:	u of Form CMS-2 Worksheet M-1	
AL I J					From 10/01/2017 To 09/30/2018		pared
					RHC I	Cost	
		Compensation	Other Costs	Total (col. '	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS				1		
0	Physi ci an	421, 596	5, 234	426, 83	0 0	426, 830	1. (
0	Physician Assistant	0	0		0 0	0	2. (
0	Nurse Practitioner	117, 595	0	117, 59	5 0	117, 595	3. (
0	Visiting Nurse	0	0		0 0	0	4.0
0	Other Nurse	90, 679	0	90, 67	9 0	90, 679	5.0
0	Clinical Psychologist	0	0		0 0	0	6.1
0	Clinical Social Worker	0	0		0 0	0	7.0
0	Laboratory Techni ci an	0	0		0 0	0	8. (
0	Other Facility Health Care Staff Costs	0	0		0 0	0	9.1
00	Subtotal (sum of lines 1 through 9)	629, 870	5, 234	635, 10	4 0	635, 104	10. (
00	Physician Services Under Agreement	0	0		0 0	0	11. (
00	Physician Supervision Under Agreement	0	0		0 0	0	12.0
00	Other Costs Under Agreement	0	0		0 0	0	13.0
00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.0
00	Medical Supplies	0	4, 356	4, 35	6 0	4, 356	15.
00	Transportation (Health Care Staff)	0	0		0 0	0	16.1
00	Depreciation-Medical Equipment	0	0		0 0	0	17.0
00	Professional Liability Insurance	0	0		0 0	0	18. (
00	Other Health Care Costs	0	0		0 0	0	19. (
00	Allowable GME Costs						20. (
00	Subtotal (sum of lines 15 through 20)	0	4, 356	4, 35	6 0	4, 356	21.0
00	Total Cost of Health Care Services (sum of	629, 870	9, 590	639, 46	0 0	639, 460	22. (
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES				- 1		
00	Pharmacy	0	0		0 0	-	
00	Dental	0	0		0 0	0	
00	Optometry	0	0		0 0	0	
01	Tel eheal th	0	0		0 0	0	
02	Chronic Care Management	0	0		0 0	0	25. (
00	All other nonreimbursable costs	0	0		0 0	0	
00	Nonallowable GME costs						27.0
00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. (
	through 27)						
~ ~	FACILITY OVERHEAD	-1			-		
00	Facility Costs	0	908				
00	Administrative Costs	153, 275	31, 974	185, 24		185, 249	
00	Total Facility Overhead (sum of lines 29 and	153, 275	32, 882	186, 15	/ 0	186, 157	31. (
	30) Total facility costs (sum of lines 22, 28	783, 145	42, 472	825, 61	_	825, 617	32. (
00							

Heal th	Financial Systems CAMER	RON MEMORIAL C	OMMUNITY HOSPI	ΓAL	In Lieu of Form CMS-2552-			
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315	Peri od:	Worksheet M-1		
			Component	CCN: 15-8530	From 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4		
					RHC I	Cost		
		Adjustments	Net Expenses					
		2	for Allocation					
			(col. 5 + col.					
			6)					
		6.00	7.00					
	FACILITY HEALTH CARE STAFF COSTS		1	1				
1.00	Physi ci an	0		1			1.00	
2.00	Physician Assistant	0					2.00	
3.00	Nurse Practitioner	0	117, 595				3.00	
4.00	Visiting Nurse	0					4.00	
5.00	Other Nurse	0	90, 679				5.00	
6.00	Clinical Psychologist	0					6.00	
7.00	Clinical Social Worker	U	0				7.00	
8.00	Laboratory Technician	U	, s				8.00	
9.00	Other Facility Health Care Staff Costs	0					9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	635, 104 0				10.00	
11. 00 12. 00	Physician Services Under Agreement Physician Supervision Under Agreement	0					12.00	
12.00	Other Costs Under Agreement	0					12.00	
13.00	Subtotal (sum of lines 11 through 13)	0					14.00	
14.00	Medical Supplies	0	4,356				15.00	
16.00	Transportation (Health Care Staff)	0	4, 330	1			16.00	
17.00	Depreciation-Medical Equipment	0					17.00	
18.00	Professional Liability Insurance	0					18.00	
19.00	Other Health Care Costs	0					19.00	
20.00	Allowable GME Costs	Ū.					20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	4, 356				21.00	
22.00	Total Cost of Health Care Services (sum of	0					22.00	
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	I			23.00	
24.00	Dental	0	0				24.00	
25.00	Optometry	0	0 0				25.00	
25.01	Tel eheal th	0	0 0				25. 01	
25.02	Chronic Care Management	0	0 0				25.02	
26.00	All other nonreimbursable costs	0	0				26.00	
27.00	Nonallowable GME costs						27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00	
	through 27)							
00.05	FACILITY OVERHEAD	-		1				
29.00	Facility Costs	0					29.00	
30.00	Administrative Costs	0		•			30.00	
31.00	Total Facility Overhead (sum of lines 29 and	0	186, 157				31.00	
32.00	30) Total facility costs (sum of lines 22, 28	0	825, 617				32.00	
32.00	and 31)	U	020,017				32.00	
			I	1			1	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider C	Provider CCN: 15-1315		Worksheet M-2	
			Component	CCN: 15-8530	From 10/01/2017 To 09/30/2018	Date/Time Pre 2/21/2019 3:4	
RHC I					Cost		
		Number of FTE	Total Visits	Producti vi t	/ Minimum Visits	Greater of	
		Personnel		Standard (1	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
. 00	Physi ci an	0. 73					1. (
. 00	Physician Assistant	0.00					2.0
. 00	Nurse Practitioner	0.85	3, 925	2, 10	1, 785		3. (
. 00	Subtotal (sum of lines 1 through 3)	1.58	8, 129		4, 851	8, 129	4. (
. 00	Visiting Nurse	0.00	0			0	5.0
. 00	Clinical Psychologist	0.00	0			0	6. (
. 00	Clinical Social Worker	0.00	0			0	7.(
. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.(
. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7.(
	onl y)						
. 00	Total FTEs and Visits (sum of lines 4	1.58	8, 129			8, 129	8.0
	through 7)						
. 00	Physician Services Under Agreements		0			0	9. (
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES						
0.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				639, 460		
1.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					11. (	
2.00						639, 460	
3.00						1.000000	
4.00					186, 157		
5.00						893, 148	
5.00					1, 079, 305		
7.00	Allowable GME overhead (see instructions)						17. (
8.00					1, 079, 305		
9.00	0 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1, 079, 305	19.

19.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)1,079,30519.0020.00Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)1,718,76520.00

SERVICES         Component CCX: 15-850         Form         10/01/2017         DetoTIme Pre ZV1/2019.3/L           It is a variable           It is a variable         It is a variable         It is a variable         It is a variable         It is a variable           It is a variable         It is a variable         It is a variable         It is a variable         It is a variable           It is a variable         It is a variable         It is a variable         It is a variable         It is a variable           It is a variable         It is a variable         It is a variable         It is a variable         It is a variable           It is a variable         It is a variable         It is a variable         It is a variable         It is a variable           It is a variable         It is a variable         It is a variable         It is a variable         It is a variable           It is a variable         It is a variable         It is a variable         It is a variable         It is a variable         It is a variable           It is a variable         It is a variable         It is a variable         It is a variable         It is a variable         It is a variable           It is a variable         It is a variable         It is a v		Financial Systems CAMERON MEMORIAL COMM ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
It is a visual of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the	SERVIC	ES				
Initial VIII         RHC I         Cost           00         Total Allowable Cost of hospital-based RHC/FOHC SERVICES         1.00           100         Total Allowable Cost of hospital-based RHC/FOHC SERVICES         1.718.765           100         Total Allowable Cost of hospital-based RHC/FOHC SERVICES         1.718.765           100         Total allowable cost excluding vaccine (line 1 minus line 2)         1.718.765           100         Total allowable cost excluding vaccine (line 1 minus line 2)         1.708.157           100         Total allowable cost excluding vaccine (line 1 minus line 2)         8.129           100         Total adjusted visits (line 4 plus line 5)         8.129           100         Adjusted cost per visit (line 3 divided by line 6)         Calculation of Limit ()           100         Pervisit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)         82.30         83.45           100         Pervisit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor records)         0         9.456           100         Program covered visits for mental health services (from contractor records)         0         9.456           100         Program covered visits for mental health services (from contractor records)         0         0           100         Program covered visits for mental health services (from contractor			Component CCN: 15-8530	10 09/30/2018		
DETERMINATION OF FATE FOR HOSPITAL-BASED RIC/FORD SERVICES         1           1         Total Allocable Cost of Pospital-based RIC/FORD Services (From Wkst. M-2, Line 20)         1.718,765           10         Cost of vaccines and their administration (from Wkst. M-4, Line 15)         1.718,765           100         Total allocable cost excluding vaccine (line 1 minus line 2)         8,129           100         Total allocable cost excluding vaccine (line 1 minus line 2)         8,129           100         Physicled cost per visit (line 3 divided by line 6)         8,129           100         Fortal adjusted cost per visit (line 3 divided by line 6)         Calculation of Limit (line 1 (line 1)           100         Pervisit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)         2.0         3.4           100         Program covered visits (see instructions)         210.13         210.13         210.13           100         Program covered visits remental healt h services (from contractor records)         0         9,456           2.00         Program covered visits from mental healt h services (line 9 x line 10)         0         9,456           2.00         Program covered visits from mental healt h services (line 9 x line 10)         0         9,456           2.00         Program covered visits from mental healt h services (from contractor records)         0         0 <th></th> <th></th> <th>Title XVIII</th> <th>RHC I</th> <th></th> <th></th>			Title XVIII	RHC I		
DETERMINATION OF FATE FOR HOSPITAL-BASED RHC/FORD SERVICES         1           Total Allowable Cost of hospital-based RHC/FORD Services (from Wkst. M-2, line 20)         1.718,765           Cost of vaccines and their administration (from Wkst. M-2, line 15)         1.718,765           Difted allowable cost excluding vaccine (line 1 minus line 2)         1.718,765           Difted allowable cost excluding vaccine (line 1 minus line 2)         8,129           Difted allowable cost excluding vaccine (line 4 plus line 5)         8,129           Difted allowable cost per visit (line 3 divided by line 6)         20           Adjusted cost per visit (line 3 divided by line 6)         Calculation of Limit (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line 1 (line						
00       Total Allowable Cost of hospital-based RIC/FORE Services (from West. M-2, line 20)       1.718, 768         00       Cost of vacches and their administration (from West. M-4, line 15)       1.0,608         00       Total allowable cost excluding vacche (line 1 minus line 2)       1.708, 157         00       Total allowable cost excluding vacche (line 1 minus line 2)       0.608         00       Total adjusted visits (line 4 plus line 5)       0.618         00       Total adjusted visits (line 4 plus line 5)       0.8, 129         00       Adjusted cost per visit (line 3 divided by line 6)       210.13         00       Perior to Jan.       On or After 1 (Rate Periad Jan. 1 (Rate 1)         01       Perior 2)       2.00       82.30         02.00       Rete for Program covered visits (see instructions)       2.01.3       2.01.3         03.00       Program covered visits (see instructions)       0       9.456         04.00       Program covered visits for mental health services (line 9 x line 10)       0       9.456         05.00       Program covered visits for mental health services (line 9 x line 12)       0       0       0         05.01       Oradiane (Medical Education Pass Through Cost (See instructions)       0       0       0       0         0.02       Graduate Medical Educat		DETERMINATION OF DATE FOR HOODITAL DACED DUG (FOUR CEDULOFO			1.00	
0.00       Cost of vaccines and their administration (from Wst. M-4, Line 15)       10.060         0.01       Total allowable cost excluding vaccine (line 1 minus line 2)       1.708.157         0.00       Physic class visits under agreement (from Wst. M-2, column 5, Line 9)       0.0         0.01       Total allowable cost per visit (line 4 plus line 5)       2.210.13         0.02       Adjusted cost per visit (line 3 divided by line 6)       Calculation of Limit (1)         0.01       Ital (from Wst. M-2, column 5, Line 8)       0.0         0.02       Adjusted cost per visit (line 3 divided by line 6)       Calculation of Limit (1)         0.01       Rate for Program covered visits (see instructions)       1.00       2.00         0.02       Reate for Program covered visits excluding mental health services (from contractor records)       0       45         0.02       Program covered cost from mental health services (from contractor records)       0       0       0         0.03       OP rogram covered cost from mental health services (from contractor records)       0       0       0         0.04       Utimit adjustement form mental health services (from contractor records)       0       0       0         0.05       Program covered visits for mental health services (from contractor records)       0       0       0       0	00		West M 2 Lipo 20)		1 710 765	1 1.
00       Total allowable cost excluding vaccine (line 1 minus line 2)       1.708.157         01       Total allowable cost excluding vaccine (line 8)       1.708.157         00       Physiclans visits under agreement (from Wkst. M-2, colum 5, line 9)       0         01       Total adjusted visits (line 4 plus line 5)       210.13         02       Adjusted cost per visit (line 3 divided by line 6)       210.13         03       Adjusted cost per visit (line 3 divided by line 6)       210.13         04       Derivation (Line 3)       Derivation (Line 3)       Derivation (Line 3)         05       Perior to Jan       On or After 1 (Rate Period Jan. 1 (Rate 1)         06       Rate for Program covered visits (see instructions)       210.13       210.13         07       Orgara covered visits for mental health services (from contractor records)       0       9,456         08       Program covered visits for mental health services (line 9 x line 12)       0       0         09       Offaduate Medical Education Pass Through Cost (see instructions)       0       0       0         09       Forgram covered visits (cline 1, 1, 4, and 15, columes), 2, and 3) *       0       0       0         00       Forgram covered visits for mental health services (line 9 x line 12)       0       0       0         00<						
000       Total Visits (from Wkst. M-2, column 5, line 8)       8, 129         001       Dotal adjusted visits (line 4 plus line 5)       0         002       Adjusted visits (line 4 plus line 5)       0         003       Adjusted visits (line 4 plus line 5)       0         004       Total adjusted visits (line 3 divided by line 6)       210.13         005       Rate for Program covered visits (see instructions)       210.13         006       Perior to Jan.       On or After 1         017       Rate for Program covered visits (see instructions)       210.13         018       Calculation of SETTLEMENT       210.13         0100       Program covered visits cover divisits cover advisits for mental health services (from contractor records)       0       9         0100       Program covered visits for mental health services (from contractor records)       0       0         0100       Program covered visits for mental health services (line 9 x line 12)       0       0         0100       Calculation Pagram covered visits for mental health services (line 9 x line 12)       0       0         0100       Program covered visits for mental health services (line 9 x line 12)       0       0       0         0100       Calculation Pagram covered visits for mental health services (see instructions)       0       0<						
000       Physicians visits under agreement (from Wkst. M-2, column 5, line 9)       0       0         101       Total adjusted visits (line 4 plus line 5)       210.33         200       Adjusted cost per visit (line 3 divided by line 6)       210.33         201       Adjusted cost per visit (line 3 divided by line 6)       210.33         202       Adjusted cost per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)       82.30         203       Rate for Program covered visits (see instructions)       210.13       210.13         204.00       Rate for Program covered visits (see instructions)       0       45         200       Program covered visits for mental health services (line 9 x line 10)       0       9,456         200       Program covered visits for mental health services (line 9 x line 10)       0       9,456         200       Program covered visits for mental health services (line 9 x line 12)       0       0         200       Program covered visits (see instructions) (from contractor records)       0       0       0         200       Program covered visits (see instructions) (from contractor 's records)       0       0       0         200       Program covered visits (see instructions) (from contractor 's records)       0       0       0         201       Total prog						
.00       Adjusted cost per visit (line 's divided by line 6)       210.13         Cal culation of Limit (1)       Cal culation of Limit (1)         Prior to Jan.       1 (Rate Period 2)         1.00       Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)       82.30         0.00       Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)       82.30         0.00       Program covered visits (see instructions)       210.13         0.00       Program covered visits excluding mental health services (from contractor records)       0         0.00       Program covered visits for mental health services (from contractor records)       0       9,456         0.00       Program covered visits for mental health services (see instructions)       0       0         0.00       Graduate Medical Education Pass Through Cost (see instructions)       0       0         0.00       Total program preventive costs ((line 16.02/line 16.01) times line 16)       0       0         0.01       Total program mon-preventive costs ((line 16.02/line 16.03) and 18) times .80)       7,424         0.10       Total program cost (see instructions)       0       7,424         0.10       Recording and their administration (from west. M-4, line 16)       0       7,424         0.10       Notal program mon-preven			line 9)			
Calculation of Limit (1)         Prior to Jan. 1 (Rate Period 2)         100       Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)       1.00       2.00         100       Rate for Program covered visits (see instructions)       210.13       210.13       210.13         100       CALCULATION OF SETTLEMENT       210.13       210.13       210.13       210.13         100       Program covered visits for mental heal th services (from contractor records)       0       9, 456         100       Program covered visits for mental heal th services (ine 9 x line 10)       0       9, 456         100       Graduate Medical Education Pass Through Cost (see instructions)       0       0       0         101       Otal program covered visits (line 16, 20/line 16, 01) times line 16)       0       0       0         102       Otal program covered visits (line 16, 20/line 16, 01) times line 16)       0       0       0         103       Total program non-preventive costs (line 16 minus lines 16, 03 and 18) times .80)       0       0       0         104       Iprogram cost (see instructions) (from contractor records)       0       0       0       0         105       Iprogram non-preventive costs (line 16 minus lines 16, 03 and 18) times .80)       0       0       0       0 <td>. 00</td> <td>Total adjusted visits (line 4 plus line 5)</td> <td></td> <td></td> <td>8, 129</td> <td>6.</td>	. 00	Total adjusted visits (line 4 plus line 5)			8, 129	6.
Prior to Jan.         Prior to Jan.         On or After 1 (Rate Period 2)           0.0         Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)         82.3         83.45           0.0         Rate for Program covered visits (see instructions)         210.13         210.13           0.00         Program covered visits excluding mental heal th services (from contractor records)         0         45           0.00         Program covered visits for mental heal th services (from contractor records)         0         9,456           0.00         Program covered visits for mental heal th services (from contractor records)         0         0           0.00         Frogram covered cost from mental heal th services (from contractor records)         0         0           0.00         Graduate Medical Education Pass Through Cost (see instructions)         0         0         0           0.00         Total program preventive costs ((line 16 minus lines 16.03 and 18) times .80)         0         9,456           0.10         Total program cost escluding vaccines (see instructions)         0         0         7,424           0.11         Frogram cost escluding vaccines (see instructions)         0         7,424         0           0.10         Total program preventive costs ((line 16 minus lines 16.03 and 18) times .80)         7,424         0	. 00	Adjusted cost per visit (line 3 divided by line 6)				7.
Image: constraint of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec				Cal cul ati on	of Limit (1)	
Image: 1         Period 2           100         Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)         82.30         210.13         210.13           100         Rate for Program covered visits (see instructions)         210.13         210.13         210.13           100         Program covered visits excluding mental healt services (from contractor records)         0         45           100         Program covered visits for mental healt hearvices (from contractor records)         0         9,456           2.00         Program covered visits for mental healt hearvices (line 9 x line 10)         0         9,456           2.00         Program covered visits for mental healt hearvices (line 9 x line 12)         0         0           0.00         Program covered visits for mental healt hearvices (see instructions)         0         0         0           0.00         Ordaudate Medical Education Pass Through Cost (see instructions)         0         0         0           0.101         Drogram preventive costs ((line 16.02/line 16.01) times line 16)         0         0         0           0.102         Of aduat program preventive costs (see instructions)         0         7,424         0           102         Of aduat program preventive costs (see instructions)         0         7,424         0 <t< td=""><td></td><td></td><td></td><td>Prior to Jan.</td><td>On or After</td><td></td></t<>				Prior to Jan.	On or After	
Der         Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)         2.00           00         Rate for Program covered visits (see instructions)         210.13         210.13           0.00         Program covered visits excluding mental health services (from contractor records)         0         45           0.00         Program covered visits for mental health services (from contractor records)         0         9,456           0.00         Program covered visits for mental health services (from contractor records)         0         0           0.01         Int adjustment for mental health services (ine 9 x line 12)         0         0         0           3.00         Program covered cost from mental health services (see instructions)         0         0         0         0           5.00         Graduate Medical Education Pass Through Cost (see instructions)         0         0         0         0           6.00         Total program preventive costs ((line 16.01) times line 16)         0         0         0           6.01         Total program no-preventive costs ((line 16.01) times line 16)         0         7,424           7.01         program no-preventive costs ((line 16.01) times line 16)         0         7,424           7.01         program no-preventive costs ((line 16.01) times line 16)         0				1 (Rate Period	Jan. 1 (Rate	
00       Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)       §2.30       §3.45         00       Rate for Program covered visits (see instructions)       210.13       210.13         0.00       Program covered visits excluding mental health services (from contractor records)       0       45         0.00       Program covered visits for mental health services (line 9 x line 10)       0       9,456         0.00       Program covered visits for mental health services (line 9 x line 12)       0       0         0.00       Program covered visits for mental health services (line 9 x line 12)       0       0       0         0.01       Optima cost cost form mental health services (line 9 x line 12)       0       0       0       0         0.02       Graduate Medical Education Pass Through Cost (see instructions)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0						
00       Rate for Program covered visits (see instructions)       210.13       210.13       210.13         0.00       Program covered visits excluding mental health services (from contractor records)       0       45         1.00       Program covered visits for mental health services (from contractor records)       0       9,456         0.00       Program covered visits for mental health services (from contractor records)       0       0       0         0.01       Int adj ustment for mental health services (ine 9 x line 12)       0       0       0       0         0.02       Program covered cost from mental health services (ine 9 x line 12)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
CALCULATION OF SETTLEMENT       CALCULATION OF SETTLEMENT         0.00       Program covered visits excluding mental health services (from contractor records)       0         0.01       Program covered visits for mental health services (from contractor records)       0         0.02       Program covered visits for mental health services (line 9 x line 10)       0         0.03       Program covered visits for mental health services (line 9 x line 12)       0         0.04       Contractor records)       0         0.05       Of raduate Medical Education Pass Through Cost (see instructions)       0         0.05       Of raduate Medical Education Pass Through Cost (see instructions)       0         0.01       Total program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *       0       9, 456         0.01       Total program preventive costs ((line 16.02/line 16.01) times line 16)       0       0         0.02       Total program cost (see instructions)       0       7, 424         0.01       Of rites V and XIX see instructions)       0       7, 424         0.01       OF rianzy colarsurance for RHC/FOHC services (see instructions) (from contractor records)       0         0.02       Desenficiary deductible for RHC only (see instructions) (from contractor records)       1,098         0.02       Net Medicare cost excluding vaccines (see instr			).6 or your contractor)			
0.000Program covered visits excluding mental health services (from contractor records)0451.00Program covered visits for mental health services (line 9 x line 10)09,4560.00Program covered visits for mental health services (line 9 x line 12)000.010.010.01000.02Graduate Medical Education Pass Through Cost (see instructions)000.030.02Forgram covered cost from mental health services (line 9 x line 12)000.010.011.111.4. and 15, columns 1, 2 and 3) *000.030.12Program covered cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *09,4560.030.12Program preventive charges (see instructions) (from contractor's records)000.031014Program non-preventive costs ((line 16.07) times line 16.0)000.041014Program cost (see instructions)07,4240.151014Program cost (see instructions)07,424100Program cost (see instructions)1001001011014Program cost (see instructions)1001021014Program cost (see instructions)100103102Program cost (see instructions)100104102101410210141051014Program cost (see instructions)100103101410210141014104102101410141014 </td <td>. 00</td> <td></td> <td></td> <td>210.13</td> <td>210.13</td> <td>9.</td>	. 00			210.13	210.13	9.
1.00Program cost excluding costs for mental health services (line 9 x line 10)09,4562.00Program covered visits for mental health services (line 9 x line 12)000.01Program covered cost from mental health services (line 9 x line 12)000.020.03Congram covered cost from mental health services (line 9 x line 12)000.030.04Congram covered cost from mental health services (line 9 x line 12)000.050.05Graduate Medical Education Pass Through Cost (see instructions)000.010.11And 15, columns 1, 2 and 3)*09,4560.0110 program preventive coarse (see instructions) (from provider's records)000.0210 tal program preventive costs ((line 16.02/line 16.01) times line 16)000.0310 tal program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)7,4240.1110 tal program cost (see instructions)07,4240.1210 tal program cost (see instructions)07,4240.1210 tal program cost (see instructions)10 ters01.0210 tal reimbursable for RHC/FOHC services (see instructions) (from contractor records)00.0310 tal reimbursable Program cost (line 20 plus line 21)13,6520.0410 wable bad debts (see instructions)00.0500 Hadicare cost excluding vaccines (see instructions)00.0600 tal program cost (see instructions)00.0700 Hadicare cost excluding vacci	0. 00		contractor records)	0	45	1 10.
3.00Program covered cost from mental health services (line 9 x line 12)04.00Limit adjustment for mental health services (see instructions)05.00Graduate Medical Education Pass Through Cost (see instructions)06.00Total program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *06.01Total program preventive charges (see instructions) (from provider's records)5, 6676.02Total program preventive costs ((line 16.02/line 16.01) times line 16)06.03Total program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)7, 424(Titles V and XIX see instructions.)07, 4246.05Total program cost (see instructions)07, 424(Titles V and XIX see instructions.)07, 4246.02Total program cost (see instructions)07, 424(D)Primary payer amounts07, 4248.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)09.00Beneficiary colnsurance for RHC/FOHC services (see instructions)10, 629.00Net Medi care cost excluding vaccines (see instructions)0010Adjusted reimbursable bad debts (see instructions)00.01Adjusted reimbursable bad debts (see instructions)00.01Net Medi care instructions)00.02Net Medi care cost excluding vaccines (see instructions)00.03Adjusted reimbursable bad debts (see instructions)00.04Net Medi care instructions) <td></td> <td>5 · · · ·</td> <td>-</td> <td></td> <td></td> <td></td>		5 · · · ·	-			
4.00Limit adjustment for mental health services (see instructions)006.00Graduate Medical Education Pass Through Cost (see instructions)006.00Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *09,4566.01Total program charges (see instructions)(from contractor's records)5,6676.02Total program preventive charges (see instructions) (from provider's records)06.03Total program non-preventive costs ((line 16.02/line 16.01) times line 16)06.04Total Program cost (see instructions)07,424(Titles V and XIX see instructions)07,00Primary payer amounts08.00Less: Beneficiary colnsurance for RHC/F0HC services (see instructions) (from contractor records)09.00Beneficiary colnsurance for RHC/F0HC services (see instructions)17,4241.00Program cost (see instructions)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Allowable bad debts (see instructions)03.01Adjusted relimbursable Program cost (line 20 plus line 21)13,6523.01Adjusted relimbursable bad debts (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS)13,6525.01Sequestration apyment adjustment amount before sequestration06.02Net relimbursable amount (see instructions)73,6526.03Columoration payment adjus	2.00					
5.00Graduate Medical Education Pass Through Cost (see instructions)06.00Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *09, 4566.01Total program charges (see instructions) (from contractor's records)006.03Total program preventive costs ((line 16.02/line 16.01) times line 16)006.04Total program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)7, 424(Titles V and XIX see instructions)07, 424(Titles V and XIX see instructions)07, 4247.00Primary payer amounts07, 4248.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)1,0989.00Beneficiary coinsurance for RHC/FQHC services (see instructions)1,0989.00Net Medicare cost excluding vaccines (see instructions)7,4241.00Program cost of vaccines (ase instructions)1,0989.01Adjusted reimbursable Program cost (line 20 plus line 21)13,6529.02Allowable bad debts (see instructions)09.03OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)09.04Nemostration payment adjustment (see instructions)09.05Sequestration adjustment amount before sequestration00.01Net reimbursable amount (see instructions)00.02Net reimbursable amount (see instructions)00.03Net reimbursable amount (see instructions)00.04Idowable bad debts (see instructions)0<	3.00	Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.
6.00Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *09, 4566.01Total program charges (see instructions) (from contractor's records)5, 66702Total program preventive charges (see instructions) (from provider's records)06.03Total program preventive costs ((line 16.02/line 16.01) times line 16)06.04Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)7, 424(Titles V and XIX see instructions.)07, 4246.05Total program cost (see instructions)07, 4247.00Primary payer amounts07, 4248.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)1769.00Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)1,0989.00Net Medicare cost excluding vaccines (see instructions)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.01Adjusted reimbursable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)05.05Pioneer AC0 demonstration payment adjustment (see instructions)05.05Pioneer AC0 demonstration payment adjustment (see instructions)06.01Net reimbursable amount (see instructions)06.02Demonstration payment adjustment amount after sequestration07.00Interim p				0	0	
6.01Total program charges (see instructions) (from contractor's records)5,6676.02Total program preventive charges (see instructions) (from provider's records)06.03Total program preventive costs ((line 16.02/line 16.01) times line 16)06.04Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)7,424(Titles V and XIX see instructions.)07,4247.00Primary payer amounts08.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)09.00Beneficiary coinsurance for RHC/F0HC services (see instructions) (from contractor records)1,0980.00Net Medicare cost excluding vaccines (see instructions)7,4240.00Net Medicare cost excluding vaccines (see instructions)1,4240.01Total reimbursable program cost (line 20 plus line 21)13,6520.02Allowable bad debts (see instructions)00.03Allowable bad debts for dual eligible beneficiaries (see instructions)00.00Net reimbursable amount (see instructions)00.01Allowable bad debts (see instructions)00.02Her reimbursable amount (see instructions)00.03Total ereimbursable einstructions)00.00Net reimbursable einstructions)00.01Allowable bad debts (see instructions)00.02Her embursable einstructions)00.03Her embursable einstructions)00.01Her embursable einstructions)0 </td <td></td> <td colspan="2"></td> <td></td> <td>15.</td>					15.	
6.02       Total program preventive charges (see instructions) (from provider's records)       0         6.03       Total program preventive costs ((line 16.02/line 16.01) times line 16)       0         6.04       Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)       7,424         (Titles V and XIX see instructions.)       0       7,424         6.05       Total program cost (see instructions)       0         7.00       Primary payer amounts       0         8.00       Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)       0         9.00       Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)       1,098         0.00       Net Medicare cost excluding vaccines (see instructions)       7,424         1.00       Program cost (see instructions)       7,424         3.00       Net Medicare cost excluding vaccines (see instructions)       7,424         3.01       Adjusted reimbursable Program cost (line 20 plus line 21)       13,652         3.01       Adjusted reimbursable bad debts (see instructions)       0         4.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         5.09       Poneer AC0 demonstration payment adjustment (see instructions)       0         6.01       Sequestrati		5		0		
6.03Total program preventive costs ((line 16.02/line 16.01) times line 16)07.01Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)7,4246.05Total program cost (see instructions)07,4247.00Primary payer amounts07,4248.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)07,4249.00Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)1,0989.00Net Medicare cost excluding vaccines (see instructions)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.01Adjusted reimbursable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)04.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.01Demonstration payment adjustment amount before sequestration06.02Demonstration payment adjustment amount before sequestration06.02Demonstration payment adjustment amount after sequestration07.02Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484						
6.04Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Tittes V and XIX see instructions.)7,4246.05Total program cost (see instructions)07.00Primary payer amounts08.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)09.00Beneficiary coinsurance for RHC/FOHC services (see instructions) (from contractor records)1,0980.00Net Medicare cost excluding vaccines (see instructions)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.00Allowable bad debts (see instructions)04.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.00Demonstration payment adjustment (see instructions)06.01Sequestration adjustment (see instructions)06.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484						
(Titles V and XIX see instructions.)6.05Total program cost (see instructions)7.00Primary payer amounts8.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)9.00Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)0.00Net Medicare cost excluding vaccines (see instructions)0.00Net Medicare cost of vaccines and their administration (from Wkst. M-4, line 16)1.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)2.00Total reimbursable Program cost (line 20 plus line 21)3.01Adjusted reimbursable bad debts (see instructions)3.01Adjusted reimbursable bad debts (see instructions)0O5.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS)0.00Net reimbursable amount defore sequestration005.00Demonstration payment adjustment (see instructions)005.01Demonstration payment adjustment sequestration0.02Demonstration payment adjustment amount after sequestration011 terim payments0.02Interim payment s0.03Tentative settlement (for contractor use only)0.04Interim payment S0.05Tentative settlement (for contractor use only)0.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)0Tentative settlement (for contractor use only)0Tentative settlement (for contractor use only)0Tentative settlement (						
6.05Total program cost (see instructions)07,4247.00Primary payer amounts08.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)1769.00Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)1,0989.00Net Medicare cost excluding vaccines (see instructions)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.01Adjusted reimbursable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.01Sequestration payment adjustment (see instructions)06.02Demonstration payment adjustment (see instructions)06.02Demonstration adjustment (see instructions)13,6526.01Sequestration adjustment (see instructions)07.02Interim payments2738.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484	0.04		S and TO) (Thes . 60)		7,424	10.
7.00Primary payer amounts08.00Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)1769.00Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)1,0980.00Net Medicare cost excluding vaccines (see instructions)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.01Adjusted reimbursable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)04.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.09Pioneer ACO demonstration payment adjustment (see instructions)06.01Sequestration adjustment (see instructions)13,6526.01Sequestration adjustment (see instructions)07.02Demonstration payment adjustment amount after sequestration07.00Interim payments08.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7, 484	6. 05				7,424	16.
records)9.00Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor1,098records)0.00Net Medicare cost excluding vaccines (see instructions)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.00Allowable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)04.10Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.50Pioneer AC0 demonstration payment adjustment (see instructions)05.99Demonstration payment adjustment (see instructions)13,6526.01Sequestration adjustment (see instructions)2736.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484	7.00				0	17.
9.00Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)1,098 records)0.00Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst. M-4, line 16)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.00Allowable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)04.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.50Pioneer ACO demonstration payment adjustment (see instructions)05.79Demonstration payment adjustment amount before sequestration06.01Sequestration adjustment (see instructions)2736.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484	8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		176	18.
records)720.00Net Medicare cost excluding vaccines (see instructions)7,42411.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,22812.00Total reimbursable Program cost (line 20 plus line 21)13,65213.00Allowable bad debts (see instructions)013.01Adjusted reimbursable bad debts (see instructions)013.02Olived reimbursable bad debts (see instructions)014.00Allowable bad debts for dual eligible beneficiaries (see instructions)015.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)015.50Pioneer AC0 demonstration payment adjustment (see instructions)015.99Demonstration payment adjustment amount before sequestration016.00Net reimbursable amount (see instructions)13,65217.00Interim payment adjustment amount after sequestration018.00Interim payments5,89519.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484						
0.00Net Medicare cost excluding vaccines (see instructions)7,4241.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.00Allowable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)04.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.01Pemonstration payment adjustment (see instructions)05.02Demonstration payment adjustment amount before sequestration06.00Net reimbursable amount (see instructions)13,6526.01Sequestration adjustment amount after sequestration06.02Demonstration payment adjustment amount after sequestration07.70Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484	9.00		ons) (from contractor		1, 098	19.
1.00Program cost of vaccines and their administration (from Wkst. M-4, line 16)6,2282.00Total reimbursable Program cost (line 20 plus line 21)13,6523.00Allowable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)04.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.09Demonstration payment adjustment (see instructions)05.09Demonstration payment adjustment amount before sequestration06.00Net reimbursable amount (see instructions)13,6526.01Sequestration adjustment (see instructions)2736.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484	0. 00				7, 424	20.
2.00Total reimbursable Program cost (line 20 plus line 21)13,6523.00Allowable bad debts (see instructions)03.01Adjusted reimbursable bad debts (see instructions)04.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.09Demonstration payment adjustment (see instructions)05.99Demonstration payment adjustment amount before sequestration06.00Net reimbursable amount (see instructions)13,6526.01Sequestration adjustment (see instructions)13,6526.02Demonstration payment adjustment amount after sequestration06.03Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484		<b>o</b> , , , , , , , , , , , , , , , , , , ,	M-4, line 16)			
3.01Adjusted reimbursable bad debts (see instructions)04.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.50Pioneer ACO demonstration payment adjustment (see instructions)05.99Demonstration payment adjustment amount before sequestration06.00Net reimbursable amount (see instructions)06.01Sequestration adjustment (see instructions)13,6526.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484	2.00	5				
4.00Allowable bad debts for dual eligible beneficiaries (see instructions)05.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.50Pioneer AC0 demonstration payment adjustment (see instructions)05.99Demonstration payment adjustment amount before sequestration06.00Net reimbursable amount (see instructions)13,6526.01Sequestration adjustment (see instructions)2736.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484	3.00	Allowable bad debts (see instructions)			0	23
5.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)05.50Pioneer AC0 demonstration payment adjustment (see instructions)05.99Demonstration payment adjustment amount before sequestration06.00Net reimbursable amount (see instructions)13, 6526.01Sequestration adjustment (see instructions)2736.02Demonstration payment adjustment amount after sequestration07.00Interim payments5, 8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7, 484	3. 01	Adjusted reimbursable bad debts (see instructions)			0	
5.50Pioneer ACO demonstration payment adjustment (see instructions)05.99Demonstration payment adjustment amount before sequestration06.00Net reimbursable amount (see instructions)13,6526.01Sequestration adjustment (see instructions)2736.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484			ructions)			
5. 99Demonstration payment adjustment amount before sequestration06. 00Net reimbursable amount (see instructions)13,6526. 01Sequestration adjustment (see instructions)2736. 02Demonstration payment adjustment amount after sequestration07. 00Interim payments5,8958. 00Tentative settlement (for contractor use only)09. 00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484						
6.00Net reimbursable amount (see instructions)13,6526.01Sequestration adjustment (see instructions)2736.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484			IS)			
6.01Sequestration adjustment (see instructions)2736.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484						
6.02Demonstration payment adjustment amount after sequestration07.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484						
7.00Interim payments5,8958.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484						
8.00Tentative settlement (for contractor use only)09.00Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)7,484						
9.00 Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28) 7,484		1.5				
			02, 27, and 28)			
	0. 00				0	

Heal th	Financial Systems CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1315	Peri od:	Worksheet M-4	
VACCIN			From 10/01/2017 To 09/30/2018	Date/Time Prepared: 2/21/2019 3:49 pm	
		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)		635, 104	635, 104	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota		e 0. 000000	0. 003739	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	,	0	2, 375	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr		0	1, 572	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus		0	3, 947	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	eet M-1, col. 7, line 22)	639, 460 1, 079, 305	639, 460	6.00
7.00	00 Total overhead (from Wkst. M-2, line 19)			1, 079, 305	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	tal direct cost (line 5	0.000000	0. 006172	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l		0	6, 661	9.00
10. 00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	0	10, 608	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	0	109	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	0.00	97.32	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini beneficiaries	stered to Program	0	64	13.00
14.00		neir) administration	0	6, 228	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (thei of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			10, 608	15.00
16. 00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		6, 228	16. 00

Health Financial Systems CAMERON MEMORIAL	COMMUNI TY HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Period: Worksheet M-5			
SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315 Component CCN: 15-8530	From 10/01/2017 To 09/30/2018		
	component con. 13-0330	10 077 307 2010	2/21/2019 3:49	
		RHC I	Cost	
			rt B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC			5, 895	1.00
2.00 Interim payments payable on individual bills, either subm	itted or to be submitted to		0	2.00
the contractor for services rendered in the cost reportin				
"NONE" or enter a zero				
3.00 List separately each retroactive lump sum adjustment amou	nt based on subsequent			3.00
revision of the interim rate for the cost reporting perio	d. Also show date of each			
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3.01			0	3. 01
3.02			0	3. 02
3. 03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3. 52			0	3. 52
3.53			0	3.53
3. 54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-	3.98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (tra	nsfer to Worksheet M-3, line		5, 895	4.00
27)				
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after d	esk review. Also show date o	f		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5. 52
Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	5.99
Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01 SETTLEMENT TO PROVIDER	-		7, 484	6. 01
6.02 SETTLEMENT TO PROGRAM			0	6. 02
7.00 Total Medicare program liability (see instructions)			13, 379	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
		1 00		
	0	1.00	2.00	