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 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1315 Worksheet S Peri od. From 10/01/2019 Parts I-III AND SETTLEMENT SUMMARY 09/30/2020 Date/Time Prepared: То 4/21/2021 9:44 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 4/21/2021 Time: 9:44 am Manually prepared cost report use only 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 0 Ē 4 [6. Date Received: 7. Contractor No. Contractor 10. NPR Date: 5.]Cost Report Status Γ As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4 Settled without Audit 8. [N]Initial Report for this Provider CCN 12. [0]If line 5, column 1 is 4: Enter Settled with Audit 9. [N]Final Report for this Provider CCN 12. [0]If line 5, column 1 is 4: Enter number of times reopened = 0-9. 11. Contractor's Vendor Code: (1) As Submitted use only (2) Settled with Audit number of times reopened = 0-9. (3)(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 OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2019 and ending 09/30/2020 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. [X] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si gned) CARLOS ALCAZAR Officer or Administrator of Provider(s) VICE PRESIDENT AND CFO Title (Dated when report is electronically signed.) Date Title XVIII Cost Center Description Title V Part A Part B HI T Title XIX 1.00 2.003.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1 00 Hospi tal 0 399, 149 -680.820 Ο 0 1 00 Subprovider - IPF 2.00 0 0 2.00 (0 Subprovider - IRF 3.00 0 0 0 0 0 0 3.00 Swing Bed - SNF Swing Bed - NF 5.00 0 0 5.00 151, 508 6.00 0 6.00 HOME HEALTH AGENCY I 9.00 0 0 9.00 C RURAL HEALTH CLINIC - FPC I 0 10.00 34,848 0 10.00 RURAL HEALTH CLINIC - URGENT CARE II 0 10 01 12 666 0 10 01 RURAL HEALTH CLINIC - OB/GYN III 0 10.02 8.502 0 10.02 200.00 Total 0 550, 657 -624, 804 0 200.00

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. lf 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.

0521	TAL AND HOSPITAL HEALTH CARE COMPLEX		Provio	ler CCN: 1	5-1315	Period: From 10/01/ To 09/30/	2020	Workshe Part I Date/Ti 4/21/20	me Pre	epared:
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00	Hospital and Hospital Health Care Co Street: 416 E MAUMEE STREET	PO Box:								1.00
. 00 . 00	City: ANGOLA	State: IN	Zin Cod	e: 47803-	Count	ty: STEUBEN				2.00
. 00	CITY. ANGOLA	Component Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P	2.00
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. 00	Hospi tal	CAMERON MEMORIAL	151315	99915	1	02/01/2003	N	0	Р	3.0
		COMMUNI TY HOSPI TAL								
. 00	Subprovider - IPF									4.0
. 00	Subprovider - IRF									5.0
. 00	Subprovider - (Other)			1						6.0
.00	Swing Beds - SNF	CAMERON MEMORIAL	15Z315	99915		02/01/2003	Ν	0	l N	7.0
		COMMUNI TY								
. 00	Swing Beds - NF			1						8.00
. 00	Hospital -Based SNF					1				9.0
D. 00	Hospi tal -Based NF					1				10.0
1.00	Hospi tal -Based OLTC					1				11.0
2.00	Hospital -Based HHA									12.0
3.00	Separately Certified ASC									13.0
4.00	Hospi tal -Based Hospi ce	CAMERON HOSPICE	151561	99915		05/01/1997				14.0
5.00	Hospital -Based Health Clinic - RHC	CAMERON FAMILY MEDICINE	158530	99915		12/31/2016	Ν	0	0	15.0
5. 01	Hospital -Based Health Clinic - RHC	CAMERON URGENT CARE	158545	99915		11/26/2019	N	0	0	15.0
5. 01		CAMERON DROENT CARE	130343	77715		11/20/2019	IN			15.0
5. 02	Hospital-Based Health Clinic - RHC	CAMERON OB/GYN	158546	99915		11/25/2019	Ν	0	0	15.0
5.00	Hospital-Based Health Clinic - FQHC									16.0
7.00	Hospital -Based (CMHC) I									17.0
B. 00	Renal Dialysis									18.0
	Other									19.0
9.00	other					1				17.0
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SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA COMMUN	Provider CC		Peri od:		Workshe	m CMS-: eet S-2	
				From 10/0 To 09/3		Part I Date/Ti 4/21/20	me Pre	pared
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	id 0 ys Mec c	ther li cai d lays	
.00 If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00	5.00	0	<u>5.00</u> 0	24.0
 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. OO 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	O	0	0		0		25. (
				Urban/R		Date of 2.0	<u>J</u>	-
. 00 Enter your standard geographic classification (not w		at the be	ginning of t		2	2. (-	26.0
 cost reporting period. Enter "1" for urban or "2" fo .00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif 	age) status r "2" for r ïcation in	ural. If a column 2.	ppl i cabl e,		2			27.0
.00 f this is a sole community hospital (SCH), enter th effect in the cost reporting period.	e number of	periods S	CH status ir	n Begi nr	0	Endi	na	35.0
				1. (2. (
. 00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for numb	ber				36.
.00 If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	r the numbe	r of perio	ds MDH statu	is	0			37.
.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)								37.0
.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.0
				Y/		Y/ 2. (-
.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet), (ii), or	(iii)? En	ter in colum			N		39.0
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i				es				
	ii)? Enter n adjustmer ber 1. Ente	in column t? Enter " r "Y" for	2 "Y" for ye Y" for yes d	or N		N		40. (
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 1.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	ii)? Enter n adjustmer ber 1. Ente	in column t? Enter " r "Y" for	2 "Y" for ye Y" for yes d	or N	V	N XVIII 2.00	XI X 3, 00	40.
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Health Financial Systems CAMERON MEMOF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C	CN: 15-1315 P	eriod: rom 10/01/2019		pared:
			NAHE 413.85 Y/N	Worksheet A Line #	4/21/2021 9:4 Pass-Through Qual i fi cati on Cri teri on Code	4 am
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHI	see If column 1	N			60.00
	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 column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 	Ν			0.00	0.00	61.00 61.01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61. 02
and primary care FTEs added under section 5503 of ACA). (see instructions) 51.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.03
instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.04 minus frite 01.03). (see first detroits) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	Dura	News	Descusor Cada			61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61.10
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, the direct GME FTE unweighted count.				0.00	0. 00	61.20
The direct one file driver gitted count.			I	<u> </u>	1.00	
ACA Provisions Affecting the Health Resources and Ser						(0.00
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct	ctions)		1 31			62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc Teaching Hospitals that Claim Residents in Nonprovide	gram. (s	<u>see instructio</u>		o 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, comple	ettings	during this o			N	63.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMP		ATA Provider (CCN: 15-1315 P	eri od:	u of Form CMS-2 Worksheet S-2	
					rom 10/01/2019 o 09/30/2020		
				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 Yea			-This base yea	r is your cost	reporti ng	
. 00	period that begins on or after J Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
				Site	nospitai		
		1.00	2.00	3.00	4.00	5.00	1
	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 col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	Unwei ghted	Ratio (col.	65.00
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
	Contion FEO1 of the ADA D	Voor FTF Deet La La	n Nonnessi des Calut	1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n wonprovider Settir	igsEffective	ioi cost report	ing periods	
5.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
	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 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	η 67. OC

Heal th	Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL	In	Li eu	of Form	n CMS-2	2552-10
HOSPI T		eriod: rom 10/01/2 p 09/30/2	2019 I 2020 I	Vorkshe Part I Date/Tii 4/21/202	ne Pre	pared:
		_		2.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub		N	2.00	01.00	70.00
	Enter "Y" for yes or "N" for no.		IN IN		0	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin (see instructions)	no. (see hi ng no.			U	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in				0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	with 42				
			_	1.0	0	
	Long Term Care Hospital PPS			1.0	0	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Er	nter	N N		80.00 81.00
	<u>TEFRA Providers</u> Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio		no.	N		85.00 86.00
87.00	§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			Ν		87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	V 1.00		XI X 2. 0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		Y		91.00
92.00	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.			Ν		92.00
93.00	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.	N		Ν		93.00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		Ν		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0.0 N	0	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 Y		0. 0 Y	0	97.00 98.00
98. 01	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. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 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.	Y		Y		98.02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N		Ν		98.03
98.04	for title V, and in column 2 for title XIX. 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	N		Ν		98.04
98. 05	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	Y		Y		98.05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, 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.	Y		Y		98.06
105 00	Rural Providers					105 00
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y N				105.00 106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train 1&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

HOSP FIAL AND HOSP FIAL HEALTH CARE COMPLEX LIBRITIFICATION (DATA Provider COE: 15-31 Provider COE: 15-31 Provider COE: 15-31 Provider COE: 15-32 100 DOI This is a rural model tail qualifying for an exception to the CRM Fee schedule? See 42 N 100 0.00 3.00 100.00 2.00 3.00 100.00 100.00 2.00 3.00 100.00 2.00 3.00 100.00 100.00 2.00 3.00 100.00 2.00 3.00 100.00 100.00 2.00 3.00 100.00 100.00 100.00 2.00 3.00 100.00 100.00 100.00 2.00 3.00 100.00	Health Financial Systems CAMERON MEMORIAL CON	MUNITY HOSPI	TAL	In Lieu	u of Form CMS-	-2552-10
1.00 2.00 1.00 <td>HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA</td> <td>Provider C</td> <td>Fr</td> <td>rom 10/01/2019 0 09/30/2020</td> <td>Part I Date/Time Pr 4/21/2021 9:</td> <td>epared:</td>	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	Fr	rom 10/01/2019 0 09/30/2020	Part I Date/Time Pr 4/21/2021 9:	epared:
108. 001s this a number tail qualifying for an exception to the URM Free schedule? See 42 N 108. 001 107. 001f this hespital qualifies as a CM or a cost provider, are N N				-		-
Description 1.00 2.00 3.00 4.00 100 Old if this heaptial qualifies as a CAH or a cost provider and N N N N N 100 Old of this heaptial provided by curvial as suppliar? Inter "Y N N N N N 100 Old of this heaptial participate in the Rural Comunity Hospital Deconstration project (\$410A N N 100 110 Old fit his fiberial qualifies as a CAH or a cost recording participate in the Frontier "C for yes or "N for no if yes. N N N 111 Old fit his fiberial qualifies as a CAH of all if participate in the Frontier Comunity in some the run of the some training participate in the Permitter Comunity in a cost of the run o		CRNA fee sche	edul e? See 42		2.00	108.00
100.001(F this hospital qualifies as a CM or a cost provider, and therapy services provides by outside supplica? Enter "Y. For yes or "W from no for each therapy. N						_
110.00[bit this hoogh tail participate in the Rural Community Hoogh tail Demonstration project (\$4104 N 110.00[bit this hoogh tail participate in the Rural Community Hoogh tail Demonstration project (\$4104 N 110.00[bit this facility qualifies as a CAH, did it participate in the Frontier Community N 110.00[bit this facility qualifies as a CAH, did it participate in the Frontier Community N 110.00[bit this facility qualifies as a CAH, did it participate in the Frontier Community N 110.00[bit this facility qualifies as a CAH, did it participate in the Frontier Community N 111.00[bit this facility qualifies as a CAH, did it participate in the Frontier Community N 111.00[bit this facility qualifies as a CAH, did it participate in the Frontier Community N 111.00[bit this hoogh tail participate in the Penergy vania Rural Healt this with the Hold this this Categories and the Hold this Categories and the Categories and the Hold this Categories and the Hold this tail to not the Categories and the Hold this Ca	therapy services provided by outside supplier? Enter "Y"					109.00
111.001 This facility qualifies as a CAR, did it participate in the Frontier Community N 111.00 Health Integration Proof of the CNH Power to column 1 is Y, enter the integration proof of the CNH Power to CAH is participating in COUMD. N 111.00 112.001 This facility qualifies and the CNH Power to CAH is participating in COUMD. N 110.001 111.00 112.001 This facility qualifies and the CNH Power to CAH is participating in COUMD. N 110.00 2.00 3.00 112.001 This facility qualifies and the CNH Power to CAH is participating in COUMD. N 100.00 2.00 3.00 112.00 112.001 This facility qualifies and the current cast reporting participating in the demonstration. 1.00 2.00 3.00 112.00 112.001 This and II-faculty at the accurrent to cast reporting participation in the demonstration. 1.00 2.00 3.00 112.00 115.001 This and II-faculty at the accurrent the date the hospital cased participation in the demonstration. 1.00	Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor		110.00			
111.001 This facility qualifies as a CAR, did it participate in the Frontier Community N 111.00 Health Integration Proof of the CNH Power to column 1 is Y, enter the integration proof of the CNH Power to CAH is participating in COUMD. N 111.00 112.001 This facility qualifies and the CNH Power to CAH is participating in COUMD. N 110.001 111.00 112.001 This facility qualifies and the CNH Power to CAH is participating in COUMD. N 110.00 2.00 3.00 112.001 This facility qualifies and the CNH Power to CAH is participating in COUMD. N 100.00 2.00 3.00 112.00 112.001 This facility qualifies and the current cast reporting participating in the demonstration. 1.00 2.00 3.00 112.00 112.001 This and II-faculty at the accurrent to cast reporting participation in the demonstration. 1.00 2.00 3.00 112.00 115.001 This and II-faculty at the accurrent the date the hospital cased participation in the demonstration. 1.00				1.00	2.00	-
112.00Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? N 112.00 Inter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration. If applicable. N 112.00 Inscell anecus Cast Reporting Information N N N 0115.00 in column 1. If column 1 is yes, enter the method used (A, B, or E only) N N 116.00 in column 1. If colum 1 is yes, enter the method used (A, B, or E only) N 116.00 115.00 in column 1. If colum 2 is 'F', enter in column 3 either '9' for yes or 'N' for yes or 'N' for no. N 116.00 116.00 is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. N 116.00 117.00 is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. 117.00 2.00 3.00 118.00 ket malpractice premiums and paid losses: 277.216 0 0 0118.01 118.00 ket malpractice premiums and paid losses: 277.216 0 0 118.02 119.00D is this a surface and paid losses reported in a cest center other than the N N 118.02 118.02	Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac	ost reporting Dumn 1 is Y, rticipating in	period? Enter enter the n column 2.			111.00
112.00Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? N 112.00 Inter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration. If applicable. N 112.00 Inscell anecus Cast Reporting Information N N N 0115.00 in column 1. If column 1 is yes, enter the method used (A, B, or E only) N N 116.00 in column 1. If colum 1 is yes, enter the method used (A, B, or E only) N 116.00 115.00 in column 1. If colum 2 is 'F', enter in column 3 either '9' for yes or 'N' for yes or 'N' for no. N 116.00 116.00 is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. N 116.00 117.00 is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no. 117.00 2.00 3.00 118.00 ket malpractice premiums and paid losses: 277.216 0 0 0118.01 118.00 ket malpractice premiums and paid losses: 277.216 0 0 118.02 119.00D is this a surface and paid losses reported in a cest center other than the N N 118.02 118.02			1.00	2.00	3 00	-
115.00 is this an all -inclusive rate provider? Enter "Y" for yes or "N" for no. N N 0 0115.00 in column 1. If column 1 is yes, enter the method used (A. B., or conly) N N 0 0115.00 in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for non term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, \$2208.1. N 116.00 116.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. N 116.00 118.00 is the malpractice insurance a claim-made or occurrence policy? Enter 1 1 118.00 118.00 118.01 is ta mounts of malpractice premiums and paid losses: 277,216 0 0 0118.00 118.02 is this a soft or EACH that qualifies for the 0utpatient hold Hamless provision in ACA N N 118.02 1.00 2.00 3.00 118.02 is an appractice premiums and paid losses reported in a cost center other than the Admin abstrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 1.00 2.00 3.00 118.02 List amounts of KAG Hard (KA S121 and applicable amodments? (see instructions) 1.00 2.00 118.02 118.02 List amounts of thall prospision in ACA S121 and applicable a	demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? s "Y", enter ne		2.00	3.00	112.00
"N" for no. 117.00 Itil shi sfacility legally-required to carry malpractice insurance? Enter 'Y' for yes or 'N" for no. 117.00 Itil shi sfacility legally-required to carry malpractice insurance? Enter 'Y' for yes or 'N" for no. 117.00 117.00 Itil sol 118.00 is the malpractice insurance a claims-made or occurrence. Premi ums Losses Insurance 118.01 List amounts of malpractice premiums and paid losses: 277,216 0 0118.01 118.02 Insurance 1.00 2.00 3.00 118.02 List amounts of malpractice premiums and paid losses reported in a cost center other than the and amounts contained therein. 1.00 2.00 119.00 Do Do NOT USE THIS LINE 119.00 2.00 N 118.02 120.00 St his a such and papicable amendments? (see instructions) Enter in column 1. "Y" for yes or "N" for no. Is this a urant hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S121 and applicable amendments? (see instructions) Enter in column 2. "Y" for yes or "N" for no.	115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3, or E only) 23" percent (includes	N			0115.00
117.000 is this facility legally-required to carry malpractice insurance? Enter Y 117.00 118.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 1 118.00 118.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 1 118.00 117.00 2.00 3.00 118.01 1.00 2.00 3.00 118.01 1.00 2.00 3.00 118.02 Are malpractice premiums and paid losses: 277,216 0 0118.01 118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 119.000 110.00 UST HIS a SCH or EACH that qualifies for the 0utpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 1. "Y" for yes or "N" for no. 119.000 112.000 UST HIS a CAL that qualifies for the 0utpatient Hold Harmless for the 0utpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) N N 121.000 Inter in column 2. "Y" for yes or "N" for no. 112.000 N N 120.000 122.00 Dot this facility incur and report costs for high cost implantable devices charged to yes		for yes or	N			116.00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 1 118.00 If the policy is claim-made. Enter 2 if the policy is occurrence. Premiums Losses Insurance 118.01List amounts of malpractice premiums and paid losses: 277,216 0 0118.01 118.02List amounts of malpractice premiums and paid losses: 277,216 0 0118.01 118.02List amounts contained therein. 1.00 2.00 118.02 118.02List amounts contained therein. 1.00 2.00 118.02 118.02Lobe amounts contained therein. 1.00 2.00 118.02 120.00[s this a SCH or EACH that qualifies for the 0utpatient Hold Hamless provision in ACA \$121.01 N 119.00 120.00[s this a rural hospital with < 100 beds that qualifies for the 0utpatient Hold Hamless provision in ACA \$121.01		ance? Enter	Y			117.00
Premiums Losses Insurance 118.01 List amounts of mal practice premiums and paid losses: 277,216 0 0 118.02 Are mal practice premiums and paid losses: 277,216 0 0 0118.01 118.02 Are mal practice premiums and paid losses reported in a cost center other than the ddministrative and General? 1.00 2.00 118.02 118.02 Are mal practice premiums and paid losses reported in a cost center other than the ddministrative and deneral? 1.00 2.00 118.02 118.02 Administrative and eneral? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 119.00 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Siz21 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. 119.00 120.00 Bate this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. 121.00 121.00 121.00 Did this facility operate a transplant center? Enter "Y" for yes and "N" for no. If worksheet A line number where these taxes are included. N 122.00 125.00 Does this a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in col	118.00 Is the mal practice insurance a claims-made or occurrence pol		1			118.00
118. 01_List amounts of malpractice premiums and paid losses: 277, 216 0 0 0118. 01 118. 02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118. 02 119. 000 NOT USE THIS LINE N 119. 000 NOT USE THIS LINE 119. 000 120. 001 St his a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA N N			Premi ums	Losses	Insurance	
118. 02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 1.00 2.00 118. 02 Mare mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118. 02 10. 00D NOT USE THIS LINE Signal applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the 0utpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. N N 120.00 121. 00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. Y 121.00 122. 00 Does the cost report contain heal thcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 N 122.00 125. 00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mn/dd/yyyy) below. 125.00 126.00 126.00 126. 00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 127.00 126.00 126.00 127. 00 If this is a Medicare certified liver transplant center, enter	118 01 list amounts of malpractice premiums and paid losses					0118 01
118. 02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118. 02 119. 00 D0 NOT USE THIS LINE N N N N 120. 00 lis this a SCH or EACH that qualifies for the 0utpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the 0utpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			211,210			
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alth Financial Systems DSPITAL AND HOSPITAL HEALTH CARE COMPLI		AL COMMUNITY HOSPIT A Provider CO			d:	u of Form CMS Worksheet S		
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133. 00 Removed and reserved 134. 00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. All Providers								
0.00 Are there any related organizatio chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column '	1. If yes, and home	office co		Y		140. (
1.00 If this facility is part of a cha	in organization ente	2.00 r on lines 141 thro	bugh 143 th	ne name a	3.00	of the home		
office and enter the home office	contractor name and c	ontractor number.						
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5.00 f costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for i clude Medicare utiliza	no in column 1. If	column 1 i				145.	
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Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 3.00 Was there a change in the order o 9.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	n column 1. (See CMS I dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y" ied cost finding metho ider that qualifies f "N" for no for each co "N" for no for each co ampus hospital that ha Name	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 for an exemption fro omponent for Part A N N N N N N N N N N N N N	40, \$4020) no. or no. res or "N" Part E 2.00 om the appl A and Part N N N N N N N N N	for no. i cati on B. (See fferent Zi p Code	Title V 3.00 of the low 42 CFR §41 N N N N N N CBSAs? CBSAs?	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 165.	
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	n column 1. (See CMS I dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y" ied cost finding metho ider that qualifies f "N" for no for each co "N" for no for each co ampus hospital that ha Name	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 for an exemption fro omponent for Part A N N N N N N N N N N N N N	40, \$4020) no. or no. res or "N" Part E 2.00 om the appl A and Part N N N N N N N N N	for no. i cati on B. (See fferent Zi p Code	Title V 3.00 of the low 42 CFR §41 N N N N N N CBSAs? CBSAs?	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N FTE/Campus 5.00	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165.	
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	n column 1. (See CMS I dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y" ied cost finding metho ider that qualifies f "N" for no for each c "N" for no for each c ampus hospital that ha Name 0 T) incentive in the A r under §1886(n)? En 05 is "Y") and is a mu	Pub. 15-2, chapter for yes or "N" for Y" for yes or "N" f od? Enter "Y" for y Part A 1.00 or an exemption froc omponent for Part A N N N N N N N N N N N N N	40, \$4020) no. for no. for no. res or "N" Part E 2.00 m the appl A and Part N N N N N N N N N	for no. i cati on B. (See fferent Zi p Code 3.00 cment Act	Ti tl e V 3.00 of the low 42 CFR §41 N N N N N CBSAS? e CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 161. 165.	

Health Financial Systems CAMERON	UNI TY HOSPI TAL	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATI	ON DATA	Provider CCN: 15-1315	Period:	Worksheet S-2	2
			From 10/01/2019 To 09/30/2020	Date/Time Pre	parad
			10 09/30/2020	4/21/2021 9:4	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date period respectively (mm/dd/yyyy)	and ending dat	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have any	days for indiv	viduals enrolled in	N	(0171.00
section 1876 Medicare cost plans reported on Wk					
"Y" for yes and "N" for no in column 1. If colu	mn 1 is yes, er	nter the number of secti	on		
1876 Medicare days in column 2. (see instruction	ns)				

)SPI 1	Financial Systems CAMERON MEMORIAL CO TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1315	Peri od:	Worksheet S-	2
				From 10/01/2019 To 09/30/2020		epared
					4/21/2021 9:	<u>44 am</u>
				Y/N 1.00	Date 2.00	-
	General Instruction: Enter Y for all YES responses. Enter M	N for all NO r	esponses. Ent			
	mm/dd/yyyy format.					_
	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	reporting period? If yes, enter the date of the change in the					
			Y/N	Date	V/I	
00		0.16	1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colu		N			2.
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, including		Y			3.
	contracts, with individuals or entities (e.g., chain home					
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Туре	Date	_
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prepared by a Cer	tified Public	Y	A	12/22/2020	4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date available	ailable in				
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	arant from	N			5.
00	those on the filed financial statements? If yes, submit re-					5.
				Y/N	Legal Oper.	
				1.00	2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf voc is t	ha providor i	s N		6.
00	the legal operator of the program?	TT yes, TS t		5 11		0.
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.
00	Were nursing school and/or allied health programs approved	and/or renewe	d during the	N		8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduata modi	cal aducation	N		9.
00	program in the current cost report? If yes, see instruction			N N		9.
0. 00	Was an approved Intern and Resident GME program initiated		the current	N		10.
	cost reporting period? If yes, see instructions.					
. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I&RinanAp	proved	N		11.
	Treaching Program on worksheet A: Triges, see Thstructions.				Y/N	
					1.00	
	Bad Debts					_
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection			act conacting	Y	12.
. 00	period? If yes, submit copy.	porrey change	during this c	ost reporting	N	13.
1.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	fyes, see in	structions.	N	14.
	Bed Complement					
6.00	Did total beds available change from the prior cost report	<u> </u>	<u>yes, see ins</u> t A		n N	15.
		Y/N	Date	Y/N	Date	_
		1.00	2.00	3.00	4.00	
	PS&R Data					
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	12/18/2020	Y	12/18/2020	16.
	date of the PS&R Report used in columns 2 and 4 . (see					
	instructions)					
. 00		N		N		17.
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.
	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. If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		19.
			1	IN		1 1 7 .
. 00	Report data for corrections of other PS&R Report					

Health Financial Systems

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

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-1315	Period: From 10/01/2019	Worksheet S Part II	
				To 09/30/2020		
		Descri	ption	Y/N	Y/N	
		C)	1.00	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:			N	N	20.00
		Y/N	Date	Y/N	Date	
21 00		1.00	2.00	3.00	4.00	21.00
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					
	Capital Related Cost			_		
	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			0	N	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost rep	oorting period?	Y	24.00
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	lf yes, see	Ν	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during t instructions.	he cost reporti	ng period? If	⁼yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th copy.	e cost reportir	ng period?lf	yes, submit	Ν	27.00
	Interest Expense				L	
28.00	Were new Loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost	reporti ng	Y	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service Re	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		debt? If yes,	see	N	30.00
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00
	instructions. Purchased Services					_
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through cor	ntractual	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competit	ive bidding? If	Υ	33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	rrangement with	n provider-bas	ed physicians?	Y	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreemer	nts with the p	orovi der-based	Y	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.			5.1	_
				Y/N 1.00	Date 2.00	
	Home Office Costs			1		
	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office?			37.00
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en					38.00
39.00	If line 36 is yes, did the provider render services to oth see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the	home office?	lfyes, see			40.00
	instructions.					
		2.	00			
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	JODI		SANDERS		41.00
	held by the cost report preparer in columns 1, 2, and 3, respectively.					
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7956		JSANDERS@BLUEA	NDCO. COM	43.00

Heal th	Financial Systems CAMERON MEMORIA	CO	MMUNI TY HOSPI TAL		In Lieu	J of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1315		ri od:	Worksheet S-2	2
				To	om 10/01/2019 09/30/2020	Part II Date/Time Pre 4/21/2021 9:4	epared: 14 am
		L					
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	N	IANAGER				41.00
	held by the cost report preparer in columns 1, 2, and 3						
	respectively.						
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 cos	t					43.00
	report preparer in columns 1 and 2, respectively.						

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STAT	ISTICAL DATA	Provider CC		Period: From 10/01/2019 To 09/30/2020	Worksheet S-3 Part I Date/Time Pre 4/21/2021 9:4	pare
					I/P Days / O/P Visits / Trips	
Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
	1.00	2.00	3.00	4.00	5.00	
 Hospital Adults & Peds. (columns 5, 6, 7 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. for the portion of LDP room available be 00 HMO and other (see instructions) HMO 1PF Subprovider 	2	23	8, 41	8 66, 576. 00	0	1. 2. 3.
00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swing Bed SNF 00 Hospital Adults & Peds. Swing Bed NF					0	4 5 6
00 Total Adults and Peds. (exclude observat beds) (see instructions)	ion	23	8, 41	8 66, 576. 00	0	7
DO INTENSIVE CARE UNIT DO CORONARY CARE UNIT .00 BURN INTENSIVE CARE UNIT .00 SURGICAL INTENSIVE CARE UNIT .00 OTHER SPECIAL CARE (SPECIFY)	31.00	2	73	3, 672. 00	0	8 9 10 11 12
 00 NURSERY 00 Total (see instructions) 00 CAH visits 00 SUBPROVIDER - IPF 00 SUBPROVIDER - IRF 00 SUBPROVIDER 00 SKILLED NURSING FACILITY 	43.00	25	9, 15	0 70, 248. 00	0 0 0	13 14 15 16 17 18 19
00 NURSING FACILITY 00 OTHER LONG TERM CARE 00 HOME HEALTH AGENCY 00 AMBULATORY SURGICAL CENTER (D.P.) 00 HOSPICE 10 HOSPICE (non-distinct part) 00 CMHC - CMHC	101.00 116.00 30.00	0		0	0	23 24 24 25
 00 RURAL HEALTH CLINIC - FPC 01 RURAL HEALTH CLINIC - URGENT CARE 02 RURAL HEALTH CLINIC - OB/GYN 25 FEDERALLY QUALIFIED HEALTH CENTER 00 Total (sum of lines 14-26) 00 Observation Bed Days 00 Ambulance Trips 00 Employee discount days (see instruction) 	88. 00 88. 01 88. 02 89. 00	25			0 0 0 0	26 26
 00 Employee discount days - IRF 00 Labor & delivery days (see instructions) 01 Total ancillary labor & delivery room outpatient days (see instructions) 00 LTCH non-covered days 		0		0		31 32 32 33

	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	F	eriod: rom 10/01/2019 o 09/30/2020	Worksheet S-3 Part I Date/Time Pre 4/21/2021 9:4	pare
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	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 for the portion of LDP room available beds)	835	70	2, 774		10.00	1.
. 00	HMO and other (see instructions)	630	255				2.
. 00	HMO I PF Subprovi der	0	200				3.
. 00	HMO IRF Subprovider	0	0				4.
00	Hospital Adults & Peds. Swing Bed SNF	371	0	371			5.
00	Hospital Adults & Peds. Swing Bed NF		0	358			6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 206	70	3, 503			7.
00	INTENSIVE CARE UNIT	43	8	153			8
00	CORONARY CARE UNIT						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGI CAL INTENSI VE CARE UNI T						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY		52	448			13
. 00	Total (see instructions)	1, 249	130	4, 104		388. 73	
. 00	CAH visits	0	0	C			15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF						17
. 00 . 00							18
. 00	SKILLED NURSING FACILITY NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						20
. 00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	
. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0.00	0.00	23
. 00	HOSPI CE	0	0	C	0.00	0.00	
. 10	HOSPICE (non-distinct part)		U.	C		01 00	24
. 00	CMHC - CMHC			-			25
. 00	RURAL HEALTH CLINIC - FPC	1, 421	2, 027	8, 616	0.00	11.05	
. 01	RURAL HEALTH CLINIC - URGENT CARE	384	2,655	13, 530	0.00	14.32	26
. 02	RURAL HEALTH CLINIC - OB/GYN	63	1, 197	3, 294	0.00	5.38	26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26
. 00	Total (sum of lines 14-26)				0.00	419.48	27
. 00	Observation Bed Days		25	1, 239			28
. 00	Ambulance Trips	0					29
. 00	Employee discount days (see instruction)			C			30
. 00	Employee discount days - IRF			C			31
. 00	Labor & delivery days (see instructions)	0	1	19			32
. 01	Total ancillary labor & delivery room			C			32
8. 00	outpatient days (see instructions)	_					
	LTCH non-covered days	0					33

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATIST	CAL DATA	Provider C	CN: 15-1315	Period: From 10/01/2019 To 09/30/2020		pared
	Full Time		Di s	charges		
Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
 1.00 Hospital Adults & Peds. (columns 5, 6, 7 ar 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER ACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.02 RURAL HEALTH CLINIC - FPC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.01 Total ancillary labor & delivery room 		0	1	63 21 73 125 0 63 21	1, 027	1.00 2.00 3.00 4.00 5.00 8.00 9.00 10.00 11.00 10.00 10.00 10.00 11.00
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges				0 0		33. (33. (

Heal th	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 10/01/2019 To 09/30/2020		
					RHC I	Cost	
					1	00	-
	Clinic Address and Identification					00	
1.00	Street				1500 W MAUMEE STREET		1.00
				ty	State	ZIP Code	
2.00	City, State, ZIP Code, County		ANGOLOA	00	2.00	3.00 46703	2.00
2.00	City, State, Zir Code, County		ANGOLOA	-		40703	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for			0	3.00
					Award 00	Date 2.00	
	Source of Federal Funds			<u> </u>	00	2.00	
4.00 5.00 6.00 7.00 8.00 9.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)					4.00 5.00 6.00 7.00 8.00 9.00
					1.00	2.00	
10.00	yes or "N" for no in column 1. If yes, indica	ther than a hospital-based RHC or FQHC? Enter "Y" for N If yes, indicate number of other operations in column 11 the type of other operation(s) and the operating					
		Sun	2		nday	Tuesday	
		from 1.00	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			08: 00	17:00	08: 00	11.00
				•	1.00	2.00	
12.00	Have you received an approval for an exception	on to the produ	uctivity stand	ard?	Y	2.00	12.00
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col- number of providers included in this report. numbers below.	d in CMS Pub. ' umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	C	13.00
					er name	CCN number	
14.00	RHC/FQHC name, CCN number			1.	00	2.00	14.00
14.00		Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in 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)						15.00
				inty	_		
2.00	City, State, ZIP Code, County		4. STEUBEN	00			2.00
2.00	Griy, State, ZIP Code, County	Tuesday		esday	Thur	rsday	2.00
		to	from	to	from	to	
		6. 00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1)	17.00	00.00	17.00	08.00	17.00	11 00
11.00	CLI NI C	17:00	08: 00	17:00	08: 00	17:00	11.00

Health Financial Systems CAM	ERON MEMORIAL C	In Lieu	u of Form CMS-2	2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1315	Period:	Worksheet S-8	
		Component	CCN: 15-8530	From 10/01/2019 To 09/30/2020	Dato/Timo Pro	narod
		component	CCN. 15-8550	10 09/30/2020	4/21/2021 9:4	4 am
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12:00				11.00

Heal th	Financial Systems CAME	RON MEMORIAL CO	MMUNI TY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
			Component		From 10/01/2019 To 09/30/2020	Date/Time Pre	
					RHC II	4/21/2021 9:4 Cost	<u>4 am</u>
						0031	
					1.	00	
1 00	Clinic Address and Identification				1201 N WAYNE	CTDEET	1 00
1.00	Street		Ci	ty	1381 N. WAYNE State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		ANGOLA			46703	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urban		1.00	3.00
3.00	HUSPITAL-BASED FUNCS UNLY: Designation - Ent				Award	Date	3.00
					. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00 7.00	Health Services for the Homeless (Section 34 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 energies as other than a h	anital based [nton "V" for	1.00 N	2.00	10.00
10.00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic				IN	0	10.00
	2. (Enter in subscripts of line 11 the type o						
	hours.)		. ,				
		Sun			nday	Tuesday	
		from 1.00	to 2.00	from 3.00	4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	0.00	4.00	5.00	
11.00	CLINIC	09:00	17: 30	08: 00	19: 30	08: 00	11.00
12.00	Have you received an approval for an excepti	on to the produ	ictivity stand	land?	1.00 Y	2.00	12.00
	Is this a consolidated cost report as define				N	0	
101.00	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report.	List the names	s of all provi	ders and			
	numbers below.			Drovia	ler name	CCN number	
					. 00	2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
15.00		1.00	2.00	3.00	4.00	5.00	15.00
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)						
			Соц	unty			
0.00	4.00						
2.00	City, State, ZIP Code, County	Tuesday	Wedn	esday	Thur	sday	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	19: 30	08: 00	19: 30	08: 00	19: 30	11.00

Health Financial Systems CAME	ERON MEMORIAL C	In Lieu	u of Form CMS-2	2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	
		Component		From 10/01/2019 To 09/30/2020	Date/Time Pre	nared
		component	0011. 10 0040	10 077 307 2020	4/21/2021 9:4	
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	19: 30	09: 00	17: 30		11.00

Heal th	Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPI	TAL	In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATI STI CAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 10/01/201 To 09/30/202		
					RHC III	Cost	1
					1	. 00	1
	Clinic Address and Identification						1
1.00	Street				306 E. MAUMEE	1.00	
				ty 00	<u>State</u> 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		ANGOLA			N 46703	2.00
						1.00	
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		1.00	3.00
				Gran	t Award	Date	
	Courses of Fodered Funds			1	. 00	2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		1			4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7.00 8.00	Appalachian Regional Commission Look-Alikes						7.00
9.00	OTHER (SPECI FY)						9.00
					1.00		
10.00	Does this facility operate as other than a h	ospital-based	RHC or EOHC? E	nter "Y" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o	ate number of	other operatio	ons in column	TV.		10.00
	hours.)					T	
		from Sun	nday to	from MC	onday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1)	1			1.4. 00		111.00
11.00				08: 00	16: 30	08: 00	11.00
					1.00	2.00	
	Have you received an approval for an excepti				Y		12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	umn 1. If yes,	enter in colu	ımn 2 the	Ν	0	13.00
	numbers below.						
					der name	CCN number	
14,00	RHC/FQHC name, CCN number			1	. 00	2.00	14.00
		Y/N	V	XVIII	XIX	Total Visits	
45.00		1.00	2.00	3.00	4.00	5.00	15.00
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						2.00
		Tuesday		esday		irsday	
		to 6.00	from 7.00	to 8.00	from 9.00	to 10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16: 30	08: 00	16: 30	08: 00	16: 30	11.00

Health Financial Systems CAM	ERON MEMORIAL C	In Lieu	u of Form CMS-	2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1315		Worksheet S-8	
		Component	CCN: 15-8546	From 10/01/2019 To 09/30/2020	Date/Time Pre	nared
		oomponent		10 07/00/2020	4/21/2021 9:4	4 am
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	12:00				11.00

Heal th	Financial Systems CAMERON MEMORIAL COMMUN	NITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1315	Peri od:	Worksheet S-1	0			
				From 10/01/2019					
				To 09/30/2020	Date/Time Pre 4/21/2021 9:4				
					4/21/2021 9.4	4 alli			
					1.00				
	Uncompensated and indigent care cost computation				1.00				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by Li	ne 202 colum	n 8)	0. 369585	1.00			
1.00	Medicaid (see instructions for each line)	vided by ii		11 0)	0. 30 9 30 3	1.00			
2.00	Net revenue from Medicaid				2, 901, 463	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal navmont	s from Modic	ai d2	Y	4.00			
4.00 5.00									
	Medicai d charges								
6.00					15, 864, 463	•			
7.00	Medicaid cost (line 1 times line 6)	(1)			5, 863, 268				
8.00	Difference between net revenue and costs for Medicaid program	(ine / mir	IUS SUII OI II	nes z anu s; i i	2, 961, 805	8.00			
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for </pre>	an aaah lin							
9.00	Net revenue from stand-al one CHIP		le)		0	9.00			
9.00 10.00	Stand-al one CHIP charges				0				
					0				
11.00	Stand-alone CHIP cost (line 1 times line 10)	(lina 11 mi	nuo Line O.	f . Toro then	0	•			
12.00	Difference between net revenue and costs for stand-alone CHIP	(ine ii m	nus i i ne 9;	ri < zero then	0	12.00			
	enter zero) Other state or local government indigent care program (see inst	tructions f	For each line)					
13.00	Net revenue from state or local indigent care program (Net incl				0	13.00			
13.00	Charges for patients covered under state or local indigent care				0	14.00			
14.00	5 1 5	e program (TH THES 0 U	0	14.00			
15.00	10) State or local indigent care program cost (line 1 times line 1/	1)			0	15.00			
16.00	State or local indigent care program cost (line 1 times line 14 Difference between net revenue and costs for state or local ind		program (Li	no 15 minus lins					
16.00		ligent care	e program (11		. 0	16.00			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	P and stat	o/Local indi	aont caro progra	ms (500				
	instructions for each line)	r anu stat		gent care progra	1115 (566				
17.00	Private grants, donations, or endowment income restricted to fu	undi na char	rity care		0	17.00			
18.00	Government grants, appropriations or transfers for support of H				0	18.00			
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local			s (sum of lines	2, 961, 805	•			
17.00	(8, 12 and 16)	margent	care program	3 (3011 01 111103	2, 701, 000	17.00			
			Uni nsured	Insured	Total (col. 1				
			patients	patients	+ col. 2)				
			1.00	2.00	3.00				
	Uncompensated Care (see instructions for each line)								
20.00	Charity care charges and uninsured discounts for the entire fac	cility	123, 71	4 65, 251	188, 965	20.00			
	(see instructions)	-							
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	45, 72	3 65, 251	110, 974	21.00			
	instructions)								
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00			
	charity care								
23.00	Cost of charity care (line 21 minus line 22)		45, 72	3 65, 251	110, 974	23.00			
					1.00				
24.00	Does the amount on line 20 column 2, include charges for patier		ond a length/	of stay limit	N	24.00			
	imposed on patients covered by Medicaid or other indigent care								
25.00	If line 24 is yes, enter the charges for patient days beyond the	ne indigent	: care progra	m's length of	0	25.00			
	stay limit								
26.00	Total bad debt expense for the entire hospital complex (see ins				4, 967, 887				
27.00	Medicare reimbursable bad debts for the entire hospital complex				560, 646				
27.01	Medicare allowable bad debts for the entire hospital complex (s	see instruc	ctions)		862, 532	27.01			
28.00	Non-Medicare bad debt expense (see instructions)				4, 105, 355	28.00			
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	bense (see	instructions)	1, 819, 164	29.00			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 930, 138	30.00			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 891, 943	31.00			

RECLAS	Financial Systems CAMER SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	RON MEMORIAL CON DF EXPENSES	Provider C	CN: 15-1315 Pe	eriod:	u of Form CMS-2 Worksheet A	2552-10
				To	rom 10/01/2019 0 09/30/2020	Date/Time Pre 4/21/2021 9:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		5, 508, 545	5, 508, 545	-160, 232	5, 348, 313	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2, 236, 214	2, 236, 214	1, 807, 744	4, 043, 958	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	71, 089	8, 176, 069	8, 247, 158	0	8, 247, 158	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	4, 278, 155	7,610,387	11, 888, 542	-117, 741	11, 770, 801	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	918, 541 0	2, 341, 444 40, 675	3, 259, 985 40, 675	0	3, 259, 985 40, 675	1
9.00	00900 HOUSEKEEPI NG	766, 434	467, 557	1, 233, 991	0	1, 233, 991	9.00
10.00	01000 DI ETARY	529, 124	390, 020	919, 144	-656, 905		10.00
11.00		0	0	0	642, 430	642, 430	•
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	794, 268 200, 780	576, 061 127, 032	1, 370, 329 327, 812	0	1, 370, 329 327, 812	•
	01500 PHARMACY	200, 780 525, 496	3, 542, 314	4, 067, 810	-2, 441, 309	1, 626, 501	15.00
	01600 MEDICAL RECORDS & LIBRARY	506, 595	102, 752	609, 347	0	609, 347	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	2, 217, 204	1, 278, 218		617, 809		•
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0	0	0	116, 548 57, 704		•
45.00	ANCI LLARY SERVICE COST CENTERS		0		37,704	37,704	45.00
	05000 OPERATING ROOM	1, 506, 192	1, 194, 935	2, 701, 127	-703, 296	1, 997, 831	50.00
	05100 RECOVERY ROOM	0	0	0	703, 296		
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	1, 114, 020 1, 732, 290	100, 525 895, 945	1, 214, 545 2, 628, 235	-795, 206 0	419, 339 2, 628, 235	
60.00	06000 LABORATORY	1, 059, 314	1, 934, 853	2, 028, 233	0	2, 028, 233	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	938, 992	322, 334	1, 261, 326	-335, 751	925, 575	
65.01	06501 SLEEP LAB	0	0	0	65, 923		•
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	958, 116 0	21, 616 5, 431	979, 732 5, 431	0 269, 828	979, 732 275, 259	1
69.01	06901 CARDI AC REHAB	58, 178	7, 494	65, 672	0	65, 672	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 650, 929	2, 650, 929	-1, 276, 176		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1, 276, 176		•
73.00 76.00	07300 DRUGS CHARGED TO PATI ENTS 03020 CHEMI CAL DEPENDENCY	0	0	0	0	0	73.00
76.01	03480 ONCOLOGY	0	1, 667, 892	1, 667, 892	0	1, 667, 892	•
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	08800 RURAL HEALTH CLINIC - FPC 08801 RURAL HEALTH CLINIC - URGENT CARE	1, 036, 038 1, 398, 793	77, 897 186, 457	1, 113, 935 1, 585, 250	0 -242, 552	1, 113, 935 1, 342, 698	
88.02	08802 RURAL HEALTH CLINIC - OB/GYN	1, 164, 283	67, 757	1, 232, 040	-185, 143		
90.00	09000 CLINIC	137, 264	24, 144	161, 408	0	161, 408	•
90.01	09001 CLINIC- ORTHO	407, 837	1, 113, 826		0	1, 521, 663	•
	09002 CLINIC - PEDS & ENT 09003 IV THERAPY	1, 167, 082 136, 606	29, 538 13, 250		395, 198		•
90. 03 90. 04	09004 0P PSYCH	558, 254	13, 250		2, 360, 744	2, 510, 600 570, 451	
	09100 EMERGENCY	1, 840, 240	221, 794		3, 145		•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	U0	0	0	0	0	101.00
	11300 INTEREST EXPENSE		1, 558, 311	1, 558, 311	-1, 558, 311		113.00
	11400 UTI LI ZATI ON REVI EW-SNF	0	0	0	0		114.00
	11600 HOSPICE	0	48	48	0	48 70, 369, 569	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	26, 021, 185	44, 504, 461	70, 525, 646	-156, 077	70, 369, 569	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	59, 534	10, 497	70, 031	0	70, 031	
	07950 DAYCARE-INFANT/TODDLER	0	0	0	0		194.00
	07951 MOB 07952 COMMUNI TY HEALTH	0	0 2, 427	0 2, 427	0		194.01 194.02
	07953 ASSISTED LIVING/CAMERON WOODS	0	2, 427	2,427	0		194.02
194.04	07954 EDUCATI ON	2, 452	23, 931	26, 383	0	26, 383	194.04
	07955 MARKETI NG	348, 803	666, 018		21, 521	1, 036, 342	
	07956 GUEST MEALS	0	0	0	14, 475	14, 475	
	07957 OUTSI DE LAUNDRY 07958 CANCER CENTER	0	0	0	0		194.07 194.08
	07959 URGENT CARE	0	0	0	242, 552	242, 552	•
194.10	07960 RHC	0	0	0	0	0	194.10
	07961 OBGYN	0	0	0	185, 143		
	07962 TRINE STUDENT HEALTH	88, 029 240, 924	1, 954 82, 836	89, 983 323, 760	0	89, 983 323, 760	
194.13	07963 OCCUPATIONAL HEALTH 07964 I MMUNI ZATION CLINIC	19, 290	82, 830 981	20, 271	80, 565		

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lieu of Form CMS-2552-10				
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C		Period: From 10/01/2019	Worksheet A			
				To 09/30/2020				
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed			
			+ col. 2)	ions (See	Trial Balance			
				A-6)	(col. 3 +-			
					col. 4)			
	1.00	2.00	3.00	4.00	5.00			
194. 16 07967 RETAIL PHARMACY	0	0	0	0 0	0	194.16		
194.17 07966 FAMILY PRACTICE CENTER	699, 217	16, 834	716, 051	-395, 198	320, 853	194.17		
200.00 TOTAL (SUM OF LINES 118 through 199)	27, 606, 286	45, 577, 211	73, 183, 497	0	73, 183, 497	200.00		

LASS	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CCN: 1	Period: From 10/01/2019	Worksheet A	
				To 09/30/2020	Date/Time Pre 4/21/2021 9:4	
	Cost Center Description	Adjustments	Net Expenses For			
		(See A-8)	Allocation			
		6.00	7.00			
	GENERAL SERVICE COST CENTERS	1 5 (1 00 4	2 707 200			
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	-1, 561, 004 -174, 442				1.0
	00400 EMPLOYEE BENEFITS DEPARTMENT	-195, 366				4.
	00500 ADMI NI STRATI VE & GENERAL	-2, 333, 317				5.
o o	DO700 OPERATION OF PLANT	-3, 300	3, 256, 685			7.
	DO800 LAUNDRY & LINEN SERVICE	0				8.
	00900 HOUSEKEEPI NG	0				9.
	01000 DI ETARY 01100 CAFETERI A	9, 142- -191, 490-				10.
	01300 NURSI NG ADMI NI STRATI ON	0				13.
	01400 CENTRAL SERVICES & SUPPLY	0				14.
	D1500 PHARMACY	-8, 330	1, 618, 171			15.
	01600 MEDICAL RECORDS & LIBRARY	-515	608, 832	 		16.
	NPATIENT ROUTINE SERVICE COST CENTERS	507.000	0.575.000			1
	03000 ADULTS & PEDIATRICS	-537, 899				30.
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0				31.
	NCILLARY SERVICE COST CENTERS	0	57,704			43.
	D5000 OPERATI NG ROOM	-541, 739	1, 456, 092			50.
	D5100 RECOVERY ROOM	0				51.
	D5200 DELIVERY ROOM & LABOR ROOM	0				52.
	05400 RADI OLOGY-DI AGNOSTI C	0				54.
		0	2, 994, 167			60.
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 925, 575			64.
	06501 SLEEP LAB	0	65, 923			65.
	06600 PHYSI CAL THERAPY	0	979, 732			66.
oo oo	06900 ELECTROCARDI OLOGY	0	275, 259			69.
	06901 CARDI AC REHAB	0	65, 672			69.
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0				71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0				72.
	07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY	0				73.
	03480 ONCOLOGY	0				76.
	DUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC - FPC	0				88.
	08801 RURAL HEALTH CLINIC - URGENT CARE	0				88.
	08802 RURAL HEALTH CLINIC - OB/GYN 09000 CLINIC	-305, 614				88.
	09001 CLINIC- ORTHO	0 -1, 262, 820				90.
	09002 CLINIC - PEDS & ENT	-1, 043, 881				90
	09003 I V THERAPY	0	2, 510, 600			90
	09004 OP PSYCH	-392, 952	177, 499			90
1	09100 EMERGENCY	0	2, 065, 179			91
	09200 OBSERVATION BEDS (NON-DISTINCT PART					92
	OTHER REIMBURSABLE COST CENTERS	0	0			101.
	SPECIAL PURPOSE COST CENTERS	0	UU			
	1300 INTEREST EXPENSE	0	0			113
. 00 1	1400 UTILIZATION REVIEW-SNF	0	0			114.
	1600 HOSPI CE	-48				116.
. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-8, 561, 859	61, 807, 710			118.
	IONREI MBURSABLE COST CENTERS	0				100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0				190 192
	07950 DAYCARE-INFANT/TODDLER	0	0			194
	07951 MOB	0	0			194
	07952 COMMUNI TY HEALTH	0	2, 427			194
. 03 0	07953 ASSISTED LIVING/CAMERON WOODS	0	0			194
	07954 EDUCATI ON	0	26, 383			194
	07955 MARKETING	0	1,036,342			194
	07956 GUEST MEALS 07957 OUTSI DE LAUNDRY	0	14, 475 0			194 194
	07957 OUTSIDE LAUNDRY 07958 CANCER CENTER	0				194
	D7958 CANCER CENTER D7959 URGENT CARE	0	242, 552			194
	07960 RHC	0	0			194.
	07961 OBGYN	0	185, 143			194
. 120	07962 TRINE STUDENT HEALTH	0	89, 983			194.
	07963 OCCUPATIONAL HEALTH	0	323, 760			194.
. 140	07964 I MMUNI ZATI ON CLI NI C	0	100, 836			194.
a = 1 -	07965 FOUNDATI ON	0	401, 143			194.

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	TAL	In Lieu	u of Form CMS-25	52-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider C	CN: 15-1315	Peri od:	Worksheet A	
				From 10/01/2019 To 09/30/2020	Date/Time Prepa	ared
				10 077 307 2020	4/21/2021 9:44	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6.00	7.00				
194.17 07966 FAMILY PRACTICE CENTER	0	320, 853			19	94.17
200.00 TOTAL (SUM OF LINES 118 through 199)	-8, 561, 859	64, 621, 638			20	00.00

Health Financial Systems RECLASSIFICATIONS

CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1315 Period: From 10/01/2019 Worksheet A-6

RECEA	STITCATIONS			FIOVIDEI CO	N. 15-1515	From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:4	epared:
		Increases					4/21/2021 9.4	
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
1 00	A - LABOR AND DELIVERY	20.00	(70.004	(0.000				1 1 00
1.00 2.00	ADULTS & PEDIATRICS NURSERY	30. 00 43. 00	672, 324 52, 830	62, 033 4, 874				1.00
2.00	EMERGENCY	43.00 91.00	2, 879	4, 874				3.00
5.00			728,033	67, 173				3.00
	B - PROPERTY INSURANCE	I	/ [
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	53, 193				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1 <u>3, 9</u> 04				2.00
	0		0	67, 097				-
1 00	C - CAFETERIA	11.00	2(0,000	070 (00				1 1 00
1.00 2.00	CAFETERIA CUEST MEALS	11.00	369, 828	272, 602				1.00
2.00	GUEST MEALS	1 <u>94.</u> 06	<u> </u>	<u>6, 1</u> 42 278, 744				2.00
	D - INTEREST EXPENSE		570, 101	270,744				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 530, 510				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27, 801				2.00
	0		o	1, 558, 311				
	E - DEPRECIATION EXPENSE							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	º_	1, 766, 039				1.00
	U F - ICU		0	1, 766, 039				-
1.00	INTENSIVE CARE UNIT	31.00	92, 308	24, 240				1.00
1.00		<u>31.00</u>	9 <u>2, 308</u> 92, 308	24, 240				1.00
	H - PROPERTY TAX		72, 300	24,240				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22, 104				1.00
	0		o	22, 104				
	J - SLEEP LAB - SALARIED STAFF							
1.00	SLEEP LAB	65.01	34, 629	31, 294				1.00
2.00	ELECTROCARDI OLOGY	<u>69.00</u>	10,082	259,746				2.00
	L - PUBLIC RELATIONS		44, 711	291, 040				
1.00	MARKETI NG	194.05	0	21, 521				1.00
			<u>_</u>	21, 521				
	N - RECOVERY ROOM							
1.00	RECOVERY ROOM	51.00	703, 296	<u>0</u>				1.00
	0		703, 296	0				_
1 00	0 - IMPLANTABLE DEVICES	70.00		4 07/ 47/				1 1 00
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1, 276, 176				1.00
		+		1, 276, 176				
	S - FOUNDATION RECLASS	I		1/2/0/1/0				1
1.00	FOUNDATI ON	194.15	7, 019	0				1.00
	0		7,019	<u>0</u>				
	T - IMMUNIZATION CLINIC RECLAS							
1.00	IMMUNIZATION CLINIC	1 <u>94.</u> 14	º_	80, 565				1.00
			0	80, 565				
1.00	U - FAMILY PRACTICE - PROV BAS CLINIC - PEDS & ENT	90.02	385, 907	9, 291				1.00
1.00	TOTALS		385, 907	9, 291				1.00
	V - IV THERAPY	I		.,				
1.00	IV THERAPY	90.03	0	2, 360, 744				1.00
	TOTALS		0	2, 360, 744				
	W - URGENT CARE - NON RHC			1				4
1.00	URGENT_CARE	1 <u>94.</u> 09	21 <u>4,023</u>	28, 529				1.00
	TOTALS X - OB/GYN NON-RHC		214, 023	28, 529				-
1.00	OBGYN	194. 11	174, 961	10, 182				1.00
1.00	TOTALS		174, 961	10, 182				1.00
500.00	Grand Total: Increases		2, 728, 419	7, 861, 756				500.00
	, , , , , , , , , , , , , , , , , , , ,	I						

th Financial Systems	CAMER	ON MEMORIAL COM				u of Form CMS-2552
LASSI FI CATI ONS			Provider C	CN: 15-1315	Period: From 10/01/2019	Worksheet A-6
					To 09/30/2020	Date/Time Prepare 4/21/2021 9:44 ar
	Decreases					
Cost Center	Line #	Salary		Wkst. A-7 Ref.	_	
6.00 A - LABOR AND DELIVERY	7.00	8.00	9.00	10.00		
0 DELIVERY ROOM & LABOR ROOM	52.00	728, 033	67, 173	(1
0	0.00	0	0	(2
o 🔄 🔜 🔜 🔜 💻	0.00	0	0	(2	3
0		728, 033	67, 173			
B - PROPERTY I NSURANCE 0 ADMI NI STRATI VE & GENERAL	5.00	0	67,097	12		1
0 ADMINISTRATIVE & GENERAL	0.00		07,097	12		2
		0	67, 097		-	-
C – CAFETERIA						
0 DI ETARY	10.00	378, 161	278, 744	(1
0	0.00		0 278, 744	(2	2
D - INTEREST EXPENSE		378, 101	278, 744			
0 INTEREST EXPENSE	113.00	0	1, 558, 311	11	1	1
o	0.00	<u>0</u>	0	11	1	2
0		0	1, 558, 311			
E - DEPRECIATION EXPENSE	1 00		1 7// 020			1
0 CAP REL COSTS-BLDG & FLXT	1.00	0	<u>1, 766, 039</u> <u>1, 766, 039</u>		9	1
F - ICU			1,700,007			
0 ADULTS & PEDIATRICS	30.00	92, 308	24, 240)	1
0		92, 308	24, 240			
H - PROPERTY TAX	5 00		00.404			
0 ADMI NI STRATI VE & GENERAL	5.00	0	2 <u>2, 1</u> 04 22, 104	13	3	1
J - SLEEP LAB - SALARIED STAFF		0	22, 104			
0 RESPIRATORY THERAPY	65.00	44, 711	291, 040	()	1
0	0.00	0	0		2	2
O L - PUBLIC RELATIONS		44, 711	291, 040			
0 ADMI NI STRATI VE & GENERAL	5.00	0	21, 521	(1
		0	21, 521	`	2	
N - RECOVERY ROOM					- 1	
O OPERATING ROOM	<u>50.</u> 00	70 <u>3, 2</u> 96	<u>0</u>	(<u>)</u>	1
0 0 - IMPLANTABLE DEVICES		703, 296	0			
0 MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 276, 176	(1
PATIENT	/ 1. 00	0	1,270,170			
0		0	1, 276, 176		1	
S - FOUNDATION RECLASS	5.00	7.010				
0 ADMI NI STRATI VE & GENERAL	<u>5.</u> 00	<u>7,019</u> 7,019	0		<u></u>	1
T - IMMUNIZATION CLINIC RECLAS	S	7,019	0			
0 PHARMACY	15.00	0	80, 565	()	1
0		<u>0</u>	80, 565			
U - FAMILY PRACTICE - PROV BAS		005 007	0.001			
0 <u>FAMI LY_PRACTI CE_CENTER</u>	1 <u>94.</u> 17	<u>385, 907</u> 385, 907	<u> </u>		2	1
V - IV THERAPY		303, 707	7, 271			
0 PHARMACY	15.00	0	2, 360, 744	()	1
TOTALS		0	2, 360, 744		<u> </u>	
W - URGENT CARE - NON RHC						
0 RURAL HEALTH CLINIC - URGENT	88.01	214, 023	28, 529	(ס	1
CARE	+	214, 023			-	
X - OB/GYN NON-RHC		217,023	20, 327			
0 RURAL HEALTH CLINIC - OB/GYN	88.02	17 <u>4, 9</u> 61	1 <u>0, 1</u> 82	(2	1
TOTALS		174, 961	10, 182		1	
.00 Grand Total: Decreases		2, 728, 419	7, 861, 756			500

In Lieu of Form CMS-2552-10

Heal th Financia	al Systems		
RECONCI LI ATI ON	OF CAPITAL	COSTS	CENTERS

CAMERON MEMORIAL COMMUNITY HOSPITAL Provider CCN: 15-1315

CCN: 15-1315 Peri od: From 10/0

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 10/01/2019 Part I

							narod
					To 09/30/2020	Date/Time Pre 4/21/2021 9:4	4 am
				Acqui si ti ons		1/21/2021 /11	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
PAR	RT I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES		•			
1.00 Lar	nd	1, 419, 368	0		0 0	0	1.00
2.00 Lar	nd Improvements	0	0		0 0	0	2.00
3.00 Bui	ildings and Fixtures	58, 020, 916	283, 730		0 283, 730	706, 401	3.00
4.00 Bui	ilding Improvements	20, 000	0		0 0	0	4.00
5.00 Fix	xed Equipment	0	0		0 0	0	5.00
6.00 Mov	vable Equipment	20, 000, 166	658, 281		0 658, 281	306, 627	6.00
7.00 HIT	T designated Assets	0	0		0 0	0	7.00
8.00 Sub	btotal (sum of lines 1–7)	79, 460, 450	942, 011		0 942, 011	1, 013, 028	8.00
	conciling Items	0	0		0 0	0	9.00
10. 00 Tot	tal (line 8 minus line 9)	79, 460, 450	942, 011		0 942, 011	1, 013, 028	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7.00				
PAR	RT I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00 Lar	nd	1, 419, 368	0				1.00
2.00 Lar	nd Improvements	0	0				2.00
3.00 Bui	ildings and Fixtures	57, 598, 245	0				3.00
4.00 Bui	ilding Improvements	20, 000	0				4.00
5.00 Fix	xed Equipment	0	0				5.00
6.00 Mov	vable Equipment	20, 351, 820	0				6.00
	T designated Assets	0	0				7.00
8.00 Sub	btotal (sum of lines 1-7)	79, 389, 433	0				8.00
9.00 Rec	conciling Items	0	0				9.00
10.00 Tot	tal (line 8 minus line 9)	79, 389, 433	0				10.00

Heal th	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	ΓAL	In Lie	eu of Form CMS-2	2552-10
RECONC	LIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1315	Period: From 10/01/2019 To 09/30/2020		pared:
			SU	IMMARY OF CAF	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			1 00
1.00	CAP REL COSTS-BLDG & FIXT	5, 508, 545			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2, 236, 214		0 0	0	
3.00	Total (sum of lines 1-2)	5, 508, 545			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capital -Relat					
		ed Costs (see					
		instructions)	5 <i>,</i>				
		14.00	15.00				
-	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	AN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	5, 508, 545				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 236, 214				2.00
3.00	Total (sum of lines 1-2)	0	7, 744, 759				3.00
	• •						•

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 10/01/2019 To 09/30/2020		pared:
	COMF	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	59, 037, 613 20, 351, 820 79, 389, 433	0	20, 351, 82	0 0. 256354	0	1.00 2.00 3.00
	ALLOCA	TION OF OTHER (F CAPI TAL	
Cost Center Description	Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	f Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		0 3, 712, 012 0 1, 616, 862 0 5, 328, 874	2, 236, 214	1.00 2.00 3.00
		SL	IMMARY OF CAPI			
Cost Center Description	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	Other) Capital-Relat ed Costs (see instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	-					
1.00CAP REL COSTS-BLDG & FLXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	0 2, 536 2, 536	13, 904		0 0	3, 787, 309 3, 869, 516 7, 656, 825	1.00 2.00 3.00

In Lieu of Form CMS-2552-10 d: Worksheet A-8

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1315	Period: From 10/01/2019	Worksheet A-8	
					To 09/30/2020	Date/Time Pre 4/21/2021 9:4	pared: 4 am
			_	Expense Classification of			
			l	/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	2.00	4.00	Ref.	
1.00	Investment income - CAP REL	1.00 A	2.00 -1,530,510CA	3.00 AP REL COSTS-BLDG & FIXT	4.00	5.00 11	1.00
2.00	COSTS-BLDG & FIXT (chapter 2)	٨			2.00	11	2 00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-25, 20504	AP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	А	0		0.00	0	3.00
4.00	Trade, quantity, and time		о		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)						
6.00	Rental of provider space by suppliers (chapter 8)	В	-16, 033 CA	AP REL COSTS-MVBLE EQUIP	2.00	9	6.00
7.00	Tel ephone servi ces (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		О		0.00	0	9.00
10.00	Provi der-based physi ci an	A-8-2	-3, 471, 167			0	10.00
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	-362, 110			0	12.00
	transactions (chapter 10)	A-0-1	-302, 110				
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -181, 971 CA	AFETERIA	0.00		
15.00	Rental of quarters to employee	b	0		0.00		
16.00	and others Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than						
17.00	patients Sale of drugs to other than	В	-8, 330 PH	IARMACY	15.00	0	17.00
18.00	patients Sale of medical records and	В	E1E ME	EDI CAL RECORDS & LI BRARY	16.00	0	18.00
16.00	abstracts	D	-515 WE	DICAL RECORDS & LIDRART	18.00	0	16.00
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.)						
	Vending machines Income from imposition of	В	-8, 519CA	AFETERIA	11.00 0.00		20.00 21.00
211 00	interest, finance or penalty					Ũ	200
22.00	charges (chapter 21) Interest expense on Medicare		О		0.00	0	22.00
	overpayments and borrowings to						
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	ORE	SPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0 PH	IYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		гио	ILIZATION REVIEW-SNF	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL		004	AP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		OCA	AP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	COSTS-MVBLE EQUIP Non-physician Anesthetist			** Cost Center Deleted **			28.00
28.00	Physicians' assistant	А	-167, 753 CL	INIC- ORTHO	90. 01	0	
30.00	5	A-8-3	0**	** Cost Center Deleted **	* 67.00		30.00
	limitation (chapter 14)						
30. 99			OAE	OULTS & PEDIATRICS	30.00		30. 99
	therapy costs in excess of	A-8-3					

31.00

32.00

33.00 33.01 33.02 33.03

33.04 33.05

33.06 33.07

33.08

33.09

th	Financial Systems	CAME	RON MEMORIAL CO	DMMUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:4	pared: 4 am
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	···· · · · · · · · · · · · · ·	(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
0	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
0	CAH HIT Adjustment for		0		0.00	0	32.00
~	Depreciation and Interest	•	F 0/7		5 00	0	
0		A		ADMI NI STRATI VE & GENERAL	5.00	0	
	EMPLOYEE CHRISTMAS PARTY	A		ADMINISTRATIVE & GENERAL	5.00	0	33.01
2	PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5.00	0	33.02
-	MEALS ON WHEELS	В			10.00	0	33.03
4	RENTAL INCOME OFFSET - CANCER	В	-30, 494	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
5	ATM SURCHARGE REVENUE	В	275	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
	DI ETI CI AN CONSULTATI ONS	В		CAFETERI A	11.00	0	
7	MIDLEVELS OFFSET	A		CLINIC - PEDS & ENT	90.02	0	33.00
, g	HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
0		~	2, 270, 200	PERIOR OF A DENERAL	5.00	0	55.00

-305,614 RURAL HEALTH CLINIC - OB/GYN

-8, 560 ADMI NI STRATI VE & GENERAL

-48 HOSPI CE

-8, 561, 859

88.02

116.00

5.00

0 33.09

0

0 33.12

33.11

50.00

MOVING EXPENSES 33.11 А 33. 12 CLEAR HOSPICE EXP А 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)

HC PHYSICIAN OFFSET

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

А

(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	COMMUNI TY HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period: From 10/01/2019	Worksheet A-8	-1
OFFICE	COSTS			To 09/30/2020		
	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 C	RGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO - CAMERON WOODS BENEFITS	0	181, 167	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CMO – CAMERON WOODS – A&G	0	30, 300	2.00
3.00	7.00	OPERATION OF PLANT	CMO - CAMERON WOODS - CENTRA	0	3, 300	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	CMO RENTAL	852, 920	986, 064	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO - RETAIL PHARMACY BENEFI	0	14, 199	4.01
5.00	0		0	852, 920	1, 215, 030	5.00

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
- · · ·		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME 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

rerinbur	Sellent under tritte Aviir.				
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 organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Health Financial Systems	CAMERON MEMORIAL COMM	NUNITY HOSPITAL	In Lieu of Form CMS-2552-10			
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME		From 10/01/2019	Worksheet A-8-1 Date/Time Prepared:		

								4/21/202	<u>21 9:4</u>	14 am
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									i i
	6.00	7.00								
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED	AS A RESULT OF	TRANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OF	R CLAIMED	HOME	
	OFFICE COSTS:									1
1.00	-181, 167	0								1.00
2.00	-30, 300	0							1	2.00
3.00	-3, 300	0							1	3.00
4.00	-133, 144	9							1	4.00
4.01	-14, 199	0							1	4.01
5.00	-362, 110									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 no	t been posted to worksneet A,	corumns r anu/or	Ζ,	the amount	arrowabre	Should be	Thurcated	TH COLUMN 4 OF	this part.	
	Rel ated Organi zati on(s)									
	and/or Home Office									
	Type of Business									
	51									
	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	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
7. 00 8. 00 9. 00 10. 00 100. 00	100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Heal th	Fi	nanci al	Systems	
	ED	DACED		

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

	ER BASED PHYSICI			Provi der (CCN: 15-1315	Period:	Worksheet A-8	
						From 10/01/2019 To 09/30/2020) Date/Time Pre 4/21/2021 9:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
				·			Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	90.01	CLINIC- ORTHO	1, 095, 067	1, 095, 067	(0 0	0	1.00
2.00		_ABORATORY	3, 539	c	3, 539	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	588, 041	537, 899	50, 142	0	0	3.00
4.00		OPERATING ROOM	541, 739				0	4.00
5.00	90. 02	DR. A	647,085			o o	0	5.00
6.00	90. 02		108, 934			0	0	
7.00	90. 02		147, 491	147, 491	(0	7.00
8,00	90.04		392, 952		(0	8,00
9.00	0, 00		0	0	(0	9,00
10.00	0.00		0				0	10.00
200.00	0.00		3, 524, 848	3, 471, 167	53, 681	, s	0	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	MKSt. A EITIC #	I denti fi er		Unadjusted RCE			of Malpractice	
		rdentifier		Limit	Conti nui ng	Share of col.	Insurance	
					Education	12	i nou ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		CLINIC- ORTHO	0.00	7.00	12.00		0	1.00
2.00		_ABORATORY	0				0	
3.00		ADULTS & PEDIATRICS	0			-	0	3.00
4.00		OPERATING ROOM	0			, v	0	
4.00 5.00	90. 02		0			-	0	5.00
6.00	90. 021		0		(°	0	
7.00	90. 021		0				0	7.00
	90. 021		0				0	
8.00 9.00	0.00	JR. D	0				0	8.00 9.00
	0.00		0				0	
10.00	0.00		0		(0	
200.00			0		(°	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	1(00	17.00	10.00		
1 00	1.00	2.00	15.00	16.00	17.00	18.00		1 00
1.00		CLINIC- ORTHO	0	0	(.,,		1.00
2.00			0	0		-		2.00
3.00		ADULTS & PEDIATRICS	0	0	(001/011		3.00
4.00		OPERATING ROOM	0	0	(4.00
5.00	90. 02		0		(011/000		5.00
6.00	90. 02		0	0				6.00
7.00	90. 02 [0	0	(7.00
8.00	90. 04 [DR. D	0					8.00
9.00	0.00		0	-		-		9.00
10.00	0.00		0	C				10.00
200.00			0	0	0	3, 471, 167		200.00

DOST ALLOATION - GENERAL SERVICE COSTS Provider COL 15:131 Provid			RON MEMORIAL CO				U OT FORM CMS	2552-10
Cost Centor Description Not Figure 2010 (100 b) 100 b	COST	ALLOCATION - GENERAL SERVICE COSTS		Provider C				
Lost Center Description Ret Licenses For Cost (frie dist) A Cost Fit NI (frie dist) A Cost Fit NI (frie dist) A Subtotal (frie dist) A 1 0 100 2.00 4.00 4.0 4.0 1 0 0 100 2.00 4.00 4.0 4.0 1 0 0 0.000 (cost cent cost centrate centrate) 1.00 2.00 4.00 4.0 1 0 0.000 (cost cent cost centrate) 3.307.300 3.307.300 3.307.200 3.307.200 1.00 2.000.000 (cost centrate) 4.00.466 1.000 1.000 0.0000 (cost centrate) 4.00.466 1.000 1.000.000 (cost centrate) 4.00.466 1.000.000 1.000.000 (cost centrate) 1.000.000 (o 09/30/2020	Date/Time Pre	pared:
Cost Conter Description International recession in cost on cut, 3) International recession cut, 3) International recession cut, 3) International recession cut, 3) International recession cut, 3) Solution recession cut, 3) Solut, 3) Solution recession recessio							4/21/2021 9:4	4 am
Inc. Cost (m) Inc. Cos				CAPITAL REI	LATED COSTS			
Inc. Cost (m) Inc. Cos		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
Image: construct construction Construct construction Construct construction Constr								
Coll 77 Coll 77 Coll 77 Coll 70 2.00 4.00 4.00 Descend, Schwicz Coll Carlins: D 1.00 2.00 4.00 4.00 4.00 0.0000 Carl FeLL COST-ALDC & FIAT 3.787.300 3.869,510 1.725,104 1.725,104 1.725,104 1.727,104 4.00 0.0000 Carlins Fish Tis Te Carlins. 0.017,104 9.05,104 3.869,510 1.725,100 1.725,104 <td></td> <td></td> <td>Allocation</td> <td></td> <td></td> <td>DEPARTMENT</td> <td></td> <td></td>			Allocation			DEPARTMENT		
Description O 1.00 2.00 4.00 4.4 100 D00000 CAP BLL 00031-WRBLE DDAYT 3.777,700 7.778 7.777,700 7.777,700 7.778 7.778,700 7.778 7.000,700 7.778 7.000,700 7.778 7.000,700 7.778 7.000,777 7.778 7.000,777 7.778 7.000,777 7.778 7.000,777 7.778 7.000,777 7.778 7.000,777 7.778 7.000,777 7.778 7.000,777 7.778 7.000,777 7.778 7.000,777 7.720,777 7.778 7.778 7.778 7.778 7.778 7.778 7.778 7.778 7.778 7.778								
CHERENAL SERVICE COST CONTENT 1 0.00000000000000000000000000000000000								
100 DOTOD CAP REL COSTS-BLDG & FIXT 3.787.309 3.787.309 3.869.516 1 1 2.00 4.00 DODOC CAP REL COSTS-WILE EXUIP 8.601.722 10.019 19.833 8.01.244 1.200 4.00 4.00 DODOC CAPRETION OF FLATURE 8.051.722 10.019 19.833 8.01.224 1.200.245 7.00 10.015 8.00 1.240 4.00 0.0000 1.01.051 8.00 1.01.051 8.00 1.040.550 9.00 0.0000 1.040.550 9.00 1.040.550 9.00 1.040.550 9.00 1.040.550 9.00 1.040.550 9.00 1.040.550 9.00 1.040.550 9.00 1.040.550 1.070.751 10.00 1.070.751 10.00 1.070.751 10.00 1.070.751 10.00 1.070.751 10.00 1.070.751 10.00 1.070.751 10.00 1.070.751 10.00 1.070.751 10.00 1.00 1.000.751 1.070.751 10.00 1.000.751 1.070.751 10.00 1.010.51 1.010.51 10.01		CENEDAL SEDVICE COST CENTEDS	0	1.00	2.00	4.00	4A	
2.00 002000 CAP REL_COSTS-MURLE EQUIP 3.869, 516 3.869, 516 2.00 00200 ADMININSTRUTE & GENERAL 9.437, 484 341, 128 311, 573 1.237, 205, 080 11, 377, 205, 526 2.00 0.00 5.00 00200 ADMININSTRUTE & SCREEBAL 9.437, 484 341, 128 311, 573 1.265, 080 11, 377, 205, 526 2.00, 000 10, 055, 526 2.00, 000 10, 055, 526 2.00, 000 10, 055, 526 2.00, 000 10, 050, 010, 010, 010, 010, 010, 010, 0	1 00		3 787 309	3 787 309	1	1		1 1 00
4.00 DODOD INFLUTY: INTERT IS DEPARTMENT 8, 051, 792 19, 619 19, 183 8, 001, 744 4, 01, 655 5, 00 7.00 DODOD OFFRATION INSTRUTY: A FIFTHAL 9, 437, 748 333, 546 332, 546 332, 546 5, 00 5								•
5.00 DOBCRO JAWINI STRATT VF & GENERAL 9, 437, 484 341, 573 1, 577, 256, 560 11, 377, 256 5, 00 8.00 DOSCO LANGO'R & LINEN SERVICE 10, 55, 48, 00 5, 568 2, 563 220, 50 11, 377, 256 5, 00 8.00 DOSCO LANGO'R & LINEN SERVICE 10, 53, 097 14, 600 106, 123 44, 360, 647 550, 199 11, 600, 123 44, 360, 647 673, 397 11, 000 10.00 DITADU CARTERLA 450, 640 66, 005 47, 778 108, 674 673, 397 11, 000 10.00 DITADU CARTERLA 450, 640 66, 005 47, 778 108, 674 673, 397 11, 000 10.00 DITADU CARTERLA 530, 692 47, 128 233, 504 160, 672 13, 000 150, 692 30, 674 127, 676 231, 000 150, 000 150, 000 150, 000 150, 000 150, 000 150, 000 150, 000 150, 002 30, 01 150, 002 30, 01 150, 223 30, 00 150, 000 150, 002 30, 01 160, 000 150, 000 150,								•
B. 00 00800 LUMDRY & LIMEN SERVICE 40, 075 35, 914 25, 502 0 101, 551 8, 00 D. 00 00000 DUSELED 73, 907 5, 685 42, 361 105, 551 8, 00 10, 00 111, 151 10, 000 111, 151 10, 000 111, 151 10, 000 111, 151 10, 000 10, 000 111, 151 10, 000 10, 000 111, 151 10, 000 10, 000 111, 151 10, 000 10, 000 111, 151 10, 000 110, 000 111, 151 10, 000 154, 148 183, 275 11, 000 156, 148 183, 275 10, 000 156, 148 183, 275 10, 000 154, 148 183, 275 10, 000 154, 148 183, 275 10, 000 10, 000 154, 148 183, 275 10, 000 10, 000 154, 148 183, 275 10, 000 10, 153, 144 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10, 174 10,	5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
9.00 00900 NUBSECEPING 1.233.99 5.98 4.333 225.217 1.495.52 9.00 9.00 110 00 CAFETEN A 430.940 60.005 47.778 108.674 673.377 11.00 110 0CAFETEN A 450.940 60.005 47.778 108.674 673.377 11.00 110 0CAFETEN A 450.940 60.005 47.778 108.674 673.377 11.00 115.00 11500 (PHARMACY AT ALS SUPELY 1.575.572 0.08.68 20 77.84.00 1.697.68 1.697.67 1.500 1.500 (PHARMACY AT ALS SUPELY 1.648.177 10.8,40 27.100 1.54.148 1.71.28 1.54.57 10.00 1.550 (PHARMACY AT ALS SUPELY 1.648.177 10.8,40 27.100 1.54.148 1.71.838.765 15.00 1.000 0.1550 (PHARMACY 0.68.832 0 22.045 1.48.8,87 784.30 10.00 1.500 0.000 0.015 A FEDRIA RECORDS & LIBRARY 0.608.832 0 22.045 1.48.8,87 784.30 10.00 1.500 0.0015 A FEDRIA RECORDS & LIBRARY 0.608.832 0 22.045 1.48.8,97 784.30 10.00 15.00 0.0015 A FEDRIA RECORDS & LIBRARY 0.62.8 1.71.63 1.00 15.00 0.0100 0.015 A FEDRIA RECORD (S. 1.104 1.55.5 1.00 1.104 1.55.6 1.00 1.500 0.0010 0.015 A FEDRIA RECORD (S. 1.104 1.55.5 1.00 1.500 0.0100 0.016 0.0176 A 1.016 1.55.0 0.0100 0.0100 0.016 0.0176 A 1.016 0.000 1.1076 N 1.000 0.500 0.011 0.0176 N 1.000 0.100 0.0101 0.01176 N 1.000 0.100 0.0101 0.01176 N 1.000 0.100 0.0101 0.01176 N 1.000 0.000 0.011 0.01176 N 1.000 0.11076 N 1.000 0.000 0.011 0.01176 N 1.000 0.000 0.011 0.01176 N 1.000 0.000 0.000 0.011 0.01176 N 1.000 0.000 0.000 0.000 0.011 0.01176 N 1.000 0.000 0.000 0.011 0.01176 N 1.000 0.0	7.00	00700 OPERATION OF PLANT	3, 256, 685	335, 646	342, 440	269, 914	4, 204, 685	7.00
10. 00 01000 DETARY 253,007 146,608 106,123 44,361 550,189 10. 00 13. 00 01000 DETERY 1,303,392 28,997 44,177 108,647 673,778 108,647 673,778 108,647 673,778 108,647 673,778 108,647 673,778 108,648 673,778 108,648 673,778 108,648 673,778 108,648 774,78 108,648 774,78 108,648 774,78 108,648 774,78 108,648 774,78 108,648 774,78 108,648 774,78 108,648 774,73 716,60 53,476,730 100,000 10,456,092 774,73 716,60 53,476,752 21,113,7345 51,00 00,000,000 14,456,092 2,971,51,53 50,00 10,100 70,326 226,522 771,003 206,664 131,7,345 51,00 00,000,000 14,456,092 2,971,71,53 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50,00 50								
11.00 01100 CAFETERIA 450, 940 64, 005 47, 778 1208, 674 673, 307 11.00 14.00 01400 CHNTRAL SERVICES & SUPPLY 327, 812 103, 613 77, 000 154, 949 155, 428 14, 00 15.00 DTSD/INMARACY 0.54, 812 173, 303 222, 829 47, 712 233, 814 128, 859 156, 949 156, 428 156, 015 16.00 DTSD/INMARACY 0.64, 812 173, 302 226, 647 156, 849 990 50, 949 990 50, 949 990 50, 949 990 50, 949 990 50, 949 990 30, 00 51, 010 115, 52, 732 211, 312 31, 00 100 900, 900 116, 913 911, 910 15, 524 99, 300 84, 80 84, 933 226, 420 271, 125 231, 332 31, 300 1300 911, 900 156, 727, 717 231, 333 235, 922 221, 531 500 900 30, 914 131, 423 733, 942 52, 000 130, 914 131, 423 733, 942 52, 010 31, 200 36, 917, 933 926, 526 990, 935 36, 912, 957, 933<								•
13.00 01300 HURSING ADMIN STEATION 1.370, 339 28, 929 47, 128 233, 396 1, 679, 782 13.00 15.00 D1500 PHARMACY 1, 418, 171 327, 812 103, 613 75, 100 55, 909 55, 425 14.00 16.00 D1500 PHARMACY 1, 418, 171 38, 406 27, 600 154, 418 1, 838, 796 15.00 10.00 D1500 ANTEN LA FETA ATRICS 0.0051 CHITERS 5, 375, 337 900, 712 28, 402 27, 125 211, 312 31.00 43.00 MARCHLARK SERVICE COST CENTERS 57, 704 13, 966 10, 109 15, 524 97, 303 34.00 50.00 D5000 OPERATING ROM 1, 456, 6092 366, 174 264, 332 133, 39, 962 2, 231, 531 50.00 50.00 50, 72 2, 94, 167 2, 24, 242 133, 45, 20, 20, 22, 20, 00 50.00 50, 72 1, 38, 910, 13, 425 1, 33, 910, 13, 22, 13, 31, 531 50.00 50.00 50, 73, 733, 734 50.00 50.00 50, 73, 734 1, 20, 717, 71, 20, 22, 21, 53, 13, 31, 531 50.00 50.00 50, 60, 64, 13, 31, 73, 735 50.00								
14 00 01400 CENTRAL SERVICE & SUPPLY 327,812 103,613 75,001 56,999 566,425 14.00 16 00 01400 MENDATINE ACUITE SERVICE COST CENTRES 3.575,332 0.26,642 148,663 784,340 16.00 16 00 DIADUTES A LIBBARY 560,863 398,766 521,962 52,346,922 733,343 0.00 10 00 DISOD FAULTES RUNT 17,744 13,966 501,923 28,792 2,231,531 50.00 300,010 14,423 733,343 0.00 00 05100 DECOVERT ROOM 1,456,002 366,174 264,433 226,624 1,317,345 51.00 00 05100 DECOVERT ROOM 10,922,423 279,017 202,402 309,033 3,017,289 44.00 0.00,033 3,017,289 44.00 0.00,033 3,017,289 44.00 0.00,033 3,017,289 44.00 0.00,033 3,017,289 44.00 0.00,033 3,017,289 44.00 0.00,033 3,017,289 44.00 0.00,033 3,017,289 44.00 0.00,033 3,017,289 40.00 0.00,033 0.00,033 <								•
15:00 01:500 PHARMENCY 1, 618, 171 38:406 27:800 15:4, 418 1, 838, 795 15:00 10:00 01:000 (MLTS & FEBLAIRICS COSDS & LIBRARY 008, 832 0 26:645 148, 863 784, 340 16:00 00 03:000 (MLTS & FEBLAIRICS 3:575, 332 550.088 398, 766 827, 966 5:346, 952 31:00 00 03:000 (MLTS & FEBLAIRICS 5:70, 704 3:866 10:100 15:522 07, 303 43:00 00 05:000 (PEATHING ROM 773, 296 2:62.02 2:31, 531 50:00<								
16. 00 00 0 26.645 148.868 784.340 16. 00 0. 00 03000 ANUTES AVICE COST CENTES 3.575.332 550.888 398.766 837.966 537.965 53.46.952 30.00 30. 00 03000 ANUTES AVICE COST CENTERS 57.704 13.966 10.107 15.524 97.303 43.00 43. 00 DASCO MURESEY 57.704 13.966 10.107 15.524 97.303 43.00 51. 00 05100 (FCONTEW ROOM 1.466.092 26.332 171.063 206.664 1.377.345 51.00 52.00 05400 (RADILTSA VICABORT LINE ROOM 4.197.339 16.715 84.485 11.328 3.44.477 60.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 66.00 171.967.024.104.879.832 65.012 12.516 12.504.143.179.845.135.00 0.0 64.00 64.00 64.00 64.00 65.712 12.516 1.61.949.97 64.00 67.316.401.899.879.840.00 0.0 1.61.014.99.97 64.0								
INPART LEAT ROUTINE SERVICE COST CENTERS								
31.00 03100 NITERSIVE CARE UNIT 116, 546 39, 237 28, 402 27, 125 211, 312 31.00 ANCILLARY SERVICE COST CENTERS								
43. 00 04300 NURSERY 57. 704 13. 966 10. 109 15. 524 97. 303 43. 00 50. 00 05000 OPERATING ROOM 1.456, 092 365, 174 264, 333 238, 932 2. 321, 531 50. 00 50. 00 05200 OPERATING ROOM 1.737, 345 51. 00 50. 00 53. 31. 92. 00 54. 00 64. 00 64. 00 64. 00 64. 00 66. 01 0. 00 0. 00 0. 00 64. 00 66. 01 0.0000 ILRBWARDENT THERAPY 22. 20. 00 58. 00 53. 00 <			3, 575, 332			821, 966	5, 346, 952	30.00
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190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19,286 13,960 0 33,246 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 70,031 0 0 17,494 87,525 192.00 194.00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 0 0 194.00 194.01 07950 DAYCARE-I NFANT/TODDLER 0 0 0 0 0 194.00 194.02 07952 COMMUNI TY HEALTH 2,427 0 0 0 194.01 194.03 07953 ASSI STED LIVING/CAMERON WOODS 0 0 0 0 194.03 194.04 07954 EDUCATI ON 26,383 0 0 721 27,104 194.04 194.05 07955 MARKETI NG 1,036,342 0 24,479 102,496 1,163,317 194.05 194.06 07956 GUEST MEALS 14,475 0 0 0 0 194.06 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0	118.00		61, 807, 710	3, 768, 023	3, 701, 775	7, 620, 046	61, 149, 485	118.00
192.00 PHYSI CI ANS' PRI VATE OFFICES 70,031 0 17,494 87,525 192.00 194.00 07950 DAYCARE-INFANT/TODDLER 0 0 0 0 194.00 194.01 07951 MOB 0 0 0 0 0 194.00 194.02 07952 COMMUNI TY HEALTH 2,427 0 0 0 194.02 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194.02 194.04 07954 EDUCATI ON 26,383 0 0 721 27,104 194.04 194.05 07955 MARKETI NG 1,036,342 0 24,479 102,496 1,163,317 194.05 194.06 07956 GUEST MEALS 14,475 0 0 2,449 16,924 194.06 194.08 07958 CANCER CENTER 0 0 0 0 194.08 194.09 07959 URGENT CARE 242,552 0 23,588 62,891 329,031 194.08 194.09 07950 RECENTE			1		1	T		
194.00 07950 DAYCARE-INFANT/TODDLER 0 0 0 0 194.00 194.01 07951 MOB 0 0 0 0 194.01 194.02 07952 COMMUNI TY HEALTH 2,427 0 0 0 2,427 194.02 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194.03 194.04 07954 EDUCATI ON 26,383 0 0 0 194.03 194.05 07955 MARKETI NG 1,036,342 0 24,479 102,496 1,163,317 194.05 194.06 07956 GUEST MEALS 14,475 0 0 0 0 194.06 194.09 07957 OUTSI DE LAUNDRY 0 0 0 0 0 194.06 194.09 07958 CANCER CENTER 0 0 0 0 194.08 194.09 07959 URGENT CARE 242,552 0 23,588 62,891 329,031 194.09 194.10 07960 RHC				19, 286	13, 960			
194.01 07951 MOB 0 0 0 0 194.01 194.02 07952 COMMUNI TY HEALTH 2, 427 0 0 0 2, 427 194.02 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194.03 194.04 07954 EDUCATI ON 26, 383 0 0 721 27, 104 194.04 194.05 07955 MARKETI NG 1, 036, 342 0 24, 479 102, 496 1, 163, 317 194.05 194.06 07956 GUEST MEALS 14, 475 0 0 2, 449 16, 924 194.06 194.08 07958 CANCER CENTER 0 0 0 194.08 194.08 194.08 194.09 194.08 194.09 194.08 194.09 194.08 194.09 194.08 194.09 194.08 194.08 194.09 194.08 194.09 194.09 194.09 194.09 194.09 194.09 194.09 194.09 194.09 194.09 194.09 194.09 194.09 194.09 194.09			70, 031	0	0	17, 494		
194.02 07952 COMMUNI TY HEALTH 2,427 0 0 0 2,427 194.02 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194.03 194.04 07954 EDUCATI ON 26,383 0 0 721 27,104 194.04 194.05 07955 MARKETI NG 1,036,342 0 24,479 102,496 1,163,317 194.05 194.06 07956 GUEST MEALS 14,475 0 0 2,449 16,924 194.06 194.08 07958 CANCER CENTER 0 0 0 0 194.07 194.08 07958 CANCER CENTER 0 0 0 0 194.07 194.09 07959 URSENT CARE 242,552 0 23,588 62,891 329,031 194.09 194.10 07960 RHC 0 0 0 0 194.09 194.11 07961 OBGYN 185,143 0 12,637 51,412 249,192 194.11			0	0	0	0		
194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 0 194.03 194.04 07954 EDUCATION 26,383 0 0 721 27,104 194.04 194.05 07955 MARKETING 1,036,342 0 24,479 102,496 1,163,317 194.05 194.06 07956 GUEST MEALS 14,475 0 0 2,449 16,924 194.06 194.08 07958 CANCER CENTER 0 0 0 194.07 194.07 194.08 07959 UTSI DE LAUNDRY 0 0 0 0 194.07 194.09 07959 URGENT CARE 242,552 0 23,588 62,891 329,031 194.09 194.10 07960 RHC 0 0 0 0 194.10 194.11 07961 OBGYN 185,143 0 12,637 51,412 249,192 194.11			2 427	0	0	0		•
194.04 07954 EDUCATI ON 26, 383 0 0 721 27, 104 194.04 194.05 07955 MARKETI NG 1, 036, 342 0 24, 479 102, 496 1, 163, 317 194.05 194.06 07956 GUEST MEALS 14, 475 0 0 2, 449 16, 924 194.06 194.07 07957 OUTSI DE LAUNDRY 0 0 0 194.07 194.08 07958 CANCER CENTER 0 0 0 194.08 194.09 07959 URGENT CARE 242, 552 0 23, 588 62, 891 329, 031 194.09 194.10 07960 RHC 0 0 0 0 194.10 194.11 07961 OBGYN 185, 143 0 12, 637 51, 412 249, 192 194.11			2, 127	0	0	0		•
194.05 07955 MARKETING 1,036,342 0 24,479 102,496 1,163,317 194.05 194.06 07956 GUEST MEALS 14,475 0 0 2,449 16,924 194.06 194.07 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 242,552 0 23,588 62,891 329,031 194.08 194.10 07960 RHC 0 0 0 0 194.10 194.11 07961 OBGYN 185,143 0 12,637 51,412 249,192 194.11			26, 383	0	0	721		
194.06 07956 GUEST MEALS 14,475 0 0 2,449 16,924 194.06 194.07 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 242,552 0 23,588 62,891 329,031 194.09 194.10 07960 RHC 0 0 0 0 194.10 194.11 07961 0BGYN 185,143 0 12,637 51,412 249,192 194.11				0	24, 479			
194.0807958CANCER CENTER000194.08194.0907959URGENT CARE242,552023,58862,891329,031194.09194.1007960RHC0000194.10194.11079610BGYN185,143012,63751,412249,192194.11			14, 475	0	0		16, 924	
194. 09 194. 10 07959URGENT CARE242, 552023, 588 062, 891329, 031194. 09194. 10 07960RHC0000194. 10194. 11 079610BGYN185, 143012, 63751, 412249, 192194. 11			0	0	0	0		
194. 10 07960 RHC 0 0 0 0 194. 10 194. 11 07961 0BGYN 185, 143 0 12, 637 51, 412 249, 192 194. 11			0	0	0	0		•
194. 11 07961 OBGYN 185, 143 0 12, 637 51, 412 249, 192 194. 11			242, 552	0	23, 588	62, 891		•
			105 140	0	0			
177. 12/07/02 Hume 0100 Hit Hene III 07, 700 0 0 0 20, 007 115, 000 194. 12				0				
	174.12		07,703	0	1 U	25, 307	115,000	1177.12

Health Financial Systems	CAMERON MEMORIAL CO	DMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 10/01/2019 To 09/30/2020	Worksheet B Part I Date/Time Pre 4/21/2021 9:4	epared: 4 am
		CAPI TAL REL	ATED COSTS			
Cost 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	
194. 13 07963 OCCUPATI ONAL HEALTH	323, 760	0	20, 38	7 70, 796	414, 943	194.13
194.14 07964 IMMUNIZATION CLINIC	100, 836	0	2, 91	2 5, 668	109, 416	194.14
194. 15 07965 FOUNDATI ON	401, 143	0	2,40	7 39, 338	442, 888	194.15
194. 16 07967 RETAIL PHARMACY	0	0		0 0	0	194.16
194.1707966 FAMILY PRACTICE CENTER	320, 853	0	67, 37	1 92, 066	480, 290	194.17
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	64, 621, 638	3, 787, 309	3, 869, 51	6 8, 091, 244	64, 621, 638	202.00

Heal th	Fi nanci al	Systems	

	Financial Systems CAME	RON MEMORIAL CO	Provider C	CN: 15-1315 P	eriod: rom 10/01/2019	u of Form CMS- Worksheet B Part I Date/Time Pre	
	Cost Center Description	ADMI NI STRATI V E & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	4/21/2021 9:4 DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	11, 377, 265 898, 457 21, 699 314, 008 117, 564 143, 891 358, 936 120, 820 392, 914 167, 598	5, 103, 142 42, 103 7, 136 174, 793 78, 695 77, 624 123, 533 45, 790 43, 887	165, 353 33, 531 108 272 0 0	1, 824, 201 22, 771 56, 927 0 14, 337 16, 024	865, 425 0 0 0 0 0 0 0	1
30.00	03000 ADULTS & PEDIATRICS	1, 142, 546	656, 792	37, 959	575, 178	825, 283	30.00
31.00	03100 I NTENSI VE CARE UNI T	45, 153	46, 781	935		40, 142	31.00
43.00	04300 NURSERY	20, 792	16, 651	6, 196	96, 987	0	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	404 045	405 070	40.070	104.000		50.00
50.00 51.00 52.00 54.00 60.00 64.00 65.00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	496, 065 281, 490 156, 833 773, 370 740, 285 0 262, 870 262, 870	435, 378 281, 755 139, 153 333, 372 109, 974 0 28, 941	8, 590 2, 465 15, 982 799 0 143	87, 288 26, 144 142, 529 84, 758 0 24, 879	0 0 0 0 0 0 0 0 0	50.00 51.00 52.00 54.00 60.00 64.00 65.00
65.01	06501 SLEEP LAB	29, 633	103, 076			0	65.01
66.00	06600 PHYSI CAL THERAPY	346, 148	248, 057		64, 939	0	66.00
69.00 69.01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	64, 068	14, 946 22, 994	0	0	0	69.00 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24, 790 293, 757	22, 994	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	293, 757 272, 693	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	272,043	0	0	-	0	73.00
76.00	03020 CHEMI CAL DEPENDENCY	0	0	0		0	76.00
76.01	03480 ONCOLOGY	492, 354	440, 056			0	1
70.01	OUTPATIENT SERVICE COST CENTERS	172,001	110,000	<u> </u>			/0.01
88.00	08800 RURAL HEALTH CLINIC - FPC	337, 996	269, 148	1, 932	78, 433	0	88.00
88.01	08801 RURAL HEALTH CLINIC - URGENT CARE	389, 217	215, 191	2, 480		0	88.01
88.02	08802 RURAL HEALTH CLINIC - OB/GYN	235, 797	117, 784	455	22, 771	0	88.02
90.00	09000 CLI NI C	45, 845	21, 091	0	0	0	90.00
90.01	09001 CLINIC- ORTHO	101, 367	157, 627			0	90.01
90.02	09002 CLINIC - PEDS & ENT	245, 352	237, 075			0	90.02
90.03	09003 I V THERAPY	551, 289	20, 219		13, 494	0	90.03
90.04		82,069			0	0	
	09100 EMERGENCY	667, 670	358, 150	30, 632	240, 359	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	V	0	101.00
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
116.00	11600 HOSPI CE	0	0	0	0	0	116.00
118.00		10, 635, 336	4, 937, 824	164, 679	1, 823, 358	865, 425	118.00
	NONREI MBURSABLE COST CENTERS					-	1.00.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 104		0			190.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES 0 07950 DAYCARE-I NFANT/TODDLER	18, 702 0	0	0	0		192.00 194.00
	07950 DATCARE-TNFANT/TODDLER	0	0		0		194.00
	207952 COMMUNI TY HEALTH	519	0		0		194.02
	3 07953 ASSI STED LI VI NG/CAMERON WOODS	0	0	0	0		194.03
	107954 EDUCATI ON	5, 792	0	0	0		194.04
	07955 MARKETI NG	248, 578	40, 319	0	0		194.05
194.06	07956 GUEST MEALS	3, 616	0	0	0	0	194.06
	07957 OUTSI DE LAUNDRY	0	0	0	0		194.07
	07958 CANCER CENTER	0	0	0	-		194.08
	07959 URGENT CARE	70, 307	38, 852				194.09
	07960 RHC	0	0	0	0		194.10
	07961 OBGYN	53, 247	20, 813	0	0		194.11
	207962 TRI NE STUDENT HEALTH 307963 OCCUPATI ONAL HEALTH	24, 755 88, 665	0 33, 579		0		194.12 194.13
	107963 OCCUPATIONAL HEALTH	23, 380	4, 797		0		194.13
	07965 FOUNDATION	94, 636	3, 964		0		194.15
	07967 RETAIL PHARMACY	0	0, 701	0	Ő		194.16
	07966 FAMILY PRACTICE CENTER	102, 628	0	0	0		194.17
					·		·

Health Fin	ancial Systems CA	MERON MEMORIAL CO	OMMUNITY HOSPI	In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS					Period:	Worksheet B	
					From 10/01/2019		
					Fo 09/30/2020	Date/Time Pre	
						4/21/2021 9:4	14 am
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	(0 0	C	201.00
202.00	TOTAL (sum lines 118 through 201)	11, 377, 265	5, 103, 142	165, 353	1, 824, 201	865, 425	202.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: com 10/01/2019 o 09/30/2020	Worksheet B Part I Date/Time Pre 4/21/2021 9:4	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
11. 00 13. 00 14. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	953, 182 31, 405 19, 467 21, 520	2, 147, 747 0	843, 582 3, 888	2, 318, 931		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
16.00	01600 MEDI CAL RECORDS & LI BRARY	43, 268	0	60	0	1, 039, 153	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	172, 614 6, 159 2, 395	33, 115	21, 095 916 0	0 0 0	7, 427 529 105	31.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 01\\ 65.\ 01\\ 66.\ 00\\ 69.\ 01\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 76.\ 00\\ \end{array}$	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06400 INTRAVENOUS THERAPY 06501 SLEEP LAB 06600 PHYSICAL THERAPY 06600 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY 03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	49, 655 36, 500 18, 098 94, 330 79, 540 0 48, 743 798 56, 157 3, 118 4, 068 0 0 0 0 0 0 0 0	195, 979 97, 126 0 0 0 0 0 0 0 0 0	65, 995 0 10, 716 12, 323 176, 430 0 6, 048 0 1, 841 702 357 247, 884 230, 109 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17, 773 0 692 173, 321 312, 843 0 13, 061 11, 027 66, 972 45, 726 15, 445 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 60.\ 00\\ 64.\ 00\\ 65.\ 01\\ 66.\ 00\\ 69.\ 01\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 76.\ 00\\ \end{array}$
88.01 88.02 90.00 90.01 90.02 90.03 90.04 91.00	001PATTENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - FPC 08801 RURAL HEALTH CLINIC - URGENT CARE 08802 RURAL HEALTH CLINIC - OB/GYN 09000 CLINIC 09001 CLINIC - ORTHO 09002 CLINIC - PEDS & ENT 09003 IV THERAPY 09004 OP PSYCH 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS	0 20, 455 9, 733 24, 333 48, 515 6, 844 18, 098 104, 709	0 0 52, 357 0 0 0 0	1, 206 19, 644 1, 524 3, 625 1, 800 2, 151 2, 302 118 24, 245	0 0 0 0 0 0 0 0 0	71, 873 11, 898 31, 711 30, 140 25, 546 50, 962 0 22, 533 110, 338	88.01 88.02 90.00 90.01 90.02 90.03 90.03
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
114.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 920, 522	0 2, 147, 747	0 834, 979	0 2, 318, 931	0 1, 019, 922	113.00 114.00 116.00 118.00
192.00 194.01 194.02 194.03 194.03 194.05 194.05 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 DAYCARE-I NFANT/TODDLER 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 07961 OBGYN 07962 TRI NE STUDENT HEALTH 07963 OCCUPATI ONAL HEALTH 07963 FOUNDATI ON 07965 FOUNDATI ON	0 0 0 0 0 0 17, 490 912 0 0 0 0 0 14, 258 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 810 0 0 3, 549 0 270 347 704 168 2, 401 0 0		0 0 0 0 0 0 0 0 0 2, 150 0 5, 609 0 0 5, 609 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00 192.00 194.00 194.01 194.02 194.03 194.03 194.04 194.05 194.06 194.07 194.09 194.09 194.10 194.11 194.12 194.13 194.14 194.15 194.15

Health Financial Systems	CAMERON MEMORIAL C	OMMUNITY HOSPIT	TAL.	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 10/01/2019	Worksheet B Part I	
				Fo 09/30/2020		
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
194.17 07966 FAMILY PRACTICE CENTER	0	0	354	4 0	11, 472	194.17
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	953, 182	2, 147, 747	843, 582	2 2, 318, 931	1, 039, 153	202.00

Heal th	Fi nanci al	Systems	
COCT AL		CENEDAL	CED

CAMERON MEMORIAL COMMUNITY HOSPITAL

eal th	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPITAI	L	In Lieu of Form CM	/S-2552-1
OST A	LLOCATION - GENERAL SERVICE COSTS		Provider CCN	: 15-1315	Period: Worksheet From 10/01/2019 Part I	В
					To 09/30/2020 Date/Time 4/21/2021	
	Cost Center Description	Subtotal	Intern &	Total	47 2 17 202 1	7.44 dill
			Residents			
			Cost & Post Stepdown			
			Adjustments			
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1				1.0
	00200 CAP REL COSTS-BLDG & FIXT					2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
	00500 ADMI NI STRATI VE & GENERAL					5.C
	00700 OPERATION OF PLANT					7.0
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG					8. C 9. C
	01000 DI ETARY					10.0
	01100 CAFETERI A					11.0
	01300 NURSI NG ADMI NI STRATI ON					13.0
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14. C
	01600 MEDICAL RECORDS & LIBRARY					16.0
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	9, 712, 902	0	9, 712, 90		30.0
	03100 INTENSIVE CARE UNIT 04300 NURSERY	390, 946 253, 378	0	390, 94 253, 37		31. C 43. C
	ANCI LLARY SERVICE COST CENTERS	203, 378	U	200, 31		43.0
	05000 OPERATI NG ROOM	3, 801, 373	0	3, 801, 37	73	50.0
	05100 RECOVERY ROOM	2, 208, 947	0	2, 208, 94		51.0
	05200 DELIVERY ROOM & LABOR ROOM	1, 185, 189	0	1, 185, 18		52.0 54.0
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	5, 164, 516 4, 969, 086	0	5, 164, 51 4, 969, 08		60.0
	06400 I NTRAVENOUS THERAPY	0	0	1, 707, 00	0	64.0
5.00	06500 RESPI RATORY THERAPY	1, 614, 890	0	1, 614, 89	20	65. C
	06501 SLEEP LAB	316, 417	0	316, 41		65.0
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	2, 406, 792 428, 392	0	2, 406, 79 428, 39		66. C
	06901 CARDI AC REHAB	183, 668	0	183, 66		69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 394	0	1, 916, 39	94	71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 778, 978	0	1, 778, 97		72.0
	07300 DRUGS CHARGED TO PATI ENTS 03020 CHEMI CAL DEPENDENCY	2, 318, 931	0	2, 318, 93		73. C 76. C
	03480 ONCOLOGY	3, 236, 574	0	3, 236, 57	74	76.0
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC - FPC	2, 342, 373	0	2, 342, 37		88.0
	08801 RURAL HEALTH CLINIC - URGENT CARE 08802 RURAL HEALTH CLINIC - OB/GYN	2, 463, 297 1, 534, 004	0	2, 463, 29 1, 534, 00		88. C 88. C
	09000 CLINIC	377, 339	0	377, 33		90.0
	09001 CLINIC- ORTHO	820, 759	0	820, 75		90.0
	09002 CLINIC - PEDS & ENT	1, 779, 153	0	1, 779, 15		90.0
	09003 I V THERAPY 09004 OP PSYCH	3, 175, 856 576, 943	0	3, 175, 85 576, 94		90. 0 90. 0
	09100 EMERGENCY	5, 223, 130	0	5, 223, 13		90.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0	-,,		92.0
	OTHER REIMBURSABLE COST CENTERS	-				
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0	101.0
	11300 I NTEREST EXPENSE					113.0
4.00	11400 UTILIZATION REVIEW-SNF					114.0
	11600 HOSPI CE	0	0	(0.100.00	0	116.0
8.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	60, 180, 227	0	60, 180, 22	27	118.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	63, 344	0	63, 34	14	190.0
2.00	19200 PHYSI CLANS' PRI VATE OFFI CES	106, 227	Ō	106, 22		192.0
	07950 DAYCARE-INFANT/TODDLER	0	0		0	194.0
	07951 MOB 07952 COMMUNITY HEALTH	0 2, 946	0	2, 94	0	194. (194. (
1 02	07953 ASSISTED LIVING/CAMERON WOODS	2, 940	0	2,94	0	194. (
		32, 896	Ő	32, 89	96	194. (
1. 03	07954 EDUCATI ON	32, 090		4 470 54		1104
4.03 4.04 4.05	07955 MARKETI NG	1, 470, 514	0	1, 470, 51		
4.03 4.04 4.05 4.06	07955 MARKETI NG 07956 GUEST MEALS		0	1, 470, 51 21, 45		194.
4.03 4.04 4.05 4.06 4.07	07955 MARKETI NG 07956 GUEST MEALS 07957 OUTSI DE LAUNDRY	1, 470, 514	0 0 0			194. 194.
4.03 4.04 4.05 4.06 4.07 4.08	07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER	1, 470, 514 21, 452 0 0		21, 45	52 0 0	194. 194. 194.
94.03 94.04 94.05 94.06 94.07 94.08 94.09	07955 MARKETI NG 07956 GUEST MEALS 07957 OUTSI DE LAUNDRY	1, 470, 514	0 0 0 0 0		52 0 0	194. (194. (194. (194. (
4. 03 4. 04 4. 05 4. 06 4. 07 4. 08 4. 09 4. 10 4. 11	07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC 07961 OBGYN	1, 470, 514 21, 452 0 445, 406 0 343, 389	0 0 0 0 0 0 0	21, 45 445, 40 343, 38	52 0 0 0 0 6 99	194.0 194.0 194.0 194.0 194.0 194.7
94.03 94.04 94.05 94.06 94.07 94.07 94.08 94.09 94.10 94.11 94.11	07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC	1, 470, 514 21, 452 0 0 445, 406 0	0 0 0 0 0 0 0 0	21, 45 445, 40	52 0 0 0 6 0 39 52	194.0 194.0 194.0 194.0 194.1 194.1 194.1 194.1 194.1

Health Financial Systems C	CAMERON MEMORIAL COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1315	Peri od: From 10/01/2019 To 09/30/2020		epared:
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		4/21/2021 9:2	
	24.00	25.00	26.00			
194. 15 07965 FOUNDATI ON	543, 889	0	543, 88	39		194.15
194. 16 07967 RETAIL PHARMACY	0	0		0		194.16
194. 17 07966 FAMILY PRACTICE CENTER	594, 744	О	594, 74	14		194.17
200.00 Cross Foot Adjustments	0	О		0		200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118 through 201)	64, 621, 638	0	64, 621, 63	38		202.00

		RON MEMORIAL CO				u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 10/01/2019 o 09/30/2020	Worksheet B Part II Date/Time Pre 4/21/2021 9:4	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUI P	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	19, 619			39, 452	4.00
	00500 ADMINISTRATIVE & GENERAL	0	343, 128			6, 114	
	00700 OPERATION OF PLANT	0	335, 646			1, 316	
	00800 LAUNDRY & LINEN SERVICE	0	35, 314			1 009	
	00900 HOUSEKEEPI NG 01000 DI ETARY	0	5, 985			1, 098	
	01100 CAFETERI A	0	146, 608 66, 005			216 530	
	01300 NURSI NG ADMI NI STRATI ON	0	28, 929	47, 128		1, 138	
	01400 CENTRAL SERVICES & SUPPLY	0	103, 613			288	
	01500 PHARMACY	0	38, 406			753	
	01600 MEDICAL RECORDS & LIBRARY	0	00,100			726	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		20/010	20/010	,20	10100
	03000 ADULTS & PEDIATRICS	0	550, 888	398, 766	949, 654	4,008	30.00
	03100 I NTENSI VE CARE UNI T	0	39, 237	28, 402		132	
	04300 NURSERY	0	13, 966			76	
Ī	ANCILLARY SERVICE COST CENTERS			•			1
	05000 OPERATI NG ROOM	0	365, 174			1, 151	50.00
	05100 RECOVERY ROOM	0	236, 322	171, 063	407, 385	1, 008	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	116, 715	84, 485	201, 200	553	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	279, 617	202, 402	482, 019	2, 482	54.00
60.00	06000 LABORATORY	0	92, 241	66, 769	159, 010	1, 518	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
	06500 RESPI RATORY THERAPY	0	24, 274	17, 571	41, 845	1, 282	65.00
	06501 SLEEP LAB	0	0	62, 581	62, 581	50	65.01
	06600 PHYSI CAL THERAPY	0	208, 058			1, 373	
	06900 ELECTROCARDI OLOGY	0	12, 536	9, 074	21, 610	14	69.00
	06901 CARDI AC REHAB	0	19, 286	13, 960	33, 246	83	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	03020 CHEMI CAL DEPENDENCY	0	0	0	0	0	76.00
	03480 ONCOLOGY	0	369, 098	267, 174	636, 272	0	76.01
	OUTPATIENT SERVICE COST CENTERS	0	0	1(2,400	1(2,400	1 405	00.00
	08800 RURAL HEALTH CLINIC - FPC	0	0			1,485	
	08801 RURAL HEALTH CLINIC - URGENT CARE 08802 RURAL HEALTH CLINIC - OB/GYN	0	0	130, 650 71, 511		1, 698 1, 418	
	09000 CLINIC	0	0			1,418	
	09001 CLINIC- ORTHO	0	0				90.00
	09002 CLINIC - PEDS & ENT	0	0	143, 937			90.01
	09003 I V THERAPY	0	16, 959			196	
	09004 OP PSYCH	0	0, 10, 10,	42, 531		800	
	09100 EMERGENCY	0	300, 399			2, 641	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	-		,	0	_,	92.00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS			-			
	11200 INTEDECT EVDENCE						113.00
	11300 INTEREST EXPENSE						114.00
	11400 UTILIZATION REVIEW-SNF						
116.00	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	0	0	0	0	0	116.00
116. 00 118. 00	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	0 3, 768, 023	0 3, 701, 775	0 7, 469, 798	0	
116. 00 118. 00	11400 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS					0 37, 153	116.00 118.00
116.00 118.00 190.00	11400 11600 11600 UTI LI ZATI ON REVI EW-SNF HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN		0 3, 768, 023 19, 286			0 37, 153 0	116. 00 118. 00 190. 00
116.00 118.00 190.00 192.00	11400 11600 11600 UTI LI ZATI ON REVI EW-SNF HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES					0 37, 153 0 85	116.00 118.00 190.00 192.00
116.00 118.00 190.00 192.00 194.00	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER					0 37, 153 0 85 0	116.00 118.00 190.00 192.00 194.00
116.00 118.00 190.00 192.00 194.00 194.01	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB					0 37, 153 0 85 0 0	116.00 118.00 190.00 192.00 194.00 194.01
116.00 118.00 190.00 192.00 194.00 194.01 194.02	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07952 COMMUNITY HEALTH					0 37, 153 0 85 0 0 0 0	116.00 118.00 190.00 192.00 194.00 194.01 194.02
116.00 118.00 190.00 192.00 194.00 194.01 194.02 194.03	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS					0 37, 153 0 85 0 0 0 0 0 0	116.00 118.00 190.00 192.00 194.00 194.01 194.02 194.03
116.00 118.00 190.00 192.00 194.00 194.01 194.02 194.03 194.04	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION			13, 960 0 0 0 0 0 0 0 0 0	33, 246 0 0 0 0 0 0 0 0	0 37, 153 0 85 0 0 0 0 0 0 4	116. 00 118. 00 190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04
116.00 118.00 190.00 192.00 194.00 194.01 194.02 194.03 194.04 194.05	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING				33, 246 0 0 0 0 0 0 0 0	0 37, 153 0 85 0 0 0 0 0 0 4 500	116. 00 118. 00 190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05
116.00 118.00 190.00 192.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS			13, 960 0 0 0 0 0 0 0 0 0	33, 246 0 0 0 0 0 0 0 0	0 37, 153 0 85 0 0 0 0 0 4 500 12	116.00 118.00 192.00 194.00 194.01 194.02 194.03 194.03 194.04 194.05 194.06
116.00 118.00 190.00 192.00 194.00 194.01 194.02 194.03 194.03 194.04 194.05 194.06 194.07	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07955 OUTSIDE LAUNDRY			13, 960 0 0 0 0 0 0 0 0 0	33, 246 0 0 0 0 0 0 0 0	0 37, 153 0 85 0 0 0 0 0 4 500 2 2 0	116.00 118.00 192.00 194.00 194.01 194.02 194.03 194.03 194.04 194.05 194.06 194.07
116.00 118.00 190.00 192.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07955 OUTSIDE LAUNDRY 07958 CANCER CENTER			13,960 0 0 0 0 0 24,479 0 0 0 0 0 0	33, 246 0 0 0 0 0 24, 479 0 0 0	0 37, 153 0 85 0 0 0 0 0 4 500 12 0 0 0 0	116. 00 118. 00 190. 00 192. 00 194. 00 194. 01 194. 03 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08
116.00 118.00 190.00 194.00 194.01 194.02 194.03 194.04 194.05 194.05 194.05 194.07 194.08 194.09	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE			13, 960 0 0 0 0 0 0 0 0 0	33, 246 0 0 0 0 0 24, 479 0 0 0	0 37, 153 0 85 0 0 0 0 0 4 500 12 0 0 0 307	116.00 118.00 190.00 192.00 194.01 194.01 194.03 194.03 194.04 194.05 194.06 194.06 194.06 194.08 194.09
116.00 118.00 190.00 192.00 194.01 194.02 194.03 194.03 194.04 194.05 194.06 194.07 194.09 194.09 194.09	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07955 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07950 RHC			13, 960 0 0 0 0 0 0 24, 479 0 0 24, 588 0	33, 246 0 0 0 0 0 24, 479 0 24, 479 0 23, 588 0	0 37, 153 0 85 0 0 0 0 0 4 500 12 0 0 0 307 0	116. 00 118. 00 190. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 09
116.00 118.00 190.00 192.00 194.00 194.02 194.03 194.03 194.04 194.05 194.06 194.07 194.08 194.09 194.10	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC 07961 OBGYN			13,960 0 0 0 0 0 24,479 0 0 0 0 0 0	33, 246 0 0 0 0 0 24, 479 0 24, 479 0 23, 588 0	0 37, 153 0 85 0 0 0 0 4 500 12 0 0 307 0 307 0 251	116. 00 118. 00 190. 00 192. 00 194. 00 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 08 194. 09 194. 10 194. 11
116.00 118.00 190.00 192.00 194.00 194.02 194.02 194.03 194.04 194.05 194.06 194.07 194.08 194.09 194.10 194.11	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07955 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07950 RHC			13, 960 0 0 0 0 0 24, 479 0 0 24, 578 0 23, 588 0 12, 637 0	33, 246 0 0 0 0 0 24, 479 0 0 23, 588 0 12, 637 0	0 37, 153 0 85 0 0 0 0 4 500 12 0 4 500 0 12 0 0 307 0 251 126	116. 00 118. 00 190. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 09

Health Financial Systems 0	AMERON MEMORIAL C	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 10/01/2019 To 09/30/2020		pared:
					4/21/2021 9:4	<u>4 am</u>
		CAPI TAL REI	LATED COSTS			
	D' a di					
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs	1.00			4.00	
	0	1.00	2.00	2A	4.00	
194.1407964 IMMUNIZATION CLINIC	0	0	2, 91		28	194.14
194. 15 07965 FOUNDATI ON	0	0	2, 40	7 2,407	192	194.15
194.1607967 RETAIL PHARMACY	0	0		0 0	0	194.16
194.17 07966 FAMILY PRACTICE CENTER	0	0	67,37	1 67, 371	449	194.17
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	3, 787, 309	3, 869, 51	6 7, 656, 825	39, 452	202.00

LLOCA	Financial Systems CAME TION OF CAPITAL RELATED COSTS	RON MEMORIAL CO	Provider C	CN: 15-1315 P	eriod: rom 10/01/2019	u of Form CMS- Worksheet B Part II Date/Time Pre 4/21/2021 9:4	epared:
	Cost Center Description	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	7.00	8.00	9.00	10.00	
00	GENERAL SERVICE COST CENTERS	1					1 1 00
. 00 . 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
. 00	00500 ADMI NI STRATI VE & GENERAL	690, 815					5.00
. 00	00700 OPERATION OF PLANT	54, 552	733, 954				7.00
. 00 . 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	1, 318 19, 066	6, 055 1, 026				8.00 9.00
	01000 DI ETARY	7, 138	25, 139	44	43, 348	285, 834	
	01100 CAFETERI A	8, 737	11, 318	112		0	1
	01300 NURSING ADMINISTRATION	21, 793	11, 164	0		0	
	01400 CENTRAL SERVICES & SUPPLY	7, 336	17, 767	0		0	1
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	23, 857 10, 176	6, 586 6, 312	0		0	
0.00	INPATIENT ROUTINE SERVICE COST CENTERS	10,170	0,012	0		0	10.00
0. 00	03000 ADULTS & PEDIATRICS	69, 391	94, 462	15, 670		272, 576	
	03100 I NTENSI VE CARE UNI T	2,742	6, 728			13, 258	
3.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 262	2, 395	2, 557	2, 411	0	43.00
0.00	05000 OPERATING ROOM	30, 120	62, 618	5, 478	3, 354	0	50.00
	05100 RECOVERY ROOM	17, 091	40, 523			0	
	05200 DELIVERY ROOM & LABOR ROOM	9, 522	20, 014			0	
	05400 RADI OLOGY-DI AGNOSTI C	46, 957	47, 947	6, 597		0	
	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	44, 948	15, 817 0	330 0		0	
	06500 RESPIRATORY THERAPY	15, 961	4, 162		-	0	
	06501 SLEEP LAB	1, 799	14, 825			0	65.0
	06600 PHYSI CAL THERAPY	21, 017	35, 677			0	
		3, 890	2, 150			0	
	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 505 17, 836	3, 307 0	0	-	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	16, 557	0	0	-	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
6.00	03020 CHEMI CAL DEPENDENCY	0	0	0		0	
6. 01	03480 ONCOLOGY OUTPATI ENT SERVI CE COST CENTERS	29, 894	63, 291	0	0	0	76.01
8.00	08800 RURAL HEALTH CLINIC - FPC	20, 522	38, 710	797	1, 950	0	88.00
	08801 RURAL HEALTH CLINIC - URGENT CARE	23, 632	30, 950		84	0	88.0
	08802 RURAL HEALTH CLINIC - OB/GYN	14, 317	16, 940			0	
	09000 CLINIC 09001 CLINIC- ORTHO	2, 784 6, 155	3, 033 22, 671	0 288		0	
	09002 CLINIC - PEDS & ENT	14, 897	34, 097		1, 143	0	
0. 03	09003 I V THERAPY	33, 473	2, 908			0	90.0
	09004 OP PSYCH	4, 983	10, 075		0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	40, 539	51, 511	12, 643	5, 975	0	91.0 92.0
2.00	OTHER REIMBURSABLE COST CENTERS						92.0
01.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 0
40.00	SPECIAL PURPOSE COST CENTERS						1110 0
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113.0 114.0
	11600 HOSPI CE	0	0	0	0	0	116.0
18.00		645, 767	710, 178	67, 971	45, 327	285, 834	118.0
~ ~	NONREI MBURSABLE COST CENTERS	401	2 207				100.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	431	3, 307 0	0	-		190. 0 192. 0
	07950 DAYCARE-INFANT/TODDLER	0	0	0	0		194.0
94.01	07951 MOB	0	0	0	0	0	194.0
	07952 COMMUNI TY HEALTH	31	0	0	0		194.0
	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194.0 194.0
	07954 EDUCATI ON 07955 MARKETI NG	352 15, 093	5, 799		0		194.0
94.06	07956 GUEST MEALS	220	0	0	0		194.0
94.07	07957 OUTSI DE LAUNDRY	0	0	0	-		194.0
	07958 CANCER CENTER	0	0	0			194.0
	07959 URGENT CARE 07960 RHC	4, 269	5, 588	278	21		194.0 194.1
	07960 RHC 07961 0BGYN	3, 233	2, 993		0		194.1
	07962 TRINE STUDENT HEALTH	1, 503	0	0	Ő		194.1
94.13	07963 OCCUPATI ONAL HEALTH	5, 383	4, 829		0		194.1
	07964 I MMUNI ZATI ON CLI NI C	1, 420	690		0		194.1
	07965 FOUNDATI ON 07967 RETAI L PHARMACY	5, 746	570 0		-		194.1 194.1
QA 14		. 0	0	. 0	U	0	1174.1

Health Fin	ancial Systems CAN	ERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provi der C	Provider CCN: 15-1315		Period: Worksheet B	
					From 10/01/2019		
					To 09/30/2020	Date/Time Pro	epared:
						4/21/2021 9:4	<u>44 am</u>
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8.00	9.00	10.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0	(201.00
202.00	TOTAL (sum lines 118 through 201)	690, 815	733, 954	68, 24	9 45, 348	285, 834	202.00

1.00 2.00 4.00 5.00 7.00	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	4/21/2021 9:4 MEDI CAL	4 am
2.00 4.00 5.00	GENERAL SERVICE COST CENTERS		ADMI NI STRATI O N	SERVICES & SUPPLY	FHARMACT	RECORDS & LI BRARY	
2.00 4.00 5.00	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	135, 895 4, 477 2, 775 3, 068 6, 169	114, 629 0 0	207, 136 955 15	101, 823 0	50, 043	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
30.00	03000 ADULTS & PEDIATRICS	24, 612	49, 479	5, 180	0	358	30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	878 341		225 0	0 0	25 5	
50.00	ANCI LLARY SERVI CE COST CENTERS	7 079	14 238	16 205	0	854	50.00
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 60.\ 00\\ 65.\ 00\\ 65.\ 01\\ 66.\ 00\\ 69.\ 01\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 76.\ 01\\ \end{array}$	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06500 RESPIRATORY THERAPY 06500 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY 03480 ONCOLOGY 0UTPATIENT SERVICE COST CENTERS	7, 079 5, 204 2, 580 13, 449 11, 340 0 6, 949 114 8, 006 444 580 0 0 0 0 0	10, 460 5, 184 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 205 0 2, 631 3, 026 43, 321 0 1, 485 0 452 172 88 60, 868 56, 501 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	856 0 33 8, 347 15, 067 0 629 531 3, 225 2, 202 744 0 0 0 0 0 0 0 0 0	51.00 52.00 54.00 60.00 64.00 65.00 65.01
88.00	08800 RURAL HEALTH CLINIC - FPC	0	0	296	0	3, 461	88.00
90. 03 90. 04 91. 00	08801 RURAL HEALTH CLINIC - URGENT CARE 08802 RURAL HEALTH CLINIC - OB/GYN 09000 CLINIC - ORTHO 09001 CLINIC - ORTHO 09002 CLINIC - PEDS & ENT 09003 IV THERAPY 09004 OP PSYCH 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0 2, 916 1, 388 3, 469 6, 917 976 2, 580 14, 928	0 2, 794 0 0 0 0	4, 823 374 890 442 528 565 29 5, 953		573 1, 527 1, 451 1, 230 2, 454 0 1, 085 5, 314	90.02 90.03 90.04
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
113.00 114.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	0 131, 239	0	0 205, 024	0 101, 823	0	113.00 114.00 116.00 118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190.00
194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 12 194. 12 194. 13 194. 14	19200 PHYSICIANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC 07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC 07965 FOUNDATION	0 0 0 0 0 2,493 130 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 199 0 0 0 871 0 871 0 66 85 173 41 590		0 0 0 0 0 0 0 0 0 104 0 270 0 0 0 0 0	192.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14 194.15

Health Financial Systems CA	MERON MEMORIAL C	OMMUNITY HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 10/01/2019	Worksheet B Part II	
				To 09/30/2020		
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
194.17 07966 FAMILY PRACTICE CENTER	0	0	8	7 0	552	194.17
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	135, 895	114, 629	207, 130	5 101, 823	50, 043	202.00

Heal th	alth Financial		Systems				
					TED	C	

CAMERON MEMORIAL COMMUNITY HOSPITAL

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315 Period: From 10/01/2	Lieu of Form CMS-2552-10 Worksheet B 019 Part II
To 09/30/2	020 Date/Time Prepared: 4/21/2021 9:44 am
Cost Center Description Subtotal Cost & Post Stepdown Adjustments	
24.00 25.00 26.00	
GENERAL SERVICE COST CENTERS	
1. 00 00100 CAP REL COSTS-BLDG & FI XT 2. 00 00200 CAP REL COSTS-MVBLE EQUI P 4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE E	1.00 2.00 4.00 5.00 7.00 8.00
9. 00 00900 HOUSEKEEPING 10. 00 11. 00 01100 CAFETERIA	9.00 10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	10.00
30. 00 03000 ADULTS & PEDI ATRI CS 1, 499, 690 0 1, 499, 690	30.00
31. 00 03100 INTENSIVE CARE UNIT 93, 927 0 93, 927 43. 00 04300 NURSERY 33, 813 0 33, 813	31.00 43.00
ANCI LLARY SERVI CE COST CENTERS	43.00
50. 00 05000 OPERATING ROOM 770, 606 0 770, 606	50.00
51. 00 05100 RECOVERY_ROOM 487, 386 0 487, 386 52. 00 05200 DELI VERY_ROOM_& LABOR_ROOM 243, 385 0 243, 385	51.00 52.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 243, 385 0 243, 385 54. 00 05400 RADI OLOGY-DI AGNOSTI C 614, 367 0 614, 367	54.00
60. 00 06000 LABORATORY 293, 458 0 293, 458	60.00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0	64.00
65. 00 06500 RESPI RATORY THERAPY 72, 990 0 72, 990 65. 01 06501 SLEEP LAB 81, 828 0 81, 828	65.00 65.01
66. 00 06600 PHYSI CAL THERAPY 431, 157 0 431, 157	66.00
69. 00 06900 ELECTROCARDI OLOGY 30, 482 0 30, 482 0 30, 482	69.00
69. 01 06901 CARDI AC REHAB 39, 553 0 39, 553 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 78, 704 0 78, 704	69.01 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73, 058 0 73, 058	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 101, 823 0 101, 823	73.00
76. 00 03020 CHEMI CAL DEPENDENCY 0 0 0 76. 01 03480 ONCOLOGY 729, 457 0 729, 457	76.00 76.01
OUTPATI ENT SERVI CE COST CENTERS	
88.00 08800 RURAL HEALTH CLINIC - FPC 230, 630 0 230, 630 88.01 08801 RURAL HEALTH CLINIC - URGENT CARE 193, 434 0 193, 434	88.00 88.01
88. 02 08802 RURAL HEALTH CLINIC - OB/GYN 109, 757 0 109, 757	88.02
90. 00 09000 CLINIC 25, 342 0 25, 342	90.00
90. 01 09001 CLINIC - ORTHO 131, 410 0 131, 410 90. 02 09002 CLINIC - PEDS & ENT 206, 575 0 206, 575	90. 01 90. 02
90. 03 09003 I V THERAPY 68, 402 0 68, 402	90.03
90. 04 09004 OP PSYCH 62, 083 0 62, 083	90.04
91. 00 09100 EMERGENCY 687, 365 0 687, 365 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0	91.00 92.00
OTHER REI MBURSABLE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
101. 00 10100 HOME HEALTH AGENCY 0 0 0	101.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	114.00
116.00 11600 HOSPICE 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 7, 390, 682 0 7, 390, 682	116.00 118.00
SUBTOTALS SUBTOTALS <thsub< th=""> SUB SUB</thsub<>	118.00
190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 36, 984 0 36, 984	190.00
192.00 PHYSI CLANS' PRI VATE OFFICES 1, 221 0 1, 221 194.00 07950 DAYCARE-INFANT/TODDLER 0 0 0	192.00 194.00
194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194. 01 07951 MOB 0 0 0	194.00
194. 02 07952 COMMUNI TY HEALTH 31 0 31	194. 02
194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194. 04 07954 EDUCATI ON 356 0 356	194. 03 194. 04
194. 05 07955 MARKETI NG 48, 563 0 48, 563	194.04
194.06 07956 GUEST MEALS 362 0 362	194.06
194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 08 07958 CANCER CENTER 0 0 0	194. 07 194. 08
194. 09 07959 URGENT CARE 35, 026 0 35, 026	194.08
194. 10 07960 RHC 0 0	194. 10
194. 11 07961 0BGYN 21, 483 0 21, 483 194. 12 07962 TRI NE STUDENT HEALTH 1, 714 0 1, 714	194. 11 194. 12
194. 12 07962 TRI NE STUDENT HEALTH 1, 714 0 1, 714 194. 13 07963 OCCUPATI ONAL HEALTH 31, 117 0 31, 117	194.12
194. 14 07964 I MMUNI ZATI ON CLI NI C 5, 091 0 5, 091	194. 14

Health Financial Systems CAME	CAMERON MEMORIAL COMMUNITY HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: Worksheet B			
				From 10/01/2019 To 09/30/2020		enared	
				10 0773072020	4/21/2021 9:4		
Cost Center Description	Subtotal	Intern &	Total				
		Residents					
		Cost & Post					
		Stepdown					
		Adjustments					
	24.00	25.00	26.00				
194. 15 07965 FOUNDATI ON	9, 505	0	9, 50	5		194.15	
194. 16 07967 RETAIL PHARMACY	0	0		0		194.16	
194.17 07966 FAMILY PRACTICE CENTER	74, 690	0	74, 69	0		194.17	
200.00 Cross Foot Adjustments	0	0		0		200.00	
201.00 Negative Cost Centers	0	0		0		201.00	
202.00 TOTAL (sum lines 118 through 201)	7, 656, 825	0	7, 656, 82	5		202.00	

		RON MEMORIAL CO	OMMUNITY HOSPIT			u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 10/01/2019	Worksheet B-1	
					09/30/2020	Date/Time Pre 4/21/2021 9:4	
		CAPI TAL REI	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
	bust benter bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	110.007	[1	I	1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	113, 897	160, 763				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	590		27, 535, 197			4.00
5.00	00500 ADMINI STRATI VE & GENERAL	10, 319					
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	10, 094				4, 204, 685 101, 551	
9.00	00900 HOUSEKEEPI NG	180			-		
10.00	01000 DI ETARY	4, 409				550, 189	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1, 985 870					
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 116					
	01500 PHARMACY	1, 155	1, 155	525, 496	0	1, 838, 795	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 107	506, 595	0	784, 340	16.00
30.00	03000 ADULTS & PEDIATRICS	16, 567	16, 567	2, 797, 220	0	5, 346, 952	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 180			0	211, 312	
43.00	04300 NURSERY	420	420	52, 830	0	97, 303	43.00
50.00	ANCILLARY SERVICE COST CENTERS	10, 982	10, 982	802, 896	0	2, 321, 531	50.00
	05100 RECOVERY ROOM	7, 107					
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 510					
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	8, 409 2, 774				3, 619, 289 3, 464, 457	
64.00	06400 I NTRAVENOUS THERAPY	0				0	
65.00	06500 RESPI RATORY THERAPY	730					
65.01 66.00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	0 6, 257	-/			138, 680 1, 619, 937	
69.00	06900 ELECTROCARDI OLOGY	377		10, 082		299, 832	
69.01	06901 CARDI AC REHAB	580		58, 178	0	116, 014	69.01
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	1, 374, 753 1, 276, 176	
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	-		1
76.00	03020 CHEMI CAL DEPENDENCY	0	-	-		-	
76.01	03480 0NC0L0GY OUTPATI ENT SERVI CE COST CENTERS	11, 100	11, 100	0	0	2, 304, 164	76.01
88.00	08800 RURAL HEALTH CLINIC - FPC	0	6, 789	1, 036, 038	0	1, 581, 785	88.00
88.01	08801 RURAL HEALTH CLINIC - URGENT CARE	0	5, 428	1, 184, 770		1, 821, 494	88.01
	08802 RURAL HEALTH CLINIC - OB/GYN 09000 CLINIC	0					
	09001 CLINIC- 0RTH0	0					
90.02	09002 CLINIC - PEDS & ENT	0					
	09003 I V THERAPY	510				2, 579, 977	1
	09004 OP PSYCH 09100 EMERGENCY	0 9,034					1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	.,	.,	.,,			92.00
101 00	OTHER REIMBURSABLE COST CENTERS						101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF				_		114.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 113, 317		0 25, 931, 667	0 -11, 377, 265		116.00
110.00	NONREIMBURSABLE COST CENTERS	113, 317	133,774	23, 731, 007	-11, 377, 203	47, 772, 220	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	580					190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 DAYCARE-I NFANT/TODDLER	0		59, 534	0		192.00 194.00
	07951 MOB	0	0	0	0		194.00
194.02	07952 COMMUNI TY HEALTH	0	0	0	0	2, 427	194.02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0		0		194.03
	07954 EDUCATI ON 07955 MARKETI NG		0 1, 017				194.04 194.05
194.06	07956 GUEST MEALS	0	0	8, 333		16, 924	194.06
	07957 OUTSI DE LAUNDRY	0	0	0	0	0	194.07
	07958 CANCER CENTER 07959 URGENT CARE		0 980	0 214, 023		0 329, 031	194.08 194.09
	07960 RHC	0		0	0		194.10
	07961 OBGYN	0					
194.12	07962 TRINE STUDENT HEALTH	0	0	88, 029	0	115, 850	1194.12

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

COST ALLOCATION - STATISTICAL BASIS			Provider C		Period: From 10/01/2019	Worksheet B-1	
						Date/Time Pre	pared:
						4/21/2021 9:4	
		CAPI TAL REL	ATED COSTS				
Cost Center Des	scription	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio		
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
194.13 07963 OCCUPATI ONAL HE	ALTH	0	847	240, 924	4 0	414, 943	194.13
194.1407964 IMMUNIZATION CL	INIC	0	121	19, 290	0 0	109, 416	194.14
194. 15 07965 FOUNDATI ON		0	100	133, 871	0	442, 888	194.15
194.1607967 RETAIL PHARMACY	,	0	0	0	0 0	0	194.16
194. 17 07966 FAMILY PRACTICE	CENTER	0	2, 799	313, 310	0 0	480, 290	194.17
200.00 Cross Foot Adju							200.00
201.00 Negative Cost C							201.00
	ocated (per Wkst. B,	3, 787, 309	3, 869, 516	8, 091, 244	1	11, 377, 265	202.00
Part I)							
	plier (Wkst. B, Part I)	33. 252052	24. 069693			0. 213680	
	ocated (per Wkst. B,			39, 452	2	690, 815	204.00
205.00 Part II) 205.00 Unit cost multi	plier (Wkst. B, Part			0.001433		0. 012974	205 00
	pilei (wkst. b, Fait			0.00143		0.012974	205.00
	amount to be allocated						206.00
(per Wkst. B-2)							
	multiplier (Wkst. D,						207.00
Parts III and I	V)					1	

	Financial Systems CAME LLOCATION - STATISTICAL BASIS	RON MEMORIAL CC	OMMUNITY HOSPI Provider C	CN: 15-1315 F	<u>In Lie</u> Period: From 10/01/2019 Fo 09/30/2020	u of Form CMS- Worksheet B-1 Date/Time Pre	epared:
	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)	<u>4/21/2021 9:4</u> CAFETERI A (FTES)	4 am
		7.00	8.00	9.00	10.00	11.00	
11.00 13.00 14.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	128, 722 1, 062 180 4, 409 1, 985 1, 958 3, 116 1, 155	46, 143 9, 357 30 76 0 0	4, 326 54 135 0 34	4 12,763 5 0 0 0 4 0	25, 070 826 512 566	13.00 14.00
	01600 MEDICAL RECORDS & LIBRARY	1, 107	0			1, 138	1
31.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	16, 567 1, 180 420	10, 593 261 1, 729	14	4 592	4, 540 162 63	31.00
50, 00	05000 OPERATING ROOM	10, 982	3, 704	320	0 0	1, 306	50.00
51.00 52.00 54.00 60.00 64.00 65.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	7, 107 3, 510 8, 409 2, 774 0 730	2, 397 688 4, 460 223 0 40	207 62 338 207 (7 0 2 0 3 0 1 0 0 0 9 0	960 476 2, 481 2, 092 0 1, 282	51.00 52.00 54.00 60.00 64.00 65.00
66.00 69.00 69.01 71.00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS	2, 600 6, 257 377 580 0 0	793 765 0 0 0 0 0	154 (((4 0 0 0 0 0 0 0	21 1, 477 82 107 0 0	69.01 71.00
73. 00 76. 00 76. 01	07300 DRUGS CHARGED TO PATI ENTS 03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY OUTPATI ENT SERVI CE COST CENTERS	0 0 11, 100	0 0 0	(0 0 0	73.00 76.00 76.01
88. 01 88. 02 90. 00 90. 01 90. 02 90. 03 90. 04 91. 00	08800 RURAL HEALTH CLINIC - FPC 08801 RURAL HEALTH CLINIC - URGENT CARE 08802 RURAL HEALTH CLINIC - OB/GYN 09000 CLINIC - ORTHO 09002 CLINIC - PEDS & ENT 09003 IV THERAPY 09004 OP PSYCH 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 09200 OBSERVATION BEDS CONTEDE	6, 789 5, 428 2, 971 532 3, 976 5, 980 510 1, 767 9, 034	539 692 127 0 195 255 483 0 8, 548	8 54 (83 109 32 (3 0 4 0 3 0 9 0 2 0 0 0	1, 276	88. 01 88. 02 90. 00 90. 01 90. 02 90. 03 90. 04
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
114.00 116.00 118.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTI LI ZATION REVI EW-SNF 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 124, 552	0 45, 955		-		113.00 114.00 116.00 118.00
190.00 192.00 194.00 194.01 194.02 194.03 194.04	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICLANS' PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION	580 0 0 0 0 0 0	0 0 0 0 0 0 0 0			0 0 0 0 0 0 0	190.00 192.00 194.00 194.01 194.02 194.03 194.04
194.06 194.07 194.08 194.09 194.10 194.11 194.12	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	1, 017 0 0 980 0 525 0 847	0 0 0 188 0 0 0 0 0	(24 0 0 0 0 375 0	194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13
194.14	07964 I MMUNI ZATI ON CLI NI C 07965 FOUNDATI ON	121 100	0			0	194. 13 194. 14 194. 15

COST ALLOCA	TION - STATISTICAL BASIS		Provider C		Period: From 10/01/2019 To 09/30/2020	Date/Time Pre	pared
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	4/21/2021 9: 4 CAFETERI A (FTES)	<u>4 am</u>
	1	7.00	8.00	9.00	10.00	11.00	
	RETAIL PHARMACY	0	0		0 0		194.1
	FAMILY PRACTICE CENTER	0	0		0 0	0	194.1
200.00	Cross Foot Adjustments						200.0
201.00	Negative Cost Centers						201. C
202.00	Cost to be allocated (per Wkst. B, Part I)	5, 103, 142	165, 353	1, 824, 20	1 865, 425	953, 182	202. C
203.00	Unit cost multiplier (Wkst. B, Part I)	39. 644676	3. 583490	421.68307	9 67.807334	38. 020822	203.0
204.00	Cost to be allocated (per Wkst. B, Part II)	733, 954	68, 249	45, 34	8 285, 834	135, 895	204. C
205.00	Unit cost multiplier (Wkst. B, Part	5. 701854	1. 479076	10. 48266	3 22. 395518	5. 420622	205.0
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.0
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.0

	Financial Systems CAME LLOCATION - STATISTICAL BASIS	RON MEMORIAL CO				u of Form CMS-2552-10
CUST A	LLUCATION - STATISTICAL DASIS		Provider C	F	veriod: rom 10/01/2019 o 09/30/2020	
	Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HR) 13. 00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUIS.) 15.00	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16.00	4/21/2021 9:44 am
1 00	GENERAL SERVICE COST CENTERS					1.00
14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINI STRATI ON 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTINE SERVICE COST CENTERS	218, 765 0 0 0	4, 678, 476 21, 564 332	100 0		1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
30.00	03000 ADULTS & PEDIATRICS	94, 428	116, 993	C		30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	3, 373 1, 319	5, 082 0	0		31.00 43.00
52.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	27, 172 19, 962 9, 893 0 0	366, 007 0 59, 433 68, 341 978, 478		0 416 104, 158	50.00 51.00 52.00 54.00 60.00
64.00 65.00	06400 I NTRAVENOUS THERAPY	0	0	C C	0	64.00
	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	0	33, 540 0	0		65.00 65.01
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	10, 210 3, 895	C	40, 247 27, 479	66.00 69.00
69.01	06901 CARDI AC REHAB	0	1, 979	C	9, 282	69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 374, 753 1, 276, 176		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 270, 170	100		73.00
	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0	0			76.00 76.01
	OUTPATIENT SERVICE COST CENTERS					
88. 00 88. 01	08800 RURAL HEALTH CLINIC - FPC 08801 RURAL HEALTH CLINIC - URGENT CARE	0	6, 690 108, 946			88.00 88.01
88. 02	08802 RURAL HEALTH CLINIC - OB/GYN	0	8, 452	C	19, 057	88.02
	09000 CLINIC 09001 CLINIC- ORTHO	5, 333	20, 104 9, 983		18, 113 15, 352	90.00 90.01
90.02	09002 CLINIC - PEDS & ENT	0	11, 932	0		90.02
	09003 I V THERAPY 09004 0P PSYCH	0	12, 767 652		0 13, 541	90.03 90.04
	09100 EMERGENCY	57, 285	134, 462	0	66, 308	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					92.00
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 218, 765	0 4, 630, 771	0 100	0 612, 925	116.00 118.00
	NONREI MBURSABLE COST CENTERS	2.0,700	1,000,771		012,720	
	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0	190.00 192.00
	07950 DAYCARE-INFANT/TODDLER	0	0	C	0	194.00
	07951 MOB 07952 COMMUNITY HEALTH	0	0	0	0	194.01 194.02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0		0	194.02
	07954 EDUCATI ON	0	0	0	0	194.04
	07955 MARKETING 07956 GUEST MEALS	0	4, 490 0		0	194.05 194.06
194.07	07957 OUTSI DE LAUNDRY	0	0	C	0	194.07
	07958 CANCER CENTER 07959 URGENT CARE	0	0 19, 680		0 1, 292	194.08 194.09
194.10	07960 RHC	0	0	c	0	194.10
	07961 OBGYN 07962 TRINE STUDENT HEALTH	0	1, 495 1, 922	0	3, 371	194. 11 194. 12
	07962 OCCUPATIONAL HEALTH	0	1, 922 3, 905	0	0	194.12
194.14	07964 IMMUNIZATION CLINIC	0	933	C	0	194.14

Health Fina	ncial Systems CAME	RON MEMORIAL CC	MMUNITY HOSPIT	TAL	In Lie	u of Form CMS-2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1
					rom 10/01/2019 o 09/30/2020	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
		N	SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT	(COSTED		(TIME SPENT)	
		NRSING HR)	REQUIS.)			
		13.00	14.00	15.00	16.00	
194. 15 07965	FOUNDATION	0	13, 318	(0 0	194.15
194. 16 07967	RETAIL PHARMACY	0	0	(0 0	194.16
194. 17 07966	FAMILY PRACTICE CENTER	0	1, 962	(6, 894	194.17
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	2, 147, 747	843, 582	2, 318, 931	1, 039, 153	202.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	9.817599	0. 180311	23, 189. 310000	1. 664024	203.00
204.00	Cost to be allocated (per Wkst. B,	114, 629	207, 136	101, 823	50, 043	204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 523982	0. 044274	1,018.230000	0. 080135	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)					

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:4	pared:
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 712, 902		9, 712, 90)2 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	390, 946		390, 94	16 0	0	31.00
43.00 04300 NURSERY	253, 378		253, 3	78 0	0	43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 801, 373		3, 801, 3		0	50.00
51.00 05100 RECOVERY ROOM	2, 208, 947		2, 208, 94	17 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 185, 189		1, 185, 18	39 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 164, 516		5, 164, 51	16 0	0	54.00
60. 00 06000 LABORATORY	4, 969, 086		4, 969, 08	36 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 614, 890	0	1, 614, 89	90 0	0	65.00
65.01 06501 SLEEP LAB	316, 417	0	010/1		0	65.01
66. 00 06600 PHYSI CAL THERAPY	2, 406, 792	0	2, 406, 79	92 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	428, 392		428, 39		0	69.00
69. 01 06901 CARDI AC REHAB	183, 668		183, 60	68 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 394		1, 916, 39	94 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 778, 978		1, 778, 9	78 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 318, 931		2, 318, 93	31 0	0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0			0 0	0	76.00
76. 01 03480 ONCOLOGY	3, 236, 574		3, 236, 5	74 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - FPC	2, 342, 373		2, 342, 3		0	
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	2, 463, 297		2, 463, 29		0	88.01
88.02 08802 RURAL HEALTH CLINIC - OB/GYN	1, 534, 004		1, 534, 00		0	88.02
90. 00 09000 CLINIC	377, 339		377, 33		0	90.00
90. 01 09001 CLINIC- ORTHO	820, 759		820, 75		0	90.01
90. 02 09002 CLINIC - PEDS & ENT	1, 779, 153		1, 779, 1		0	90.02
90. 03 09003 I V THERAPY	3, 175, 856		3, 175, 8		0	90.03
90. 04 09004 OP PSYCH	576, 943		576, 94		0	90.04
91.00 09100 EMERGENCY	5, 223, 130		5, 223, 13		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	2, 731, 983		2, 731, 98	33	0	92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0			0	0	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	0			0		116.00
200.00 Subtotal (see instructions)	62, 912, 210					200.00
201.00 Less Observation Beds	2, 731, 983		2, 731, 98			201.00
202.00 Total (see instructions)	60, 180, 227	0	60, 180, 22	27 0	0	202.00

Health Financial Systems CAN		MMUNITY HUSPI			U OT FORM CMS	2002 10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1315	Period:	Worksheet C	
				From 10/01/2019	Part I	norod.
				To 09/30/2020	Date/Time Pre 4/21/2021 9:4	
		Title	XVIII	Hospi tal	Cost	
		Charges		nospi tai	CUST	
Cast Contar Description	Inpatient	Outpati ent	Total (col)	6 Cost or Other	TEFRA	
Cost Center Description	Thpatrent	outpatrent			Inpatient	
			+ col. 7)	Ratio		
	(00	7.00	0.00	0.00	Ratio	
UNDATIONT DOUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	8, 342, 495		8, 342, 49	F		200.00
						30.00
31. 00 03100 I NTENSI VE CARE UNI T	380, 000		380, 00			31.00
43. 00 04300 NURSERY	445,000		445,00	0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 872, 642	14, 478, 256			0.00000	
51.00 05100 RECOVERY ROOM	715, 418	3, 505, 207			0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 360, 895	380, 357	1, 741, 25	2 0. 680653	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 886, 115	31, 864, 603	33, 750, 71	8 0. 153019	0.000000	54.00
60. 00 06000 LABORATORY	2, 312, 689	17, 375, 132	19, 687, 82	1 0. 252394	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0.000000	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 513, 234	907, 226	2, 420, 46	0 0. 667183	0.000000	65.00
65. 01 06501 SLEEP LAB	0	1,053,550			0.000000	
66. 00 06600 PHYSI CAL THERAPY	660, 361	3, 486, 028			0.000000	
69. 00 06900 ELECTROCARDI OLOGY	230, 676	1, 893, 617			0.000000	
69. 01 06901 CARDI AC REHAB	1, 870	369, 189			0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	557, 450					
		2, 360, 939			0.000000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	568, 473	1, 767, 355			0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 808, 515	5, 156, 476			0.000000	
76. 00 03020 CHEMI CAL DEPENDENCY	0	0		0 0. 000000	0.000000	
76. 01 03480 ONCOLOGY	0	16, 741, 255	16, 741, 25	5 0. 193329	0.00000	76.01
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC - FPC	16, 401	1, 225, 068				88.00
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	0	2, 781, 006	2, 781, 00	6		88.01
88.02 08802 RURAL HEALTH CLINIC - OB/GYN	0	1, 020, 616	1, 020, 61	6		88.02
90. 00 09000 CLINIC	0	565, 123	565, 12	3 0. 667711	0.000000	90.00
90. 01 09001 CLINIC- ORTHO	0	374, 109	374, 10	9 2. 193903	0.000000	90.01
90. 02 09002 CLINIC - PEDS & ENT	2, 884	1, 144, 726	1, 147, 61	0 1.550312	0.000000	90.02
90. 03 09003 I V THERAPY	0	8, 317, 896	8, 317, 89	6 0. 381810	0.000000	90.03
90. 04 09004 OP PSYCH	0	258,008			0.000000	
91. 00 09100 EMERGENCY	474, 191	19, 749, 819			0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	70, 653	1, 836, 245			0. 000000	
OTHER REIMBURSABLE COST CENTERS	10,000	1,000,210	1, 700, 07	1. 102001	0.000000	12.00
101. 00 10100 HOME HEALTH AGENCY	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS	V	0		0		101.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
		~		0		
116.00 11600 HOSPI CE	0	100 (11 00)	1/2 021 7/	0		116.00
200.00 Subtotal (see instructions)	24, 219, 962	138, 611, 806	162, 831, 76	ö		200.00
201.00 Less Observation Beds	04.010.010	400 (44 00)	4/0 004 7/			201.00
202.00 Total (see instructions)	24, 219, 962	138, 611, 806	162, 831, 76	8		202.00

?	IERUN MEMORIAL CON		In Lieu	J OI FOIM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1315	Peri od: From 10/01/2019	Worksheet C Part I	
			To 09/30/2020	Date/Time Pre 4/21/2021 9:4	epared:
		Title XVIII	Hospi tal	4/21/2021 9.4 Cost	+4 alli
Cost Center Description	PPS Inpatient		nospi tai	0031	
obst benter bescription	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11100				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM	0.000000				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
65. 01 06501 SLEEP LAB	0. 000000				65.01
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 06901 CARDI AC REHAB	0.000000				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000				76.00
76. 01 03480 ONCOLOGY	0. 000000				76.01
OUTPATIENT SERVICE COST CENTERS	0.000000				70.01
88. 00 08800 RURAL HEALTH CLINIC - FPC					88.00
88. 01 08801 RURAL HEALTH CLINIC - URGENT CARE					88.01
88. 02 08802 RURAL HEALTH CLINIC - OB/GYN					88.02
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 CLINIC- ORTHO	0. 000000				90.00
90. 02 09002 CLINIC - PEDS & ENT	0. 000000				90.02
90. 03 09003 I V THERAPY	0. 000000				90.02
90. 04 09004 0P PSYCH	0. 000000				90.04
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000				72.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					1.01.00
113. 00 11300 I NTEREST EXPENSE					113.00
114. 0011400 UTILI ZATI ON REVIEW-SNF					114.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	I				1202.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1315	Period: From 10/01/2019 To 09/30/2020 Hospital	Worksheet C Part I Date/Time Pre 4/21/2021 9:4	
		Ti tl	e XIX		PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	9, 712, 902		9, 712, 90	2 0	9, 712, 902	
31.00 03100 INTENSIVE CARE UNIT	390, 946		390, 94	6 0	390, 946	31.00
43. 00 04300 NURSERY	253, 378		253, 37	8 0	253, 378	43.00
ANCILLARY SERVICE COST CENTERS	·					
50. 00 05000 OPERATI NG ROOM	3, 801, 373		3, 801, 37		3, 801, 373	
51.00 05100 RECOVERY ROOM	2, 208, 947		2, 208, 94		2, 208, 947	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 185, 189		1, 185, 18		1, 185, 189	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 164, 516		5, 164, 51		5, 164, 516	
60. 00 06000 LABORATORY	4, 969, 086		4, 969, 08	6 0	4, 969, 086	
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 614, 890	0	1, 614, 89		1, 614, 890	
65.01 06501 SLEEP LAB	316, 417	0			316, 417	
66. 00 06600 PHYSI CAL THERAPY	2, 406, 792	0	2/ 100/ 17		2, 406, 792	
69. 00 06900 ELECTROCARDI OLOGY	428, 392		428, 39		428, 392	1
69. 01 06901 CARDI AC REHAB	183, 668		183, 66		183, 668	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 394		1, 916, 39		1, 916, 394	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 778, 978		1, 778, 97		1, 778, 978	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 318, 931		2, 318, 93		2, 318, 931	1
76.00 03020 CHEMI CAL DEPENDENCY	0			0 0	0	
76.01 03480 ONCOLOGY	3, 236, 574		3, 236, 57	4 0	3, 236, 574	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - FPC	2, 342, 373		2, 342, 37		2, 342, 373	
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	2, 463, 297		2, 463, 29		2, 463, 297	
88.02 08802 RURAL HEALTH CLINIC - OB/GYN	1, 534, 004		1, 534, 00		1, 534, 004	1
90. 00 09000 CLINIC	377, 339		377, 33		377, 339	
90. 01 09001 CLI NI C- ORTHO	820, 759		820, 75		820, 759	1
90. 02 09002 CLINIC - PEDS & ENT	1, 779, 153		1, 779, 15		1, 779, 153	
90. 03 09003 I V THERAPY	3, 175, 856		3, 175, 85		3, 175, 856	
90. 04 09004 OP PSYCH	576, 943		576, 94		576, 943	
91. 00 09100 EMERGENCY	5, 223, 130		5, 223, 13		5, 223, 130	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 731, 983		2, 731, 98	3	2, 731, 983	92.00
OTHER REI MBURSABLE COST CENTERS					0	101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0			0	0	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 HOSPI CE				0	Λ	116.00
200.00 Subtotal (see instructions)	62, 912, 210	0	62, 912, 21	0 0		
201.00 Less Observation Beds	2, 731, 983	0	2, 731, 98		2, 731, 983	
202.00 Total (see instructions)	60, 180, 227	0				
		-				

	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet C Part I Date/Time Pre 4/21/2021 9:4	pared:
				e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Rati o	
	1	6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	, ,			-		
30.00	03000 ADULTS & PEDIATRICS	8, 342, 495		8, 342, 4			30.00
	03100 INTENSIVE CARE UNIT	380, 000		380, 00			31.00
43.00	04300 NURSERY	445, 000		445, 00	00		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 872, 642	14, 478, 256			0.000000	50.00
51.00	05100 RECOVERY ROOM	715, 418	3, 505, 207			0.000000	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 360, 895	380, 357	1, 741, 2	0. 680653	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 886, 115	31, 864, 603	33, 750, 7	0. 153019	0.000000	54.00
60.00	06000 LABORATORY	2, 312, 689	17, 375, 132	19, 687, 8	0. 252394	0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0.000000	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	1, 513, 234	907, 226	2, 420, 4	60 0. 667183	0.000000	65.00
65.01	06501 SLEEP LAB	0	1, 053, 550	1, 053, 5	50 0. 300334	0.000000	65.01
66.00	06600 PHYSI CAL THERAPY	660, 361	3, 486, 028	4, 146, 3	0. 580455	0.000000	66.00
69.00	06900 ELECTROCARDI OLOGY	230, 676	1, 893, 617	2, 124, 29	0. 201663	0.000000	69.00
69.01	06901 CARDI AC REHAB	1, 870	369, 189	371, 0	59 O. 494983	0.000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	557, 450	2, 360, 939	2, 918, 3	0. 656662	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	568, 473	1, 767, 355	2, 335, 8	0. 761605	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 808, 515	5, 156, 476	6, 964, 9	0. 332941	0.000000	73.00
76.00	03020 CHEMI CAL DEPENDENCY	0	0		0 0.000000	0.000000	76.00
76.01	03480 ONCOLOGY	0	16, 741, 255	16, 741, 2	0. 193329	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS			•			1
88.00	08800 RURAL HEALTH CLINIC - FPC	16, 401	1, 225, 068	1, 241, 4	69 1.886775	0.000000	88.00
88.01	08801 RURAL HEALTH CLINIC - URGENT CARE	0	2, 781, 006	2, 781, 00	0. 885758	0.000000	88.01
88.02	08802 RURAL HEALTH CLINIC - OB/GYN	0	1, 020, 616	1, 020, 6	1. 503018	0.000000	88.02
90.00	09000 CLINIC	0	565, 123	565, 12	0. 667711	0.000000	90.00
90.01	09001 CLINIC- ORTHO	0	374, 109	374, 10	2. 193903	0.000000	90.01
90.02	09002 CLINIC - PEDS & ENT	2, 884	1, 144, 726	1, 147, 6	1. 550312	0.000000	90.02
90.03	09003 I V THERAPY	0	8, 317, 896	8, 317, 8	0. 381810	0.000000	90.03
90.04	09004 OP PSYCH	0	258, 008	258, 00	2. 236144	0.000000	90.04
91.00	09100 EMERGENCY	474, 191	19, 749, 819	20, 224, 0	0. 258264	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	70, 653	1, 836, 245	1, 906, 89	78 1. 432684	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	· · · ·					1
101.00	10100 HOME HEALTH AGENCY	0	0		0		101.00
	SPECIAL PURPOSE COST CENTERS	· · · · ·					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	0	0		0		116.00
200.00	Subtotal (see instructions)	24, 219, 962	138, 611, 806	162, 831, 70	68		200.00
201.00							201.00
202.00		24, 219, 962	138, 611, 806	162, 831, 70	58		202.00

	ERUN MEMORIAL CON	INUNITE HUSPITAL	III LIEU		2002-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet C Part I Date/Time Pre 4/21/2021 9:4	
		Title XIX	Hospi tal	PPS	
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 SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 219088				50.00
51.00 05100 RECOVERY ROOM	0. 523370				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 680653				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 153019				54.00
60. 00 06000 LABORATORY	0. 252394				60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 667183				65.00
65. 01 06501 SLEEP LAB	0. 300334				65.01
66. 00 06600 PHYSI CAL THERAPY	0. 580455				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 201663				69.00
69. 01 06901 CARDI AC REHAB	0. 494983				69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 656662				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 761605				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 332941				73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000				76.00
76. 01 03480 0NC0L0GY	0. 193329				76.01
OUTPATIENT SERVICE COST CENTERS	0. 193329				70.01
88.00 08800 RURAL HEALTH CLINIC - FPC	1. 886775				88.00
88. 01 08801 RURAL HEALTH CLINIC - URGENT CARE	0. 885758				88.01
88. 02 08802 RURAL HEALTH CLINIC - OB/GYN	1. 503018				88.02
90. 00 09000 CLINIC	0. 667711				90.00
90. 01 09000 CLINIC- ORTHO	2. 193903				90.00
90. 02 09002 CLINIC - PEDS & ENT	1. 550312				90.01
90. 02 09002 CETNIC - PEDS & ENT 90. 03 09003 IV THERAPY	0. 381810				90.02
90. 04 09004 OP PSYCH	2. 236144				90.03
90. 04 109004 0F PSTCH 91. 00 109100 EMERGENCY	0. 258264				90.04
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 432684				91.00
OTHER REIMBURSABLE COST CENTERS	1. 432004				92.00
101.00 10100 HOME HEALTH AGENCY					101.00
					101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					113.00
116.00 11600 HOSPICE					116.00
200.00 Subtotal (see instructions)					200.00
201.00Less Observation Beds202.00Total (see instructions)					201.00
202.00 Total (see instructions)					202.00

near th	Financial Systems CAME	ERON MEMORIAL CO	DMMUNITY HOSPI	FAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provider C	CN: 15-1315	Period:	Worksheet C	
REDUCT	IONS FOR MEDICAID ONLY				From 10/01/2019	Part II	
					To 09/30/2020	Date/Time Pre	epared:
			T: +1	e XIX	Hospi tal	4/21/2021 9:4 PPS	4 am
	Cast Contar Decarintian	Total Cost	Capital Cost		Capital	Operating	
	Cost Center Description			Operating		Cost	
		(Wkst. B,	(Wkst. B,	Cost Net of			
		Part I, col.	Part II col.	Capital Cos	L	Reduction	
		26)	26)	(col. 1 -		Amount	
		1.00	2.00	col. 2) 3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	05000 OPERATING ROOM	2 001 272	770 (0(2 0 2 0 7	57 0	0	50.00
		3, 801, 373				-	
	05100 RECOVERY ROOM	2, 208, 947	487, 386			0	
	05200 DELIVERY ROOM & LABOR ROOM	1, 185, 189				0	
	05400 RADI OLOGY-DI AGNOSTI C	5, 164, 516				0	
	06000 LABORATORY	4, 969, 086				0	
	06400 I NTRAVENOUS THERAPY	0	-		0 0	0	
	06500 RESPI RATORY THERAPY	1, 614, 890				0	
	06501 SLEEP LAB	316, 417	81, 828			0	65.01
66.00	06600 PHYSI CAL THERAPY	2, 406, 792	431, 157	1, 975, 63	35 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	428, 392	30, 482	397, 91	10 0	0	69.00
69.01	06901 CARDI AC REHAB	183, 668	39, 553	144, 11	15 0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 394	78, 704	1, 837, 69	90 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 778, 978	73, 058	1, 705, 92	20 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 318, 931	101, 823		0 80	0	73.00
76.00	03020 CHEMI CAL DEPENDENCY	0	0		0 0	0	76.00
	03480 ONCOLOGY	3, 236, 574	729, 457	2, 507, 1 [.]	17 0	0	76.01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC - FPC	2, 342, 373	230, 630	2, 111, 74	43 0	0	88.00
	08801 RURAL HEALTH CLINIC - URGENT CARE	2, 463, 297				0	
	08802 RURAL HEALTH CLINIC - OB/GYN	1, 534, 004				0	
	09000 CLINIC	377, 339				0	
	09001 CLINIC- ORTHO	820, 759				0	
	09002 CLINIC - PEDS & ENT	1, 779, 153				0	
	09003 I V THERAPY	3, 175, 856				0	
	09004 OP PSYCH	576, 943				0	
	09100 EMERGENCY	5, 223, 130				0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 731, 983				0	
	OTHER REIMBURSABLE COST CENTERS	2,731,903	421, 024	2, 310, 13	J9 0	0	92.00
	10100 HOME HEALTH AGENCY	0	0	[0 0	0	101 00
		0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	1			1		110.00
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF	-	-			-	114.00
	11600 HOSPI CE	0	e e e e e e e e e e e e e e e e e e e		0 0		116.00
200.00		52, 554, 984					200.00
201.00		2, 731, 983 49, 823, 001					201.00
202.00	Total (line 200 minus line 201)						

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F	RATIOS NET OF	Provider C	CN: 15-1315	Peri od:	Worksheet C	
EDUCTIONS FOR MEDICAID ONLY				From 10/01/2019	Part II	
				To 09/30/2020	Date/Time Pr 4/21/2021 9:	44 am
		Ti tl	e XIX	Hospi tal	PPS	TT GIII
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
•	Capital and	(Worksheet C,	Cost to			
	Operating	Part I,	Charge Rati	0		
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS			1			
D. OO 05000 OPERATING ROOM	3, 801, 373					50.0
1.00 05100 RECOVERY ROOM	2, 208, 947					51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	1, 185, 189					52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 164, 516					54.0
D. 00 06000 LABORATORY	4, 969, 086	19, 687, 821				60.0
4. 00 06400 I NTRAVENOUS THERAPY	0					64.0
5. 00 06500 RESPI RATORY THERAPY	1, 614, 890					65.
5. 01 06501 SLEEP LAB	316, 417	1, 053, 550				65.
6. 00 06600 PHYSI CAL THERAPY	2, 406, 792	4, 146, 389				66.
9. 00 06900 ELECTROCARDI OLOGY	428, 392	2, 124, 293	0. 2016	63		69.
9. 01 06901 CARDI AC REHAB	183, 668	371, 059	0. 4949	83		69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 916, 394	2, 918, 389	0. 6566	62		71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 778, 978		0. 7616	05		72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	2, 318, 931	6, 964, 991	0. 3329	41		73.
6. 00 03020 CHEMI CAL DEPENDENCY	0	0	0.0000	00		76.
6. 01 03480 ONCOLOGY	3, 236, 574	16, 741, 255	0. 1933	29		76.
OUTPATIENT SERVICE COST CENTERS						
B. OO 08800 RURAL HEALTH CLINIC - FPC	2, 342, 373					88.
8.01 08801 RURAL HEALTH CLINIC - URGENT CARE	2, 463, 297					88.
8.02 08802 RURAL HEALTH CLINIC - OB/GYN	1, 534, 004	1, 020, 616	1. 5030	18		88.
D. 00 09000 CLINIC	377, 339	565, 123	0. 6677	11		90.
D. 01 09001 CLINIC- ORTHO	820, 759	374, 109	2. 1939	03		90.
D. 02 09002 CLINIC - PEDS & ENT	1, 779, 153	1, 147, 610	1. 5503	12		90.
D. 03 09003 I V THERAPY	3, 175, 856					90.
D. 04 09004 OP PSYCH	576, 943					90.
1.00 09100 EMERGENCY	5, 223, 130					91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 731, 983	1, 906, 898	1. 4326	84		92.
OTHER REIMBURSABLE COST CENTERS						
D1.0010100 HOME HEALTH AGENCY	0	0	0.0000	00		101.
SPECIAL PURPOSE COST CENTERS	- I		1			
13.00 11300 INTEREST EXPENSE						113.
14.00 11400 UTILIZATION REVIEW-SNF						114.
16. 00 11600 HOSPI CE	0	0	0.0000	00		116.
00.00 Subtotal (sum of lines 50 thru 199)	52, 554, 984	153, 664, 273				200.
01.00 Less Observation Beds	2, 731, 983	0				201.
D2.00 Total (line 200 minus line 201)	49, 823, 001	153, 664, 273				202.

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Peri od:	Worksheet D	
				From 10/01/2019 To 09/30/2020		pared.
					4/21/2021 9:4	
			XVIII	Hospi tal	Cost	
Cost Center Description		Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col . 26) 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	770, 606	17, 350, 898	0.0444	660, 548	29, 337	50.00
51. 00 05100 RECOVERY ROOM	487, 386				14, 958	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	243, 385	1, 741, 252			1, 549	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	614, 367	33, 750, 718				
60. 00 06000 LABORATORY	293, 458	19, 687, 821	0.01490			
64.00 06400 INTRAVENOUS THERAPY	0	0			0	1
65. 00 06500 RESPI RATORY THERAPY	72, 990	2, 420, 460	0. 03015	394, 365	11, 892	65.00
65.01 06501 SLEEP LAB	81, 828	1, 053, 550	0. 07766	69 0	0	
66. 00 06600 PHYSI CAL THERAPY	431, 157	4, 146, 389		34 149, 105	15, 505	66.00
69. 00 06900 ELECTROCARDI OLOGY	30, 482	2, 124, 293	0. 01434	19 205, 343	2, 946	69.00
69. 01 06901 CARDI AC REHAB	39, 553	371, 059	0. 10659	95 210	22	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 704	2, 918, 389		305, 384	8, 236	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	73, 058	2, 335, 828	0. 03127	236, 720	7,404	
73.00 07300 DRUGS CHARGED TO PATIENTS	101, 823	6, 964, 991			6, 069	
76.00 03020 CHEMI CAL DEPENDENCY	0	0	0.00000		0	
76. 01 03480 ONCOLOGY	729, 457	16, 741, 255	0. 0435	72 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	L					
88.00 08800 RURAL HEALTH CLINIC - FPC	230, 630				0	
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	193, 434	2, 781, 006			0	00101
88. 02 08802 RURAL HEALTH CLINIC - OB/GYN	109, 757	1, 020, 616			0	88.02
90.00 09000 CLINIC	25, 342	565, 123			0	90.00
90. 01 09001 CLINIC- ORTHO	131, 410				0	
90. 02 09002 CLINIC - PEDS & ENT 90. 03 09003 IV THERAPY	206, 575 68, 402	1, 147, 610 8, 317, 896			0	
90. 03 09003 TV THERAPY 90. 04 09004 0P PSYCH	68, 402	8, 317, 896 258, 008			0	
90. 04 09004 0P PSYCH 91. 00 09100 EMERGENCY	687, 365	20, 224, 010			169	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	421, 824	1, 906, 898				
200.00 Total (lines 50 through 199)	6, 185, 076			3, 615, 911		
	0,100,070	100,004,270	I	5, 015, 711	117,742	200.00

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-1315	Period: From 10/01/2019	Worksheet D Part IV	
THROUGH COSTS) Date/Time Pre	
		Title	XVIII	Hospi tal	4/21/2021 9:4 Cost	4 am
Cost Center Description	Non Physician	Nursing	Nursing		Allied Health	
	Anesthetist	School	School	Post-Stepdown		
		Post-Stepdown		Adjustments		
		Adjustments		.,		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 (0 0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0 0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0 0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0 0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0 0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0 0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0 0	65.00
65.01 06501 SLEEP LAB	0	0		0 0	0 0	65.01
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0 0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0 0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 0	0 0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0	0		0 0	0 0	76.00
76. 01 03480 ONCOLOGY	0	0		0 (0 0	76.01
OUTPATIENT SERVICE COST CENTERS	1					
88.00 08800 RURAL HEALTH CLINIC - FPC	0	0		0 (88.00
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	0	0		0 0	0 0	
88. 02 08802 RURAL HEALTH CLINIC - OB/GYN	0	0		0 0	0 0	88.02
90. 00 09000 CLINIC	0	0		0 (0 0	90.00
90. 01 09001 CLINIC- ORTHO	0	0		0 (0 0	90.01
90. 02 09002 CLINIC - PEDS & ENT	0	0		0 0	0 0	90.02
90. 03 09003 I V THERAPY	0	0		0 0	0	90.03
90. 04 09004 0P PSYCH	0	0		0 0	0 0	
91.00 09100 EMERGENCY	0	0		0 (0 0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_		U	0	
200.00 Total (lines 50 through 199)	0	0	1	0 0	ין U	200.00

Heal th Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1315 Period: From 10/01/2019 To 09/30/2020 Worksheet D Part IV Date/Time Prepared: 4/21/2021 9: 44 am Cost Center Description AII Other Medical Education Cost Total Cost (sum of cols. 4) Total Outpatient Cost (sum of cols. 2, 3, and 4) Total Cost (from Wkst. Cost . 2, 3, and 4) Ratio of Cost to Charges (col. 5 + col. 7) (see instructions) ANCILLARY SERVICE COST CENTERS 0 0 0 0 17, 350, 898 0.000000 50.00
Title XVIII Hospital Cost Cost Center Description AII Other Medical Education Total Cost (sum of cols. Total Total Charges Outpatient Cost (sum of cols. 2, 3, and 4) Ratio of Cost (from Wkst. Ratio of Cost (sum of cols. 4.00 5.00 6.00 7.00 8.00
Cost Center Description All Other Medical Education Total Cost (sum of cols. Total Outpatient Total Charges (from Wkst. Ratio of Cost to Charges All Other Medical Cost Medical Education Total Cost (sum of cols. Total Outpatient Total Charges (from Wkst. Ratio of Cost to Charges All Other Total Cost (sum of cols. Outpatient Cost (sum of cols. 2, 3, and 4) Total Charges Col. 5 ÷ col. 8) Col. 7) (see instructions) ANCILLARY SERVICE COST CENTERS ANCINERS Anciners Total Cost (sum of cols. Total Cost (sum of cols.
Medical (sum of cols. Outpatient (from Wkst. to Charges Education 1, 2, 3, and Cost Cost (sum of cols. Cost (sum of cols. C, Part I, col. 5 + col. 7) ANCI LLARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00
Education Cost 1, 2, 3, and 4) Cost (sum of col s. 2, 3, and 4) C, Part I, col . 8) (col . 5 ÷ col . 7) 4.00 5.00 6.00 7.00 8.00
Cost 4) col s. 2, 3, and 4) col . 8) col . 7) (see i nstructions) 4.00 5.00 6.00 7.00 8.00
ANCI LLARY SERVICE COST CENTERS and 4) (see i nstructions)
4.00 5.00 6.00 7.00 8.00 ANCI LLARY SERVICE COST CENTERS
ANCI LLARY SERVICE COST CENTERS
50.00 US000 UPERATING ROOM U U U U U U U U U U U U U U U U U U
51. 00 05100 RECOVERY ROOM 0 0 4, 220, 625 0. 00000 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 741, 252 0. 00000 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 33, 750, 718 0. 00000 54. 00
60. 00 06000 LABORATORY 0 0 0 19, 687, 821 0. 00000 60. 00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0.000000 64. 00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 2, 420, 460 0. 00000 65. 00
65. 01 06501 SLEEP LAB 0 0 1, 053, 550 0. 00000 65. 01
66. 00 06600 PHYSI CAL THERAPY 0 0 0 4, 146, 389 0. 00000 66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 2, 124, 293 0. 00000 69. 00
69. 01 06901 CARDI AC REHAB 0 0 371, 059 0. 00000 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 2, 918, 389 0. 00000 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 2, 335, 828 0.00000 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 6, 964, 991 0. 00000 73. 00
76.00 03020 CHEMICAL DEPENDENCY 0 0 0 0 0.00000 76.00
76. 01 03480 ONCOLOGY 0 0 16, 741, 255 0. 00000 76. 01
OUTPATIENT SERVICE COST CENTERS
88.00 08800 RURAL HEALTH CLINIC - FPC 0 0 1, 241, 469 0.00000 88.00
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE 0 0 2, 781, 006 0.000000 88.01
88. 02 08802 RURAL HEALTH CLINIC - 0B/GYN 0 0 1, 020, 616 0. 00000 88. 02
90. 00 09000 CLINIC 0 0 565, 123 0. 00000 90. 00
90. 01 09001 CLINIC- 0RTHO 0 0 374, 109 0. 000000 90. 01
90. 02 09002 CLINIC - PEDS & ENT 0 0 1, 147, 610 0. 000000 90. 02
90. 03 09003 I V THERAPY 0 0 0 8, 317, 896 0. 00000 90. 03
90. 04 09004 0P PSYCH 0 0 0 258,008 0.00000 90. 04
91. 00 09100 EMERGENCY 0 0 0 20, 224, 010 0. 000000 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 1, 906, 898 0. 00000 92. 00
200.00 Total (lines 50 through 199) 0 0 153,664,273 200.00

Health Financial Systems CAM	ERON MEMORIAL COM	MUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS		Provider CCN: 15-1315		Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2019 To 09/30/2020		nared
				10 07/30/2020	4/21/2021 9:44 am	
			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 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	((0.540	[50.00
50. 00 05000 OPERATING ROOM	0. 000000	660, 548		0 0		
51.00 05100 RECOVERY ROOM	0. 000000	129, 535	0 0			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	11, 081		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	501, 745		0 0	0	54.00
	0. 000000	584, 530		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	394, 365		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	149, 105		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	205, 343		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	210		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	305, 384		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	236, 720		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	415, 164		0 0	0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0. 000000	0		0 0		76.00
76.01 03480 ONCOLOGY	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS				-	-	
88.00 08800 RURAL HEALTH CLINIC - FPC	0. 000000	0		0 0		88.00
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	0. 000000	0		0 0	-	88.01
88.02 08802 RURAL HEALTH CLINIC - OB/GYN	0. 000000	0		0 0	0	88.02
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 CLINIC- ORTHO	0. 000000	0		0 0	0	90.01
90. 02 09002 CLINIC - PEDS & ENT	0. 000000	0		0 0	0	90.02
90. 03 09003 I V THERAPY	0. 000000	0		0 0	0	90.03
90. 04 09004 OP PSYCH	0. 000000	0		0 0	0	90.04
91.00 09100 EMERGENCY	0. 000000	4, 963		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	17, 218		0 0		92.00
200.00 Total (lines 50 through 199)	I I	3, 615, 911		0 0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provider C	CN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet D Part V Date/Time Pre 4/21/2021 9:4	epared: 4 am
		Title	Title XVIII		Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To			
	Part I, col.		Ded. & Coins			
	9	2.00	(see inst.)		F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 219088	0	3, 358, 94	49 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 219088				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 523370				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 153019				0	
50. 00 06000 LABORATORY	0. 252394		3, 767, 60		0	
54. 00 06400 INTRAVENOUS THERAPY	0. 252394		3, 707, 00		0	
55. 00 06500 RESPIRATORY THERAPY	0. 667183		204, 65	-	0	
55. 01 06500 SLEEP LAB	0. 300334				0	
56. 00 06600 PHYSI CAL THERAPY	0. 580455				0	
59. 00 06900 ELECTROCARDI OLOGY	0. 201663		470, 1		0	
59. 01 06901 CARDI AC REHAB	0. 494983		114, 14		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 656662		451, 34		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 761605		451, 64		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 332941		956, 23		0	
76.00 03020 CHEMI CAL DEPENDENCY	0. 000000			0 0	0	
76. 01 03480 ONCOLOGY	0. 193329		5, 880, 28	82 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
38.00 08800 RURAL HEALTH CLINIC - FPC						88.00
38.01 08801 RURAL HEALTH CLINIC - URGENT CARE						88.01
38.02 08802 RURAL HEALTH CLINIC - OB/GYN						88.02
90. 00 09000 CLINIC	0. 667711		241, 65		0	90.00
20. 01 09001 CLINIC- ORTHO	2. 193903	0	56, 9		0	
90.02 09002 CLINIC - PEDS & ENT	1. 550312		50, 18		0	90.02
90. 03 09003 I V THERAPY	0. 381810		4, 511, 90	60 17, 825	0	
90.04 09004 OP PSYCH	2. 236144		22, 49		0	
91.00 09100 EMERGENCY	0. 258264		0,		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 432684	0	1, 042, 99		0	1
200.00 Subtotal (see instructions)		0	34, 090, 0	77 25, 072	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	34, 090, 0	77 25, 072	0	202.00

ealth Financial Systems PPORTIONMENT OF MEDICAL, OTHER HEALTH SER		RON MEMORIAL COMMUNITY HOSPITAL O VACCINE COST Provider CCN: 15-1315		In Lieu of Form CMS-2552- Period: Worksheet D		
PPORTIONMENT OF MEDICAL, OTHER HEALTH SEP	VICES AND VACCINE COST	PLOVIDEL CCN. 15-		om 10/01/2019	Part V	
			To	09/30/2020	Date/Time Pre	epared
					4/21/2021 9:4	14 am
	0	Title XVIII		Hospi tal	Cost	
Cost Costos Decesiation	Cost					
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
		Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS	0,00					
D. 00 05000 OPERATI NG ROOM	735, 905	0				50.0
I. 00 05100 RECOVERY ROOM	310, 016	0				51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	2,007	o				52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 095, 452	o				54.0
0. 00 06000 LABORATORY	950, 935	0				60.0
00 06400 INTRAVENOUS THERAPY	0	0				64.0
5. 00 06500 RESPI RATORY THERAPY	136, 540	o				65.0
5. 01 06501 SLEEP LAB	52, 095	o				65.0
0. 00 06600 PHYSI CAL THERAPY	632, 914	o				66.0
2. 00 06900 ELECTROCARDI OLOGY	94, 816	o				69.0
2. 01 06901 CARDI AC REHAB	56, 500	o				69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PA	TI ENT 296, 383	o				71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	343, 975	o				72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	318, 370	1, 004				73.0
5. 00 03020 CHEMI CAL DEPENDENCY	0	0				76.0
5. 01 03480 ONCOLOGY	1, 136, 829	0				76.0
OUTPATIENT SERVICE COST CENTERS						
3. 00 08800 RURAL HEALTH CLINIC - FPC						88.0
8.01 08801 RURAL HEALTH CLINIC - URGENT (CARE					88.0
B. 02 08802 RURAL HEALTH CLINIC - OB/GYN						88.0
0. 00 09000 CLINIC	161, 353	0				90.0
0. 01 09001 CLINIC- ORTHO	124, 998	0				90.0
0. 02 09002 CLINIC - PEDS & ENT	77, 802	0				90.0
0. 03 09003 I V THERAPY	1, 722, 711	6, 806				90. (
0. 04 09004 OP PSYCH	50, 300	0				90.0
00 09100 EMERGENCY	901, 517	1, 092				91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINC)		0				92.0
00.00 Subtotal (see instructions)	10, 695, 697	8, 902				200. (
01.00 Less PBP Clinic Lab. Services-	Program 0					201. (
Only Charges						
02.00 Net Charges (line 200 - line 2	201) 10, 695, 697	8, 902				202.0

Health Financial Systems CAME	Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-					
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D	
				From 10/01/2019	Part I	
				To 09/30/2020		pared:
		T: +1		lleen! tel	4/21/2021 9:4	4 am
Cast Castan Dagarintian	Carrital		e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 499, 690	133, 447	1, 366, 24	3 4, 013	340.45	30.00
31.00 INTENSIVE CARE UNIT	93, 927		93, 92	7 153	613.90	31.00
43.00 NURSERY	33, 813		33, 81	3 448	75.48	43.00
200.00 Total (lines 30 through 199)	1, 627, 430		1, 493, 98	3 4, 614		200.00
Cost Center Description	Inpati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 ADULTS & PEDIATRICS	70	23, 832				30.00
31.00 INTENSIVE CARE UNIT	8	4, 911				31.00
43. 00 NURSERY	52	3, 925				43.00
200.00 Total (lines 30 through 199)	130					200.00
	1 100	52,000	I			200.00

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	TAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 10/01/2019	Worksheet D Part	
				To 09/30/2020		pared:
					4/21/2021 9:4	4 am
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II, col. 26)	col. 8)	col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	770, 606	17, 350, 898	0.04441	3 115, 496	5, 130	50.00
51.00 05100 RECOVERY ROOM	487, 386	4, 220, 625	0. 11547	7 18, 152	2,096	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	243, 385	1, 741, 252	0. 13977	6 161, 010	22, 505	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	614, 367	33, 750, 718	0. 01820	3 55, 740	1, 015	54.00
60. 00 06000 LABORATORY	293, 458	19, 687, 821	0. 01490	6 58, 613	874	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.0000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	72, 990	2, 420, 460		5 7, 855	237	65.00
65. 01 06501 SLEEP LAB	81, 828	1, 053, 550			0	65.01
66. 00 06600 PHYSI CAL THERAPY	431, 157	4, 146, 389	0. 10398		328	66.00
69. 00 06900 ELECTROCARDI OLOGY	30, 482	2, 124, 293			26	69.00
69. 01 06901 CARDI AC REHAB	39, 553	371, 059			0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 704	2, 918, 389			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	73, 058	2, 335, 828	0. 03127	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	101, 823	6, 964, 991	0. 01461		716	
76.00 03020 CHEMI CAL DEPENDENCY	0	0	0.0000	0 0	0	76.00
76. 01 03480 ONCOLOGY	729, 457	16, 741, 255	0. 04357	2 0	0	76.01
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC - FPC	230, 630				0	88.00
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	193, 434	2, 781, 006			0	88.01
88.02 08802 RURAL HEALTH CLINIC - OB/GYN	109, 757	1, 020, 616			0	88.02
90. 00 09000 CLINIC	25, 342	565, 123			0	90.00
90. 01 09001 CLINIC- ORTHO	131, 410				0	90.01
90.02 09002 CLINIC - PEDS & ENT	206, 575	1, 147, 610			0	90.02
90. 03 09003 I V THERAPY	68, 402	8, 317, 896			0	90.03
90. 04 09004 OP PSYCH	62, 083	258, 008			0	90.04
91.00 09100 EMERGENCY	687, 365	20, 224, 010			847	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	421, 824	1, 906, 898			0	92.00
200.00 Total (lines 50 through 199)	6, 185, 076	153, 664, 273		495, 718	33, 774	200.00

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	TAL	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					•	
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0		31.00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	(col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDIATRICS	0	0	.,			
31.00 03100 INTENSIVE CARE UNIT		0	15			
43. 00 04300 NURSERY		0	44			
200.00 Total (lines 30 through 199)		0	4, 61	4	130	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 <u>x col. 8)</u> 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0 0 0					30.00 31.00 43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems CAME	eu of Form CMS-2	2552-10				
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-1315	Period: From 10/01/2019	Worksheet D Part IV	
THROUGH COSTS				To 09/30/2020) Date/Time Pre	
			e XIX	llooni tal	4/21/2021 9:4 PPS	4 am
Cost Center Description	Non Physician	Nursing	Nursing	Hospital	Allied Health	
cost center bescription	Anesthetist	School	School	Post-Stepdown		
		Post-Stepdown	3011001	Adjustments		
	0001	Adjustments		ridj do tillorreo		
	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 0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	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		0 0	0 0	65.00
65. 01 06501 SLEEP LAB	0	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	0		0 (0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				72.00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0				76.00
76. 01 03480 ONCOLOGY	0			0 0		76.00
OUTPATIENT SERVICE COST CENTERS	0	0		0 (<u>, 0</u>	70.01
88.00 08800 RURAL HEALTH CLINIC - FPC	0	0		0 (0 0	88.00
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	0	0		0 0	0	
88.02 08802 RURAL HEALTH CLINIC - OB/GYN	0	0		0 0	0	88.02
90. 00 09000 CLINIC	0	0		0 0	0 0	90.00
90. 01 09001 CLI NI C- ORTHO	0	0		0 0	0 0	90.01
90. 02 09002 CLINIC - PEDS & ENT	0	0		0 0	0 0	90.02
90. 03 09003 I V THERAPY	0	0		0 (0 0	90.03
90. 04 09004 OP PSYCH	0	0		0 0	0 0	90.04
91. 00 09100 EMERGENCY	0	0		0 0	0 0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00 Total (lines 50 through 199)	0	0	1	0 0	0 0	200.00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	VICE OTHER DAS	S Provider C	°N· 15_1315	Period:	Worksheet D	
	H COSTS	WICE OTHER TAS			From 10/01/2019	Part IV	
THROOC	1 00010				To 09/30/2020	Date/Time Pre	pared:
					lleen! tel	4/21/2021 9:4	4 am
	Cost Center Description	All Other	Total Cost	e XIX Total	Hospi tal Total Charges	PPS	
	cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges	
		Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
		0031	(and 4)	001.0)	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 17, 350, 898	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 4, 220, 625		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 741, 252	0. 000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 33, 750, 718	0. 000000	54.00
60.00	06000 LABORATORY	0	0		0 19, 687, 821	0. 000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0. 000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 2, 420, 460	0.000000	65.00
65.01	06501 SLEEP LAB	0	0		0 1,053,550	0.000000	65.01
	06600 PHYSI CAL THERAPY	0	0		0 4, 146, 389	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 2, 124, 293		
	06901 CARDI AC REHAB	0	0		0 371, 059		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 918, 389		•
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 2, 335, 828		•
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 6, 964, 991	0. 000000	
	03020 CHEMI CAL DEPENDENCY	0			0 0	0. 000000	
76. 01	03480 ONCOLOGY	0	0		0 16, 741, 255	0.000000	76.01
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC - FPC	0			0 1, 241, 469		
	08801 RURAL HEALTH CLINIC - URGENT CARE	0	0		0 2, 781, 006		
	08802 RURAL HEALTH CLINIC - OB/GYN	0	0		0 1,020,616		
		0	0		0 565, 123		
	09001 CLINIC ORTHO		0		0 374, 109		
	09002 CLINIC - PEDS & ENT 09003 IV THERAPY				0 1, 147, 610		
	09003 IV THERAPY 09004 OP PSYCH				0 8, 317, 896 0 258, 008		
	09004 OP PSYCH 09100 EMERGENCY				0 20, 224, 010		
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0 20, 224, 010		
	1072001003LRVATION DEDS (NUN-DISTINCT PART	ı U	u U	1	0 1, 700, 898		1 72.00

Health Financial Systems CAME	RON MEMORIAL COM	MUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-1315	Peri od:	Worksheet D	
THROUGH COSTS				From 10/01/2019 To 09/30/2020		pared:
					4/21/2021 9:4	4 am
			e XIX	Hospi tal	PPS	
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 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)	10.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 000000	115, 496		0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000			0 0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	18, 152		0 0		51.00
		161, 010		0 0	0	
	0. 000000	55, 740		0 0	0	54.00 60.00
	0. 000000	58, 613		0 0	0	60.00 64.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00 65.00
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	0.000000	7,855		0 0	0	65.00
		0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 152		0 0	0	66.00 69.00
	0. 000000	1, 795		0 0	0	69.00 69.01
69. 01 06901 CARDI AC REHAB 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 000000	0		0 0	0	71.00
	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	Ũ		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	48, 981		0 0	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000	0		0 0		76.00
76.01 03480 ONCOLOGY	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - FPC	0.000000	0			0	88.00
88.00 08800 RURAL HEALTH CLINIC - FPC 88.01 08801 RURAL HEALTH CLINIC - URGENT CARE	0. 000000	0				88.00
		0		0 0	-	
88. 02 08802 RURAL HEALTH CLINIC - OB/GYN	0. 000000	0		0 0	0	88.02
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00 90.01
90. 01 09001 CLINIC - ORTHO	0. 000000	0			0	
90. 02 09002 CLINIC - PEDS & ENT 90. 03 09003 IV THERAPY	0. 000000	0			0	90. 02 90. 03
90. 03 09003 I V THERAPY 90. 04 09004 0P PSYCH	0.000000	0		0 0	0	90.03 90.04
		24 024			0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0.000000	24, 924		0 0	0	91.00
	0.000000	40E 710				92.00
200.00 Total (lines 50 through 199)	1	495, 718	l	0 0	I 0	200.00

CAMERON MEMORIAL COMMUNITY HOSPITAL

iear tri	Financial Systems CAMERON	MEMORIAL COMMU	NI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-
	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-1315	Peri od:	Worksheet D-1	
				From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:44	
			Title XVIII	Hospi tal	Cost	
	Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00 2.00	Inpatient days (including private room days and Inpatient days (including private room days, ex				4, 742 4, 013	
2.00 3.00	Private room days (excluding private room days, ex do not complete this line.			rivate room days,	4,013	
4.00 5.00	Semi-private room days (excluding swing-bed and Total swing-bed SNF type inpatient days (includ			er 31 of the cost	2, 774 93	4.0 5.0
6. 00	reporting period Total swing-bed SNF type inpatient days (includ reporting period (if calendar year, enter 0 on	31 of the cost	278	6.0		
7.00	Total swing-bed NF type inpatient days (includi reporting period		n days) through Decembe	r 31 of the cost	90	7.0
8.00	Total swing-bed NF type inpatient days (includi reporting period (if calendar year, enter 0 on		n days) after December :	31 of the cost	268	8.0
9.00	Total inpatient days including private room day newborn days) (see instructions)		0	5 0	835	9.0
	Swing-bed SNF type inpatient days applicable to through December 31 of the cost reporting period	d (see instruct	i ons)		93	
	December 31 of the cost reporting period (if ca	ılendar year, en	iter 0 on this line)			11.0
	Swing-bed NF type inpatient days applicable to through December 31 of the cost reporting peric Swing-bed NF type inpatient days applicable to	d		<u> </u>	0	
	after December 31 of the cost reporting period Medically necessary private room days applicable	(if cal endar ye	ear, enter 0 on this li	ne)	0	
	Total nursery days (title V or XIX only)		in (exer during swring bed	uays)	0	
	Nursery days (title V or XIX only)				0	
	SWING BED ADJUSTMENT					
	Medicare rate for swing-bed SNF services applic reporting period		C C			17.0
	Medicare rate for swing-bed SNF services applied reporting period				129. 14	18.0
	Medicaid rate for swing-bed NF services applica reporting period Medicaid rate for swing-bed NF services applica		C C		129.14	
	reporting period Total general inpatient routine service cost (s				9, 712, 902	
	Swing-bed cost applicable to SNF type services 5 x line 17)			ting period (line		
23.00	Swing-bed cost applicable to SNF type services x line 18)	after December	31 of the cost reportion	ng period (line é	0	23.
24.00	Swing-bed cost applicable to NF type services t $7 \times \text{line 19}$	hrough December	31 of the cost report	ng period (line	11, 623	24.
	Swing-bed cost applicable to NF type services a x line 20)	fter December 3	31 of the cost reporting	g period (line 8	34, 610	
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of s PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	wing-bed cost (line 21 minus line 26)		864, 284 8, 848, 618	
	General inpatient routine service charges (excl Private room charges (excluding swing-bed charge		l and observation bed c	narges)	0 0	
30.00	Semi -private room charges (excluding swing-bed	charges)			0	
31.00		•	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ Average semi-private room per diem charge (line				0.00 0.00	
	Average per diem private room charge differenti		us line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential				0.00	
	Private room cost differential adjustment (line	•	,		0	36.
	General inpatient routine service cost net of s 27 minus line 36)		nd private room cost d	fferential (line	8, 848, 618	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS TH				2 204 02	1 20
20.00		per alem (see	LUSTRUCTIONS)		2, 204. 99	38.
	Adjusted general inpatient routine service cost		-	1	1 011 147	30
39.00	Program general inpatient routine service cost Medically necessary private room cost applicabl	(line 9 x line	38)		1, 841, 167 0	

MPUTA	TION OF INPATIENT OPERATING COST		Provi der C		Period: From 10/01/2019	Worksheet D-1	1
					To 09/30/2020		
			Title	xviii	Hospi tal	4/21/2021 9:4 Cost	44 an
	Cost Center Description	Total Inpatient Cost	Total I npati ent Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
00	HIDSEDV (title V & VIV entry)	1.00	2.00 C	3.00	4.00	5.00 0	42
	NURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units		U	0.0	0 0	0	42
	NTENSI VE CARE UNI T	390, 946	153	2, 555. 2	0 43	109, 874	43
	CORONARY CARE UNI T						44
	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT						46
00 [0	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	•					1.00	
	Program inpatient ancillary service cost (Wk					1, 380, 537	
	Total Program inpatient costs (sum of lines ASS THROUGH COST ADJUSTMENTS	41 through 48)	(see Instructi	ons)		3, 331, 578	49
	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D. sur	n of Parts I and	0	50
	II)						
	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	0	51
	and IV) Fotal Program excludable cost (sum of lines	50 and 51				о	52
	fotal Program inpatient operating cost exclu		elated. non-ph	vsician anesth	netist. and	0	
	nedical education costs (line 49 minus line						
	ARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
	Farget amount per discharge Farget amount (line 54 x line 55)					0.00 0	
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	
	Bonus payment (see instructions)		arget amount (11110 33)	0	
.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							59
	narket basket		0		. ,		
	esser of lines 53/54 or 55 from prior year					0.00	
	fline 53/54 is less than the lower ofline which operating costs (line 53) are less that					0	61
	amount (line 56), otherwise enter zero (see		ts (11163 54 X	00), 01 1/0 01	the target		
. 00 🖡	Relief payment (see instructions)					0	62
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63
	ROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	te through Door	ombor 21 of th	o cost roporti	na pariod (Saa	205 064	64
	nstructions)(title XVIII only)	is through beck		e cost reporti	ng period (see	205, 064	04
	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reporting	g period (See	612, 987	65
	nstructions)(title XVIII only)						
	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	818, 051	66
	CAH (see instructions) Fitle V or XIX swing-bed NF inpatient routin	e costs throug	h December 31	of the cost re	eporting period	0	67
	(line 12 x line 19)	io ocoro rin ougi			spor ring por ou		
	Title V or XIX swing-bed NF inpatient routin	e costs after l	December 31 of	the cost repo	orting period	0	68
	(line 13 x line 20)			- (0)		0	
	Fotal title V or XIX swing-bed NF inpatient ART III - SKILLED NURSING FACILITY, OTHER N					0	69
	Skilled nursing facility/other nursing facil)		70
. 00 A	Adjusted general inpatient routine service c	ost per diem (l	line 70 ÷ line	2)			71
	Program routine service cost (line 9 x line	,					72
	Medically necessary private room cost applic	0	•	,			73
	Fotal Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74
	26, line 45)	Service		NOT KONCEL D, P	art II, COLUMNI		'
	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
	Program capital-related costs (line 9 x line						77
	npatient routine service cost (line 74 minu			de)			78
	Aggregate charges to beneficiaries for exces			· · · · · · · · · · · · · · · · · · ·	us line 70)		79
	Fotal Program routine service costs for comp npatient routine service cost per diem limi		cost rimitatio		103 ITTE /7)		81
	npatient routine service cost per drem rimining		1)				82
	Reasonable inpatient routine service costs (83
	Program inpatient ancillary services (see in		-				84
00 L	Jtilization review - physician compensation		ons)				85
	Total Program inpatient operating costs (sum		hrough 85)				86
	ART IV - COMPUTATION OF OBSERVATION BED PAS					1 000	
. 00 T	Total observation bed days (see instructions					1, 239 2, 204. 99	
	Adjusted general inpatient routine cost per	alem (line // -	÷IINe ハ				

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 10/01/2019 To 09/30/2020		
					4/21/2021 9:4	4 am
		Title		Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 499, 690	9, 712, 902	0. 15440	2, 731, 983	421, 824	90.00
91.00 Nursing School cost	0	9, 712, 902	0.00000	0 2, 731, 983	0	91.00
92.00 Allied health cost	0	9, 712, 902	0.00000	0 2, 731, 983	0	92.00
93.00 All other Medical Education	0	9, 712, 902	0.00000	0 2, 731, 983	0	93.00

CAMERON MEMORIAL COMMUNITY HOSPITAL

Heal th	Financial Systems CAMERON MEMORIAL COMM	IUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1315	Peri od:	Worksheet D-1			
			From 10/01/2019 To 09/30/2020	Date/Time Pre	pared:		
				4/21/2021 9:4	4 am		
	Cast Contar Description	Title XIX	Hospi tal	PPS			
	Cost Center Description			1.00			
	PART I - ALL PROVIDER COMPONENTS						
	I NPATI ENT DAYS						
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			4, 742 4, 013			
3.00	Private room days (excluding swing-bed and observation bed da		rivate room davs	4,013			
	do not complete this line.			_			
4.00	Semi-private room days (excluding swing-bed and observation b			2, 774	4.00		
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	er 31 of the cost	93	5.00		
6.00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	278	6.00		
0.00	reporting period (if calendar year, enter 0 on this line)			270			
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	90	7.00		
8.00	reporting period Total swing-bed NF type inpatient days (including private roo	m dave) after December	21 of the cost	268	8.00		
0.00	reporting period (if calendar year, enter 0 on this line)	Sill days) al tel becember :	ST OF THE COST	200	0.00		
9.00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	70	9.00		
	newborn days) (see instructions)				10.00		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10.00		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00		
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	•				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12.00		
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room davs)	0	13.00		
	after December 31 of the cost reporting period (if calendar y	year, enter 0 on this li	ne)	5			
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0			
15.00					15.00		
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			52	16.00		
17.00		ces through December 31	of the cost		17.00		
	reporting period				10.00		
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18.00		
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	129. 14	19.00		
	reporting period	-					
20.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	129. 14	20.00		
21.00	Total general inpatient routine service cost (see instruction	าร)		9, 712, 902	21.00		
22.00		per 31 of the cost repor	ting period (line	0	22.00		
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 21 of the cost reportin	ng pariod (line 4	0	23.00		
23.00	x line 18)	ST OF the cost reportin	ng period (inne d	0	23.00		
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	11, 623	24.00		
25 00	7 x line 19)	21 of the east reporting	a ported (line 0	24 (10	25 00		
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 OI the cost reporting	y period (inne a	34, 610	25.00		
26.00	Total swing-bed cost (see instructions)			864, 284	26.00		
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 848, 618	27.00		
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation bed c	hardes)	0	28.00		
29.00	Private room charges (excluding swing-bed charges)		nai ges)	0	1		
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	1		
32.00 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00			
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00			
35.00							
36.00							
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost d	irrerential (line	8, 848, 618	37.00		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1		
	Adjusted general inpatient routine service cost per diem (see			2, 204. 99			
		2 20)					
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			154, 349 0			

	ATION OF INPATIENT OPERATING COST		Provider C		eriod: rom 10/01/2019	Worksheet D-1	
					09/30/2020	Date/Time Pre 4/21/2021 9:4	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpati ent	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
		1.00	2.00	3.00	4.00	5.00	42
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	253, 378	448	565.58	52	29, 410	42.
	INTENSIVE CARE UNIT	390, 946	153	2, 555. 20	8	20, 442	
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGI CAL I NTENSI VE CARE UNI T						40.
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			197, 897	48
00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		402, 098	49
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D sum	of Parts L and	32, 668	50
. 00	111)			in intot. D, Sum		02,000	
. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D, si	um of Parts II	33, 774	51
00	and IV) Total Program excludable cost (sum of lines	50 and 51)				66, 442	52
00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	ysician anesth	etist, and	335, 656	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54
	Target amount per discharge					0.00 0	
	00 Target amount (line 54 x line 55) 00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						
3. 00 Bonus payment (see instructions)							57 58
i9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th							59
00	market basket Lesser of lines 53/54 or 55 from prior year	cost report um	ndated by the	market hasket		0.00	60
	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	the target		
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62
3.00 Allowable Inpatient cost plus incentive payment (see instructions)							63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doc	ombor 21 of th	o cost roportiu	a poriod (Soo	0	64
. 00	instructions) (title XVIII only)	ts through bece		e cost reportin	ig period (see	0	04
00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	period (See	0	65
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII)	lonly) For	0	66
	CAH (see instructions)						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost re	porting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	rting period	0	68
	(line 13 x line 20)				0	_	
. 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						70
	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line Medically necessary private room cost applic		m (line 14 x l	ine 35)			72
00	Total Program general inpatient routine serv	0	•				74
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, Pa	art II, column		75
00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital-related costs (line 9 x line	76)					77
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		arovi den recor	ds)			78
00	Total Program routine service costs for comp	· · ·		,	us line 79)		80
00	Inpatient routine service cost per diem limi						81
00 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82
00	Program inpatient ancillary services (see in		137				84
00	Utilization review - physician compensation	(see instructio					85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		nrough 85)				86
						1, 239	87
. 00	Total observation bed days (see instructions)				1/20/	1 .

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 10/01/2019 To 09/30/2020	Date/Time Pre	nared
				10 07/00/2020	4/21/2021 9:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 499, 690	9, 712, 902	0. 15440	2 2, 731, 983	421, 824	90.00
91.00 Nursing School cost	0	9, 712, 902	0.00000	0 2, 731, 983	0	91.00
92.00 Allied health cost	0	9, 712, 902	0.00000	0 2, 731, 983	0	92.00
93.00 All other Medical Education	0	9, 712, 902	0.00000	0 2, 731, 983	0	93.00

Health Financial Systems CAMERON MEMORIAL CO				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1315	Period: From 10/01/2019	Worksheet D-3	
			To 09/30/2020		
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00		col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			1 225 001		20.00
30. 00 103000 ADDELTS & PEDIATRICS 31. 00 103100 INTENSIVE CARE UNIT			1, 325, 091 107, 500		30.00
43. 00 04300 NURSERY			107, 500		43.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 21908	660, 548	144, 718	50.00
51. 00 05100 RECOVERY ROOM		0. 5233			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 68065		7,542	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1530			•
60. 00 06000 LABORATORY		0. 25239		147, 532	•
64. 00 06400 I NTRAVENOUS THERAPY		0. 00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0.66718		263, 114	65.00
65. 01 06501 SLEEP LAB		0. 30033		0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 5804		86, 549	
69. 00 06900 ELECTROCARDI OLOGY		0. 2016			69.00
69. 01 06901 CARDI AC REHAB		0. 49498	33 210	104	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 65666	305, 384	200, 534	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 76160	236, 720	180, 287	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 33294	415, 164	138, 225	73.00
76.00 03020 CHEMI CAL DEPENDENCY		0.0000	0 0	0	76.00
76. 01 03480 ONCOLOGY		0. 19332	29 0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC - FPC		0.0000		0	
88.01 08801 RURAL HEALTH CLINIC - URGENT CARE		0.0000		0	88.01
88.02 08802 RURAL HEALTH CLINIC - OB/GYN		0.0000		0	88.02
90. 00 09000 CLINIC		0.6677		0	90.00
90. 01 09001 CLI NI C- ORTHO		2. 19390		0	90.01
90. 02 09002 CLINIC - PEDS & ENT		1. 5503		0	90.02
90. 03 09003 I V THERAPY		0. 3818		0	90.03
90. 04 09004 OP PSYCH		2. 23614		0	90.04
91.00 09100 EMERGENCY		0. 25820			•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 43268			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 615, 911	1, 380, 537	•
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	3, 615, 911		202.00

	Financial Systems CAMERON MEMORIAL COMM				In Lie	u of Form CMS-2	
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1315		ri od:	Worksheet D-3	
		Component	CCN: 15-Z315	To	om 10/01/2019 09/30/2020		narod
		component	CCN. 13-2313	10	077 307 2020	4/21/2021 9:4	
		Title	e XVIII	Swi	ng Beds - SNF		
	Cost Center Description		Ratio of Cos	st	I npati ent	I npati ent	
			To Charges	5	Program	Program Costs	
					Charges	(col. 1 x	
						col. 2)	
			1.00		2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS				3, 188		30.00
	03100 INTENSIVE CARE UNIT				0		31.00
43.00	04300 NURSERY						43.00
	ANCI LLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM		0. 2190		2, 593	568	
	05100 RECOVERY ROOM		0. 5233		0		51.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 6806		0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 1530		30, 698		54.00
	06000 LABORATORY		0. 2523		62, 137	15, 683	60.00
	06400 I NTRAVENOUS THERAPY		0.0000		0	0	
	06500 RESPIRATORY THERAPY		0.6671		72, 575	48, 421	65.00
	06501 SLEEP LAB		0.3003		0	0	65.01
	06600 PHYSI CAL THERAPY		0.5804		182, 584	105, 982	66.00
	06900 ELECTROCARDI OLOGY		0.2016		23, 538		69.00
	06901 CARDI AC REHAB		0. 4949		839		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 6566		33, 569		
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.7616		0	0	
	07300 DRUGS CHARGED TO PATIENTS		0. 3329		93, 203		73.00
	03020 CHEMI CAL DEPENDENCY		0.0000		0	0	76.00
76.01	03480 ONCOLOGY OUTPATIENT SERVICE COST CENTERS		0. 1933	29	0	0	76.01
88.00	08800 RURAL HEALTH CLINIC - FPC		0.0000			0	88.00
	08800 RURAL HEALTH CLINIC - URGENT CARE		0.0000			0	88.01
	08802 RURAL HEALTH CLINIC - OB/GYN		0.0000			0	88.02
	09000 CLINIC		0. 6677		0	0	90.00
	09001 CLINIC- ORTHO		2. 1939			0	90.00
	09002 CLINIC - PEDS & ENT		1. 5503		0	0	90.01
	09002 CLINIC - PEDS & ENT		0. 3818		0	0	90.02
	09003 I V THERAPT		2. 2361		0	0	90.03
	09100 EMERGENCY		0. 2582		300	-	90.04
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 4326		2,949		
200.00			1. 4320	-04	504, 985	237, 889	
200.00		: (line 61)			504, 9 85 0	237,007	200.00
201.00	Net charges (line 200 minus line 201)		1		504, 985		201.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSE	PI TAL	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTION	IMENT Provi der	CCN: 15-1315	Peri od:	Worksheet D-3	
			From 10/01/2019		
			To 09/30/2020) Date/Time Pre 4/21/2021 9:4	
	Ti	tle XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
···· • ··· •		To Charges		Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTI	ERS			1	
30. 00 03000 ADULTS & PEDIATRICS			94, 103		30.00
31.00 03100 INTENSIVE CARE UNIT			(31.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS			- 1	1	
50. 00 05000 OPERATI NG ROOM		0. 2190			
51.00 05100 RECOVERY ROOM		0. 5233			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 6806			
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1530			
60. 00 06000 LABORATORY		0. 2523			60.00
64.00 06400 I NTRAVENOUS THERAPY		0.0000		-	
65.00 06500 RESPIRATORY THERAPY		0. 6671			65.00
65. 01 06501 SLEEP LAB		0. 3003			65.01
66.00 06600 PHYSI CAL THERAPY		0. 5804			
69. 00 06900 ELECTROCARDI OLOGY		0. 2016			69.00
69. 01 06901 CARDI AC REHAB		0. 4949			69.01
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PA		0. 6566		-	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.7616		-	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3329			
76. 00 03020 CHEMI CAL DEPENDENCY		0.0000			76.00
76. 01 03480 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS		0. 1933	29 (0	76.01
88.00 08800 RURAL HEALTH CLINIC - FPC		1. 8867	75 (0	88.00
88. 01 08800 RURAL HEALTH CLINIC - URGENT (MDE	0. 8857			88.00
88. 02 08802 RURAL HEALTH CLINIC - OB/GYN	AKE	1. 5030			88.02
90. 00 09000 CLINIC		0. 6677		-	90.00
90. 01 09000 CLINIC- ORTHO		2. 1939			90.00
90. 02 09002 CLINIC - PEDS & ENT		1. 5503		-	90.01
90. 02 09002 CEINIC - PEDS & ENT 90. 03 09003 I V THERAPY		0. 3818		-	90.02
90. 03 09003 TV THERAPT 90. 04 09004 OP PSYCH		2. 2361			90.03
90. 04 109004 0P PSTCH 91. 00 09100 EMERGENCY		0. 2582		-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	ΡΔΩΤ	1. 4326		0,437	91.00
200.00 Total (sum of lines 50 through		1. 4320	495, 718	-	
	vices-Program only charges (line 61		495,710		200.00
202.00 Net charges (line 200 minus li			495, 718		202.00
202.00 mot charges (The 200 millios H	10 2017	I.	495,710	1	1-02.00

	Financial Systems CAMERON MEMORIAL COM ATION OF REIMBURSEMENT SETTLEMENT Common and a set of the set of t	Provider CCN: 15-1315	Period: From 10/01/2019	u of Form CMS-2 Worksheet E Part B	<u>2002-10</u>
			To 09/30/2020		
		Title XVIII	Hospi tal	Cost	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			10, 704, 599	1.00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru-	ctions)		10, 704, 599	2.00
3.00	OPPS payments			0	3.00
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instruction	uctions)		0.000	•
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
8.00	Transitional corridor payment (see instructions)			0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, col. 13, line 200		0	9.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			10, 704, 599	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for			0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13		on a chargebasi's	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	(0)		0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	nlvifline 18 exceeds l	ine 11) (see	0	
19.00	instructions)	The to exceeds t	The TT) (See	0	19.00
20.00	Excess of reasonable cost over customary charges (complete or instructions)	nlyifline 11 exceeds l	ine 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			10, 811, 645	21.00
22.00	Interns and residents (see instructions)	tructions)		0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		0	23.00 24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u>,</u>			
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on li		ructions)	79, 593 6, 038, 895	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			4, 693, 157	
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payor payments			4, 693, 157 6, 468	
31.00	Primary payer payments Subtotal (line 30 minus line 31)			4, 686, 689	
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)		0	
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 826, 325	
35.00	Adjusted reimbursable bad debts (see instructions)			537, 111	35.00
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	tructions)		487, 698 5, 223, 800	
38.00	MSP-LCC reconciliation amount from PS&R			0,220,000	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	nc)		0	39.00 39.50
39. 50 39. 97	Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for repla	aced devices (see instru	icti ons)	0	•
39.99 40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 5, 223, 800	39.99 40.00
40. 01	Sequestration adjustment (see instructions)			60, 596	40.01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
41.00	Interim payments			5, 844, 024	
41.01 42.00	Interim payments-PARHM Tontative settlement (for contractors use only)			0	41.01 42.00
42.00	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00
43.00	Balance due provider/program (see instructions)			-680, 820	
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2	chapter 1.	0	43.01 44.00
	§115. 2			0	
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	93.00

	n Financial Systems CAMERON MEMORIAL CO SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Date/Time Pre	pared:
			XVIII	llooni tol	4/21/2021 9:4	4 am
			t Part A	Hospi tal Par	Cost T B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	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		2, 557, 2:	25 0	5, 844, 024 0	1.00 2.00 3.00
3.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER	04/29/2020	110, 00		0	3.01
3.02				0	0	3.02
3.03 3.04				0	0	3.03 3.04
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51 3.52				0	0	3.51 3.52
3.52 3.53				0	0	3.52
3.53				0	0	3.53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		110, 00	-	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 667, 22	25	5, 844, 024	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5.01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.01
5.01				0	0	5.01
5.03				0	0	5.03
	Provider to Program			-		
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.51 5.52
5. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		399, 14		0	6.01
6.02	SETTLEMENT TO PROGRAM		2 0// 2	0	680, 820	6.02
7.00	Total Medicare program liability (see instructions)		3, 066, 3	74 Contractor	5,163,204 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	
8.00	Name of Contractor					8.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 10/01/201		
		Component (CCN: 15-Z315	To 09/30/202	0 Date/Time Pre 4/21/2021 9:4	
		Title	XVIII	Swing Beds - SN		
		I npati en	t Part A	Pa	art 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		858, 5	45 0	C	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.
01	ADJUSTMENTS TO PROVIDER	04/29/2020	38, 9	00	C	3.
02				0	C	
03				0	0	
04 05				0		
05	Provider to Program			0		<u> </u>
50	ADJUSTMENTS TO PROGRAM			0	0) 3
51				0	C	
52				0	0	
53 54				0		
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		38, 9	-		
	3. 50-3. 98)					
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)		897, 4	45	C	4
	TO BE COMPLÉTED 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)					5
	Program to Provider					
D1	TENTATI VE TO PROVI DER			0	0	
)2)3				0		
	Provider to Program		I			4 3
50	TENTATI VE TO PROGRAM			0	C	5
51				0	C	
52 99	Subtatal (aum of Lines E 01 E 40 minus aum of Lines			0		
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0) 5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		151, 5	08	0	
)2	SETTLEMENT TO PROGRAM			0	C	
00	Total Medicare program liability (see instructions)		1, 048, 9	53 Contractor	NPR Date) 7
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Health Financial Systems CAMERON MEMORIAL C	OMMUNI TY HOSPI TAL	In Lie	u of Form CMS.	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Period: From 10/01/2019 To 09/30/2020		epared:	
	Title XVIII	Hospi tal	Cost	
			1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT				_
1.00 Total hospital discharges as defined in AARA §4102 from Wk		1.00		
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1		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			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.				6.00
7.00 CAH only - The reasonable cost incurred for the purchase o line 168	f certified HIT technology	Wkst. S-2, Pt. I		7.00
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 sequestrati	on (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 an	d line 31) (see instructio	ns)		32.00

CALCULAT	inancial Systems CAMERON MEMORIAL COMMUNI ION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pr	rovider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet E-2	
	C	omponent CCN: 15-Z315	From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:4	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
00			1.00	2.00	
	DMPUTATION OF NET COST OF COVERED SERVICES		024 222	0	1.0
	npatient routine services – swing bed-SNF (see instructions) npatient routine services – swing bed-NF (see instructions)		826, 232	0	2.0
		A and cum of Wkct D	240 249	0	
	ncillary services (from Wkst. D-3, col. 3, line 200, for Part / art V, cols. 6 and 7, line 202, for Part B) (For CAH and swing			0	3.0
	nstructions)	-bed pass-through, see	5		
	ursing and allied health payment-PARHM (see instructions)				3.0
	er diem cost for interns and residents not in approved teaching	g program (see		0.00	4.0
	nstructions)				
5. 00 Pi	rogram days		371	0	5.0
5.00 In	nterns and residents not in approved teaching program (see ins	tructions)		0	6.0
	tilization review - physician compensation - SNF optional metho	od only	0		7.0
	ubtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 066, 500	0	8.0
	rimary payer payments (see instructions)		0	0	9.0
	ubtotal (line 8 minus line 9)		1, 066, 500	0	10.0
	eductibles billed to program patients (exclude amounts applical rofessional services)	bie to physician	0	0	11.0
	ubtotal (line 10 minus line 11)		1, 066, 500	0	12.0
	oinsurance billed to program patients (from provider records)	(exclude_coinsurance	5, 236	0	13.0
	or physician professional services)		0,200	0	
	0% of Part B costs (line 12 x 80%)			0	14.0
15.00 Si	ubtotal (see instructions)		1, 061, 264	0	15.0
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.0
	ioneer ACO demonstration payment adjustment (see instructions)				16.5
	ural community hospital demonstration project (§410A Demonstra	tion) payment	0		16.5
	djustment (see instructions)		0	0	14 0
	emonstration payment adjustment amount before sequestration		0	0	16.9 17.0
	djusted reimbursable bad debts (see instructions)		0	0	17.0
	llowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	18.0
	otal (see instructions)		1, 061, 264	0	19.0
	equestration adjustment (see instructions)		12, 311	0	19.0
19.02 De	emonstration payment adjustment amount after sequestration)		0	0	19.0
1	equestration adjustment-PARHM pass-throughs				19.0
1	nterim payments		897, 445	0	20.0
1	nterim payments-PARHM			0	20.0
1	entative settlement (for contractor use only) entative settlement-PARHM (for contractor use only)		0	0	21.0 21.0
1	alance due provider/program (line 19 minus lines 19.01, 20, and	4 21)	151, 508	0	21.0
1	al ance due provider/program-PARHM (see instructions)		131, 300	0	22.0
	rotested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	0	23.0
	hapter 1, §115.2				
	ural Community Hospital Demonstration Project (§410A Demonstrat				
	s this the first year of the current 5-year demonstration perio	od under the 21st			200. 0
	entury Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement edicare swing-bed SNF inpatient routine service costs (from Wk:	at D 1 Dt 11 line			201.0
	6 (title XVIII hospital))	St. D-1, Pt. 11, 111e			201.0
	edicare swing-bed SNF inpatient ancillary service costs (from)	Wkst. D-3. col. 3. lir	ne		202.0
	00 (title XVIII swing-bed SNF))				
03. 00 To	otal (sum of lines 201 and 202)				203.0
	edicare swing-bed SNF discharges (see instructions)				204.0
	omputation of Demonstration Target Amount Limitation (N/A in fi	rst year of the curre	ent 5-year demons	tration	
	eriod) edicare swing-bed SNF target amount				1205 O
	edicare swing-bed SNF inpatient routine cost cap (line 205 time	as line 204)			205. 0 206. 0
	ijustment to Medicare Part A Swing-Bed SNF Inpatient Reimburser				200.0
	rogram reimbursement under the §410A Demonstration (see instru				207.0
	edicare swing-bed SNF inpatient service costs (from Wkst. E-2,		1		208.0
	nd 3)				
209. 00 Ad	djustment to Medicare swing-bed SNF PPS payments (see instruct	ions)			209. 0
210. 00 Re	eserved for future use				210. 0
	omparision of PPS versus Cost Reimbursement				
. 15. UÜL FO	otal adjustment to Medicare swing-bed SNF PPS payment (line 204	y plus line 210) (see			215.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020		pare
		Title XVIII	Hospi tal	4/21/2021 9:4 Cost	4 ar
		in the Aviii	nospi tai	COST	
				1.00	
00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR M	EDICARE PART A SERVICES - CO	ST REIMBURSEMENT	2 221 570	1 1
00	Inpatient services	-+		3, 331, 578 0	
00	Nursing and Allied Health Managed Care payment (see in	structions)		0	
00 00	Organ acquisition Subtotal (sum of lines 1 through 3)			3, 331, 578	-
00	Primary payer payments			10, 056	
00	Total cost (line 4 less line 5). For CAH (see instruct	ions)		3, 354, 838	
00	COMPUTATION OF LESSER OF COST OR CHARGES			5, 334, 030	
	Reasonable charges				
00	Routine service charges			0	17
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
	Total reasonable charges			0	
	Customary charges				1
I. 00	Aggregate amount actually collected from patients liab	le for payment for services o	n a charge basis	0	11
2.00	Amounts that would have been realized from patients li	able for payment for services	on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 4	13.13(e)			
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (comp	lete only if line 14 exceeds	line 6) (see	0	1
	instructions)				
6.00	Excess of reasonable cost over customary charges (comp	lete only if line 6 exceeds l	ine 14) (see	0	10
7 00	instructions)	:+		0	1-
7.00	Cost of physicians' services in a teaching hospital (s COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	17
8 00	Direct graduate medical education payments (from Works	beet E_4 line 49)		0	1 18
	Cost of covered services (sum of lines 6, 17 and 18)			3, 354, 838	
	Deductibles (exclude professional component)			276, 012	
	Excess reasonable cost (from line 16)			270,012	
	Subtotal (line 19 minus line 20 and 21)			3, 078, 826	
	Coinsurance			0,0,0,020	2
	Subtotal (line 22 minus line 23)			3, 078, 826	
	Allowable bad debts (exclude bad debts for professiona	I services) (see instructions)	36, 207	
	Adjusted reimbursable bad debts (see instructions)		,	23, 535	
7.00	Allowable bad debts for dual eligible beneficiaries (s	ee instructions)		14, 891	2
3.00	Subtotal (sum of lines 24 and 25, or line 26)	·		3, 102, 361	28
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	2
9.50	Pioneer ACO demonstration payment adjustment (see inst	ructions)		0	20
9. 99	Demonstration payment adjustment amount before sequest	ration		0	20
	Subtotal (see instructions)			3, 102, 361	
	Sequestration adjustment (see instructions)			35, 987	
	Demonstration payment adjustment amount after sequestr	ation		0	
	Sequestration adjustment-PARHM				30
	Interim payments			2, 667, 225	
	Interim payments-PARHM				31
	Tentative settlement (for contractor use only)			0	
	Tentative settlement-PARHM (for contractor use only)	4 00 00 04 1 00			32
	Balance due provider/program (line 30 minus lines 30.0		4	399, 149	
	Balance due provider/program-PARHM (lines 2, 3, 18, an			_	33
4.00	Protested amounts (nonallowable cost report items) in	accordance with CMS Pub. 15-2	, chapter 1,	0	34

	Financial Systems CAMERON MEMORIAL COMM ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315		J OF Form CMS-2	
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020		par
		Title XIX	Hospi tal	4/21/2021 9:4 PPS	4 d
			I npati 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		- 1 1		
00	Inpatient hospital/SNF/NF services		0		
00	Medical and other services			0	
00 00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		U U	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routine service charges		94, 103		8
00	Ancillary service charges		495, 718	0	
	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10
	Total reasonable charges (sum of lines 8 through 11)		0 589, 821	0	
2.00	CUSTOMARY CHARGES		507, 021	0	1 14
3.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	113
	basi s	5		-	
4.00	Amounts that would have been realized from patients liable fo		on 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
5.00 7.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	589, 821 589, 821	0	
7.00	line 4) (see instructions)	Ty IT ITTLE TO EXCEEds	507, 021	0	
8.00	Excess of reasonable cost over customary charges (complete on	lvifline 4 exceeds lin	ne O	0	18
	16) (see instructions)			-	
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see inst		0	0	
1.00	Cost of covered services (enter the lesser of line 4 or line		0	0	2'
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi			
	Other than outlier payments		298, 360	0	
	Outlier payments Program capital payments		0	0	23
	Capital exception payments (see instructions)		0		2
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		298, 360	0	
8.00	Customary charges (title V or XIX PPS covered services only)		0	0	28
9.00	Titles V or XIX (sum of lines 21 and 27)		298, 360	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	298, 360	0	
	Deducti bl es		0	0	
	Coinsurance Allowable bad debts (see instructions)		6, 213 0	0	
	Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	292, 147	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	~	0	0	
	Subtotal (line 36 ± line 37)		292, 147	0	38
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)		292, 147	0	
	Interim payments		292, 147	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43

	E SHEET (If you are nonproprietary and do not maintain	Provider C		eriod: rom 10/01/2019	Worksheet G	
una-t nly)	ype accounting records, complete the General Fund column			09/30/2020	Date/Time Pre 4/21/2021 9:4	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	19, 298, 493	0	0	0	1 1
00	Temporary investments	17,270,170	0	0	0	2
00	Notes receivable	0	0	0	0	3
00	Accounts receivable	8, 511, 128	0	0	0	
00	Other receivable	785, 247		0	0	5
00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	1 6
00	Inventory	1, 395, 002	0	0	0	7
00	Prepaid expenses	736, 753	0	0	0	8
00	Other current assets	0	0	0	0	9
	Due from other funds	0	0	0	0	10
. 00	Total current assets (sum of lines 1-10)	30, 726, 623	0	0	0	11
~~	FI XED_ASSETS	1 110 0/7			0	
	Land	1, 419, 367		0	0	
	Land improvements	0	0	0	0	13
	Accumulated depreciation	E7 410 34E	, °	0		15
	Buildings Accumulated depreciation	57, 618, 245 -24, 594, 174			0	16
	Leasehold improvements	-24, 374, 1/4	0		0	17
	Accumulated depreciation	0	0	0	0	18
	Fixed equipment	0	0	0	0	19
	Accumulated depreciation	0	0	0	0	20
	Automobiles and trucks	0	0	0	0	21
. 00	Accumulated depreciation	0	0	0	0	22
. 00	Major movable equipment	20, 351, 820	0	0	0	23
. 00	Accumulated depreciation	-16, 676, 039	0	0	0	24
. 00	Minor equipment depreciable	0	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	
	Minor equipment-nondepreciable	0	0	0	0	
0.00	Total fixed assets (sum of lines 12-29)	38, 119, 219	0	0	0	30
00	OTHER ASSETS Investments	25, 804, 843	0	0	0	31
	Deposits on Leases	25, 604, 645	0	0	0	32
	Due from owners/officers	0	0	0	0	33
	Other assets	933, 114	-	0	0	
	Total other assets (sum of lines 31-34)	26, 737, 957		0	0	
	Total assets (sum of lines 11, 30, and 35)	95, 583, 799		0	0	
	CURRENT LI ABI LI TI ES		-		-	
. 00	Accounts payable	2, 022, 075	0	0	0	37
. 00	Salaries, wages, and fees payable	3, 501, 635	0	0	0	38
. 00	Payroll taxes payable	0	0	0	0	39
. 00	Notes and Loans payable (short term)	8, 713, 784	0	0	0	40
. 00	Deferred income	0	0	0	0	41
	Accelerated payments	0				42
	Due to other funds	0	0	0	0	
	Other current liabilities	654, 980		0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	14, 892, 474	0	0	0	45
00	LONG TERM LI ABI LI TI ES	~	-	0		1.
	Mortgage payable Notes payable	0	0	0	0	
	Unsecured Loans	0	0	0	0	47
	Other long term liabilities	45, 392, 510	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	45, 392, 510		0	0	
	Total liabilities (sum of lines 45 and 50)	60, 284, 984		0	0	
	CAPITAL ACCOUNTS	33, 201, 704		. 0	0	1
. 00	General fund balance	35, 298, 815				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
3. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	05 065 5			-	
). 00). 00	Total fund balances (sum of lines 52 thru 58)	35, 298, 815		0	0	
	Total liabilities and fund balances (sum of lines 51 and	95, 583, 799	0	0	0	60

STATEM	Financial Systems CAMER ENT OF CHANGES IN FUND BALANCES	RON MEMORIAL CON	Provider CC		Per	i od:	u of Form CMS Worksheet G		552-10
OTATEM						om 10/01/2019 09/30/2020			bared:
							4/21/2021 9	: 44	1 am
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund		
							Funu	+	
		1.00	2.00	3.00		4.00	5.00	-	
1.00	Fund balances at beginning of period		34, 890, 275			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		408, 540						2.00
3.00	Total (sum of line 1 and line 2)		35, 298, 815			0			3.00
4.00	Additions (credit adjustments) (specify)	0			0			0	4.00
5.00 6.00		0			0			0	5.00 6.00
8.00 7.00		0			0			0	8.00 7.00
8.00		0			0			0	8.00
9.00		Ő			Ö			ŏ	9,00
10.00	Total additions (sum of line 4-9)		0			0			10.00
11.00	Subtotal (line 3 plus line 10)		35, 298, 815			0			11.00
12.00	Deductions (debit adjustments) (specify)	0			0				12.00
13.00		0			0			0	13.00
14.00		0			0			0	14.00
15.00 16.00		0			0			0	15.00 16.00
17.00		0			0			0	17.00
18.00	Total deductions (sum of lines 12-17)	0	0		Ŭ	0		Ĭ	18.00
19.00	Fund balance at end of period per balance		35, 298, 815			0			19.00
	sheet (line 11 minus line 18)								
		Endowment	PI ant	Fund					
		Fund							
		6.00	7.00	8.00					
1.00	Fund balances at beginning of period	0			0				1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)								2.00
3.00	Total (sum of line 1 and line 2)	0			0				3.00
4.00	Additions (credit adjustments) (specify)		0						4.00
5.00 6.00			0						5.00 6.00
7.00			0						7.00
8.00			0						8.00
9.00			0						9.00
10.00	Total additions (sum of line 4-9)	0			0				10.00
11.00	Subtotal (line 3 plus line 10)	0			0				11.00
12.00	Deductions (debit adjustments) (specify)		0						12.00
13.00			0						13.00
14.00			0						14.00
15.00			0						15.00 16.00
16.00 17.00			0						16.00
			U		~				
17.00	Total deductions (sum of lines 12-17)	0	1		0				18.00
	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0			0				18.00 19.00

TATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1315	Peri od:	Worksheet G-2	2
				From 10/01/2019 To 09/30/2020		
	Cost Center Description		I npati ent	Outpati ent	Total	
	T		1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
00	General Inpatient Routine Services		8, 787, 4	05	8, 787, 495	1 1 0
. 00 . 00	Hospital SUBPROVIDER - IPF		0, 707, 4	95	0, /0/, 495	1.0
. 00	SUBPROVIDER - IRF					3.0
. 00	SUBPROVI DER					4.0
. 00	Swing bed - SNF			0	0	
. 00	Swing bed - NF			0	0	
. 00	SKILLED NURSING FACILITY					7.0
. 00	NURSING FACILITY					8.0
. 00	OTHER LONG TERM CARE					9.0
0.00	Total general inpatient care services (sum of lines 1-9)		8, 787, 49	95	8, 787, 495	10.0
	Intensive Care Type Inpatient Hospital Services				1	
1.00	I NTENSI VE CARE UNI T		380, 00	00	380, 000	
2.00	CORONARY CARE UNIT					12.0
3.00	BURN INTENSIVE CARE UNIT					13.0
						14.0
5.00	OTHER SPECIAL CARE (SPECIFY)	£ 11	200.0	00	200,000	15.0
6.00	Total intensive care type inpatient hospital services (sum c 11-15)	DETTNES	380, 00	00	380, 000	16.0
7.00	Total inpatient routine care services (sum of lines 10 and 1	(6)	9, 167, 49	05	9, 167, 495	17.0
8.00	Ancillary services	10)	14, 488, 3			
9.00	Outpatient services		547, 7			
			16, 40			
0.01	RURAL HEALTH CLINIC - URGENT CARE			0 2, 781, 006		
				0 1, 020, 616		
1.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.0
2.00	HOME HEALTH AGENCY			C	0	22.0
3.00	AMBULANCE SERVI CES					23.0
4.00	СМНС					24.0
5.00	AMBULATORY SURGI CAL CENTER (D. P.)					25.0
6.00	HOSPICE			0 0		
7.00	HOSPITALIST FEES			0 0	-	
7.01	OTHER REVENUE		558, 30			
7.02 8.00	PROFESSIONAL FEES	2 to Wkat	190, 29			
8.00	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	3 LO WKSL.	24, 968, 63	29 142, 097, 481	167, 066, 110	28.0
	PART II - OPERATING EXPENSES				1	1
9.00	Operating expenses (per Wkst. A, column 3, line 200)			73, 183, 497		29.0
0.00	ADD (SPECIFY)			0		30.0
1.00				0		31.0
2.00				0		32.0
3.00				0		33.0
4.00				0		34.0
5.00				0		35.0
6.00	Total additions (sum of lines 30-35)			C		36.0
7.00	DEDUCT (SPECI FY)			0		37.0
8.00				0		38.0
9.00				0		39.0
0.00				0		40.0
1.00	Total doductions (sum of lines 27 41)					41.0
2.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line	(1) (+		73, 183, 497		42.0
3.00						

Heal th	Financial Systems CAMERON	I MEMORIAL COMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1315	Period: From 10/01/2019 To 09/30/2020	Worksheet G-3 Date/Time Pre 4/21/2021 9:4	pared:
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I,	column 3 line 28)		167, 066, 110	1.00
2.00	Less contractual allowances and discounts on pa			98, 807, 361	2.00
3.00	Net patient revenues (line 1 minus line 2)			68, 258, 749	3.00
4.00	Less total operating expenses (from Wkst. G-2,	Part II. line 43)		73, 183, 497	4.00
5.00	Net income from service to patients (line 3 mir			-4, 924, 748	5.00
	OTHER I NCOME			.,,	
6.00	Contributions, donations, bequests, etc			189, 250	6.00
7.00	Income from investments			2,083,369	7.00
8.00	Revenues from telephone and other miscellaneous	s communication services		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
13.00	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests	5		0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical suppl	ies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patier	nts		0	17.00
18.00	Revenue from sale of medical records and abstra	acts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc	c.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and	canteen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER INCOME			825, 774	24.00
24.01	OTHER (SPECIFY)			0	24.01
24.02	GAIN/LOSS ON DISPOSAL OF ASSETS			-104, 821	24.02
24.50	COVI D-19 PHE Fundi ng			2, 339, 716	24.50
25.00	Total other income (sum of lines 6-24)			5, 333, 288	25.00
26.00	Total (line 5 plus line 25)			408, 540	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscr			0	28.00
29.00	Net income (or loss) for the period (line 26 mi	nus line 28)		408, 540	29.00

	J	TON WEWORTAL CO					
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315	Period: From 10/01/2019	Worksheet M-1	
			Component	CCN: 15-8530	To 09/30/2020		pared:
						4/21/2021 9:4	
					RHC I	Cost	
		Compensati on	Other Costs		1 Reclassi fi cat		
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00	0.00	1.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physician	411, 175	9, 348	420, 52	-4, 441	416, 082	1.00
2.00	Physician Assistant	411, 175	7, 340	420, 52	-4, 441	410,082	
3.00	Nurse Practitioner	233, 563	0	233, 56	-2, 522	231, 041	3.00
4.00	Visiting Nurse	233, 503	0	233, 50	0 -2, 522	231,041	4.00
5.00	Other Nurse	278,009		278,00		278,009	5.00
6.00	Clinical Psychologist	270,007		270,00		270,009	6.00
7.00	Clinical Social Worker	16, 109		16, 10	-174		7.00
8.00	Laboratory Techni ci an	10, 107		10, 10	0 0	15, 755	8.00
9.00	Other Facility Health Care Staff Costs	0				0	9.00
10.00	Subtotal (sum of lines 1 through 9)	938, 856	9, 348	948, 20	-7,137		•
11.00	Physician Services Under Agreement	, 50, 550 0	, 340	740,20	0 7,137	0	
12.00	Physician Supervision Under Agreement	0				0	
13.00	Other Costs Under Agreement	0				0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	4, 737	4, 73	-	4,737	
16.00	Transportation (Health Care Staff)	0	0	1,70	0 0	0	
17.00	Depreciation-Medical Equipment	0	0		0 0	0	
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Heal th Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs	-	-		-		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	4, 737	4,73	37 0	4, 737	
22.00	Total Cost of Health Care Services (sum of	938, 856	14, 085				•
	lines 10, 14, and 21)				.,		
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 7,163	7, 163	25.01
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 7,163	7, 163	28.00
	through 27)						
	FACILITY OVERHEAD				-		
29.00	Facility Costs	0	657			657	29.00
30.00	Administrative Costs	97, 182	63, 155				•
31.00	Total Facility Overhead (sum of lines 29 and	97, 182	63, 812	160, 99	-26	160, 968	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 036, 038	77, 897	1, 113, 93	5 0	1, 113, 935	32.00
	and 31)			I		I	I

ANALYSIS OF HOSPITAL-BASED RHC/FORE COSTS Provider COS	Heal th	Financial Systems CAMER	RON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lieu	u of Form CMS-	2552-10
Component CCN: 15-8530 To 09/30/2020 Date/Time Prep 42/20201 9:44 Adjustments Met Expenses for Al location (col. 6) RHC I Cost 100 Physician Physician Assistant 0 416,082 0 0 2.00 Physician Assistant 0 416,082 0 0 0.00 Wirse Practitioner 0 231,041 0 0 0.00 Wirse Practitioner 0 216,099 0 0 0.00 Clinical Seychologist 0 278,009 0 0 0.00 User Additioner 0 10,00 935,009 0 0 0.00 User Additioner 0 15,935 0 0 0 0.00 User Additioner Agreement 0 0 0 0 0 0 10.00 Subtotal (sum of lines 11 through 9) 0 941,067 0 0 0 10.00 Physician Services (sum of lines 10 through 9) 0 0 0 0 0<	ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315		Worksheet M-1	1
Adjustments Net Expenses for All ocation (col. 5 + col. 6) RHC I Cost FACILITY HEALTH CARE STAFF COSTS 6.00 7.00 1.00 Physician 0 416,082 1.00 Physician Assistant 0 416,082 20.0 210,011 1.00 Physician Assistant 0 210,011 211,041 20.0 1.00 Physician Assistant 0 211,041 20.0 211,041 4.00 Visiting Marse 0 216,009 210,041 20.0 0.00 Clinical Social Worker 0 210,047 218,009 0 0.01 Clinical Social Worker 0 15,925 0 278,009 0.01 Clinical Social Worker 0 0 0 0 0.00 Subtrofal (sup of lines 1 fines 1 fines greenent 0 0 0 0 12.00 Physician Supervision Under Agreement 0 0 0 0 0 13.00 Other Costs Under Agreement 0 0 0				Component	CCN: 15-8530		Dato/Timo Pro	anarod
Interpretation Net Expenses for Adjustments Net Expenses for Allocation (col. 5 + col. 6) RHC I Cost 1.00 Physician Physician Sistant 0 7.00 -				component	CGN. 15-8550	10 09/ 30/ 2020	4/21/2021 9:4	44 am
Adjustments Net Expenses Allocation (col. 5 + col. 6) FAULUTY HEALTH CARE STAFF COSTS 00 Physiclan 2.00 Physiclan Sasistant 0.0 Wirse Practitioner 0.0 Visiting Nurse 0.0 Clinical Social Worker 0.0 Clinical Social Worker 0.0 Clinical Social Worker 0.0 Other Facility Health Care Staff Costs 0.0 Outroid Social Worker 0.0 Other Staff Costs 0.0 Other Costs 0.0 O						RHC I		
For All Location (Col. 5, - col. 6) Physician 1.00 Physician 0.00 0.01 Physician 0.01 0.02 0.03.00 0.04 0.05 0.05 0.06 0.07 0.00 0.01 0.01 0.02 0.03.00 0.03.00 0.04 0.05 0.06 0.07 0.08 0.08 0.01			Adjustments	Net Expenses		· · · · · · · · · · · · · · · · · · ·		
Image: control of the second			2	for				
Image: color bit is and the image is a color bit is color bit is color bit is a color bit is color bit is color bit is				Allocation				
6.00 7.00 Physician 0 416.082 2.00 Physician Assistant 0 0 3.00 Nurse Practitioner 0 0 0.00 Visiting Nurse 0 0 0.00 Clinical Social Worker 0 0 0.01 Clinical Social Worker 0 0 0.01 Laboratory Technician 0 0 0.00 Subtotal (sum of lines 1 through 9) 0 941.067 11.00 Physician Supervision Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Heal th Care Staff) 0 0 17.00 Bysician Supervision Under Agreement 0 0 18.00 Professional Liability Insurance 0 0				(col. 5 +				
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician Assistant 0 416,082 2.00 Physician Assistant 0 0 3.00 Nurse Practitioner 0 231,041 4.00 Visiting Nurse 0 231,041 4.00 Visiting Nurse 0 278,009 6.01 Clinical Psychologist 0 0 0 7.00 Clinical Psychologist 0 0 0 0.00 Other Facility Health Care Staff Costs 0 0 0 9.00 Other Facility Health Care Staff Costs 0 0 0 10.00 Subtotal (sum of lines 11 through 9) 0 941,067 0 11.00 Physician Supplies 11 through 13) 0 0 0 12.00 Physician -Medical Equipment 0 0 0 0 13.00 Medical Supplies 1 through 13) 0 0 0 13.00 Medical Supplies 1 through 20) 0 4,737 <td></td> <td></td> <td></td> <td>col. 6)</td> <td></td> <td></td> <td></td> <td></td>				col. 6)				
1:00 Physician 0 416.082 2:00 Physician Assistant 0 0 3:00 Nurse Practitioner 0 231.041 4:00 Visiting Nurse 0 0 5:00 Other Nurse 0 231.041 6:00 Clinical Social Worker 0 15.935 6:00 Laboratory Technician 0 0 0:00 Subtotal (sum of lines 1 through 9) 0 941.067 0:00 Subtotal (sum of lines 1 through 9) 0 941.067 0:00 Other Acst Inty Regrement 0 0 0:00 Other Costs Under Agreement 0 0 0:00 Other Costs Under Agreement 0 0 0:00 Other Malt Care Staff) 0 0 0 0:00 Other Agreement 0 0 0 0:00 Other Agreement 0 0 0 0:00 Other Agreement 0 0 0 0:00 Other He			6.00	7.00				
2.00 Phýsician Assistant 0 0 3.00 Nurse Practitioner 0 231,041 4.00 Visiting Nurse 0 0 0.00 Other Nurse 0 278,009 0.01 Clinical Psychologist 0 0 0.01 Clinical Psychologist 0 15,935 0.01 Other Facility Health Care Staff Costs 0 0 0.02 Other Facility Health Care Staff Costs 0 0 0.03 Obtotal (sum of lines 1 through 9) 0 941,067 11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 1 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Health Care Staff) 0 0 17.00 Depreciation-Medical Equiptement 0 0 18.00 </td <td></td> <td></td> <td></td> <td></td> <td>1</td> <td></td> <td></td> <td>-</td>					1			-
3.00 Nurse Practitioner 0 231,041 0.00 Visiting Nurse 0 0 0.00 Clinical Social Worker 0 278,009 0.01 Clinical Social Worker 0 0 0.01 Clinical Social Worker 0 0 0.01 Laboratory Technician 0 0 0.00 Subtotal (sum of lines 1 through 9) 0 941,067 11.00 Physician Servision Under Agreement 0 0 12.00 Physician Servision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Heal th Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 17.00 Bubtotal (sum of lines 15 through 20) 0 4,737 17.00 Subtotal (sum of lines 5 through 20) 0 4,737			-		1			1.00
4.00 Visiting Nurse 0 0 5.00 Other Nurse 0 278,009 6.00 Clinical Psychologist 0 0 7.00 Clinical Social Worker 0 15,935 8.00 Laboratory Technician 0 0 9.00 Other Facility Health Care Staff Costs 0 0 9.00 Other Facility Health Care Staff Costs 0 0 10.00 Subtotal (sum of lines 1 through 9) 0 941.067 11.00 Physician Supervision Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 15.00 Medical Supplies 0 4,737 0 0 17.00 Depreciation-Medical Equipment 0 0 0 0 18.00 Pharmacy 0 0 0 0 0 0 <td></td> <td>5</td> <td>0</td> <td>, s</td> <td></td> <td></td> <td></td> <td>2.00</td>		5	0	, s				2.00
5.00 Other Nurse 0 278,009 6.00 Clinical Psychologist 0 0 00 Clinical Social Worker 0 90 0.00 Laboratory Technician 0 0 0.00 Subtotal (sum of lines 1 through 9) 0 941,067 11.00 Physician Services Under Agreement 0 0 12.00 Physician Services Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Heal th Care Staff) 0 0 10.00 Physician Services (sum of lines 15 through 20) 0 4,737 10.00 Allowable GME Costs 0 0 11.00 Physican Services (sum of lines 15 through 20) 4,737 12.00 Votatal (sum of lines 15 through 20) 4,737 12.00 Pharmacy 0 0 10 To			0	231, 041				3.00
6.00 Clinical Psychologist 0 0 7.00 Clinical Social Worker 0 15,935 8.00 Laboratory Technician 0 0 9.00 Other Facility Health Care Staff Costs 0 0 9.00 Other Facility Health Care Staff Costs 0 0 9.00 Physician Services Under Agreement 0 0 11.00 Physician Supervision Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 0 15.00 Medical Supplies 0 4,737 0 0 16.00 Transportation (Health Care Staff) 0 0 0 0 17.00 Depreciation-Medical Equipment 0 0 0 0 17.00 Detrefessional Liability Insurance 0 0 0 0 17.01 Subtotal (sum of lines 15 th			0	0				4.00
7.00 Clinical Social Worker 0 15,935 8.00 Laboratory Technician 0 0 9.00 Other Facility Health Care Staff Costs 0 0 10.00 Subtotal (sum of lines 1 through 9) 0 941,067 11.00 Physic lan Supervision Under Agreement 0 0 12.00 Physic lan Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Trasportation (Health Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Other Fascility Insurance 0 0 19.00 Other Health Care Costs 0 0 10.01 Subtotal (sum of lines 15 through 20) 0 4,737 10.01 Subtotal (sum of lines 15 through 20) 0 4,737 10.02 Total Cost of Health Care Services (sum of 0 945,804 0 11.01 Subtotal (sum of lines 15 </td <td></td> <td></td> <td>0</td> <td>278,009</td> <td></td> <td></td> <td></td> <td>5.00</td>			0	278,009				5.00
8.00 Laboratory Technician 0 0 9.00 Other Facility Heal th Care Staff Costs 0 10.00 Subtotal (sum of lines 1 through 9) 941,067 11.00 Physician Services Under Agreement 0 12.00 Physician Services Under Agreement 0 13.00 Other Costs Under Agreement 0 13.00 Other Costs Under Agreement 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Professional Liability Insurance 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 10.01 Mawable GME Costs 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 4,737 22.00 Phamacy 0 0 0 23.00 Phamacy 0 0 0 24.00 Dental 0 7,163 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td>6.00</td></t<>			0	0				6.00
9.00 Other Facility Health Care Staff Costs 0 00 Subtotal (sum of lines 1 through 9) 0 10.00 Physician Supervision Under Agreement 0 11.00 Physician Supervision Under Agreement 0 12.00 Physician Supervision Under Agreement 0 13.00 Other Costs Under Agreement 0 14.00 Subtotal (sum of lines 11 through 13) 0 15.00 Medical Supplies 0 16.00 Transportation (Health Care Staff) 0 17.00 Depreciation-Medical Equipment 0 18.00 Professional Liability Insurance 0 19.00 Other Health Care Costs 0 10.00 Subtotal (sum of lines 15 through 20) 0 4, 737 10.01 Subtotal (sum of Lines 15 through 20) 0 4, 737 10.02 Dental 0 0 0 10.05 Other Keatth Care Services (sum of 945, 804 0 0 10.05 Other Health Care Services (sum of 0 0 0 0 23.00 Pharmacy 0 0 <t< td=""><td></td><td></td><td>0</td><td></td><td>1</td><td></td><td></td><td>7.00</td></t<>			0		1			7.00
10.00 Subtotal (sum of lines 1 through 9) 0 941,067 11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Health Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Health Care Staff) 0 0 10.00 Byperciation of Health Care Staff) 0 0 10.00 Operciation of Health Care Staff) 0 0 10.00 Other Health Care Staff) 0 0 11.00 Subtotal (sum of lines 15 through 20) 0 4,737 10.01 Cost Grave Management 0 0 11.01 Cost Other THAN RHC/FOHC SERVICES 0 0 11.01 Dental 0 0			0	-				8.00
11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Health Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 10.00 Other Health Care Costs 0 0 11.00 Other Health Care Services (sum of lines 15 through 20) 0 4,737 10.01 Obtotal (sum of lines 15 through 20) 0 4,737 10.02 Dental 0 0 11.05 10, 14, and 21) 0 0 0 23.00 Pharmacy 0 0 0 24.00 Dental 0 0 0 25.01 Tel heal th 0 7,163 0 26.00 Tel heal th 0 0 0			0	, v				9.00
12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Heal th Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Health Care Costs 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 4,737 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 0 945,804 10.00 Dental 0 0 0 23.00 Pharmacy 0 0 0 25.00 Optometry 0 0 0 25.01 Telehealth 0 0 0 26.02 Chronic Care Management 0 0 0 27.00 Nonal I owable GME costs 0 0 0 28.00 Total Nonrei mbursab			0					10.00
13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Heal th Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Heal th Care Costs 0 0 20.00 Allowable GME costs 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 4,737 22.00 Total Cost of Heal th Care Services (sum of lines 15 through 20) 0 4,737 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.01 Tel eheal th 0 7,163 25.02 Chronic Care Management 0 0 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Noall lowable GME costs (sum of lines 23 0 7,163 2		5	0	, s				11.00
14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 4,737 16.00 Transportation (Heal th Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Heal th Care Costs 0 0 20.00 Allowable GME Costs 4,737 21.00 Subtotal (sum of lines 15 through 20) 0 4,737 22.00 Total Cost of Heal th Care Services (sum of 0 945,804 1ines 10, 14, and 21) 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.01 Teleheal th 0 0 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Noallowable GME costs 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 7,163			0	-				12.00
15.00 Medical Supplies 0 4,737 16.00 Transportation (Heal th Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Health Care Costs 0 0 20.00 Allowable GME Costs 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 4,737 22.00 Total Cost of Health Care Services (sum of 0 945,804 11 ines 10, 14, and 21) 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.01 Teleheal th 0 7,163 25.02 Chronic Care Management 0 0 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonal Iowable GME costs 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 7,163			0	, s				13.00
16.00 Transportation (Heal th Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Heal th Care Costs 0 0 20.00 Allowable GME Costs 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 4, 737 22.00 Total Cost of Heal th Care Services (sum of 0 945, 804 1 ines 10, 14, and 21) 0 0 0 COSTS OTHER THAN RHC/FOHC SERVICES Pharmacy 0 0 23.00 Pharmacy 0 0 0 24.00 Dental 0 0 0 25.01 Teleheal th 0 0 0 25.02 Chronic Care Management 0 0 0 26.00 All other nonreimbursable costs 0 0 0 27.00 Nonallowable GME costs 0 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 7, 163			0	-				14.00
17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Health Care Costs 0 0 20.00 Allowable GME Costs 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 4,737 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 0 0 COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.01 Telehealth 0 7,163 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonallowable GME costs 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 through 27) 0 0 FACILITY OVERHEAD 0 657 0 160, 311 29.00 Facility Costs 0 160, 968 30) 160, 968			0					15.00
18.00 Professional Liability Insurance 0 0 19.00 Other Heal th Care Costs 0 0 20.00 Allowable GME Costs 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 4,737 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 0 945,804 COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.00 Optometry 0 0 0 25.01 Tel eheal th 0 7,163 0 25.02 Chronic Care Management 0 0 0 26.00 All other nonreimbursable costs 0 0 0 27.00 Nonall owable GME costs 0 0 0 0 28.00 Total Nonreimbursable costs (sum of lines 23 0 7,163 0 657 29.00 Facility Costs 0 657 0 160,311 160,968 30) Verhead (sum of lines 29 and 30) 0			0	, s				
19.00 Other Heal th Care Costs 0 0 20.00 All owable GME Costs 0 4, 737 21.00 Subtotal (sum of lines 15 through 20) 0 4, 737 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 0 945, 804 COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.00 Optometry 0 0 25.01 Tel eheal th 0 7, 163 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonal Iowable GME costs 0 0 28.00 Total Nonreimbursable costs (sum of lines 23 0 7, 163 Horough 27) FACILLITY OVERHEAD 7, 163 7, 163 29.00 Facility Costs 0 657 30.0 Adm in strative Costs 0 160, 311 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 160, 968			0	-				17.00
20.00 Allowable GME Costs 4,737 21.00 Subtotal (sum of lines 15 through 20) 0 4,737 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 0 945,804 COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.01 Tel eheal th 0 0 25.02 Chronic Care Management 0 0 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonallowable GME costs 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 7, 163 29.00 Facility Overhead 0 657 30.0 Administrative Costs 0 160, 311 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 160, 968			0	-				19.00
21.00Subtotal (sum of lines 15 through 20) Total Cost of Heal th Care Services (sum of lines 10, 14, and 21)04,737 945,80423.00Pharmacy O0024.00Dental0025.00Optometry0025.01Tel eheal th07,16325.02Chronic Care Management0026.00All other nonreimbursable costs0027.00Total Nonreimbursable Costs (sum of lines 2307,16328.00Total Nonreimbursable Costs0029.00Facility Costs065730.00Administrative Costs0160,31131.00Total Facility Overhead (sum of lines 29 and 30)0160,968			0					20.00
22.00Total Cost of Health Care Services (sum of Lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES0945, 80423.00Pharmacy0024.00Dental0025.00Optometry0025.01Teleheal th07, 16325.02Chronic Care Management0026.00All other nonreimbursable costs0027.00Nonal I owabl e GME costs0028.00Total Nonreimbursable Costs (sum of Lines 2307, 163FACILITY OVERHEAD29.00Facility CostsO 65730.00Administrative Costs31.00Total Facility Overhead (sum of Lines 29 and 30)0			0	1 727				20.00
Lines 10, 14, and 21) O COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 24.00 Dental 0 0 25.00 Optometry 0 0 25.01 Tel eheal th 0 7, 163 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonal I owable GME costs 0 0 28.00 Total Nonreimbursable Costs (sum of Lines 23 0 7, 163 29.00 Facility Costs 0 657 30.00 Administrative Costs 0 160, 311 31.00 Total Facility Overhead (sum of Lines 29 and 30) 0 160, 968			0					21.00
COSTS OTHER THAN RHC/FOHC SERVICES23.00Pharmacy0024.00Dental0025.00Optometry0025.01Teleheal th07, 16325.02Chronic Care Management0026.00All other nonreimbursable costs0027.00Nonal I owable GME costs0028.00Total Nonreimbursable Costs (sum of lines 2307, 16329.00Facility Costs065730.00Administrative Costs0160, 31131.00Total Facility Overhead (sum of lines 29 and 30)0160, 968	22.00		0	943,004				22.00
23.00 Pharmacy 0 0 24.00 Dental 0 0 25.00 Optometry 0 0 25.01 Tel eheal th 0 7,163 25.02 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonal lowable GME costs 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 7,163 through 27) FACILITY OVERHEAD 0 657 29.00 Facility Costs 0 657 30.00 Administrative Costs 0 160, 311 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 160, 968								
24.00Dental0025.00Optometry0025.01Teleheal th07, 16325.02Chronic Care Management0026.00All other nonreimbursable costs0027.00Nonal lowable GME costs0028.00Total Nonreimbursable Costs (sum of lines 2307, 16328.00Facility Costs065730.00Administrative Costs0160, 31131.00Total Facility Overhead (sum of lines 29 and 30)0160, 968	23.00		0	0				23.00
25.00Optometry0025.01Telehealth07, 16325.02Chronic Care Management0026.00All other nonreimbursable costs0027.00Nonal lowable GME costs07, 16328.00Total Nonreimbursable Costs (sum of lines 2307, 163FACILITY OVERHEAD29.00Facility Costs30.00Administrative Costs31.00Total Facility Overhead (sum of lines 29 and 30)0				-	1			24.00
25.01Tel eheal th07, 16325.02Chronic Care Management0026.00All other nonreimbursable costs0027.00Nonal I owable GME costs0028.00Total Nonreimbursable Costs (sum of lines 2307, 163FACI LI TY OVERHEAD29.00Faci li ty Costs30.00Admini strative Costs31.00Total Faci li ty Overhead (sum of lines 29 and 30)0			0	0)			25.00
25.02Chronic Care Management0026.00All other nonreimbursable costs0027.00Nonallowable GME costs07,16328.00Total Nonreimbursable Costs (sum of lines 23 through 27)07,163FACILITY OVERHEAD29.00Facility Costs030.00Administrative Costs0100Total Facility Overhead (sum of lines 29 and 30)0160,968			0	7, 163				25.01
26.00 All other nonreimbursable costs 0 0 27.00 Nonallowable GME costs 0 7,163 28.00 Total Nonreimbursable Costs (sum of lines 23 0 7,163 FACILITY OVERHEAD 29.00 Facility Costs 0 30.00 Administrative Costs 0 160,311 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 160,968	25.02	Chronic Care Management	0		1			25.02
28.00Total Nonreimbursable Costs (sum of lines 23 through 27)07,163FACILITY OVERHEAD29.00Facility Costs0657065730.00Administrative Costs01.00Total Facility Overhead (sum of lines 29 and 30)0	26.00		0	0				26.00
through 27)FACILITY OVERHEAD29.00Facility Costs030.00Administrative Costs010.00Total Facility Overhead (sum of lines 29 and 30)0	27.00	Nonallowable GME costs						27.00
FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30)	28.00	Total Nonreimbursable Costs (sum of lines 23	0	7, 163				28.00
29.00 Facility Costs 0 657 30.00 Administrative Costs 0 160, 311 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 160, 968		through 27)						
30. 00Administrative Costs0160, 31131. 00Total Facility Overhead (sum of lines 29 and 30)0160, 968		FACILITY OVERHEAD						
31.00 Total Facility Overhead (sum of lines 29 and 0 160, 968 30)	29.00	Facility Costs	0	657				29.00
30)			-		•			30.00
	31.00	Total Facility Overhead (sum of lines 29 and	0	160, 968				31.00
32 00 Total facility costs (sum of lines 22 28 0 1 113 935								
	32.00	Total facility costs (sum of lines 22, 28	0	1, 113, 935	1			32.00
and 31)		and 31)		I				I

Heal th	Financial Systems CAMEI	RON MEMORIAL CO	DMMUNITY HUSPI	IAL	In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315	Period:	Worksheet M-1	
			Component	CCN: 15-8545	From 10/01/2019 To 09/30/2020		
					RHC II	Cost	
		Compensati on	Other Costs	Total (col.	1 Recl assi fi cat		
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	369, 645	0				1.00
2.00	Physician Assistant	116, 073	0	116, 0	73 0	116, 073	2.00
3.00	Nurse Practitioner	242, 282	0	242, 2	82 0	242, 282	3.00
4.00	Visiting Nurse	0	0		0 0	-	
5.00	Other Nurse	144, 473	0	144, 4	73 0	144, 473	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	7, 553	0	7,5	53 0	7, 553	9.00
10.00	Subtotal (sum of lines 1 through 9)	880, 026	0	880, 0	26 0	880, 026	10.00
11.00	Physician Services Under Agreement	0	44, 654	44,6	54 0	44, 654	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	44,654	44,6	54 0	44,654	14.00
15.00	Medical Supplies	0	124, 643	124, 6	43 0	124, 643	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	124, 643	124, 6	43 0	124, 643	21.00
22.00	Total Cost of Health Care Services (sum of	880, 026	169, 297	1, 049, 3	23 0	1, 049, 323	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	25.01
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	
	through 27)					-	
	FACILITY OVERHEAD			•			1
29.00	Facility Costs	0	1, 202	1, 2	02 0	1, 202	29.00
30.00	Admini strati ve Costs	304, 745	15, 957				30.00
31.00	Total Facility Overhead (sum of lines 29 and		17, 159				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 184, 771	186, 456	1, 371, 2	27 -28, 529	1, 342, 698	32.00
	and 31)						
	-			-			-

Heal th	Financial Systems CAMER	RON MEMORIAL CO	DMMUNITY HOSPI	TAL	In Lieu	u of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315	Peri od:	Worksheet M-	1
			Component	CCN: 15-8545	From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:4	
					RHC II	Cost	
		Adjustments	Net Expenses				
		. ,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS			1			_
1.00	Physi ci an	0	369, 645				1.00
2.00	Physician Assistant	0	116, 073				2.00
3.00	Nurse Practitioner	0	242, 282	1			3.00
4.00	Visiting Nurse	0)				4.00
5.00	Other Nurse	0	144, 473	3			5.00
6.00	Clinical Psychologist	0					6.00
7.00	Clinical Social Worker	0	(7.00
8.00	Laboratory Technician	0	(8.00
9.00	Other Facility Health Care Staff Costs	0	7, 553				9.00
10. 00 11. 00	Subtotal (sum of lines 1 through 9)	0	880, 026				10.00
12.00	Physician Services Under Agreement	0	44,654				12.00
	Physician Supervision Under Agreement Other Costs Under Agreement	0					12.00
13.00	Subtotal (sum of lines 11 through 13)	0	44, 654				14.00
	Medical Supplies	0	124, 643				15.00
16.00	Transportation (Health Care Staff)	0	124,04	1			16.00
17.00	Depreciation-Medical Equipment	0					17.00
	Professional Liability Insurance	0					18.00
	Other Health Care Costs	0					19.00
	Allowable GME Costs	Ū					20.00
21.00	Subtotal (sum of lines 15 through 20)	0	124, 643	3			21.00
22.00	Total Cost of Health Care Services (sum of	0	1,049,323				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	(D			23.00
24.00	Dental	0	(24.00
25.00	Optometry	0	(25.00
25.01	Tel eheal th	0	(25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	(26.00
27.00	Nonallowable GME costs	_					27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	(28.00
	through 27)						-
20.00	FACILITY OVERHEAD Facility Costs	0	1, 202				29.00
29.00 30.00	Administrative Costs	0	292, 173	•			30.00
30.00	Total Facility Overhead (sum of lines 29 and	0	292, 173				30.00
51.00	30)	0	273, 373				31.00
32.00	Total facility costs (sum of lines 22, 28	0	1, 342, 698	3			32.00
52.00	and 31)	0	1,012,070				02.00
			I	1			I

			NUNUUNI IT HUSPI				2002-1
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Peri od:	Worksheet M-1	
			Component		From 10/01/2019 To 09/30/2020	Date/Time Pre	nared
			component	CCN. 15-0540	10 077 307 2020	4/21/2021 9:4	
					RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	740, 505	0	740, 50	-111, 278	629, 227	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	169, 894	0	169, 89	4 -25, 532	144, 362	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	208, 122	0	208, 12	-31, 275	176, 847	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 118, 521	0	1, 118, 52	-168, 085	950, 436	10.00
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	0		0 0	0	15.00
16.00	Transportation (Health Care Staff)	0	2,932	2, 93	2 0	2, 932	
17.00	Depreciation-Medical Equipment	0	2, ,02		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs	J	0		0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2, 932	2, 93	2 0	2, 932	
22.00	Total Cost of Health Care Services (sum of	1, 118, 521	2,932				
22.00	lines 10, 14, and 21)	1, 110, 321	2,752	1, 121, 40	100,000	755, 500	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	I					1
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0		24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	25.0
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs	0	0		0 0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
20.00	through 27)	0	0		0 0	0	20.00
	FACILITY OVERHEAD			I			1
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Admi ni strati ve Costs	45, 763	64, 825		-		30.00
31.00	Total Facility Overhead (sum of lines 29 and		64, 825				31.00
51.00	30)	45,705	04,020	110, 50	-17,037	75, 527	
				1	1		1
32.00	Total facility costs (sum of lines 22, 28	1, 164, 284	67, 757	1, 232, 04	-185, 144	1, 046, 897	32.00

			JMMUNITY HOSPI			I OF FORM CMS-	2002 1
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315	Peri od:	Worksheet M-7	1
			Component	CCN: 15-8546	From 10/01/2019 To 09/30/2020	Date/Time Pre	epared.
			componente		10 07/00/2020	4/21/2021 9:4	
			_		RHC III	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		(00	col. 6)	-			
	FACILITY HEALTH CARE STAFF COSTS	6.00	7.00				
1.00	Physician	-259, 639	369, 588	1			1.00
2.00	Physician Assistant	-237,037	0	1			2.00
3.00	Nurse Practi ti oner	-45, 975	98, 387				3.00
4.00	Visiting Nurse	43, 773	0, 30,				4.00
5.00	Other Nurse	0	176, 847				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	0)			9.00
10.00	Subtotal (sum of lines 1 through 9)	-305, 614	644, 822				10.0
11.00	Physician Services Under Agreement	0	0)			11.0
12.00	Physician Supervision Under Agreement	0	0				12.0
13.00	Other Costs Under Agreement	0	0				13.0
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.0
15.00	Medical Supplies	0	0				15.00
16.00	Transportation (Health Care Staff)	0	2, 932				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2, 932	•			21.00
22.00	Total Cost of Health Care Services (sum of	-305, 614	647, 754				22.00
	Lines 10, 14, and 21)						-
22.00	COSTS OTHER THAN RHC/FQHC SERVICES		0				
23.00 24.00	Pharmacy	0	0				23.00
	Dental	0					24.00
25.00 25.01	Optometry Telehealth	0					25.0
25.01	Chronic Care Management	0					25.0
26.02	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs	0	0				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	o				28.00
20.00	through 27)	0					20.00
	FACILITY OVERHEAD		1	1			1
29.00	Facility Costs	0	0				29.00
30.00	Administrative Costs	0	93, 529				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	93, 529	•			31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-305, 614	741, 283				32.00
02.00							

	Financial Systems CAME ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC	ERON MEMORIAL C			Period:	u of Form CMS-2 Worksheet M-2	
ILL00		OERVI OEO			From 10/01/2019		
			Component	CCN: 15-8530	To 09/30/2020	Date/Time Pre 4/21/2021 9:4	
			_		RHC I	Cost	
		Number of FTE	Total Visits		Minimum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
. 00	Physi ci an	0.70			1 1		1.0
. 00	Physician Assistant	0.00			1 0		2.0
. 00	Nurse Practitioner	1.67			1 2		3.0
. 00	Subtotal (sum of lines 1 through 3)	2.37	8, 553		3	8, 553	4.0
. 00	Visiting Nurse	0.00	0			0	5.0
. 00	Clinical Psychologist	0.00	0			0	6.0
. 00	Clinical Social Worker	0.08	63			63	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	1
. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7.0
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	2.45	8, 616			8, 616	8.0
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE 1			RVICES			
0.00						945, 804	
	Total nonreimbursable costs (from Wkst. M-1,					7, 163	
2.00						952, 967	
3.00						0. 992483	
4.00				ine 31)		160, 968	
5.00	Parent provider overhead allocated to facili	ity (see instru	ctions)			1, 228, 438	
6.00						1, 389, 406	
7.00	Allowable GME overhead (see instructions)					0	1
8.00						1, 389, 406	
9.00	Overhead applicable to hospital-based RHC/FC	QHC services (I	ine 13 x line	18)		1, 378, 962	19. (

19.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)1,378,96219.0020.00Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)2,324,76620.00

	Financial Systems CAME TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	ERON MEMORIAL CO	Provider C		Period:	u of Form CMS-2 Worksheet M-2	
ALLUCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FUHC	SERVICES	Provi der C		From 10/01/2019	worksneet M-2	
			Component		09/30/2020	Date/Time Pre 4/21/2021 9:4	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
	<u> </u>	1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1	-				
I. 00	Physi ci an	1.00			1		1.00
2.00	Physician Assistant	0. 68			1		2.00
8.00	Nurse Practitioner	1.72			2		3.00
1.00	Subtotal (sum of lines 1 through 3)	3.40			4	12, 978	4.00
5.00	Visiting Nurse	0.00				0	5.00
5.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
	onl y)						
3.00	Total FTEs and Visits (sum of lines 4	3.40	12, 978			12, 978	8.00
	through 7)						
9.00	Physician Services Under Agreements		552			552	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE 1					1.00	
10 00	Total costs of health care services (from W			WICE5		1, 049, 323	10 00
	Total nonreimbursable costs (from Wkst. M-1,					1, 047, 323	
	Cost of all services (excluding overhead) (s					1,049,323	
	Ratio of hospital-based RHC/FQHC services (1					1.000000	
	Total hospital-based RHC/FQHC overhead - (fi			ine 31)		293, 375	
	Parent provider overhead allocated to facili					1, 120, 599	
	Total overhead (sum of lines 14 and 15)		01101107			1, 413, 974	
	rotar overhead (sam of frites if and is)						
	Allowable GME overhead (see instructions)					01	
17.00	Allowable GME overhead (see instructions) Enter the amount from line 16					0 1, 413, 974	

19.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)1,413,97419.0020.00Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)2,463,29720.00

	Financial Systems CAM	ERON MEMORIAL CO	Provider C		Period:	u of Form CMS-2 Worksheet M-2	
ALLUCA	ATTON OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVICES	Provi der C		Period: From 10/01/2019		
			Component		To 09/30/2020		
			_		RHC III	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions	- 1	I	1	- F	-	
. 00	Physi ci an	0.75			1 1		1.0
2.00	Physician Assistant	0.00			1 0		2.0
. 00	Nurse Practitioner	0.63			1 1		3.0
. 00	Subtotal (sum of lines 1 through 3)	1.38			2	3, 294	4.0
. 00	Visiting Nurse	0.00				0	5.0
. 00	Clinical Psychologist	0.00				0	6.0
. 00	Clinical Social Worker	0.00				0	7.0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.0
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.0
	onl y)						
3.00	Total FTEs and Visits (sum of lines 4	1.38	3, 294			3, 294	8.0
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE					1.00	
0 00	Total costs of health care services (from W			NT CL3		647, 754	1 10 0
	Total nonreimbursable costs (from Wkst. M-1					047,754	
	Cost of all services (excluding overhead) (647, 754	
3.00	Ratio of hospital -based RHC/FQHC services (1. 000000	
	Total hospital-based RHC/FQHC overhead - (f			ino 21)		93, 529	
	Parent provider overhead allocated to facil					792, 721	
	Total overhead (sum of lines 14 and 15)	ity (see fiistiu				886, 250	
	Allowable GME overhead (see instructions)					000,230	
	Enter the amount from line 16					886, 250	
	Overhead applicable to hospital-based RHC/F	OHC services (1	ing 13 v ling	18)		886, 250	
17.00	Internet applicable to nospital -Dased RHC/F			10)		000,230	17.0

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 1, 534, 004
 20.00

LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	INITY HOSPITAL Provider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet M-3	
RVICES	Component CCN: 15 0520	From 10/01/2019	Data /Tima Dra	
	Component CCN: 15-8530	To 09/30/2020	Date/Time Pre 4/21/2021 9:4	
	Title XVIII	RHC I	Cost	
		-	1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	n Wkst M-2 line 20)		2, 324, 766	1 1.
00 Cost of vaccines and their administration (from Wkst. M-4, lir			33, 710	
00 Total allowable cost excluding vaccine (line 1 minus line 2)			2, 291, 056	
00 Total Visits (from Wkst. M-2, column 5, line 8)			8, 616	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5.
00 Total adjusted visits (line 4 plus line 5)			8, 616	
00 Adjusted cost per visit (line 3 divided by line 6)		Calculation	265.91	7.
		Prior to Jan.	On or After	
		1 (Rate	Jan. 1 (Rate	
		Period 1)	Period 2)	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1.00	2.00	8
00 Rate for Program covered visits (see instructions)	o or your contractor)	265.91	265.91	
CALCULATION OF SETTLEMENT		200.71	200. 71	1 1
.00 Program covered visits excluding mental health services (from	contractor records)	0	1, 419	10
.00 Program cost excluding costs for mental health services (line	9 x line 10)	0	377, 326	11
.00 Program covered visits for mental health services (from contra	-	0	2	
.00 Program covered cost from mental health services (line 9 x lin		0	532	
.00 Limit adjustment for mental health services (see instructions) .00 Graduate Medical Education Pass Through Cost (see instructions		0	532	
.00 Graduate Medical Education Pass Through Cost (see instructions .00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	·	0	377, 858	15
.01 Total program charges (see instructions)(from contractor's red		0	180, 805	
.02 Total program preventive charges (see instructions)(from provi	·		5, 268	
.03 Total program preventive costs ((line 16.02/line 16.01) times	line 16)		11, 009	16
.04 Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		269, 848	16
(Titles V and XIX see instructions.)			000 057	
.05 Total program cost (see instructions) .00 Primary payer amounts		0	280, 857 0	
.00 Primary payer amounts .00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		29, 539	
records)			27, 337	10
.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		29, 198	19
records)				
.00 Net Medicare cost excluding vaccines (see instructions)			280, 857	
.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		21,074	
.00 Total reimbursable Program cost (line 20 plus line 21) .00 Allowable bad debts (see instructions)			301, 931 0	22
. 01 Adjusted reimbursable bad debts (see instructions)			0	
.00 Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/		0	
.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
. 99 Demonstration payment adjustment amount before sequestration			0	
.00 Net reimbursable amount (see instructions)			301, 931	
. 01 Sequestration adjustment (see instructions)			3, 502	
.02 Demonstration payment adjustment amount after sequestration .00 Interim payments			0 263, 581	
.00 Tentative settlement (for contractor use only)			203, 581	
.00 Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		34, 848	
.00 Protested amounts (nonallowable cost report items) in accordar			01,010	
chapter I, §115.2				1

	TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1315	Period:	Worksheet M-3	
ERVI CE	S	Component CCN: 15-8545	From 10/01/2019 To 09/30/2020	Date/Time Pre	
		Title XVIII	RHC II	4/21/2021 9:4	4 am
			KHC II	Cost	
			-	1.00	
-	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			2, 463, 297	1.
1	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		0	2.
	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			2, 463, 297 12, 978	3.
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		552	5.
	Total adjusted visits (line 4 plus line 5)			13, 530	
	Adjusted cost per visit (line 3 divided by line 6)			182.06	7
			Calculation	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	
00			1.00	2.00	-
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	0.6 or your contractor)	0.00 182.06	0. 00 182. 06	
	CALCULATION OF SETTLEMENT		102.00	102.00	1
	Program covered visits excluding mental health services (from	contractor records)	0	384	10
1	Program cost excluding costs for mental health services (line		0	69, 911	11
2.00	Program covered visits for mental health services (from contr	actor records)	0	0	12
1	Program covered cost from mental health services (line 9 x li		0	0	13
1	Limit adjustment for mental health services (see instructions		0	0	14
	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	-	0	69, 911	15 16
	Total program charges (see instructions)(from contractor's re	-	0	67, 456	
	Total program preventive charges (see instructions)(from prov			0	16
1	Total program preventive costs ((line 16.02/line 16.01) times	,		0	16
	Total Program non-preventive costs ((line 16 minus lines 16.0	03 and 18) times .80)		55, 929	16
	(Titles V and XIX see instructions.)			55 000	
	Total program cost (see instructions)		0	55, 929 0	16
	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0	18
	records)			0	
	Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		12, 046	19
	records)				
	Net Medicare cost excluding vaccines (see instructions)			55, 929	
1	Program cost of vaccines and their administration (from Wkst. Total reimbursable Program cost (line 20 plus line 21)	M-4, ITNE 16)		0 55, 929	21
	Allowable bad debts (see instructions)			55, 424	23
	Adjusted reimbursable bad debts (see instructions)			0	23
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
	Demonstration payment adjustment amount before sequestration			0	
	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			55, 929 649	1
	Demonstration payment adjustment amount after sequestration			049	
	Interim payments			42, 614	
	Tentative settlement (for contractor use only)			0	28
	Balance due component/program (line 26 minus lines 26.01, 26.			12, 666	
0.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-II	.	0	30

	Financial Systems CAMERON MEMORIAL COMM ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CE		Component CCN: 15-8546	From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:4	parec
		Title XVIII	RHC III	Cost	4 411
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	West M 2 Lipo 20)		1, 534, 004	1.
1	Cost of vaccines and their administration (from Wkst. M-4, li	· · · · · ·		4, 535	
	Total allowable cost excluding vaccine (line 1 minus line 2)	ne roy		1, 529, 469	
	Total Visits (from Wkst. M-2, column 5, line 8)			3, 294	
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
	Total adjusted visits (line 4 plus line 5)			3, 294	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			464.32	7.
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20) 6 or your contractor)	1.00	2.00	8.
	Rate for Program covered visits (see instructions)		464.32	464.32	
	CALCULATION OF SETTLEMENT				
0.00	Program covered visits excluding mental health services (from	n contractor records)	0	63	10.
	Program cost excluding costs for mental health services (line		0	29, 252	11.
	Program covered visits for mental health services (from contr		0	0	
1	Program covered cost from mental health services (line 9 x li		0	0	
1	Limit adjustment for mental health services (see instructions		0	0	
1	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	-	0	29, 252	15.
	Total program charges (see instructions) (from contractor's re		0	12, 271	
	Total program preventive charges (see instructions)(from prov	·		712	
	Total program preventive costs ((line 16.02/line 16.01) times			1, 697	
6.04	Total Program non-preventive costs ((line 16 minus lines 16.0	03 and 18) times .80)		21, 342	16.
	(Titles V and XIX see instructions.)				
	Total program cost (see instructions)		0	23, 039	
1	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 878	
	records)			070	10.
9.00	Beneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		2, 136	19.
	records) Net Medicare cost excluding vaccines (see instructions)			23, 039	20.
1	Program cost of vaccines and their administration (from Wkst.	M_{-4} line 16)		23,039	
1	Total reimbursable Program cost (line 20 plus line 21)			23, 284	
	Allowable bad debts (see instructions)			0	
3. 01	Adjusted reimbursable bad debts (see instructions)			0	23.
1	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	IS)		0	
	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 23, 284	
	Sequestration adjustment (see instructions)			23, 284 270	
	Demonstration payment adjustment amount after sequestration			270	
	Interim payments			14, 512	
	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 26.			8, 502	29.
	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	ance with CMS Pub. 15-II	,	0	30

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL			In Lie	u of Form CMS-2	2552-10
			Peri od:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8530	From 10/01/2019 To 09/30/2020		
		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)		941, 067	941, 067	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	333	4, 101	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	5	4, 597	4, 684	
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		4, 930		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22		945, 804	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 378, 962		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	tal direct cost (line 5	0. 005212	0. 009288	8.00
9.00	0.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7, 187	12, 808	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	12, 117	21, 593	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	23	283	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1		526.83	76.30	12.00
13.00			19	145	13.00
14.00	00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		10, 010	11, 064	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			33, 710	15.00
16.00				21, 074	16.00

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	Period:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-8546	From 10/01/2019 To 09/30/2020	Date/Time Pre 4/21/2021 9:4	pared: 4 am
		Title XVIII	RHC III	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		644, 822	644, 822	
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot		e 0. 000000	0.002021	
3.00	Pneumococcal and influenza vaccine health care staff cost (li	<i>,</i>	0	1, 303	
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	5	0	612	
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		0	1, 915	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22) 647, 754 886, 250	647, 754	
7.00				886, 250	
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	tal direct cost (line 5	0. 000000	0. 002956	8.00
9.00	9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			2,620	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	0	4, 535	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	0	37	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	0.00	122.57	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	0	2	13.00
	benefi ci ari es	-			
14.00	00 Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	245	14.00
15.00	0 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			4, 535	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		245	16. 00

ANALYSIS	Financial Systems CAMERON MEMORIAL CO S OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR S RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet M-5	
				WORKSneet M-5	
	S RENDERED TO TROOM DENETTOTARTES		From 10/01/2019		
		Component CCN: 15-8530	To 09/30/2020		
		-		4/21/2021 9:44	4 am
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00 T	Fotal interim payments paid to hospital-based RHC/FQHC			234, 281	1.00
2.00 1	nterim payments payable on individual bills, either submit	ted or to be submitted to		0	2.00
1	the contractor for services rendered in the cost reporting	period. If none, write			1
	'NONE" or enter a zero				1
	_ist separately each retroactive lump sum adjustment amount				3.00
r	revision of the interim rate for the cost reporting period.	Also show date of each			1
	payment. If none, write "NONE" or enter a zero. (1)				1
P	Program to Provider				
3.01	9		04/29/2020	29, 300	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				o	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 5	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		29, 300	3.99
	Fotal interim payments (sum of lines 1, 2, and 3.99) (trans		9	263, 581	4.00
	27)				
Т	O BE COMPLETED BY CONTRACTOR				
5.00 L	ist separately each tentative settlement payment after des_	k review. Also show date c	of		5.00
e	each payment. If none, write "NONE" or enter a zero. (1)				1
P	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Ρ	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99 S	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.99
6.00 D	Determined net settlement amount (balance due) based on the	cost report. (1)			6.00
6.01 S	SETTLEMENT TO PROVIDER	• • •		34, 848	6.01
6.02 S	SETTLEMENT TO PROGRAM			0	6.02
7.00 T	Total Medicare program liability (see instructions)			298, 429	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00 N	Name of Contractor				8.00

ANALYSI	2				2552-10	
SERVI CE		Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of I ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR Provider CCN: 15-1315 Period: Work				
	S RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8545	From 10/01/2019 To 09/30/2020		pared:	
			RHC II	Cost		
				t B		
			mm/dd/yyyy	Amount		
			1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC			42, 614	1.00	
	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.00	
	the contractor for services rendered in the cost reporting			Ű	2.00	
	"NONE" or enter a zero					
	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00	
	revision of the interim rate for the cost reporting period.					
	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				Ő	3.51	
3.52				0	3.52	
3.53				0	3.53	
3.54				Ő	3.54	
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.99	
	Total interim payments (sum of lines 1, 2, and 3.99) (trans			42, 614	4.00	
	27)		, 	12,011		
	TO BE COMPLETED BY CONTRACTOR					
	List separately each tentative settlement payment after des	k review. Also show date o	f		5.00	
	each payment. If none, write "NONE" or enter a zero. (1)					
F	Program to Provider					
5.01	<u>u</u>			0	5.01	
5.02				0	5.02	
5.03				0	5.03	
F	Provider to Program					
5.50				0	5.50	
5.51				0	5.51	
5.52				0	5.52	
5.99	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				6.00	
6.01	SETTLEMENT TO PROVIDER	• • •		12, 666	6.01	
6.02	SETTLEMENT TO PROGRAM			0	6.02	
7.00	Total Medicare program liability (see instructions)			55, 280	7.00	
			Contractor	NPR Date		
			Number	(Mo/Day/Yr)		
		0	1.00	2.00		
8.00	Name of Contractor				8.00	

ANALYSIS OF PAVMENTS TO UGSPTIAL-BASED PHC/FORC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-8346 Provider CCN: 15-8346 Porid: To 09/30/2020 Worksheet M-5 Date/Time Prepared: 2/1/2021 04 4 am 100 Total Interim payments paid to hospital-based RHC/FOHC 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 1.00 14,512 1.00 3.01 0 1.4,512 0 3.01 3.01 0 3.01 0 3.01 3.01 0 0 0 3.01 3.01 0 0 3.01 0 3.01 3.02 0 0 3.01 0 3.01 3.02 0 3.01 0 3.01 0 3.01 3.01 0 0 0 3.01 0 3.01 0 3.01 3.02 0 0 3.01 0 3.01 0 3.01 0 3.01 3.01 0 0 0 0 3.01 0 3.01 3.01 3.01 3.01	Heal th	Financial Systems CAMERON MEMORIAL CO	OMMUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
SERVICES RENDERED TO PROGRAM BENEFICIARIES Component CON: 15-8546 From 10/01/2019 TO 09/30/2020 Date/Time Prepared: 1/21/2021 9/ 44 am 1:00 Total interim payments paid to hospital-based RK/FOHC RHC III RHC III 0 1:00 Total interim payments paid to hospital-based RK/FOHC 1.00 2.00 14,512 1.00 1:00 List separately each retroactive lump sum adjustment anount based on subsequent revelsion of the interim rate from the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 3.01 0:01 Program 0 3.02 3:02 0 0 3.03 3:03 0 0 3.04 3:04 0 0 3.05 3:05 0 0 3.05 3:06 0 0 3.05 3:07 0 0 3.01 3:08 0 3.04 0 3.05 3:09 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.96) 0 3.55 5:01 1:11 separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5.00		2		riod: Worksheet M-5		
Provider Ref 111 Cost 1.00 Total interlin payments paid to hospital-based RHC/FQHC 1.00 2.00 1.00 Interlin 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. 1.00 2.00 14, 512 1.00 2.00 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 3.01 Program to Provider 0 3.02 3.03 3.03 3.01 0 3.03 3.03 3.03 3.04 3.05 Provider to Program 0 3.05 3.0				From 10/01/2019	Date/Time Pre	
Pert B Pert B 1.00 Total Interim payments paid to hospital-based RHC/FOHC 1.00 2.00 2.00 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. 1.00 1.4,512 1.00 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the Interim nate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 3.00 9 Provider 0 3.01 3.00 3.01 0 3.00 3.00 3.00 3.02 0 3.00 3.00 3.00 3.03 04 0 3.00 3.00 3.05 0 3.00 3.00 3.00 3.05 0 3.00 3.00 3.00 3.05 0 3.50 0 3.50 3.51 0 3.50 3.50 3.50 3.52 0 3.52 0 3.52 5.52 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
Imm/dd/yyyy Amount 1.00 Total Interim payments paid to hospital-based RHC/FOHC 1.00 2.00 1.100 Total Interim payments payable on Individual bils, either submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. 1.00 1.00 1.00 2.00 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 3.00 3.00 Program to Provider 0 3.00 3.00 3.00 3.00 3.01 Program to Provider 0 3.00 3.00 3.00 3.03 0 3.00 0 3.00 3.00 3.02 0 3.00 0 3.00 3.00 3.03 0 3.00 0 3.00 3.00 3.03 0 3.00 0 3.00 3.00 3.04 0 3.00 3.00 3.00 3.00 3.05 0 3.00 3.00						
Total interim payments paid to hospital-based RHC/FOHC 1.00 2.00 1.00 1.00 2.00 1.00 2.00 1.00 1.00 1.00 2.00 1.00 1.00 2.00 1.00						
1.00 Total interim payments paid to hospital-based RHC/FDHC 14,512 1.00 2.00 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. 10,00 11,00 2.00 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 3.00 Program to Provider 0 3.00 0 3.00 3.01 0 3.00 0 3.00 Provider to Program 0 3.01 0 3.02 3.03 0 3.00 0 3.00 9 0 3.01 0 3.00 1.02 0 3.01 0 3.00 3.03 0 3.00 0 3.00 9 0 11,512 1.00 0 3.00 3.04 0 3.00 0 3.00 0 3.00 3.05 0 3.05 0 3.05 3.05 3.05 3.05 <						
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"NONE" or enter a zero 3.00 1.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 0 3.01 1.01 Program to Provider 0 3.02 3.02 0 3.02 3.03 0 3.02 3.04 0 3.02 3.05 0 3.03 9 0 1.01 3.09 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 3.51 3.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 14,512 4.00 20 0 5.00 5.00 5.00 5.01 5.01 5.00 Program to Provider 0 5.01 5.01 5.01 5.01 5.02 5.02 5.00 Determined net settlement amount (balance due) based on the cost report. (1) 8.502 5.52 5.52 5.00 Determined net settlement amount (balance due) based on the cost report. (1) 8.502 5.52 5.00 Total Medicare program liability (see instructions)		Interim payments payable on individual bills, either submit				
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3.01 0 3.02 3.02 0 3.02 3.04 0 3.03 3.04 0 3.03 3.04 0 3.03 3.05 0 3.03 50 0 3.65 3.50 0 3.50 3.51 0 3.51 3.52 0 3.52 3.53 0 3.53 3.54 0 3.53 3.59 Subtotal (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 14, 512 4.00 27) 10 EcomPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5.00 Proyram to Provider 0 5.01 5.02 0 5.02 5.03 0 5.50 5.04 0 5.51 5.05 0 5.52 5.04 0 5.51 5.05 0 5.51 5.06 0 5.51 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
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