3 Signatory Title

4 Date

CEO

(Dated when report is electronica

CAMERON MEMORIAL COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

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	is required by law (42 USC 1395g; 42 CFR 413.20(b) le since the beginning of the cost reporting period				FORM APPROVED OMB NO. 0938-00 EXPIRES 03-31-2	
HOSPITAL AND AND SETTLEME) HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC INT SUMMARY	CATION Pro	ovider CCN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepa 2/24/2022 4:28	
PART I - COS	ST REPORT STATUS					
Provi der use onl y	 [X] Electronically prepared cost report [] Manually prepared cost report [0] If this is an amended report enter the table. [F] Medicare Utilization. Enter "F" for full 	number of or "L" f	or low.			28 pm
Contractor use only	 5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report (3) Settled with Audit 9. [N]Final Report (4) Reopened (5) Amended 	port for t rt for thi	11.(his Provider CCN12.	NPR Date: Contractor's Vendo [0]If line 5, cc number of tin	or Code: olumn 1 is 4: En nes reopened = 0	4 nter)-9.
PART II - CE	RTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMIN	ISTRATOR C	R PROVIDER(S)			
ADMI NI STRATI PROVI DED OR	ATION OR FALSIFICATION OF ANY INFORMATION CONTAINE VE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTI VE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	LAW. FUR	THERMORE, IF SERVICE	ES IDENTIFIED IN T	HIS REPORT WERE	
CER	TIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	ATOR OF PR	OVI DER(S)			
el ec Stat repo repo acco regu	REBY CERTIFY that I have read the above certificat ctronically filed or manually submitted cost repor- tement of Revenue and Expenses prepared by CAMERON porting period beginning 10/01/2020 and ending 09/30 port and statement are true, correct, complete and pordance with applicable instructions, except as no ulations regarding the provision of health care seport were provided in compliance with such laws and	t and subm MEMORIAL 0/2021 and prepared f ted. I fur rvices, ar	itted cost report ar COMMUNITY HOSPITAL (to the best of my H rom the books and re ther certify that I d that the services	nd the Balance She (15–1315) for th knowledge and beli ecords of the prov am familiar with	eet and ne cost ef, this /ider in the laws and	
SI GNAT	URE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
	1	2	SIG	NATURE STATEMENT		
1	Angie Logan	Y	I have read and agr statement. I certif signature on this c binding equivalent	y that I intend m ertification be t	y electronic he legally	1
2 Si gnat	ory Printed Name Angie Logan					2

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	· · · · · · · · · · · · · · · · · · ·	1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-487, 386	-206, 013	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-249, 015	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		25, 589		0	10.00
10.01	RURAL HEALTH CLINIC II	0		24, 575		0	10.01
10. 02	RURAL HEALTH CLINIC III	0		4, 656		0	10.02

200.00 Total 0 -736, 401 -151, 193 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. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	der CCI	N: 15-1315	Period: From 10/01/ To 09/30/		Workshe Part I Date/Ti	me Pre	epare
	1.00	2.00		3.00			1.00	2/24/20)22 4:2	28 pm
	Hospital and Hospital Health Care Co			0.00						
0	Street: 416 E MAUMEE STREET	P0 Box:								1.
0	City: ANGOLA	State: IN	Zip Cod			ty: STEUBEN	Dayma	nt Syst	om (D	2.
		Component Name	CCN Number	CBS Numb		r Date Certified		0, or		
							V	XVIII		1
	[1.00	2.00	3.0	0 4.00	5.00	6.00	7.00	8.00	
~	Hospital and Hospital-Based Componer		454045	0000	15 4	00 (01 (0000	N	0	D	-
0	Hospi tal	CAMERON MEMORIAL COMMUNITY HOSPITAL	151315	9997	15 1	02/01/2003	N	0	P	3
С	Subprovider - IPF									4
0	Subprovider - IRF									5
0	Subprovider - (Other)		457045							6
C	Swing Beds - SNF	CAMERON MEMORIAL COMMUNITY	15Z315	9997	15	02/01/2003	N	0	N	7
0	Swing Beds - NF									8
С	Hospital-Based SNF									9
00	Hospital-Based NF									10
00 00	Hospital-Based OLTC Hospital-Based HHA									11
00	Separately Certified ASC									13
00	Hospi tal -Based Hospi ce									14.
00	Hospital-Based Health Clinic - RHC	CAMERON FAMILY MEDICINE		9991		12/31/2016		0	0	15.
01	Hospital-Based Health Clinic - RHC	CAMERON URGENT CARE	158545	9997	15	11/26/2019	N	0	0	15
02	Hospital-Based Health Clinic - RHC	CAMERON OB/GYN	158546	999	15	11/25/2019	N	0	0	15.
									_	
00	Hospital-Based Health Clinic - FQHC									16.
00 00	Hospital-Based (CMHC) I									17.
	Renal Dialysis Other									10.
00					1	From:		То):	
						1.00		2.0	00	
									10004	00
00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					10/01/2		09/30/	/2021	
00	Type of Control (see instructions)								/2021	
00	Type of Control (see instructions)			_	1.00	10/01/2	020			
	Type of Control (see instructions)	currently, receiving pa	vments fo	r		10/01/2 2 2.00	020	09/30/		21
	Type of Control (see instructions)				1.00 N	10/01/2	020	09/30/		21.
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		1.00	2.00	3.00	4.00	5.00	,	6.00	1
4.00	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.	0	0		0		0	С	24. (
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					Begi ni 1. (i ng: 00	-
6.00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		script line	36 for num	ber				36.0
7.00 7.01	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	r the numbe	·		us	0			37.
8.00	accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)	or yes or "	N" for no.	(see					38.0
	greater than 1, subscript this line for the number o enter subsequent dates.	f periods i	n excess o	f one and					
					Y/			/N	
9.00	Does this facility qualify for the inpatient hospita	l payment a	diustment	for low vol	1.(ume N			00 N	39.0
	hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	the mileage ii)? Enter n adjustmer	e requireme in column nt? Enter "	nts in 2 "Y" for y Y" for yes y	es or N	1	I	N	40.
0. 00	no in column 2 for discharges on or after October 1			yes or "N"					
0. 00	no in column 2, for discharges on or after October 1			yes or "N"		V	XVIII		-
	Prospective Payment System (PPS)-Capital	. (see inst	ructions)			1.00			_
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	. (see inst	ructions)			1.00			45.
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks	. (see inst nt for disp eption for	ructions) proportiona extraordin	te share in ary circums	accordance	1.00	2.00	3.00	45.0
5. 00 5. 00 7. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS	. (see inst nt for disp eption for t. L, Pt. I capital? E	proportions) extraordin II and Wks	te share in ary circums t. L-1, Pt. r yes or "N	accordance tances I through " for no.	1.00) 2.00 N N N	3.00 N N N	46.
5. 00 5. 00 7. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS	. (see inst nt for disp eption for t. L, Pt. I capital? E	proportions) extraordin II and Wks	te share in ary circums t. L-1, Pt. r yes or "N	accordance tances I through " for no.	1.00) 2.00 N N	3.00 N N	46.
00 0. 00 0. 00 0. 00 0. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals	. (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved C e to columr rograms in cable CRs)	eructions) proportiona extraordin II and Wks Thter "Y fo Y" for yes ME program 1 is "Y", the prior	te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen	accordance tances I through " for no. no. " for yes o hospital ul timate	1.00 N N N N N N) 2.00 N N N	3.00 N N N	46. 47. 48.
5. 00 5. 00 7. 00 3. 00 5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for js "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	. (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved C e to columr rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet	extraordin extraordin II and Wks Enter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor te Workshee	te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	accordance tances I through " for no. no. " for yes o hospital ultimate reduction? approved If column ? Enter "Y	1.00 1.00 N N N N N Or N 1) 2.00 N N N	3.00 N N N	46.
5. 00 5. 00 7. 00 3. 00 5. 00 7. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon	. (see inst nt for disp eption for t. L, Pt. I capital? E t? Enter " approved C e to columr rograms in cable CRs) lumn 2. period duri r yes or "N th of this Y", complet I, if appli bursement f	extraordin extraordin II and Wks Enter "Y fo Y" for yes ME program 1 is "Y", the prior MA direct ng which r " for no i cost repor ce Workshee cable. For physici	te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period t E-4. If c	accordance tances I through " for no. no. " for yes of hospital ultimate reduction? approved If column ? Enter "Yo olumn 2 is	1.00 1.00 N N N N N Or N 1) 2.00 N N N	3.00 N N N	46. 47. 48. 56.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-1315	Period: From 10/01/2020 To 09/30/2021		pared:
			NAHE 413.89 Y/N	5 Worksheet A Line #	Pass-Through Qualification Criterion Code	
			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 (adjustement? Enter "Y" for yes or "N" for no in col	85? (umn 1. CR) NAH	see lf column 1	N			60.00
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	1
 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 	N			0.00	0.00	61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care						61.02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care						61.03
and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						01.03
 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 						61.04
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)						01.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		N				61.06
	Pro	ogram Name	Program Cod	I ME FTE Count	FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME		1.00	2.00	3.00	4.00	61.10
FTE unweighted count. 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
· · · · · · · · · · · · · · · · · · ·					1.00	
ACA Provisions Affecting the Health Resources and Ser					1	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	t reporting p	eriod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	a Teach gram. (<u>see instructio</u>		to 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, completing	ettings	during this d			N	63.00

SPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider C		eri od:	Worksheet S-2	
				rom 10/01/2020 o 09/30/2021	Part I Date/Time Pre 2/24/2022 4:2	pared: 8 pm
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Base Yea			-This base year	r is your cost	reporti ng	
period that begins on or after 00 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 you of (column 1 divided by (column	s yes, or your facili aber of unweighted no ptations occurring in e number of unweighte pur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
	5		FTEs Nonprovider	FTEs in Hospital	3/ (col. 3 + col. 4))	
		0.00	Site	1.00		4
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	45 0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	gsEffective	for cost report	ing periods	
beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1+	unweighted non-prima occurring in all nonp unweighted non-prima cal. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1 00	2 00	Si te	4.00	5.00	-
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	1.00	2.00	3.00	<u>4.00</u> 0.00	<u>5.00</u> 0.000000	67.0

Heal th	Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL	١r	Li eu	of Form	n CMS-2	2552-10
HOSPI T		eriod: rom 10/01/ p 09/30/	2020 2021	Workshe Part I Date/Ti	me Pre	pared:
				2/24/20	22 4:2	8 pm
	Langtingt Developting Facility DDC		1.00	2.00	3.00	1
70.00	<u>Inpatient Psychiatric Facility PPS</u> Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	provi der?	N			70.00
71 00	Enter "Y" for yes or "N" for no.				0	71 00
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				0	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac	hi ng				
	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)	5 1				
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
	subprovider? Enter "Y" for yes and "N" for no.				_	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o				0	76.00
	no. Column 2: Did this facility train residents in a new teaching program in accordance	with 42				
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	,				
	Long Term Care Hospital PPS			1.0	0	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? E	inter	N		81.00
	TEFRA Provi ders					
	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
80.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	[]				86.00
87.00	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		XIX	<	
		1.00		2.0	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
01 00	yes or "N" for no in the applicable column.	N		Y		01 00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		ř		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			N		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N		N		93.00
0.4 00	"Y" for yes or "N" for no in the applicable column.	N		N		04.00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		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	0.00		0. 0 N	0	95.00 96.00
90.00	applicable column.	N		IN		90.00
	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.0	0	97.00 98.00
98.00	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	Y		Y		98.00
00.01	column 1 for title V, and in column 2 for title XIX.	N/		V		00.01
98.01	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	Y		Y		98.01
00 02	title XIX.	Y		Y		98.02
90. UZ	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	T		T		90.02
00 02	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)	N		N		98.03
90.03	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	N		IN		90.03
00 04	for title V, and in column 2 for title XIX.	N		N		00.04
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N		N		98.04
	in column 2 for title XIX.	Y		Y		98.05
96.03	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			T		96.05
00.04	column 2 for title XIX.	V		V		00.04
96.00	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	Y		Y		98.06
	column 2 for title XIX.					
105.00	Rural Providers Does this hospital qualify as a CAH?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N				106.00
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R	N				107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)					
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&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)					

Health Financial Systems CAMERON MEMORIAL COM	MUNITY HOSPI	TAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S-2 Part I Date/Time Pre 2/24/2022 4:2	epared:
			V 1.00	XI X 2.00	-
108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 42	Ν		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 f this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
110.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. I	f yes,	1.00 N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dumn 1 is Y, Ticipating ir	period? Enter enter the column 2.	Ν		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal 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 the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.	period? s "Y", enter ne	N	2.00		112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N		(0115.00
in column 1. If column 1 is yes, enter the method used (A, B 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 the definition in CMS Pub.15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes rs) based on				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		1			118.00
		Premi ums	Losses	I nsurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118.01
		27,232	0		
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment	(" for yes or the Outpatient	Ν	Ν	119.00 120.00	
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Υ		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below.	-				
126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2	2.				126.00
127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2		ication date			127.00
128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2	er the certif	fication date			128.00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		cation date in			129.00

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE	CAMERON MEMORIA EX IDENTIFICATION DATA			Peri od		u of Form CMS Worksheet S-	-2
					0/01/2020 9/30/2021	Part I Date/Time Pr 2/24/2022 4:	repared
					1.00	2.00	-
0.00 If this is a Medicare certified p			tification	-	1.00	2.00	130.
date in column 1 and termination 1.00 If this is a Medicare certified in	ntestinal transplant c	enter, enter the ce	ertificatio	on			131.0
date in column 1 and termination 2.00 f this is a Medicare certified is			cation dat	P			132.
in column 1 and termination date,			outron du				102
3. 00 Removed and reserved 4. 00 If this is an organ procurement o and termination date, if applicab All Providers		er the OPO number i	n column 1				133. 134.
0.00 Are there any related organization chapter 10? Enter "Y" for yes or	"N" for no in column 1.	. If yes, and home	office cos		Y		140.
are claimed, enter in column 2 the 1.00	e nome office chain hu	2.00	tions)		3.00		
If this facility is part of a cha	in organization, enter	on lines 141 thro	ugh 143 th	e name ar		of the home	
office and enter the home office 1.00Name:	contractor name and co Contractor's Name		Contra	ctor's Nu	mbor:		141.
2.00 Street:	PO Box:	5.	Contrac		linder.		141.0
3. 00 Ci ty:	State:		Zip Co	de:			143.
						1.00	_
4.00 Are provider based physicians' co	sts included in Worksh	eet A?				Y	144.
					1.00	2.00	_
5.00 If costs for renal services are c	laimed on Wkst. A. lin	e 74, are the costs	s for		1.00	2.00	145.
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for no clude Medicare utiliza for no in column 2.	o in column 1. If o tion for this cost	column 1 is reporting	5			
							146.
6.00Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS P			lf	N		140.
yes, enter the approval date (mm/	n column 1. (See CMS Pu dd/yyyy) in column 2.	ub. 15-2, chapter 4	40, §4020)	lf	N	1.00	
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/ 7.00Was there a change in the statist	n column 1. (See CMS Pu dd/yyyy) in column 2. ical basis? Enter "Y"	ub. 15-2, chapter 4	40, §4020) no.	lf	N	N	147.
Enter "Y" for yes or "N" for no in 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	n column 1. (See CMS Po dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y"	ub. 15-2, chapter 4 for yes or "N" for " for yes or "N" fo	40, §4020) no. or no.		N		147. 148.
Enter "Y" for yes or "N" for no i	n column 1. (See CMS Po dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y"	ub. 15-2, chapter 4 for yes or "N" for " for yes or "N" fo d? Enter "Y" for ye Part A	40, §4020) no. pr no. es or "N" 1 Part B	for no.	itle V	N N N Title XIX	147. 148.
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Health Financial Systems C	UNI TY HOSPI TAL	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	IFICATION DATA		Period:	Worksheet S-2	2
			From 10/01/2020 To 09/30/2021		norod.
			10 09/30/2021	Date/Time Pre 2/24/2022 4:2	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginnin period respectively (mm/dd/yyyy)	g date and ending dat	te for the reporting			170.00
			1.00	2.00	1
171.00 If line 167 is "Y", does this provider ha	ve any days for indiv	viduals enrolled in	N	(171.00
section 1876 Medicare cost plans reported	on Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. I	f column 1 is yes, er	nter the number of section	on		
1876 Medicare days in column 2. (see inst	ructions)				

	Financial Systems CAMERON MEMORIAL CO FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1315	Period:	Worksheet S-	-2
				From 10/01/2020 To 09/30/2021	Date/Time Pr	
				N/ (1)	2/24/2022 4:	28 pm
				Y/N	Date 2,00	_
	General Instruction: Enter Y for all YES responses. Enter M	for all NO r	snonses Ent	1.00	2.00	_
	mm/dd/yyyy format.		esponses. Ent		the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in a	column 2. (see	instructions	5)		
			Y/N	Date	V/I	
	1		1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare I		N			2.
	yes, enter in column 2 the date of termination and in colum	mn 3, "V" for				
~~	voluntary or "I" for involuntary.		N			
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of		Y			3
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)	or or minut				
	<u></u>		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		•			
00	Column 1: Were the financial statements prepared by a Cer-	tified Public	Y	A	12/21/2021	4.
	Accountant? Column 2: If yes, enter "A" for Audited, "C" i					
	or "R" for Reviewed. Submit complete copy or enter date available	ailable in				
	column 3. (see instructions) If no, see instructions.					_
00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit rea	conciliation.) (/N		_
				Y/N 1.00	Legal Oper. 2.00	_
	Approved Educational Activities			1.00	2.00	-
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If yes in	s the provide	er N		6.
00	is the legal operator of the program?	2. 11 yes, 13	s the provide	71 IN		0.
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions		Ν		7.
00	Were nursing programs and/or allied health programs approve		wed during th			8.
00	cost reporting period? If yes, see instructions.		and during th			0.
00	Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	n N		9.
	program in the current cost report? If yes, see instruction					
0. 00	Was an approved Intern and Resident GME program initiated of	or renewed in [•]	the current	Ν		10.
	cost reporting period? If yes, see instructions.					
. 00		l & R in an App	proved	Ν		11
	Teaching Program on Worksheet A? If yes, see instructions.					_
					Y/N	_
					1.00	_
00	Bad Debts		+!		V	- 12
	Is the provider seeking reimbursement for bad debts? If yes				Y	12
. 00	If line 12 is yes, did the provider's bad debt collection pariod2 if was submit conv	porrey change of	during this c	ost reporting	Ν	13
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	onte waivod? L	F vos soo ir	etructione	Ν	14.
. 00	Bed Complement	ents warveur i	i yes, see ii	ISTI UCTI OIIS.	IN	- 14.
00	Did total beds available change from the prior cost report	ing period? If	ves see ins	structions	N	15.
	pra total bodo ataliabilo onaligo riom tilo pri di boot roporti		t A	Par		
		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?	Y	11/30/2021	Y	11/30/2021	16
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
00	instructions)	N		NI		1-
. 00	Was the cost report prepared using the PS&R Report for	N		Ν		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		Ν		18
. 00	Report data for additional claims that have been billed	111		IN		10
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
	bot i i jos, soo instructions.	l		Ν		19.
. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		IN IN		
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		i N		

Health Financial Systems

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

Health Financial Systems CAMERON MEMORIAL	eu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet Part II Date/Time	S-2 Prepared:		
	Deser)/ /NI	2/24/2022	4:28 pm		
		iption O	Y/N 1.00	Y/N 3.00			
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N	20.00		
	Y/N	Date	Y/N	Date			
	1.00	2.00	3.00	4.00			
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
				1.00			
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EX	CEPT CHILDRENS	HOSPLTALS)		1.00			
Capital Related Cost							
22.00 Have assets been relifed for Medicare purposes? If yes, s	ee instructions			N	22.00		
23.00 Have changes occurred in the Medicare depreciation expens reporting period? If yes, see instructions.			ng the cost	N	23.00		
24.00 Were new leases and/or amendments to existing leases ente If yes, see instructions	red into during	this cost rep	porting period?	Y	24.00		
25.00 Have there been new capitalized leases entered into durin instructions.	g the cost repo	rting period?	lf yes, see	N	25.00		
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during instructions.	the cost report	ing period? If	f yes, see	Ν	26.00		
	Has the provider's capitalization policy changed during the cost reporting period? If yes, sub						
Interest Expense				Y	28.00		
period? If yes, see instructions.	period? If yes, see instructions.						
29.00 Did the provider have a funded depreciation account and/o treated as a funded depreciation account? If yes, see ins	tructions			Y	29.00		
30.00 Has existing debt been replaced prior to its scheduled ma instructions.	5	J		N	30.00		
31.00 Has debt been recalled before scheduled maturity without instructions.	issuance of new	debt? If yes,	see	N	31.00		
Purchased Services 32.00 Have changes or new agreements occurred in patient care s	ervices furnish	ed through cor	tractual	Y	32.00		
arrangements with suppliers of services? If yes, see inst 33.00 [If line 32 is yes, were the requirements of Sec. 2135.2 a	ructions.	0			33.00		
no, see instructions. Provi der-Based Physici ans				·			
34.00 Are services furnished at the provider facility under an	arrangement wit	h provider-bas	ed physicians?	Y	34.00		
35.00If Jine 34 is yes, were there new agreements or amended e		nts with the p	orovi der-based	Y	35.00		
physicians during the cost reporting period? If yes, see	instructions.		N/ (N)		_		
			Y/N	Date			
Home Office Costs			1.00	2.00			
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been	prepared by the	home office?	N		36.00		
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home o					38.00		
the provider? If yes, enter in column 2 the fiscal year e 39.00 If line 36 is yes, did the provider render services to ot	nd of the home	offi ce.			39.00		
se instructions. 40.00 If f line 36 is yes, did the provider render services to th		J			40.00		
instructions.					40.00		
Cost Report Preparer Contact Information	1.	00	2.	00			
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	JODI		SANDERS		41.00		
42.00 Enter the employer/company name of the cost report	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		
	I		I		Ш		

Heal th	Financial Systems CAMERON MEMORIAL	COM	MUNITY HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1315		ri od:	Worksheet S-2	
				To	om 10/01/2020 09/30/2021		pared: 8 pm
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	MA	ANAGER				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 cost						43.00
	report preparer in columns 1 and 2, respectively.						

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 10/01/2020 To 09/30/2021	Date/Time Pre 2/24/2022 4:2	epare
					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 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider 	30. 00	23	8, 39	5 78, 744. 00	0	2
00 HMO I RF Subprovi der						4
00 Hospital Adults & Peds. Swing Bed SNF 00 Hospital Adults & Peds. Swing Bed NF					0	
 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) 		23	8, 39	5 78, 744. 00	-	
DO INTENSIVE CARE UNIT CORONARY CARE UNIT OO BURN INTENSIVE CARE UNIT OO SURGICAL INTENSIVE CARE UNIT	31.00	2	73	0 3, 024. 00	0	10 10
00 OTHER SPECIAL CARE (SPECIFY)	10.00					12
00 NURSERY 00 Total (see instructions) 00 CAH visits 00 SUBPROVIDER - IPF 00 SUBPROVIDER - IRF 00 SUBPROVIDER	43.00	25	9, 12	5 81, 768. 00	0 0 0	14
00 SKI LLED NURSI NG FACI LI TY 00 NURSI NG FACI LI TY 00 OTHER LONG TERM CARE 00 HOME HEALTH AGENCY 00 AMBULATORY SURGI CAL CENTER (D. P.) 00 HOSPI CE	101. 00	0		0	o	19 20 21
 10 HOSPICE (non-distinct part) 00 CMHC - CMHC 00 RURAL HEALTH CLINIC 01 RURAL HEALTH CLINIC II 	30.00 88.00 88.01				0	
02 RURAL HEALTH CLINIC III 25 FEDERALLY QUALIFIED HEALTH CENTER 00 Total (sum of lines 14-26)	88.01 88.02 89.00	25			0	26 26 27
 00 Observation Bed Days 00 Ambulance Trips 00 Employee discount days (see instruction) 00 Employee discount days - IRF 					0	28 29 30 31
 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 		0		0		32 32
.00 LTCH non-covered days .01 LTCH site neutral days and discharges						33

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	1	Period: From 10/01/2020 Fo 09/30/2021		pare
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	840	23	3, 28			1.
. 00	HMO and other (see instructions)	1, 106	253				2.
.00	HMO IPF Subprovider	0	0				3.
00	HMO IRF Subprovider	0	0				4.
00	Hospital Adults & Peds. Swing Bed SNF	613	0	613	3		5.
00 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	1, 453	0 23	812 4, 706			6
00	beds) (see instructions)	FO	o	10			
00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	52	0	120			8
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGI CAL I NTENSI VE CARE UNI T						111
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY		7	420	5		13
. 00	Total (see instructions)	1, 505	30	5, 258		421.00	
. 00	CAH visits	0	0	(15
. 00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER – IRF						17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY	0	0	(0.00	0.00	
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE	0	0	(0.00	
. 10 . 00	HOSPICE (non-distinct part) CMHC - CMHC			(24
. 00	RURAL HEALTH CLINIC	1, 322	2, 362	9, 054	0.00	13.29	
. 00	RURAL HEALTH CLINIC II	999	2, 302 3, 487	9,054 14,624		13. 29	
. 01	RURAL HEALTH CLINIC III	88	1, 443	3, 842		8. 52	
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	3, 042			
. 00	Total (sum of lines 14-26)	0	0	· · · · · · · · · · · · · · · · · · ·	0.00		
. 00	Observation Bed Days		25	1, 40'		101110	28
. 00	Ambul ance Trips	0					29
. 00	Employee discount days (see instruction)			(D		30
. 00	Employee discount days - IRF			(D		31
. 00	Labor & delivery days (see instructions)	0	0	(D		32
. 01	Total ancillary labor & delivery room outpatient days (see instructions)			(D		32
. 00	LTCH non-covered days	0					33
01	LTCH site neutral days and discharges	0					33

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet S-3 Part I Date/Time Pre 2/24/2022 4:2	pared:
		Full Time		Di s	charges		
	Component	Equivalents Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 24.\ 10\\ 25.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 01\\ 26.\ 02\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 01\\ 32.\ $	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) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC II RURAL HEALTH CLINIC II FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0	2:	29 11 54 129 0 0	990	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 21.00 22.00 23.00 24.00 25.00 26.25 27.00 28.00 29.00 30.00 31.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0 0		33.00 33.01

Heal th	Financial Systems CAME	RON MEMORIAL CO	OMMUNITY 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 10/01/2020 To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
					RHC I	Cost	
					1.	00	
1.00	Clinic Address and Identification Street				1500 W MAUMEE	STDEET	1.00
1.00			Ci	ty	State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		ANGOLOA		IN	46703	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur:	al or "II" for	urban		1.00	3.00
5.00	Those TRE-DASED Tones oner. Designation - Entr				Award	Date	3.00
					. 00	2.00	
	Source of Federal Funds					1	
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34)						5.00 6.00
7.00	Appal achi an Regi onal Commi ssi on	U(U), PHS ACT)					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	appital based I		nton "V" for	1.00 N	2.00	10.00
10.00	Does this facility operate as other than a hurden yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of (other operatio	ns in column	N		10.00
		Sun	day	Mor	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC			08: 00	17:00	08: 00	11.00
11.00	CETNIC			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?	N		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. numbers below.	umn 1. lf yes,	enter in colu	mn 2 the	N	C	13.00
			-	Provi d	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	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
	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)						13.00
				inty			
				00			
2.00	City, State, ZIP Code, County		STEUBEN	ocdav		rsday	2.00
		Tuesday to	from	esday to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17: 00	08: 00	17:00	08: 00	17:00	11.00

Health Financial Systems CAM	ERON MEMORIAL C	COMMUNITY HOSPI	TAL	In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1315	Period:	Worksheet S-8	}
		Component	CCN: 15-8530	From 10/01/2020 To 09/30/2021	Date/Time Pre 2/24/2022 4:2	epared: 8 pm
			-	RHC I	Cost	
	Fri	i day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12: 00				11.00

Heal th	Financial Systems CAMEI	RON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATI STI CAL DATA		Provider C		Period:	Worksheet S-8	
			Component		From 10/01/2020 To 09/30/2021		
					RHC II	Cost	- p
					1.	00	
	Clinic Address and Identification						
1.00	Street		Ci	ty	1381 N. WAYNE State	STREET ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		ANGOLA			46703	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "II" for	urhan		1.00	3.00
3.00	Those the brock relies oner. Designation Ent				Award	Date	3.00
				1	. 00	2.00	
4 00	Source of Federal Funds	A = +)		T			1 1 00
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00 5.00
6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	0	10.00
	yes or "N" for no in column 1. If yes, indic 2.(Enter in subscripts of line 11 the type o						
	hours.)	i otner operat	TUII(S) and the	operating			
			iday		nday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00		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 prod	uctivity ctopd	land?	1.00 N	2.00	12.00
	Is this a consolidated cost report as define				N	0	
	30.8? Enter "Y" for yes or "N" for no in col					_	
	number of providers included in this report.	List the name	s of all provi	ders and			
	numbers below.			Provi c	ler name	CCN number	
					. 00	2.00	
14.00	RHC/FQHC name, CCN number	V/ /81		X)/111	VIV	Total Marit	14.00
		Y/N 1.00	V 2.00	XVIII 3.00	XI X 4. 00	Total Visits 5.00	
15.00	Have you provided all or substantially all		2.00	0.00		0.00	15.00
	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)		Col	L			
				00			
2.00	City, State, ZIP Code, County						2.00
		Tuesday		esday to		rsday to	
		to 6.00	from 7.00	to 8.00	from 9.00	to 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	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1315	Period:	Worksheet S-8	
		Component	CCN: 15-8545	From 10/01/2020 To 09/30/2021	Dato/Timo Pro	narod
		component	CON. 15-6545	10 07/30/2021	Date/Time Pre 2/24/2022 4:2	8 pm
				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 Lie	eu of Form CMS-:	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	;
			Component		From 10/01/2020 To 09/30/2021	Date/Time Pre	
					RHC III	2/24/2022 4:2 Cost	28 pm
					1		-
	Clinic Address and Identification					. 00	-
1.00	Street				101	STREET, SUI TE	1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		ANGOLA	00		46703	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		1.00	3.00
	· · · · · · · · · · · · · · · · · · ·			Grant	t Award	Date	
	Source of Federal Funds			1	. 00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A	ct)					5.00
6.00 7.00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	O(d), PHS Act)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N N		10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o hours.)	r otner operat	ion(s) and the	operating			
	······································	Sur	nday	Мо	nday	Tuesday	
		from 1 00	to	from 2.00	to	from F 00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			08: 00	16: 30	08: 00	11.00
					1.00	2.00	
12.00	Have you received an approval for an excepti	on to the prod	luctivity stand	ard?	N	2.00	12.00
13.00	Is this a consolidated cost report as define				Ν	0	13.00
	30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.						
	numbers below.						
					der name	CCN number	
14.00	RHC/FQHC name, CCN number				. 00	2.00	14.00
		Y/N	V	XVIII	XIX	Total Visits	
15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
15.00	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)	L	Соц	L Inty			
				00			
2.00	City, State, ZIP Code, County	Tuesday	Wedn	esday	Thu	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) CLINIC	16: 30	08:00	16: 30	08: 00	16: 30	11.00
	102	1.0.00	100.00	1.0.00	00.00	1.0.00	1

Health Financial Systems CAN	MERON MEMORIAL C	COMMUNITY HOSPI	TAL	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: 15-8546	From 10/01/2020 To 09/30/2021	Date/Time Pre	narod
		component	CCN. 13-0340	10 077 507 2021	2/24/2022 4:2	18 pm
				RHC III	Cost	
	Fri	i day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12: 00				11.00

Heal th	Financial Systems CAMERON MEMORIAL COMMUN	NETY HOSPETA	L	In Lie	u of Form CMS-2	2552-10
		Provider CCN		Peri od:	Worksheet S-1	
				From 10/01/2020		
				To 09/30/2021		
					2/24/2022 4:2	8 pm
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by lin	ne 202 colum	n 8)	0. 341275	1.00
	Medicaid (see instructions for each line)				•	1
2.00	Net revenue from Medicaid				3, 500, 629	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 supplemen			ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaid	1		0	5.00
6.00	Medi cai d charges				22, 888, 788	
7.00	Medicaid cost (line 1 times line 6)	<i></i>			7, 811, 371	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line / minu	is sum of li	nes 2 and 5; if	4, 310, 742	8.00
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for </pre>	or oach line	.)			
9.00	Net revenue from stand-al one CHIP		:)		0	9.00
10.00	Stand-al one CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mir	nus line 9:	if < zero then	0 0	
	enter zero)		,			
	Other state or local government indigent care program (see ins	tructions fo	r each line)		
13.00	Net revenue from state or local indigent care program (Not inc	luded on lin	nes 2, 5 or	9)	0	
14.00	Charges for patients covered under state or local indigent car	e program (N	lot included	in lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 1		<i>.</i>		0	
16.00	Difference between net revenue and costs for state or local in	digent care	program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CH	ID and state	/local indi	ant core progra		
	instructions for each line)	IP and state		gent care progra	ans (see	
17.00	Private grants, donations, or endowment income restricted to f	unding chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of				0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loca			s (sum of lines	4, 310, 742	19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fa	cility	208, 10	2 0	208, 102	20,00
20100	(see instructions)		200,10	-	200,102	20100
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	71, 02	0 0	71, 020	
~~ ~~	instructions)					21.00
		66				
22.00	Payments received from patients for amounts previously written	off as		0 0	0	
	Payments received from patients for amounts previously written charity care	off as	71 02	-	_	22.00
22.00	Payments received from patients for amounts previously written	off as	71, 02	-	_	22.00
	Payments received from patients for amounts previously written charity care	off as	71, 02	-	71, 020	22.00
	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22)			0 0	_	22.00
23.00	Payments received from patients for amounts previously written charity care	nt days beyc		0 0	71, 020	22.00 23.00 24.00
23.00	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t	nt days beyc program?	ond a length	0 0 of stay limit	71, 020	22.00 23.00
23.00 24.00 25.00	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit	nt days beyc program? he indigent	ond a length	0 0 of stay limit	71, 020 1. 00 N 0	22.00 23.00 24.00 25.00
23.00 24.00 25.00 26.00	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in	nt days beyc program? he indigent structions)	ond a length care progra	0 0 of stay limit	71, 020 1. 00 N 0 4, 737, 561	22.00 23.00 24.00 25.00 26.00
23.00 24.00 25.00 26.00 27.00	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital comple	nt days beyc program? he indigent structions) x (see instr	ond a length care progra ructions)	0 0 of stay limit	71, 020 1. 00 N 0 4, 737, 561 392, 276	22.00 23.00 24.00 25.00 26.00 27.00
23.00 24.00 25.00 26.00 27.00 27.01	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex (nt days beyc program? he indigent structions) x (see instr	ond a length care progra ructions)	0 0 of stay limit	71, 020 1. 00 N 0 4, 737, 561 392, 276 603, 501	22.00 23.00 24.00 25.00 26.00 27.00 27.01
23.00 24.00 25.00 26.00 27.00 27.01 28.00	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex (Non-Medicare bad debt expense (see instructions)	nt days beyc program? he indigent structions) x (see instr see instruct	nd a length care progra ructions) ions)	0 0 of stay limit n's length of	71, 020 1. 00 N 0 4, 737, 561 392, 276 603, 501 4, 134, 060	22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00
23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex (Non-Medicare allowable bad debts for the entire hospital complex (Non-Medicare and non-reimbursable Medicare bad debt ex	nt days beyc program? he indigent structions) x (see instr see instruct	nd a length care progra ructions) ions)	0 0 of stay limit n's length of	71, 020 1. 00 N 0 4, 737, 561 392, 276 603, 501 4, 134, 060 1, 622, 076	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00
23.00 24.00 25.00 26.00 27.00 27.01 28.00	Payments received from patients for amounts previously written charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patie imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex (Non-Medicare bad debt expense (see instructions)	nt days beyo program? he indigent structions) x (see instr see instruct pense (see i	nd a length care progra ructions) ions)	0 0 of stay limit n's length of	71, 020 1. 00 N 0 4, 737, 561 392, 276 603, 501 4, 134, 060	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00

	Financial Systems CAME SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	RON MEMORIAL COM OF EXPENSES	MUNITY HOSPIT Provider CC	CN: 15-1315 Pe	eriod:	u of Form CMS-2 Worksheet A	2552-10
				T	rom 10/01/2020 p 09/30/2021	Date/Time Pre 2/24/2022 4:2	pared: 8 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		5,009,776	5,009,776	209, 345	5, 219, 121	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2,051,543	2,051,543	1, 368, 877	3, 420, 420	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	79, 733	10, 089, 629	10, 169, 362	0		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	5,651,166	8, 204, 914	13, 856, 080	-167, 967	13, 688, 113	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 060, 694 0	3, 645, 123 48, 546	4, 705, 817 48, 546	-19, 326 0		7.00 8.00
9.00	00900 HOUSEKEEPI NG	880, 221	640, 158	1, 520, 379	0		9.00
10.00	01000 DI ETARY	574, 329	394, 107	968, 436	-629, 871	338, 565	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 598, 958	0 48, 411	0 647, 369	568, 472 0		
14.00	01400 CENTRAL SERVICES & SUPPLY	223, 889	213, 445	437, 334	0		
15.00	01500 PHARMACY	859, 749	4, 442, 340	5, 302, 089	-3, 800, 842	1, 501, 247	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	589, 511	94, 344	683, 855	0	683, 855	16.00
30.00	03000 ADULTS & PEDIATRICS	2, 589, 388	1, 121, 853	3, 711, 241	496, 884	4, 208, 125	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	75, 058	75, 058	31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	12, 053	12, 053	43.00
50.00	05000 OPERATING ROOM	1, 613, 337	1, 478, 777	3, 092, 114	-725, 308	2, 366, 806	50.00
51.00	05100 RECOVERY ROOM	0	0	0	725, 308	725, 308	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	1, 183, 826 1, 968, 458	153, 566 990, 694	1, 337, 392 2, 959, 152	-585, 171 0	752, 221 2, 959, 152	
60.00	06000 LABORATORY	1, 968, 438	2, 287, 724	2, 939, 152	0	3, 339, 994	
65.00	06500 RESPI RATORY THERAPY	1,055,634	179, 707	1, 235, 341	-227, 898		
65.01	06501 SLEEP LAB	0	0	0	75, 814		
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	1,043,565	21, 441 6, 861	1, 065, 006 6, 861	0 152, 084	.,,	
69.01	06901 CARDI AC REHABI LI TATI ON	54, 957	6, 393	61, 350	0		
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	2, 781, 578	2, 781, 578	-1, 829, 666		
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 829, 666 921, 972	1, 829, 666 921, 972	
76.00	03020 CHEMI CAL DEPENDENCY	0	0	0	0	0	76.00
76.01	O3480 ONCOLOGY	0	1, 448, 379	1, 448, 379	0	1, 448, 379	76.01
88.00	OUTPATIENT SERVICE COST CENTERS	1, 113, 407	44, 482	1, 157, 889	0	1, 157, 889	88.00
88.01	08801 RURAL HEALTH CLINIC II	1, 570, 351	158, 637	1, 728, 988	0	1, 728, 988	88.01
88.02	08802 RURAL HEALTH CLINIC III	1,087,351	119, 197	1, 206, 548	0	1, 206, 548	
90. 00 90. 01	09000 CLINIC 09001 CLINIC- ORTHO	132, 200 366, 464	19, 525 874, 174	151, 725 1, 240, 638	0	151, 725 1, 240, 638	
90.02	09002 CLINIC - PEDS, ENT, FP	1, 182, 886	25, 788	1, 208, 674	56, 644	1, 265, 318	90.02
	09003 I NTRAVENOUS THERAPY	82, 840	16, 087	98, 927	2, 822, 226		
90. 04 90. 05	09004 PSYCHI ATRY 09005 CARDI OLOGY	668, 436 691, 694	13, 259 32, 387	681, 695 724, 081	0	681, 695 724, 081	90.04 90.05
91.00	09100 EMERGENCY	1, 965, 996	288, 549		1, 176		91.00
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						1011.00
	11300 I NTEREST EXPENSE		1, 485, 960		-1, 485, 960		113.00
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	0	0	0	0		114.00 116.00
118.00		29, 941, 310	48, 437, 354	78, 378, 664	-156, 430		
400.00	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		190.00 192.00
	07950 DAYCARE-INFANT/TODDLER	0	0	0	0		192.00
	07951 MOB	0	0	0	0		194.01
	07952 COMMUNITY HEALTH	0	3, 049	3, 049	0		194.02
	07953 ASSI STED LI VI NG/CAMERON WOODS 07954 EDUCATI ON	0	0	0	0		194.03 194.04
194.05	07955 MARKETI NG	229, 717	834, 642	1, 064, 359	50, 759	1, 115, 118	194.05
		0	0	0	61, 399		194.06
	07957 OUTSI DE LAUNDRY 07958 CANCER CENTER	0	0	0	0		194.07 194.08
194.09	07959 URGENT CARE	0	o	0	0	0	194.09
	07960 RHC	0	0	0	0		194.10
	07961 OBGYN 07962 TRI NE STUDENT HEALTH	0 127, 857	0 2, 005	0 129, 862	0	0 129, 862	194. 11 194. 12
	07963 OCCUPATI ONAL HEALTH	233, 073	114, 816	347, 889	0	347, 889	
	07964 I MMUNI ZATI ON CLINI C	0	0	0	0		194.14
194.15	07965 FOUNDATI ON	147, 968	217, 406	365, 374	3, 484	368, 858	194. 15

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	TAL	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C		Period: From 10/01/2020	Worksheet A	
				o 09/30/2021	Date/Time Pre 2/24/2022 4:2	
Cost Center Description	Sal ari es	Other	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	
194.1607967 CAMERON FAMILY MEDICINE - NORTH	613, 213	101, 901	715, 114	30, 826	745, 940	194.16
194.1707966 CAMERON FAMILY MEDICINE - FREMONT	588, 761	26, 057	614, 818	9, 962	624, 780	194.17
200.00 TOTAL (SUM OF LINES 118 through 199)	31, 881, 899	49, 737, 230	81, 619, 129	0	81, 619, 129	200.00

In Lieu of Form CMS-2552-10 Worksheet A

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JF EXPENSES	Provider C	N: 15-1315	Period: From 10/01/ To 09/30/	/2021 Date/Ti	me Prepared:
	Cost Center Description	Adjustments	Net Expenses			2/24/20	22 4:28 pm
		(See A-8)	For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	-575, 439					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-142,014					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-233, 063					4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-2, 689, 015 0					5.00
8.00	00800 LAUNDRY & LINEN SERVICE	0					8.00
9.00	00900 HOUSEKEEPI NG	0	1, 520, 379				9.00
10.00	01000 DI ETARY	-6, 688					10.00
	01100 CAFETERI A	-176, 340					11.00
	01300 NURSING ADMINISTRATION	0	647, 369				13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	-3, 300 -9, 060					14.00
	01600 MEDICAL RECORDS & LIBRARY	-723					16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	120	000,102				
30.00	03000 ADULTS & PEDIATRICS	-758, 554	3, 449, 571				30.00
	03100 I NTENSI VE CARE UNI T	0					31.00
43.00	04300 NURSERY	0	12, 053				43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	(02.012	1 (72 704				
	05000 OPERATING ROOM 05100 RECOVERY ROOM	-693, 012 0					50.00
	05200 DELIVERY ROOM & LABOR ROOM	0					52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	2, 959, 152				54.00
	06000 LABORATORY	-2, 521	3, 337, 473				60.00
65.00	06500 RESPI RATORY THERAPY	0					65.00
	06501 SLEEP LAB	0	75, 814				65.01
		0	1, 065, 006				66.00
	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON	0	158, 945 61, 350				69.00 69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	921, 972				73.00
	03020 CHEMI CAL DEPENDENCY	0	0				76.00
76.01	03480 ONCOLOGY	-32, 168	1, 416, 211				76.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	1, 157, 889				88.00
	08801 RURAL HEALTH CLINIC II	0					88.01
	08802 RURAL HEALTH CLINIC III	-429, 611					88.02
90.00	09000 CLI NI C	0	151, 725				90.00
	09001 CLINIC- ORTHO	-999, 379					90.01
	09002 CLINIC - PEDS, ENT, FP	-1, 169, 614	95, 704				90.02
	09003 I NTRAVENOUS THERAPY 09004 PSYCHI ATRY	-647, 063	2, 921, 153 34, 632				90.03 90.04
	09005 CARDI OLOGY	-578, 646					90.05
	09100 EMERGENCY	0					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	-					
101.00	10100 HOME HEALTH AGENCY	0	0				101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0	0				113.00
	11400 UTI LI ZATI ON REVI EW-SNF	0	-				114.00
	11600 HOSPI CE	0	0				116.00
118.00		-9, 146, 210	69, 076, 024				118.00
100 07	NONREI MBURSABLE COST CENTERS	-	-				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	-				190.00
	07950 DAYCARE-INFANT/TODDLER		0				192.00 194.00
	07951 MOB	0 0	0				194.00
	07952 COMMUNI TY HEALTH	0	3, 049				194.02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0				194.03
	07954 EDUCATI ON	0	0				194.04
	07955 MARKETI NG	0	1, 115, 118				194.05
	07956 GUEST MEALS 07957 OUTSI DE LAUNDRY	0	61, 399 0				194.06 194.07
	07957 OUTSTDE LAUNDRY 07958 CANCER CENTER	0	0				194.07
	07959 URGENT CARE	0	0				194.00
194.10	07960 RHC	0	0				194.10
194 11	07961 OBGYN	0	0				194.11
	1070/0 TRUNE CTURENT UEAL TU		129, 862				194.12
194.12	07962 TRINE STUDENT HEALTH	0					
194. 12 194. 13	07963 OCCUPATI ONAL HEALTH	0	347, 889				194.13
194. 12 194. 13 194. 14		0	347, 889 0				194. 13 194. 14 194. 15

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	TAL	In Lieu	J of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider C	CN: 15-1315	Peri od:	Worksheet A	
				From 10/01/2020 To 09/30/2021	Date/Time Pre	narod
				10 097 307 2021	2/24/2022 4:2	
Cost Center Description	Adjustments	Net Expenses		·		
	(See A-8)	For				
		Allocation				
	6.00	7.00				
194.1707966 CAMERON FAMILY MEDICINE - FREMONT	0	624, 780				194.17
200.00 TOTAL (SUM OF LINES 118 through 199)	-9, 146, 210	72, 472, 919				200.00

Health Financial Systems RECLASSIFICATIONS

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

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

RECLAS	SI FI CATI ONS			Provider (CN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Date/Time	
		Increases					2/24/2022	4:28 pm
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - LABOR AND DELIVERY							
1.00	ADULTS & PEDIATRICS	30.00	504, 937	67, 005				1.00
2.00	NURSERY	43.00	10, 641	1, 412				2.00
3.00	EMERGENCY		<u> </u>	138				3.00
			516, 616	68, 555				
1 00	B - PROPERTY INSURANCE CAP REL COSTS-BLDG & FIXT	1 00	0	72 007				1.00
1.00 2.00	CAP REL COSTS-BLDG & FIXT	1.00 2.00	0	73, 097 14, 306				1.00
2.00	CAP REL COSTS-MUBLE EQUIP	2.00	<u>0</u>	<u>14, 308</u> 87, 403				2.00
	C - CAFETERIA		<u>v</u>	07,100				
1.00	CAFETERIA	11.00	337, 131	231, 341				1.00
2.00	GUEST MEALS	194.06	36, 413	24, 986				2.00
	0		373, 544	256, 327				
	D - INTEREST EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 482, 858				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	3, 102				2.00
			0	1, 485, 960				_
1.00	E - DEPRECIATION EXPENSE CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 357, 591				1.00
1.00	CAP REL COSTS-MUBLE EQUIP		<u>0</u>	1, 357, 591				1.00
	F - ICU		9	1, 337, 371				
1.00	I NTENSI VE CARE UNI T	31.00	67, 583	7, 475				1.00
	0		67, 583	7,475				
	G – PROPERTY TAX							
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	2 <u>6, 3</u> 21				1.00
	0		0	26, 321				
	H - SLEEP LAB - SALARIED STAF							
1.00	SLEEP LAB	65.01	40, 745	35,069				1.00
2.00	ELECTROCARDIOLOGY		<u>18, 179</u>	6 <u>5,687</u>				2.00
	U I - PUBLIC RELATIONS		58, 924	100, 756				
1.00	MARKETI NG	194.05	0	50, 759				1.00
1.00				<u>50, 759</u>				1.00
	J - RECOVERY ROOM		-					
1.00	RECOVERY ROOM	51.00	725, 308					1.00
	0		725, 308	0				
	K - IMPLANTABLE DEVICES							
1.00	IMPL. DEV. CHARGED TO	72.00		1, 829, 666				1.00
	PATI ENTS	+	— — — ₀	1, 829, 666				
	L - FOUNDATION RECLASS		U	1, 829, 000				_
1.00	FOUNDATION	194. 15	3, 484	0				1.00
1.00			3, 484					1.00
	M - IMMUNIZATION CLINIC RECLA	ISS	0,101	0				
1.00	CLINIC - PEDS, ENT, FP	90. 02	0	56, 644				1.00
	0		0	56, 644				1
	N – DRUGS RECLASS							
1.00	DRUGS_CHARGED_TO_PATIENTS		0	3, 744, 198				1.00
	TOTALS		0	3, 744, 198				
	0 - IV THERAPY			0.000.00/				
1.00	INTRAVENOUS_THERAPY			2,822,226				1.00
	TOTALS P - EKG HST RECLASS		U	2, 822, 226				
1.00	ELECTROCARDI OLOGY	69.00	68, 218	0				1.00
1.00	TOTALS		68, 218	ö				1.00
	Q - OFFSITE RECLASS		00,210	0				
1.00	CAMERON FAMILY MEDICINE -	194.16	0	30, 826				1.00
	NORTH							
2.00	CAMERON FAMILY MEDICINE -	194. 17	0	9, 962				2.00
	FREMONT							
3.00		0.00	0	0				3.00
	TOTALS		0	40, 788				
500.00	Grand Total: Increases		1, 813, 677	11, 934, 669				500.00
	'							

	Financial Systems SIFICATIONS	GAMEN	RON MEMORIAL CON		CCN: 15-1315	Peri od:	of Form CMS-2552 Worksheet A-6
.0110				in our der		From 10/01/2020	
						To 09/30/2021	Date/Time Prepare 2/24/2022 4:28 pm
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	·	
	6.00	7.00	8.00	9.00	10.00		
00	A - LABOR AND DELIVERY DELIVERY ROOM & LABOR ROOM	52.00	516, 616	68, 555	-	0	1.
00	DELIVERT ROOM & EABOR ROOM	0.00	0	00, 000		0	2.
00		0.00	0	(0	3.
	0		516, 616	68, 555	5	1	
	B - PROPERTY INSURANCE						
00	ADMINISTRATIVE & GENERAL	5.00	0	87, 403		2	1.
00		0.00	0			2	2.
	C – CAFETERIA		U	87, 403	3		
0	DI ETARY	10.00	373, 544	256, 327	7	0	1.
0		0.00	0	200,027		0	2.
	0		373, 544	256, 327	7		
	D - INTEREST EXPENSE				1	1	
C	INTEREST EXPENSE	113.00	0	1, 485, 960		1	1.
C		0.00	0	1, 485, 960		1	2.
	E - DEPRECIATION EXPENSE		U	1, 485, 900	J		
0	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 357, 591	1	9	1.
-			0	1, 357, 591		7	
	F - ICU						
)	ADULTS & PEDIATRICS		6 <u>7, 5</u> 83	<u>7,4</u> 75		0	1.
	0		67, 583	7, 475	ō		
`	G - PROPERTY TAX	5.00	0	24 221	1 1	2	1
C	ADMI NI STRATI VE & GENERAL		0	2 <u>6, 3</u> 21 26, 321		3	1.
	H - SLEEP LAB - SALARIED STAF	F	0	20, 32	•		
С	RESPI RATORY THERAPY	65.00	58, 924	100, 756	5	0	1.
C		0.00	0	(Ō	2.
	0		58, 924	100, 756	5		
~	I - PUBLIC RELATIONS	E 00	0	E0.7E0		0	1
0	ADMI NI STRATI VE & GENERAL	<u>5.00</u>	0	5 <u>0, 759</u> 50, 759		Q	1.
	J - RECOVERY ROOM	I	0	50,75	/		
С	OPERATI NG ROOM	50.00	725, 308			0	1.
	0		725, 308			1	
	K - IMPLANTABLE DEVICES				.1		
C	MEDICAL SUPPLIES CHARGED TO	71.00		1, 829, 666	5	0	1.
	PATI ENT	+		1,829,666	<u> </u>	-	
	L - FOUNDATION RECLASS	I	0	1, 02 7, 000	<u> </u>		
)	ADMI NI STRATI VE & GENERAL	5.00	3, 484	()	0	1.
	0		3, 484				
	M - IMMUNIZATION CLINIC RECLA				-	-	
0	PHARMACY	<u>15.</u> 00	0	56,644		Ō	1.
	0 N - DRUGS RECLASS		0	56, 644	+		
С	PHARMACY	15.00	0	3, 744, 198	3	0	1.
-	TOTALS		— — — 0	3, 744, 198		Ť	1.
	0 - IV THERAPY						
0	DRUGS_CHARGED_TO_PATIENTS	73.00	0	<u>2, 822, 2</u> 26		0	1.
	TOTALS		0	2,822,226	5		
2	P - EKG HST RECLASS	(F. 00)	(0.010	-			
0	RESPIRATORY_THERAPY	<u>65.</u> 00	6 <u>8, 2</u> 18	(<u> </u>	Q	1.
	IUIALS		68, 218	L L			

 Q - OFFSITE RECLASS

 CAP REL COSTS-BLDG & FIXT

 CAP REL COSTS-MVBLE EQUIP

 OPERATION OF PLANT

 TOTALS
 68, 218 U 1.00 2.00 0 0 1.00 15, 340 9 1.00 6, 122 1<u>9, 3</u>26 40, 788 9 2.00 2.00 0 7.00 3.00 3.00 0 500.00 Grand Total: Decreases 1, 813, 677 11, 934, 669 500.00

Heal th	Fi nanci a	I Sys	stems		
RECONC	I LI ATI ON	OF C	API TAL	COSTS	CENTERS

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Domation Total Disposal s and Retirements 1.00 2.00 3.00 4.00 5.00 2.00 Land 0 0 0 0.00 2.00 Land 1.419,368 600,335 0 6.00,335 0 2.00 Buildings and Fixtures 57,618,245 1,843,484 0 1,843,484 0 3.00 4.00 Building Improvements 0 <th></th> <th></th> <th></th> <th>1</th> <th>rom 10/01/2020 To 09/30/2021</th> <th></th> <th>pared: 8 pm</th>				1	rom 10/01/2020 To 09/30/2021		pared: 8 pm
Balances Retirements 1.00 2.00 3.00 4.00 5.00 1.00 Land 1.00 2.00 3.00 4.00 5.00 1.00 Land 1.419,368 600,335 0 600,335 0 1.00 2.00 Land Improvements 1.419,368 600,335 0 0 0 0 2.00 3.00 Building and Fixtures 57,618,245 1.843,484 0 1.843,484 0 3.00 4.00 5.00 5.00 Fixed Equipment 0				Acquisitions			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00 2.00 Land 1, 419, 368 600, 335 0 600, 335 0 1.00 2.00 Land improvements 1, 419, 368 600, 335 0 600, 335 0 1.00 3.00 Building more the second of			Purchases	Donati on	Total		
PART I - ANALYSI S OF CHANGES IN CAPITAL ASSET BALANCES 0							
1.00 Land 1,419,368 600,335 0 600,335 0 1.00 2.00 Land Improvements 0			2.00	3.00	4.00	5.00	
2.00 Land Improvements 0					1		
3.00 Buildings and Fixtures 57, 618, 245 1, 843, 484 0 1, 843, 484 0 3.00 4.00 Building Improvements 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 0		1, 419, 368	600, 335	(600, 335	0	
4.00 Building Improvements 0 </td <td></td> <td>0</td> <td>0</td> <td>(</td> <td>0 0</td> <td>0</td> <td>2.00</td>		0	0	(0 0	0	2.00
5.00 Fixed Equipment 0		57, 618, 245	1, 843, 484	(1, 843, 484	0	3.00
6.00 Movable Equipment 20, 351, 820 1, 738, 017 0 1, 738, 017 2, 660, 420 6.00 7.00 HIT designated Assets 0	4.00 Building Improvements	0	0	(0 0	0	4.00
7.00 HIT designated Assets 0 0 0 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 79, 389, 433 4, 181, 836 0 4, 181, 836 2, 660, 420 8.00 9.00 Reconciling Items 0	5.00 Fixed Equipment	0	0	(0 0	0	5.00
8.00 Subtotal (sum of lines 1-7) 79, 389, 433 4, 181, 836 0 4, 181, 836 2, 660, 420 8.00 9.00 Reconciling Items 0	6.00 Movable Equipment	20, 351, 820	1, 738, 017	(1, 738, 017	2, 660, 420	6.00
9.00 Reconciling Items 0 0 0 0 0 0 9.00 10.00 Total (line 8 minus line 9) 79, 389, 433 4, 181, 836 0 4, 181, 836 2, 660, 420 10.00 Image: Constraint of the state	7.00 HIT designated Assets	0	0	(0 0	0	7.00
10.00 Total (line 8 minus line 9) 79, 389, 433 4, 181, 836 0 4, 181, 836 2, 660, 420 10.00 Ending Fully Balance Depreciated Assets 6.00 7.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 1.00 Land 0 0 0 0 0 2.00 3.00 8uildings and Fixtures 59, 461, 729 0 3.00 4.00 5.00 Fixed Equipment 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 5.00 6.00 7.00 3.00 4.00 5.00 6.00 7.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 4.00 5.00 6.00 7.00 5.00 6.00 7.00 6.00 7.00 6.00 7.00 8.00<		79, 389, 433	4, 181, 836	(4, 181, 836	2, 660, 420	8.00
Ending Balance Fully Depreciated Assets 6.00 7.00 PART 1 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2,019,703 0 2.00 Land Improvements 0 0 3.00 Buildings and Fixtures 59,461,729 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Nowable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00	9.00 Reconciling Items	0	0	(0 0	0	9.00
Bal ance Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 6.00 7.00 1.00 Land 2,019,703 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 59,461,729 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 4.00 6.00 Movable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 7.00 8.00 Subtotal (sum of Lines 1-7) 80,910,849 0 8.00 9.00	10.00 Total (line 8 minus line 9)	79, 389, 433	4, 181, 836	(4, 181, 836	2, 660, 420	10.00
Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 1.00 1.00 Land 2,019,703 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 59,461,729 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of Lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00		Endi ng					
Barry Instruction 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2,019,703 0 2.00 Land Improvements 0 0 3.00 Buildings and Fixtures 59,461,729 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 19,429,417 0 6.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00		Bal ance	Depreciated				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2,019,703 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 59,461,729 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00							
1.00 Land 2,019,703 0 1.00 2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 59,461,729 0 3.00 4.00 Building Improvements 0 0 0 5.00 Fixed Equipment 0 0 4.00 6.00 Movable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00			7.00				
2.00 Land Improvements 0 0 2.00 3.00 Buildings and Fixtures 59,461,729 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00							
3.00 Buildings and Fixtures 59,461,729 0 3.00 4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00	1.00 Land	2, 019, 703	0				1.00
4.00 Building Improvements 0 0 4.00 5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00		0	0				
5.00 Fixed Equipment 0 0 5.00 6.00 Movable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00		59, 461, 729	0				3.00
6.00 Movable Equipment 19,429,417 0 6.00 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00	4.00 Building Improvements	0	0				4.00
7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00	5.00 Fixed Equipment	0	0				5.00
8.00 Subtotal (sum of lines 1-7) 80,910,849 0 8.00 9.00 Reconciling Items 0 0 9.00	6.00 Movable Equipment	19, 429, 417	0				6.00
9.00 Reconciling Items 0 0 9.00	7.00 HIT designated Assets	0	0				7.00
	8.00 Subtotal (sum of lines 1-7)	80, 910, 849	0				8.00
10.00 Total (line 8 minus line 9) 80,910,849 0 10.00	9.00 Reconciling Items	0	0				9.00
	10.00 Total (line 8 minus line 9)	80, 910, 849	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1315 Period: To 10/01/2020 To 09/30/2021 Porvider A-7 Part I I adte/Time Prepared: 2/24/2022 4:28 pm Cost Center Description Depreciation Lease Interest Insurance (see instructions) Taxes (see instructions) 9.00 10.00 11.00 12.00 13.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 0 0 0 1.00 0.00 CAP REL COSTS-MUBLE EQUIP 5,009,776 0 0 0 2.00 3.00 Total (sum of lines 1-2) 5,009,776 0 0 0 3.00 Other CAPITAL Other Description Other Total (sum of lines 1-2) Other Total (sum of cols. 9 through 14) instructions) PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 Cost Center Description Other Total (1) Capital -Relations) PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 Cost Center Description Other Total (1) Capital -ReL COSTSNUBLE EQUIP O CAP REL COSTSNUBLE EQUIP<	Heal th	Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
To 09/30/2021 Date/Time Prepared: 2/24/2022 4:28 pm SUMMARY OF CAPITAL Depreciation Lease Interest Insurance Taxes (see instructions) PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 5,009,776 0 <	RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1315			
Cost Center Description Depreciation Lease Interest Insurance (see instructions) Taxes (see instructions) PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 0 0 0 0 0 0 0 0 1.00 2.00 CAP REL COSTS-BLDG & FIXT 5,009,776 0 0 0 0 2.00 0 0 2.00 1.00 3.00 Total (sum of lines 1-2) 5,009,776 2,051,543 0 0 0 2.00 3.00 Cost Center Description Other (sum of cols. ed Costs (see 0 structions) Total (1) (sum of cols. ed Costs (see 9 through 14) instructions) 0 0 0 3.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 15.00 14.00 15.00 14.00 15.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 2.00 5,009,776 2.007,76 2.007,76 1.00 2.00 CAP REL COSTS-BLDG & FIXT 0 5,009,776 2.00 2.00 1.00 2.00 CAP REL COSTS-MUBLE EQUIP 0 2.007,76 2.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>narod</td>								narod
SUMMARY OF CAPITAL Cost Center Description Lease Interest Insurance (see instructions) Taxes (see instructions) PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 5,009,776 0								

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1315 F	Period:	Worksheet A-7	
					rom 10/01/2020		
				1	Го 09/30/2021		
						2/24/2022 4: 28	8 pm
		COM	PUTATION OF RAT	ITOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	S CENTERS		_			
. 00	CAP REL COSTS-BLDG & FIXT	61, 481, 432	0	61, 481, 432	0. 759866	0	1.
. 00	CAP REL COSTS-MVBLE EQUIP	19, 429, 417	0	19, 429, 417	0. 240134	0	2.
3.00	Total (sum of lines 1-2)	80, 910, 849	0	80, 910, 849	1. 000000	0	3.
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS	5 CENTERS		•			
. 00	CAP REL COSTS-BLDG & FIXT	0	0	(3, 636, 845	0	1.0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(1, 212, 557	2, 051, 543	2.0
. 00	Total (sum of lines 1-2)	0	0	(4, 849, 402	2, 051, 543	3.0
			SL	IMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	•		(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS						
. 00	CAP REL COSTS-BLDG & FIXT	907, 419	73, 097	26, 32	0	4, 643, 682	1.
. 00	CAP REL COSTS-MVBLE EQUIP	0	14, 306	(0 0	3, 278, 406	2.
3.00	Total (sum of lines 1-2)	907, 419	87, 403	26, 32		7, 922, 088	3.

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

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet A-8 Date/Time Pre	
					10 09/30/2021	2/24/2022 4:2	
			То	Expense Classification o /From Which the Amount i			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - CAP REL	A		P REL COSTS-BLDG & FIXT	1.00		1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	А	-3, 102 CA	P REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other (chapter 2)	A	0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		О		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	В	-16, 617 AD	MINISTRATIVE & GENERAL	5.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8.00	21) Television and radio service (chapter 21)		0		0.00	0	8.00
9. 00 10. 00	Parking Lot (chapter 21) Provi der-based physici an	A-8-2	0 -4, 310, 990		0.00	0 0	
11.00			0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-405, 575			0	12.00
13.00 14.00	Laundry and linen service	В	0 -171, 959 CA		0. 00 11. 00		
15.00	Cafeteria-employees and guests Rental of quarters to employee and others		-171, 959CA 0	IFEIERIA	0.00		1
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than patients	В	-8, 320 PH	IARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	В	-723 ME	DI CAL RECORDS & LI BRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.) Vending machines Income from imposition of	В	-4, 381 CA	FETERI A	11.00 0.00		20.00 21.00
21.00	interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	ORE	SPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OPH	IYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review -		оит	ILIZATION REVIEW-SNF	114.00		25.00
26.00	physicians' compensation (chapter 21) Depreciation - CAP REL		OCA	P REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		OCA	P REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist	_		* Cost Center Deleted **			28.00
29. 00 30. 00	Adjustment for occupational	A A-8-3		INIC- ORTHO * Cost Center Deleted **	* 90. 01 * 67. 00		29.00 30.00
30. 99	therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see		OAD	ULTS & PEDIATRICS	30. 00		30. 99
30. 99	limitation (chapter 14)		OAD	ULTS & PEDI ATRI CS	30.00		:

Health Financial Systems	CAME	RON MEMORIAL C	OMMUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Period:	Worksheet A-8	
				From 10/01/2020 To 09/30/2021		pared:
		1			2/24/2022 4:2	
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
				- 1		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	2.00	3.00	4.00	Ref.	
31.00 Adjustment for speech	A-8-3		3.00 *** Cost Center Deleted ***	4.00	5.00	31.00
pathology costs in excess of	A-0-3		Cost center bereted	00.00		31.00
limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest						
33.00 LOBBYING EXPENSES	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.01 MEALS ON WHEELS	В		DI ETARY	10.00		
33.02 RENTAL INCOME OFFSET - CANCER	В	-32, 168	ONCOLOGY	76.01	0	33.02
CENTER		04.400		5.00		
33. 03 ATM SURCHARGE REVENUE	B		ADMINISTRATIVE & GENERAL RURAL HEALTH CLINIC III	5.00 88.02		
33.04 RHC OB PHYSICIAN & MIDLEVELS	A	-429,011	RURAL HEALTH CLINIC III	88.02	0	33.04
33. 05 HAF EXPENSE	A	-2 552 155	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33. 06 PHYSI CI AN RECRUI TMENT	A		ADMI NI STRATI VE & GENERAL	5.00		
33.07 PHYSI CLAN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5.00		
33.08 PEDS/ENT MIDLEVELS OFFSET	A	-148, 017	CLINIC - PEDS, ENT, FP	90.02	0	33.08
33.09 PSYCH MIDLEVELS OFFSET	A		PSYCHI ATRY	90.04	0	00.07
50.00 TOTAL (sum of lines 1 thru 49)		-9, 146, 210				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						
(1) Description - all chapter reference(2) Basis for adjustment (see instruct		olumn pertain t	o CMS Pub. 15-1.			
A. Costs - if cost, including appli		l can be deter	mined			
B. Amount Received - if cost canno			in ned.			
(3) Additional adjustments may be mad			bscripts thereof.			
Note: See instructions for column 5						

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-25						2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOL		ME Provider CCN: 15-1315	Period: From 10/01/2020	Worksheet A-8	3-1			
OFFICE				To 09/30/2021	Date/Time Pre 2/24/2022 4:2			
	Line No.	Cost Center	Expense Items	Amount of	Amount			
				Allowable Cost				
					Wks. A, column			
					5			
	1.00	2.00	3.00	4.00	5.00			
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME							
	OFFICE COSTS:		-					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CMO AND MOB RENTAL	848, 360	987, 272	1.00		
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - CAMERON WOODS	0	207, 002	2.00		
3.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	26, 850	3.00		
3.01	14.00	CENTRAL SERVICES & SUPPLY	CMO EXPENSE - CAMERON WOODS	0	3, 300	3.01		
4.00	5.00	ADMINISTRATIVE & GENERAL	CMO EXPENSE - CAMERON WOODS	0	3, 450	4.00		
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - RETAIL PHARMA	c o	26, 061	4.01		
5.00	0		0	848, 360	1, 253, 935	5.00		
* Tho	* The amounts on Lines 1.4 (and subscripts as appropriate) are transferred in detail to Workshoot A. column 4. Lines as							

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		
					ļ	
Symbol (1)	Name	Percentage of	Name	Percentage of		
		Ownership		Ownershi p		
1.00	2.00	3.00	4.00	5.00		
 B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	С	CAMERON MEDICAL	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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 CON	MUNI TY HOSPI TAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1315	From 10/01/2020	Worksheet A-8-1 Date/Time Prepared:	

			2/24/2022 4:.	28 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	-138, 912	9		1.00
2.00	-207,002	0		2.00
3.00	-26, 850	0		3.00
3.01	-3, 300	0		3.01
4.00	-3, 450	0		4.00
4.01	-26,061	0		4.01
5.00	-405, 575			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.

1103 110	been posted to worksheet A,			Financated fin condinin 4 of	this part.
	Rel ated Organi zati on(s)				
	and/or Home Office				
	Type of Business				
	6.00				
	B. INTERRELATIONSHIP TO RELA	D 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.

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
6. 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	

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

	R BASED PHYSIC			Provi der 0		Period: From 10/01/2020	Worksheet A-8	
						To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
	1.00	0.00	2.00	4.00	F 00	(00	Hours	
1 00	1.00	2.00 PHARMACY	3.00	4.00	5.00	6.00	7.00	1 00
1.00 2.00		ADULTS & PEDIATRICS	758, 554	740 758, 554			0	1.00 2.00
2.00		OPERATING ROOM	693, 012	693, 012			0	2.00
4.00		LABORATORY	7, 563	2, 521	5,042		0	4.00
4.00 5.00		CLINIC- ORTHO	858, 746	821, 246	37, 500		0	5.00
6.00		CLINIC - PEDS, ENT, FP	1, 021, 597	1, 021, 597	37, 300		0	6.00
7.00		PSYCHI ATRY	434, 674	434, 674			0	7.00
8.00		CARDI OLOGY	578, 646	578, 646			0	8.00
9.00	0.00	0/110102001	0	0,0,010			0	9,00
10.00	0.00		0	0			0	10.00
200.00	0.00		4, 353, 532	4, 310, 990	42, 542		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er		Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	15.00	PHARMACY	0	0	C	0 0	0	1.00
2.00		ADULTS & PEDIATRICS	0	0	C	0 0	0	2.00
3.00		OPERATING ROOM	0	0	C	0 0	0	3.00
4.00		LABORATORY	0	0	C	0	0	4.00
5.00		CLINIC- ORTHO	0	0	C	0	0	5.00
6.00		CLINIC – PEDS, ENT, FP	0	0	C	0 0	0	6.00
7.00		PSYCHI ATRY	0	0	C	0	0	7.00
8.00		CARDI OLOGY	0	0	C	0	0	8.00
9.00	0.00		0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	10.00
200.00			0	0			0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		PHARMACY	0	0	(1.00
2.00		ADULTS & PEDIATRICS	0	0		758, 554		2.00
3.00		OPERATING ROOM	0	0		693,012		3.00
4.00		LABORATORY	0	0	C	2, 521		4.00
5.00	90.01	CLINIC- ORTHO	0	0	C	821, 246		5.00
6.00		CLINIC - PEDS, ENT, FP	0	0	C	1, 021, 597		6.00
7.00		PSYCHI ATRY	0	0	C	434, 674		7.00
8.00		CARDI OLOGY	0	0	C			8.00
9.00	0.00		0	0	C			9.00
10.00	0.00		0	0	C	0 0		10.00
200.00			0	0	C	4, 310, 990		200.00

In Lieu of Form CMS-2552-10 Worksheet B

	RON MEMORIAL CO	DMMUNITY HOSPIT	FAL	In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1315 Pe Fr Tc	eriod: com 10/01/2020 o 09/30/2021	Worksheet B Part I Date/Time Pre 2/24/2022 4:2	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT	4, 643, 682	4, 643, 682				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	3, 278, 406		3, 278, 406			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	9, 936, 299			9, 996, 810		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	10, 999, 098			1, 775, 308	13, 548, 963	
7.00 00700 OPERATION OF PLANT	4, 686, 491	455, 980		333, 423	5, 686, 732	
8. 00 00800 LAUNDRY & LI NEN SERVI CE	48, 546			0	118, 702	
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	1, 520, 379			276, 692	1, 808, 962	
11. 00 01100 CAFETERIA	331, 877			63, 116 105, 975	663, 134	1
13. 00 01300 NURSING ADMINI STRATI ON	392, 132 647, 369			188, 279	629, 238 901, 973	
14. 00 01400 CENTRAL SERVICES & SUPPLY	434, 034			70, 378	710, 257	
15. 00 01500 PHARMACY	1, 492, 187			270, 257	1, 838, 744	
16.00 01600 MEDICAL RECORDS & LIBRARY	683, 132			185, 309	891, 563	
INPATIENT ROUTINE SERVICE COST CENTERS					,	
30. 00 03000 ADULTS & PEDI ATRI CS	3, 449, 571	764, 196	353, 351	951, 438	5, 518, 556	30.00
31.00 03100 INTENSIVE CARE UNIT	75, 058	53, 305	24, 647	21, 244	174, 254	
43. 00 04300 NURSERY	12, 053	18, 973	8, 773	3, 345	43, 144	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 673, 794	496, 093	229, 386	279, 147	2, 678, 420	50.00
51.00 05100 RECOVERY ROOM	725, 308	321, 047	148, 447	227, 996	1, 422, 798	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	752, 221	158, 558		209, 733	1, 193, 827	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 959, 152			618, 773	4, 133, 429	
60.00 06000 LABORATORY	3, 337, 473			330, 775	3, 851, 501	
65. 00 06500 RESPI RATORY THERAPY	1,007,443			291, 866	1, 347, 534	
65.01 06501 SLEEP LAB	75, 814			12, 808	142, 929	
66.00 06600 PHYSI CAL THERAPY	1,065,006			328, 038	1, 803, 083	
69.00 06900 ELECTROCARDI OLOGY	158, 945			27, 158	211,008	
69. 01 06901 CARDI AC REHABI LI TATI ON	61, 350			17, 275	120, 243	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	951, 912			0	951, 912	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 829, 666		-	0	1, 829, 666	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 CHEMI CAL DEPENDENCY	921, 972	0		0	921, 972 0	
76. 01 03480 0NC0L0GY	1, 416, 211	0		0	1, 648, 061	1
OUTPATIENT SERVICE COST CENTERS	1,410,211	0	231,030	U	1, 040, 001	70.01
88.00 08800 RURAL HEALTH CLINIC	1, 157, 889	0	141, 805	349, 993	1, 649, 687	88.00
88.01 08801 RURAL HEALTH CLINIC II	1, 728, 988			493, 630	2, 358, 992	
88. 02 08802 RURAL HEALTH CLINIC III	776, 937			341, 802	1, 191, 761	
90. 00 09000 CLINIC	151, 725			41, 556		90.00
90. 01 09001 CLINIC- ORTHO	241, 259			115, 196	439, 503	
90. 02 09002 CLINIC - PEDS, ENT, FP	95, 704	0	124, 907	371, 833	592, 444	90.02
90. 03 09003 I NTRAVENOUS THERAPY	2, 921, 153	23, 716	10, 966	26, 040	2, 981, 875	90.03
90. 04 09004 PSYCHI ATRY	34, 632	0	36, 908	210, 119	281, 659	90.04
90. 05 09005 CARDI OLOGY	145, 435	0	30, 746	217, 430	393, 611	90.05
91. 00 09100 EMERGENCY	2, 255, 721	411, 936	190, 472	618, 325	3, 476, 454	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS				. 1		101
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS	1		I			112 00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		_			~	114.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 69, 076, 024	U 1 411 E10	2 220 400	0 9, 374, 257	0 68, 363, 301	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	09, 076, 024	4, 611, 518	3, 220, 400	9, 314, 257	08, 303, 301	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 201	12, 115	0	28 216	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			0		192.00
194. 00 07950 DAYCARE-INFANT/TODDLER	0	0 0	2, 110			192.00
194. 01 07951 MOB	0	0	0	0		194.01
194. 02 07952 COMMUNI TY HEALTH	3,049	0	0	0		194.02
194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS	0	0	0	0	0	194.03
194. 04 07954 EDUCATI ON	0	0	0	o	0	194.04
194. 05 07955 MARKETI NG	1, 115, 118	0	21, 243	72, 210	1, 208, 571	
194.0607956 GUEST MEALS	61, 399		0	11, 446		194.06
194. 07 07957 OUTSI DE LAUNDRY	0	0	0	0	0	194.07
194.0807958 CANCER CENTER	0	0	0	0		194.08
194. 09 07959 URGENT CARE	0	0	0	0		194.09
194. 10 07960 RHC	0	0	-	0		194.10
194. 11 07961 OBGYN	0	0	0	0		194.11
194. 12 07962 TRI NE STUDENT HEALTH	129, 862	0	0	40, 191	170, 053	194.12

Health Financial Systems	CAMERON MEMORIAL C	OMMUNITY HOSPIT	TAL	In Lie	u of Form CMS-2	2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CO		Period: From 10/01/2020 To 09/30/2021	Worksheet B Part I Date/Time Pre 2/24/2022 4:2	
		CAPI TAL REL	LATED 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	347, 889	0	17, 69	2 73, 265		
194.1407964 IMMUNIZATION CLINIC	0	0		0 0		194.14
194. 15 07965 FOUNDATI ON	368, 858		4,84			
194.1607967CAMERON FAMILY MEDICINE - NORTH	745, 940			0 192, 760		
194.1707966CAMERON FAMILY MEDICINE - FREMONT	624, 780	0		0 185, 073		
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	72, 472, 919	4, 643, 682	3, 278, 40	6 9, 996, 810	72, 472, 919	202.00

Heal th	Fi nanci al	Systems	

Cost Center Description April INSTRATIV Classifier A (0.00) Due Norm Due Norm Due Norm 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.0000 0.000 0.000 0.000 0.000 0.000 0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000000 0.00000 0.0000		Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPI Provider C	CN: 15-1315 P	In Lie eriod: rom 10/01/2020 o 09/30/2021	u of Form CMS-: Worksheet B Part I Date/Time Pre 2/24/2022 4:2	pared:
Control Contro <thcontrol< th=""> <thcontrol< th=""> <thco< th=""><th></th><th>Cost Center Description</th><th>E & GENERAL</th><th>PLANT</th><th>LINEN SERVICE</th><th></th><th>DI ETARY</th><th></th></thco<></thcontrol<></thcontrol<>		Cost Center Description	E & GENERAL	PLANT	LINEN SERVICE		DI ETARY	
1.00 DOUID GAP KEL DOIS S-BLO & FIXI 1.00 1.00 0.000 APR LOSTS-WELD & FIXI 2.00 4.00 DOUD GAP KEL DOIS S-BLO & FIXI 1.3.948, 960 7.00 7.00 4.00 DOUD GAP KEL DOIS S-BLO & FIXI 1.3.948, 960 7.00 7.00 0.00 DOUD GAP KEL DOIS S-BLO & FIXI 1.3.948, 960 7.00		GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
2.00 00000 DATURE EVENT SUPPORT 13, 545 06 4, 900 4, 900 4, 900 4, 900 4, 900 4, 900 4, 900 8, 994, 125 4, 900 4, 900 8, 994, 125 4, 900 8, 994, 125 4, 900 8, 994, 125 9, 900 13, 900 13, 900 14, 900	1.00							1 1.00
4.00 Deckol File DVEF. ENFIFITS DFPARTMENT 13, 848, exp 4.00 4.00 7.00 DUTOR DFFANT TRUE TYPE ALTRIE TO FFARTMENT 13, 848, exp 5.00 5.0								•
5.00 DODDOL ALIMIN MISTATI TUPE & CLEMENAL 13, 545, 963								•
7.00 DOTOD DEFAULT ON F PLANT 1, 307. 593 6, 994, 325 7.00 F.7.00 0.00 DEBUGE LARDY & L. HAR SHOLCE 27.244 57.01 22.3, 100 2.2, 746, 583 10.00 0.00 DEBUGE LARDY & L. HAR SHOLCE 27.944 57.00 12.0, 100 2.2, 746, 583 10.00 0.00 DEBUGE LARD SHOLES & TABLE SHOLES 12.0, 100 13.00 13.00 13.00 13.00 DIADE KIRSLIN, SKIN CES SILVA 453.00 57.00 82.00 13.00 13.00 14.00 DIADE KIRSLIN, SKIN CES SILVA 453.00 65.9 57.60 10.00 10.00 10.00 10.00 12.00 10.00<			13, 548, 963					•
9.00 DORODAL INSISTATION 41.5, 95.3 9.4.6.3 42. PTI 57.2.5, SIM 9.0.00 <td>7.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>	7.00							•
10.00 DICODO DIETNARY 152, 461 217, 710 16 65, 122 1, 083, 665 10, 00 13.00 DITORO MIRSING AMAN NISTANCION 277, 400 93, 842 0 0 0 0 0 11, 00 13.00 DITORO MIRSING AMAN NISTANCION 277, 400 93, 842 0	8.00	00800 LAUNDRY & LINEN SERVICE	27, 294	57, 014	203, 010			8.00
11.00 01100 CAFETERIA 144.667 106.666 0 0 0 13.00 0 13.00 0 13.00 0 13.00 0 <td< td=""><td>9.00</td><td>00900 HOUSEKEEPI NG</td><td>415, 953</td><td>9, 663</td><td>42, 010</td><td>2, 276, 588</td><td></td><td>9.00</td></td<>	9.00	00900 HOUSEKEEPI NG	415, 953	9, 663	42, 010	2, 276, 588		9.00
12.00 01300 UNESING ADM NI STRATION 207, 400 93, 842 0 0 0 14.00 12.00 101200 PRARACY SIPPITY 143, 316 16.7, 724 0 18, 00 0 0 16, 00 12.00 101200 PRARACY SIPPITY 143, 316 16.7, 724 0 0 0 16, 00 13.00 03000 ADULTS & FUENTRICS 126, 693, 790, 00 52, 641 7.44, 574 1, 056, 423 30, 00 10.01 03000 ADULTS & FUENTRICS 0 7.00 0 30, 00 28, 243 10, 600 177, 676 0 7.00 0 30, 00 30, 00 28, 247 18, 847 2, 070 28, 243 30, 00 51, 00	10.00	01000 DI ETARY	152, 481	217, 910	18	50, 122	1, 083, 665	10.00
14.00 ONDO CNITAGL SERVICES & SUPPLY 16.3 and 167.284 0 18.66 0 15.00 16.00 DISOD PRAMACY 222.801 62.007 0 20.49 0 15.00 16.00 DISOD PRAMACY 220.500 50.430 0	11.00		144, 687	106, 566	10	24, 543	0	11.00
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16.00 DIAGO MEDICAL DECROPS A LIBRAY 205,008 59,430 0 0 0 16 10000 ADULTS & PEDIATRICS 1,268,937 998,200 53,641 744,574 1,055,420 30,00 10000 ADULTS NUT CARE SET ENTERS 9,021 22,548 2,079 10,377 28,443 31,00 0.00 DEGION CECONETRY ROW 31,00 310,01 310,01 310,01 310,01 310,01 310,01 310,00								•
INPATE BUT ROUTE SERVICE COST CENTERS 1.268,937 908.200 53.641 744,574 1,055,420 30.00 31.00 0.0000 0.0000 0.0000 0.000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>•</td>							-	•
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ANCILLARY SERVICE COST CENTERS								•
90. 00 05000 0FEAT 0570 10. 870 177. 670 0 0.00 52. 00 05200 DELIVERY ROOM 327. 158 381. 544 10. 871 115. 168 05.00 52.00 05200 DELIVERY ROOM 224. 509 188. 437 2.8.678 147. 601 054.00 054.00 DEADOL LABORATORY 885. 614 188. 524 383 39. 874 0 60.00 064.01 054.00 054.00 064.01 054.00 064.01 064.01 054.00 066.00 066.00 066.00 066.00 066.00 067.00 070.00 0 <t< td=""><td>43.00</td><td></td><td>9,921</td><td>22, 548</td><td>2,070</td><td>27,999</td><td>0</td><td>43.00</td></t<>	43.00		9,921	22, 548	2,070	27,999	0	43.00
51.00 00100 RECOVERY ROOM 327, 158 381, 544 10, 871 115, 108 0 51.00 54.00 05200 RESOLUTIVERY ROOM 4.1A80, ROOM 274, 509 188, 437 12, 667 147, 601 0 52.00 54.00 05400 RADICLORY-DI ARONSTIC 990, 441 418, 678 147, 601 0 64.00 65.00 RESPERATORY THERAPY 309, 852 39, 191 153 25, 234 0 65.00 66.00 REGOULAR REPERATORY THERAPY 309, 852 39, 191 153 25, 234 0 65.01 66.00 RECOULAR REPERATORY THERAPY 329, 852 9, 101 52, 200 65.01 66.01 66.01 66.01 66.01 66.01 66.01 66.01 66.01 66.01 66.01 67.01 67.01 67.01 67.01 67.01 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00<	E0 00		41E 074	E00 E74	16 900	177 475	0	E0 00
52. 00 05200 DELL'ICEN ROM & LABOR ROM 274, 509 188, 437 2, 867 36, 697 0 52. 00 60. 00 06000 LABORANICANY 885, 614 148, 924 383 69, 874 0 60. 00 65. 01 06500 LABORANICAY 885, 614 148, 924 383 69, 874 0 60. 00 66. 01 06500 LABORANICAY 143, 615 333, 227 3, 00 66. 00 67. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00							-	•
54. 00 6400 [A0010LORY-DI ARNOSTIC 950, 441 451, 442 18, 778 147, 601 0 54. 00 66. 00 66000 [RESPIRATORY THERAPY 309, 852 39, 191 153 25, 234 0 65. 00 66. 00 66000 [RESPIRATORY THERAPY 319, 982 39, 191 153 25, 234 0 65. 00 66. 00 66000 [HVISICAL THERAPY 414, 601 333, 227 3, 703 83, 307 0 66. 00 69. 01 60001 [LCRTCRACRIN OLOGY 48, 519 0 0 0 67. 00 0 0 0 0 67. 00 <							-	•
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76. 00 00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td>•</td>						-		•
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OUTPATI ENT SERVICE COST CENTERS 001760 (RINAL HEALTH CLINIC 11 379, 329 364, 472 2, 412 88, 837 0 88, 00 88, 00 08800 (RINAL HEALTH CLINIC 11 542, 427 350, 513 2, 760 1, 037 0 88, 00 90, 00 09000 (LINIC - 0RTHO 111 224, 034 187, 645 49 5, 531 0 90, 00 90, 01 09001 (LINIC - 0RTHO 101, 659 213, 454 1, 158 75, 011 90, 00 90, 02 90, 02 09003 (LINIC - 0RTHO 101, 659 213, 454 1, 158 75, 011 90, 01 90, 02 90, 03 90, 03 90, 04 90, 04 90, 04 90, 05 90, 03 90, 04 90, 04 90, 05 90, 05 90, 02 313, 827 0 90, 01 90, 02 90, 05 79, 92, 36 318, 827 0 90, 01 90, 02 90, 05 79, 92, 36 318, 827 0 90, 01 90, 02 90, 02 90, 05 79, 92, 36 316, 348 0 0 90, 02			378, 955			-		•
B8. 00 D6801 RURAL HEALTH CLINIC II 542,427 350.513 2,760 1,037 0 88.01 80. 02 08000 QRAL HEALTH CLINIC III 274,034 187,685 49 5.531 0.80.0 90. 00 09000 CLINIC - 0RTHO 101,059 213,454 1,158 75.011 0 90.02 90. 02 09002 CLINIC - PEDS, ENT, FP 136,227 321,040 36 51.851 0 90.02 90. 04 90004 PSYCHI ATRY 645,652 28.185 2.116 22.469 90.03 90. 05 08000 EXTRY 645,757 79.025 3 13.827 90.05 91.00 09100 ENERSENATION BEDS (NON-DISTINCT PART 799,376 489,559 36,766 393.028 91.00 91.00 91.00 1100 IMBE HEALTH ACENCY 0 0 0 0 11.00 91.00 111.00 IMDE HEALTH ACENCY 0 0 0 0 11.00			· · · · ·					1
B8. 02 OBB02 RURAL HEALTH CLINIC III 274,034 187,685 49 5,531 0 88.00 90. 00 OPODO CLINIC - ORTHO 101,059 213,454 1,158 75,011 0 90.01 90. 01 OPODO CLINIC - ORTHO 101,059 213,454 1,158 75,011 0 90.01 90. 02 OPODO CLINIC - ORTHO 101,059 213,454 1,158 75,011 0 90.01 90. 03 OPODO CLINIC - ORTHO 685,652 28,185 2,116 22,469 0 90.03 90. 04 OPODO ELARDIOLOCY 90,507 79,025 3 13,827 0 90.05 91.00 OPODO ELERCENCY 799,376 489,559 36,766 393,028 91.00 92.00 91.00 OPODO ELER REIMBURSABLE COST CENTERS 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114	88.00	08800 RURAL HEALTH CLINIC	379, 329	364, 472	2, 412	88, 837	0	88.00
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90.01 0001 0001 010, 059 213, 454 1, 158 75, 011 0 90, 00 90, 02 90, 03 90, 02 90, 02 90, 02 90, 02 90, 02 90, 02 90, 02 90, 02 90, 05 90, 05 90, 05 90, 05 90, 02 90, 05 90, 02 90, 05 90, 02 90, 05			274, 034	187, 685	49	5, 531	0	•
90.02 0002 0111 C PP 136, 227 321,040 36 51,851 0 90,03 <td></td> <td></td> <td>47, 531</td> <td>26, 735</td> <td></td> <td></td> <td>0</td> <td>•</td>			47, 531	26, 735			0	•
90.03 09003 INTRAVENUUS THERAPY 685, 652 28, 185 2, 116 22, 469 0 90.04 90.04 09004 PSYCHI ATRY 647, 765 94, 863 368 346 0 90.04 90.05 09005 CARDI OLGGY 90, 507 79, 025 3 13, 827 0 90.03 91.00 09005 CARDI OLGGY 799, 376 489, 559 36, 766 393, 028 0 91.00 92.00 092000 OBSEVATION BEDS 0 0 0 0 0 92.00 90.0100 INTERNST LAN DERVENT 0 0 0 0 0 0 0 114.00 11400 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 0 0 0 0 0 114.00 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 1144.00 0							-	•
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SPECIAL PURPOSE COST CENTERS 113. 00 INTRERST EXPENSE 114. 00 INTLIZATION REVIEW-SNF 100 0 0 0 114. 00 INTLIZATION REVIEW-SNF 0 0 0 114. 00 INTLIZATION REVIEW-SNF 0 0 0 0 114. 00 INTEREST EXPENSE 0 0 0 0 0 114. 00 INTLIZATION REVIEW-SNF 0 0 0 0 0 116.00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 12, 603, 997 6, 845, 240 201, 448 2, 268, 638 1, 083, 665 1190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 8, 810 31, 138 0 0 190.00 19200 PHYSI CLANS' PRI VATE OFFICES 485 5, 422 0 0 0 194.00 194. 00 0795D MAXCRE - INFANT/TODDLER 0 0 0 0 194.01 194. 02 07952 COMMUNI TY HEALTH 701 0 0	101 00		0	0	0	0	0	101 00
113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 ITLICATION REVIEW-SNF 0 0 0 0 116.00 INDERICE 0 0 0 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 12,603,997 6,845,240 201,448 2,268,638 1,083,665 118.00 NORRE IMBURSABLE COST CENTERS 0 0 0 0 0 194.00 0 0 0 194.00 0 0 0 192.00 190.00 194.01 0 0 0 0 194.00 0 0 0 0 0 194.00 0 </td <td>101.00</td> <td></td> <td>0</td> <td><u> </u></td> <td>0</td> <td>0</td> <td>0</td> <td>101.00</td>	101.00		0	<u> </u>	0	0	0	101.00
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NONRE I MBURSABLE COST CENTERS 1900 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 8,810 31,138 0 0 0 1902.00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 485 5,422 0 0 0 192.00 194.00 O7950 DAYCARE - I NFANT/TODDLER 0 0 0 0 0 194.01 194.01 O7951 MOB 0 0 0 0 0 0 194.01 194.02 O7952 COMMUNI TY HEALTH 701 0 0 0 194.02 194.02 O7953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194.03 194.04 07954 EDUCATI ON 0 0 0 0 0 194.05 194.06 07955 MARKETI NG 277, 899 54, 598 0 0 0 194.07 194.06 07956 CUST MEALS 16, 750 0 0 0 0 194.07			12, 603, 997	6, 845, 240	201, 448	2, 268, 638		
192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 485 5,422 0 0 192.00 194.00 07950 DAYCARE - I NFANT/TODDLER 0 0 0 0 194.01 194.01 07951 MOB 0 0 0 0 0 194.02 194.02 07952 COMMUNI TY HEALTH 701 0 0 0 194.02 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194.03 194.04 07955 MARKETI NG 277, 899 54, 598 0 0 194.04 194.06 07956 GUEST MEALS 16, 750 0 0 0 194.06 194.09 07958 CANCER CENTER 0 0 0 0 194.06 194.09 07958 CANCER CENTER 0 0 0 0 194.08 194.10 07960 RHC 0 0 0 0 194.08 194.10 07961 OBGYN 0 0 0 0 1						· · · · · · · ·		1
194. 00 07950 DAYCARE-INFANT/TODDLER 0 0 0 0 194. 00 194. 01 07951 MOB 0 0 0 0 0 194. 01 194. 02 07952 COMMUNI TY HEALTH 701 0 0 0 194. 02 194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194. 03 194. 04 07954 EDUCATI ON 0 0 0 0 0 194. 03 194. 05 07955 MARKETI NG 277, 899 54, 598 0 0 194. 06 194. 06 194. 06 07956 GUEST MEALS 16, 750 0 0 0 194. 06 194. 08 07958 CANCER CENTER 0 0 0 0 194. 08 194. 09 07959 URGENT CARE 0 0 0 0 194. 09 194. 09 07959 URGENT CARE 0 0 0 0 194. 09 194. 10 07960 RHC 0 0	190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 810	31, 138	0	0	0	190.00
194. 01 07951 MOB 0 0 0 194. 01 194. 02 07952 COMMUNI TY HEALTH 701 0 0 0 194. 02 194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194. 03 194. 04 07954 EDUCATI ON 0 0 0 0 0 194. 04 194. 05 07955 MARKETI NG 277, 899 54, 598 0 0 194. 06 194. 06 07956 GUEST MEALS 277, 899 54, 598 0 0 194. 06 194. 06 07955 GUEST MEALS 16, 750 0 0 194. 07 194. 07 194. 08 07958 CANCER CENTER 0 0 0 194. 07 194. 08 194. 07 194. 09 07959 URGENT CARE 0 0 0 0 194. 07 194. 10 07960 RHC 0 0 0 0 194. 07 194. 10 07960 RHC 0 0 0 0	192.00	19200 PHYSICIANS' PRIVATE OFFICES	485	5, 422	0	0	0	192.00
194.02 07952 COMMUNI TY HEALTH 701 0 0 194.02 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194.03 194.04 07954 EDUCATI ON 0 0 0 0 0 194.03 194.04 07954 EDUCATI ON 0 0 0 0 0 194.03 194.05 07955 MARKETI NG 277,899 54,598 0 0 194.06 194.06 07955 GUEST MEALS 16,750 0 0 0 194.06 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194.06 194.09 07958 CANCER CENTER 0 0 0 0 194.09 194.09 07959 URGENT CARE 0 0 0 0 194.09 194.10 07960 RHC 0 0 0 0 194.10 194.11 07961 DBGYN 0 0 0 0 194.12	194.00	07950 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194.03 194.04 07954 EDUCATI ON 0 0 0 0 0 194.04 194.05 07955 MARKETI NG 277,899 54,598 0 0 194.05 194.06 07956 GUEST MEALS 16,750 0 0 0 194.05 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194.07 194.08 07958 CANCER CENTER 0 0 0 0 194.07 194.09 07959 URGENT CARE 0 0 0 0 194.07 194.09 07959 URGENT CARE 0 0 0 0 194.09 194.10 07960 RHC 0 0 0 0 194.09 194.11 07961 BGYN 0 0 0 0 194.10 194.12 07962 TRI NE STUDENT HEALTH 39,102 0 0 0 194.13 <t< td=""><td>194.01</td><td>07951 MOB</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>194.01</td></t<>	194.01	07951 MOB	0	0	0	0	0	194.01
194.04 07954 EDUCATI ON 0 0 0 0 194.04 194.05 07955 MARKETI NG 277,899 54,598 0 0 194.05 194.06 07956 GUEST MEALS 16,750 0 0 0 194.06 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194.07 194.08 07958 CANCER CENTER 0 0 0 0 194.07 194.08 07958 CANCER CENTER 0 0 0 0 194.07 194.08 07959 URGENT CARE 0 0 0 0 194.09 194.10 07960 RHC 0 0 0 0 194.09 194.11 07960 RHC 0 0 0 0 194.09 194.12 07960 RHC 0 0 0 0 194.10 194.12 07961 DBGYN 0 0 0 0 194.12 194.12 07962 TRI NE STU	194.02	07952 COMMUNI TY HEALTH	701	0	0	0	0	194.02
194.05 07955 MARKETING 277,899 54,598 0 0 194.05 194.06 07956 GUEST MEALS 16,750 0 0 0 194.06 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194.07 194.08 07958 CANCER CENTER 0 0 0 0 194.08 194.09 07959 URGENT CARE 0 0 0 0 194.09 194.10 07960 RHC 0 0 0 0 194.09 194.11 07960 RHC 0 0 0 0 194.10 194.12 07962 TRI NE STUDENT HEALTH 39,102 0 0 194.12 194.12 07963 OCCUPATI ONAL HEALTH 39,102 0 0 194.12 194.14 07964 IMUNI ZATI ON CLINIC 0 0 0 194.14 194.14 07964 FOUNDATI ON 98,248 12,455 0 0 0 194.14 194.16 07967	194.03	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.06 07956 GUEST MEALS 16,750 0 0 0 194.06 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194.07 194.08 07958 CANCER CENTER 0 0 0 0 194.08 194.09 07959 URGENT CARE 0 0 0 0 194.09 194.10 07969 URGENT CARE 0 0 0 0 194.09 194.10 07969 URGENT CARE 0 0 0 0 194.09 194.10 07969 URGENT CARE 0 0 0 0 194.10 194.11 07960 RHC 0 0 0 0 194.10 194.12 07962 TRI NE STUDENT HEALTH 39,102 0 0 194.12 194.12 07963 OCCUPATI ONAL HEALTH 100,908 45,472 0 0 194.12 194.14 07964 IMUNI ZATI ON CLI NI C 0 0 0 194.14 194.15 07965 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>194.04</td>			0	0	0	0	0	194.04
194.07 07957 OUTSI DE LAUNDRY 0 0 0 194.07 194.08 07958 CANCER CENTER 0 0 0 0 194.08 194.09 07959 URGENT CARE 0 0 0 0 194.09 194.10 07959 URGENT CARE 0 0 0 0 194.09 194.10 07969 URGENT CARE 0 0 0 0 194.09 194.10 07960 RHC 0 0 0 0 194.10 194.11 07961 DBGYN 0 0 0 0 194.11 194.12 07962 TRI NE STUDENT HEALTH 39,102 0 0 0 194.12 194.13 07963 OCCUPATI ONAL HEALTH 100,908 45,472 0 0 194.13 194.14 07964 IMUNI ZATI ON CLI NIC 0 0 0 194.14 194.15 07965 FOUNDATI ON 98,248 12,455 0 0 0 194.16 194.16	194.05	07955 MARKETI NG	277, 899	54, 598	0	0		
194.08 07958 CANCER CENTER 0 0 0 194.08 194.09 07959 URGENT CARE 0 0 0 0 194.09 194.10 07959 URGENT CARE 0 0 0 0 194.09 194.10 07960 RHC 0 0 0 0 194.10 194.11 07961 OBGYN 0 0 0 0 194.11 194.12 07962 TRI NE STUDENT HEALTH 39,102 0 0 0 194.12 194.13 07963 OCCUPATI ONAL HEALTH 100,908 45,472 0 0 194.13 194.14 07964 I MUNI ZATI ON CLI NI C 0 0 0 194.14 194.15 07965 FOUNDATI ON 98,248 12,455 0 0 0 194.15 194.16 07967 CAMERON FAMI LY MEDI CI NE - NORTH 215,845 0 997 7,950 0 194.16			16, 750	0	0	0		
194.09 07959 URGENT CARE 0 0 0 194.09 194.10 07960 RHC 0 0 0 0 194.10 194.11 07960 RHC 0 0 0 0 194.10 194.11 07960 RHC 0 0 0 0 194.10 194.12 07961 DBGYN 0 0 0 0 194.11 194.12 07963 CCUPATI ONAL HEALTH 39,102 0 0 0 194.12 194.13 07964 LMUNI ZATI ON CLI NI C 0 0 0 194.13 194.14 07965 FOUNDATI ON 98,248 12,455 0 0 194.15 194.16 07967 CAMERON FAMI LY MEDI CI NE - NORTH 215,845 0 997 7,950 0 194.16			0	0	0	0		
194. 10 07960 RHC 0 0 0 194. 10 194. 11 07961 0BGYN 0 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 39, 102 0 0 0 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 100, 908 45, 472 0 0 194. 13 194. 14 07964 I MMUNI ZATI ON CLI NI C 0 0 0 194. 13 194. 15 07965 FOUNDATI ON 98, 248 12, 455 0 0 194. 15 194. 16 07967 CAMERON FAMI LY MEDICINE - NORTH 215, 845 0 997 7, 950 0 194. 16			0	0	0	0		•
194.11 07961 0BGYN 0 0 0 194.11 194.12 07962 TRI NE STUDENT HEALTH 39,102 0 0 0 194.12 194.13 07963 OCCUPATI ONAL HEALTH 100,908 45,472 0 0 194.13 194.14 07964 IMMUNI ZATI ON CLI NI C 0 0 0 0 194.14 194.15 07965 FOUNDATI ON 98,248 12,455 0 0 194.15 194.16 07967 CAMERON FAMILY MEDI CI NE - NORTH 215,845 0 997 7,950 0 194.16			0	0	0	0		•
194.12 07962 TRI NE STUDENT HEALTH 39,102 0 0 194.12 194.13 07963 OCCUPATI ONAL HEALTH 100,908 45,472 0 0 194.13 194.14 07964 IMMUNI ZATI ON CLI NI C 0 0 0 0 194.14 194.15 07965 FOUNDATI ON 98,248 12,455 0 0 194.15 194.16 07967 CAMERON FAMILY MEDICINE - NORTH 215,845 0 997 7,950 0 194.16			0	0	0	0		
194.13 07963 OCCUPATI ONAL HEALTH 100,908 45,472 0 0 194.13 194.14 07964 I MMUNI ZATI ON CLI NI C 0 0 0 0 194.14 194.15 07965 FOUNDATI ON 98,248 12,455 0 0 0 194.15 194.16 07967 CAMERON FAMILY MEDICINE - NORTH 215,845 0 997 7,950 0 194.16			0	0	0	0		
194.14 07964 I MMUNI ZATI ON CLI NI C 0 0 0 194.14 194.15 07965 FOUNDATI ON 98,248 12,455 0 0 194.15 194.16 07967 CAMERON FAMILY MEDICINE - NORTH 215,845 0 997 7,950 0 194.16					-	0		•
194.15 07965 FOUNDATI ON 98,248 12,455 0 0 194.15 194.16 07967 CAMERON FAMILY MEDICINE - NORTH 215,845 0 997 7,950 0 194.16						0	0	194.13
194. 16 07967 CAMERON FAMILY MEDICINE - NORTH 215, 845 0 997 7, 950 0 194. 16			-	-	-	0		
						0		
194. 1/10/9661 CAMERON FAMILY MEDICINE - FREMONI 186, 218 0 565 0 0 194. 17								
	194.17	UV900 CAMERUN FAMILY MEDICINE - FREMONT	186, 218	0	J 565	0	0	194. 17

Health Fin	ancial Systems CA	MERON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS	-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS					Period:	Worksheet B	
					From 10/01/2020		
				-	To 09/30/2021		
						2/24/2022 4:	28 pm
	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)	13, 548, 963	6, 994, 325	203, 010	2, 276, 588	1, 083, 66	5 202.00

	Financial Systems CAME ALLOCATION - GENERAL SERVICE COSTS	KON MEMORIAL C	OMMUNITY HOSPIT Provider CC	CN: 15-1315 P	Period:	u of Form CMS-2 Worksheet B	2002-10
					rom 10/01/2020 o 09/30/2021	Part I Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	2/24/2022 4: 2 MEDI CAL RECORDS &	
		11.00	N 13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	905, 044					10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	905, 044 50, 847					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	18, 866		1, 078, 389			14.00
15.00	01500 PHARMACY	16, 915	0	4, 844	2, 365, 360		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	43, 280	0	988	0	1, 200, 267	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	454.004	544 400			7. (()	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	154, 221 3, 527		36, 666 C		7, 663 281	30.00 31.00
43.00	04300 NURSERY	3, 527		C		201	43.00
. 5. 50	ANCI LLARY SERVICE COST CENTERS	777	1, 307		<u> </u>	21	
50.00	05000 OPERATING ROOM	47, 183	157, 441	96, 774	0	22, 911	50.00
51.00	05100 RECOVERY ROOM	33, 350		C		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29, 755		15, 618		1, 169	
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	95, 565 72, 521		19, 208 213, 226		201, 096 329, 874	54.00 60.00
65.00	06500 RESPIRATORY THERAPY	43, 588		11, 369		14, 784	65.00
65.01	06501 SLEEP LAB	2, 910		0		7, 392	65.01
66.00	06600 PHYSI CAL THERAPY	52, 696	0	2, 586	0	87, 221	66.00
69.00	06900 ELECTROCARDI OLOGY	4, 486		797		56, 657	69.00
	06901 CARDI AC REHABI LI TATI ON	3, 527		336		22, 415	69.01
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	C	-	201, 419 387, 148		0	71.00
73.00	07300 DRUGS CHARGED TO PATI ENTS	C	-	007,110		0	73.00
76.00	03020 CHEMI CAL DEPENDENCY	C	0	C		0	76.00
76.01	O3480 ONCOLOGY	C	0	0	0	0	76.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	C		2 2/1	0	75, 232	88.00
88. 00 88. 01	08801 RURAL HEALTH CLINIC	C		2, 361 18, 562		15, 232	88.00
88.02	08802 RURAL HEALTH CLINIC III	29, 173		2, 303		45, 235	
90.00	09000 CLI NI C	9, 039	30, 136	3, 711	0	3, 073	90.00
90.01	09001 CLINIC- ORTHO	18, 284		2, 519		28, 325	
90.02	09002 CLINIC - PEDS, ENT, FP	27, 735		2, 595		48, 925	90.02
90.03 90.04	09003 I NTRAVENOUS THERAPY 09004 PSYCHI ATRY	4, 520 18, 798		3, 267 189		0 32, 642	
	09005 CARDI OLOGY	11, 436		523		5, 159	
	09100 EMERGENCY	98, 373		38, 107	0	128, 328	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	C	0	C	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS		<u>1</u>	0	<u>и</u> Ч	0	
113.00	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
	11600 HOSPI CE	001 074					116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	891, 074	1, 254, 062	1, 065, 116	2, 365, 360	1, 118, 403	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		C	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	C			192.00
10/ 00	07950 DAYCARE-INFANT/TODDLER	C	0 0	C	0 0		194.00
				0		0	194.01
194.01	07951 MOB	C	0	0	0		
194. 01 194. 02	07952 COMMUNI TY HEALTH			0	-		194.02
194.01 194.02 194.03	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS	0 0 0		C	0	0	194. 02 194. 03
194.01 194.02 194.03 194.04	07952 COMMUNI TY HEALTH	C C C C 10, 649		-	0 0	0 0	194.02
194.01 194.02 194.03 194.04 194.05 194.06	07952 COMMUNI TY HEALTH 07953 ASSI STED LI VI NG/CAMERON WOODS 07954 EDUCATI ON 07955 MARKETI NG 07956 GUEST MEALS	0 0 0 0 10, 649 3, 321		C		0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07	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		0	C C 194		0 0 0 0 0	194.02 194.03 194.04 194.05 194.06 194.07
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER	3, 321	0	C C 194		0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE	3, 321	0	C C 194 C C C C C C C C		0 0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10	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	3, 321	0	C C 194		0 0 0 0 0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07955 MARKETING 07956 GUEST MEALS 07957 OUTSIDE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE	3, 321	0	0 0 194 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09
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	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 07960 RHC 07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH	3, 321	0	C C 194 C C C C C C C C C C C C C C C C C C C		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 00 194. 10 194. 10 194. 12 194. 13 194. 14	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 07964 INMUNIZATION CLINIC	3, 321	0	0 0 194 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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. 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	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 07960 RHC 07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH	3, 321	0	0 0 194 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	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	CAMERON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
				From 10/01/2020 To 09/30/2021	Part I Date/Time Pre 2/24/2022 4:2	pared: 8 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	0	1, 361	0	27, 054	194.17
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	905, 044	1, 254, 062	1, 078, 389	2, 365, 360	1, 200, 267	202.00

Heal th Financial		Systems	
COCT AL		CENEDAL	CED

CAMERON MEMORIAL COMMUNITY HOSPITAL

Health Financial Systems	CAMERON MEMORIAL CO	MMUNITY HOSPITA	L	In Lieu of Form	CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN			et B ne Prepared: 2 4:28 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		2 4.20 pm
GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
					1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OP LANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LI BRARY INPATIENT ROUTINE SERVICE COST CEI CEI CEI					1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00
30. 00 03000 ADULTS & PEDIATRICS	10, 262, 306	0	10, 262, 30	6	30.00
31.00 03100 INTENSIVE CARE UNIT	333, 142	0	333, 14		31.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	107, 769	0	107, 76	99	43.00
50. 00 05000 OPERATING ROOM	4, 402, 656	0	4, 402, 65	6	50.00
51.00 05100 RECOVERY ROOM	2, 402, 077	0	2, 402, 07		51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 842, 479	0	1, 842, 47		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	6, 017, 460 5, 591, 917	0	6, 017, 46 5, 591, 91		54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	1, 791, 705	0	1, 791, 70		65.00
65.01 06501 SLEEP LAB	355, 837	0	355, 83		65.01
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	2, 780, 424 341, 706	0	2, 780, 42 341, 70		66.00 69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	207, 992	0	207, 99		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO		0	1, 372, 21		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIEN 73.00 07300 DRUGS CHARGED TO PATIENTS		0	2,637,52		72.00 73.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CHEMICAL DEPENDENCY	1, 725, 073	0	1, 725, 07	0	73.00
76. 01 03480 ONCOLOGY	2, 624, 410	0	2, 624, 41		76.01
OUTPATIENT SERVICE COST CENTERS	2 5 (2 2 2 2		2 5 (2 2 2		
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	2, 562, 330 3, 274, 291	0	2, 562, 33 3, 274, 29		88. 00 88. 01
88.02 08802 RURAL HEALTH CLINIC III	1, 735, 771	0	1, 735, 77		88.02
90.00 09000 CLINIC	343, 187	0	343, 18		90.00
90. 01 09001 CLINIC- ORTHO 90. 02 09002 CLINIC - PEDS, ENT, FP	879, 313 1, 180, 853	0	879, 31 1, 180, 85		90. 01 90. 02
90. 03 09003 I NTRAVENOUS THERAPY	5, 502, 341	0	5, 502, 34		90.02
90. 04 09004 PSYCHI ATRY	493, 630	0	493, 63	0	90.04
90. 05 09005 CARDI OLOGY 91. 00 09100 EMERGENCY	594, 091 5, 788, 130	0	594, 09 5, 788, 13		90.05 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTIN		0	5,700,15		92.00
OTHER REIMBURSABLE COST CENTERS				-	
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 UTILIZATION REVIEW-SNF					114.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 th	0 1rough 117) 67, 150, 631	0	67, 150, 63	0	116.00 118.00
NONREI MBURSABLE COST CENTERS		<u>ч</u>	07, 150, 05		110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP &		0	78, 26		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	8, 017	0	8, 01	7	192.00 194.00
194. 00 07950 DAYCARE-INFANT/TODDLER 194. 01 07951 MOB	0	0		0	194.00
194. 02 07952 COMMUNI TY HEALTH	3, 750	0	3, 75	0	194.02
194. 03 07953 ASSI STED LI VI NG/CAMERON WOOD	DS 0	0		0	194.03
194. 04 07954 EDUCATI ON 194. 05 07955 MARKETI NG	0 1, 551, 911	0	1, 551, 91	1	194.04 194.05
194. 06 07956 GUEST MEALS	92, 916	0	92, 91		194.06
194. 07 07957 OUTSI DE LAUNDRY	0	0	-	0	194.07
194. 08 07958 CANCER CENTER 194. 09 07959 URGENT CARE	0	0		0	194.08 194.09
194. 0907959 URGENT CARE 194. 1007960 RHC		0		0	194.09
194. 11 07961 OBGYN	0	0		0	194.10
194. 12 07962 TRINE STUDENT HEALTH	209, 579	0	209, 57		194.12
194. 13 07963 OCCUPATI ONAL HEALTH 194. 14 07964 I MMUNI ZATI ON CLI NI C	586, 408 0	0	586, 40	0	194.13 194.14
	I U	U U		<u>Ч</u>	174.14

Health Financial Systems C/	AMERON MEMORIAL CO	MMUNITY HOSPITA	AL.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN		Period: From 10/01/2020 To 09/30/2021	
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
194. 15 07965 FOUNDATI ON	537, 978	0	537, 97	8	194.15
194.1607967 CAMERON FAMILY MEDICINE - NORTH	1, 228, 414	0	1, 228, 41	4	194.16
194.1707966 CAMERON FAMILY MEDICINE - FREMONT	1,025,051	0	1,025,05	1	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)	72, 472, 919	0	72, 472, 91	9	202.00

2.00 002000 CAP FEL COSTS-WELE EDUIP 3 4 2.2 7 60.511 60.511 10.5 60.511 10.7 50.5 60.511 10.7 50.5 60.511 10.7 50.5 60.511 10.7 50.5 60.511 10.7 50.5 60.511 10.7 50.5 60.511 10.7 50.5 70.5 60.511 10.7 50.5 70.5 </th <th>Heal th</th> <th>Financial Systems CAME</th> <th>RON MEMORIAL CO</th> <th>OMMUNITY HOSPIT</th> <th>FAL</th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	FAL	In Lie	u of Form CMS-2	2552-10	
Cost Control Description Directly registed (cost) Directly Provide (cost) Directly Provide (cost) <thdirectly Provide (cost) <thdirectly Provi</thdirectly </thdirectly 	ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	F	rom 10/01/2020	Part II Date/Time Pre	pared:	
Chempel Service Cost Centres 1 0.00000000000000000000000000000000000		Cost Center Description	Assigned New Capital			Subtotal	EMPLOYEE BENEFI TS		
1.00 00100 CAP FEL COSTS-BLOB & FIXT 1. 0.00 00200 CAP FEL COSTS-BLOB & FIXT 0 4.00 00400 EMULVEE EMERT IS DEPARTMENT 0 6.00 00500 CAP FEL COSTS-BLOB & FIXT 0 7.00 00500 CAP FEL COSTS-BLOB & FIXT 0 7.00 00500 LANDEY & LIVER SERVICE 0 47.774 58.00 0.075 8.00 00500 LANDEY & LIVER SERVICE 0 47.774 58.00 0.076 0.075 9.00 00500 LANDEY & LIVER SERVICE 0 8.13 3.760 11.871 1.421 10.00 01500 LIVER 0 183.399 84.722 286.141 382 10 10.00 01400 CANTRAL SERVICE 0 140.760 45.066 43.727 27.74 1.225 10.00 1400 CANTRAL SERVICE 0 140.760 45.066 44.441 14.441 14.441 14.00 140.760 45.372 77.745 5.776 1.775 1.775 1.775 1.775 1.775 1.775 1			0	1.00	2.00	2A	4.00		
2.10 BODORI GAP, BEL COSTS, MURL F COUP 2 2 4 0 64.00 100.00 10			1						
5.00 ODOCOL AUMINISTRATIVE & GENERAL 0 450.737 333.818 774.557 10.779 5.70 0.00 ODOCOLAMADRY A. LINEN SERVICE 0 47.957.85 11.988 666.918 2.019 7. 0.00 ODOCOLAMADRY A. LINEN SERVICE 0 47.974 22.182 11.989 1.683 56.980 210.988 666.918 2.182 11.989 1.683 56.980 210.988 666.918 2.182 11.989 1.683 57.980 210.983 56.985 210.983 56.985 1.11.10 66.985 2.13.123 1.464 1.1.11 66.355 1.464 1.1.11 66.695 2.3.122 7.62.30 1.646.84 1.1.17.947 5.76.00 30.300 1.111.95.576 1.1.17.947 5.76.00 30.300 1.1117.947 5.76.00 30.300 1.1117.947 5.76.90 3.3.38 24.647 7.77.957 7.77.97 7.77.977 7.797 7.77.977 7.797 7.797 7.797 7.797 7.797 7.797 7.797 7.797 7.797 <td>2.00</td> <td>00200 CAP REL COSTS-MVBLE EQUIP</td> <td>0</td> <td>38 036</td> <td>22 475</td> <td>5 60 511</td> <td>60 511</td> <td>1.00 2.00 4.00</td>	2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	38 036	22 475	5 60 511	60 511	1.00 2.00 4.00	
8.00 0.00000 LUMBRY ALLINEN SERVICE 0 77,074 22,122 70,156 0 8 9.00 000000 DETRAT 0 133,353 B4,722 22,814 32,813 3,760 11,83,353 644,722 22,81,41 32,813 131 3,760 11,83,353 644 11,32 642 11,33 140 10,100 11,33,353 642 11,33 140 10,100 11,33 642 11,33 142 11,33 140 11,100 11,000 11,33 642 11,33 142 14,300 11,33 142 14,300 14,300 14,401 14,300 14,401 14,401 14,300 14,401 14,300 14,401 14,300 14,401 14,300 14,401 14,411 14,411 14,411 14,411 14,411 14,404 14,411 14,411 14,411 14,411 14,411 14,411 14,411 14,411 14,411 14,411 14,411 14,411 14,411 14,411 14,41	5.00	00500 ADMINI STRATI VE & GENERAL	0	450, 739	323, 818	3 774, 557	10, 739	5.00	
10. 00 01000 01 FTAPY 0 183.559 84.780 266.141 382 10. 11. 00 01000 DESTERIA 0 886.669 41.462 131.131 66.05 20.51.131 64.21 11. 13. 00 01000 DECORETERIA SAUMA STRATON 0 28.914 33.51 63.05 20.52.15 1.40 114. 14. 00 I1400 I14000 I14000 I14000 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0						
11.00 01100 CAFTERIA 0 096,669 41,462 131,131 64/2 11.1 13.00 01300 DERING ADMINISTRATION 0 20,814 35,511 66,525 1,140 13,131 14.00 01400 CENTRAL SERVICE SA SUPPLY 0 140,760 66,085 206,646 426 14.20 11.00 DIDON FULL MERSERVICE COST CENTRES 0 0 23,122 23,122 1,122 15.20 1,533 351 11,1747 2,547 1,640 13.00 130,00 03000 INTENSIVE CARE UNIT 0 533,055 24,647 177,752 1,640 53.00 11,640 53.056 24,647 177,752 1,640 53.050 11,154,747 1,640 53.050 11,640,747 1,640 53.050 11,640,747 1,640 1,541 1,540 44.51,774 1,640 1,540 1,540 44.51,775 1,642 1,550 1,642 1,550 1,642 1,550 1,642 1,550 1,642 1,550 1,642 1,550 1,642 1,642 1,550 1,642 1,550 1,6			0					•	
12.00 DI 300 NURES MG ADDI MISTRATION 0 2.9, E14 36, E11 66, 225 1, 140 13.00 10.00 DI 500 PHAARMACY 0 52, 175 22, 122 72, 300 1, 638 15.00 10.00 DI 500 PHAARMACY 0 0 53, 353 1, 117, 547 57, 540 10.00 10.00 DI 500 PHAARMACY 0 0 353, 351 1, 117, 547 57, 540 10.00 130, 77, 557 52, 77, 557 52, 769 10.00 130, 77, 557 52, 77, 557 10.00 130, 77, 557 52, 77, 557 11, 117, 547 10.00 110, 670, 780, 780, 77, 575 52, 77, 557 11, 75, 542 55, 504 23, 747 1, 640 51, 504 51, 159 11, 75, 742 55, 504 24, 749 11, 75, 542 55, 504 24, 749 11, 75, 742 12, 746 54, 307 54, 307 54, 407 14, 408 16, 74, 746 54, 307 54, 407 54, 404 13, 301 12, 746 54, 504 14, 746 64, 414 13, 50 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td>10.00</td></t<>			0					10.00	
14.00 00 10400 CENTRAL SERVICES & SUPPLY 0 140, 760 65,085 205,045 426 142,125 76,500 1,531 15 16 0 10400/EDCAL RECORDS & LIBRAYY 0 0 23,122 23,321 1,122 15 16 0 10400/EDCAL RECORDS & LIBRAYY 0 0 23,122 23,321 1,122 15,33 16 16 16 17,7452 27,146 220 30 00000 17,7452 5,763 31 16 17,7452 5,763 31 16 00000 17,7452 50,763 17,7452 27,146 220 33 30 10 000000 16,856 17,315 23,135 16,130 12,125 25,125 16,165 16,165 16,165 16,173 15,125 16,156 16,165 16,165 16,175 16,175 16,165 16,175 16,175 16,175 16,165 16,175 16,175 16,175 16,175 16,165 16,175 16,175 16,165 16,175 16,165 16,175 16,175 16,165 16,175 17,1315 23,155 17,1			0					•	
15. 00 00 92. 17b 24.12b 76. 300 1, 636 5. 10 01 000000 023.122 23.122 23.122 23.122 12. 1 00 03000 000175 A PEDIATRICS 0 53.351 1, 117, 547 5, 703 0 30 0 30.00 1, 636 5. 764, 196 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 50.00<			0					•	
16.00 0 0 0 23.122 1.12 1.12 1.11 0.00 03000 AULTS & FEURIARICS 0 764.196 33.351 1.117.547 57.00 30.00 0.00 03000 AULTS & FEURIARICS 0 18.073 8.773 27.746 20 43.0 0.00 05100 PERATINE KOWL & LABOR KOWL 0 229.386 725.479 1.6900 0.00 05100 PECATERY BOOM 0 125.113 57.3.316 229.386 73.44 49.4993 1.770 52.5 51.00 DECONCY-DI ARING KOMA LABOR KOM 0 125.311 57.942 133.253 2.002 60.0 66.00 66.00 66.00 175.642 135.55 54.371 66.6 66.6 66.6 66.6 66.6 67.9142 143.25 1.767 67.6 65.6 66.6 67.9142 135.55 1.767 67.6 65.6 66.6 66.6 67.6 77.77 77.77 77.77 77.77 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td>•</td>			-					•	
IDARTIENT ROUTER SERVICE COST CENTERS 0 7 <th colspan<="" td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td></th>	<td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>								•
30. 00 03000 ADULTS & PEDIATRICS 0 764, 196 353, 11, 117, 547 5, 760 30. 01 43. 00 04300 AULTSENVE CASE LUNIT 0 53, 300 244, 647 77, 952 129 31. 43. 00 05000 OPERATING ROAM 0 496, 073 227, 379 77, 746 20 43. MACLLARW SERVICE COST CENTERS 0 321, 047 148, 447 469, 494 1, 380 51. 1, 717, 952 1, 740 55. 56. 55. 55. 55. 56. 56. 56. 56. 56. 56. 56. 56. 57. 56.	10.00		0	0	23, 122	2 23, 122	1, 122	10.00	
31. 00 00 03100 INTERSIVE CARE UNIT 0 53. 305 24. 447 77, 922 129 31. 30. 00 04300 (MURSERY 0 18, 773 8, 773 227, 746 24 30. 00 000 (5000 (PERTIN & ROM 0 321, 047 148, 447 440, 449 1.680 51 50. 00 005000 (DERGUNEY ROM 0 321, 047 148, 447 440, 449 1.680 55 50. 00 0500 (DERGUNEY ROM 0 321, 047 148, 447 440, 449 1.380 51 50. 00 0500 (DERGUNEY ROM 0 321, 05 31, 052 33, 055 31, 055 31, 055 33, 07 44, 47 440, 494 1.380 51 50. 00 0500 (DERGUNEY ROM 0 32, 977 77, 75, 248 48, 225 77, 76 77, 78 44, 05 76 65 60 0600 129, 648 141, 00, 99 129, 648 141, 00, 99 16 90 16 91 96 65 77, 75 24, 92 91 91 91 91 91 91 91 91 </td <td>30 00</td> <td></td> <td>0</td> <td>764 196</td> <td>353 351</td> <td>1 117 547</td> <td>5 760</td> <td>30.00</td>	30 00		0	764 196	353 351	1 117 547	5 760	30.00	
43.00 00 016, 973 0, 773 27, 746 20 43.00 ABCLLLARY SERVICE COST CENTERS U <thu< th=""> U <thu< th=""> <thu< t<="" td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></thu<></thu<></thu<>									
ANCILLARY SERVICE COST CENTERS									
51.00 65100 RECOVERY ROOM 0 321.047 148.447 148.447 1469.494 1.380 51.20 52.00 DESCODELVERY ROOM 0 158.58 73.315 231.873 1.270 52.30 54.00 DESCODELVERY ROOM 0 158.58 73.315 231.873 1.270 52.30 20.00 460.00 0.00 DESCODELVERY ROOM 0 1.37.542 440.255 231.873 1.77.67 65.00 650.00 660.00 PHARTORY THERAPY 0 129.648 410.039 1.986 66.00 0 0.00									
52.00 05200 DELLVERY ROOM & LABOR ROOM 0 158.558 73.315 231.873 1.270 52.00 60.00 06000 LABORATORY 0 125.311 57.942 158.554 2.746 54. 60.00 06500 LABORATORY 0 125.311 57.942 158.255 2.002 60.0 65.01 06500 PHYSICAL THERAPY 0 2.077 15.248 48.420.09 1.76.65.61 06500 DELLCERDCARDIOLOGY 0 0 0 7.875 24.905 1.64 69.00 06900 ELECERDCARDIOLOGY 0 17.030 7.875 24.905 1.64 69.00 <	50.00	05000 OPERATING ROOM	0	496, 093	229, 386	5 725, 479	1, 690	50.00	
54. 00 05400 RADI LOCY-DI AGNOSTI C 0 379. 862 175. 642 555. 504 3. 746 54. 00 05600 RESPI RATORY THERAPY 0 32. 977 15. 248 48. 225 1. 767 65. 0 05600 RESPI RATORY THERAPY 0 280. 391 129. 648 410. 039 1. 986 66. 0 06600 PHYSI CAL THERAPY 0 175. 375 24. 905 146 69. 0 0600 CARDI AC REHABL LI STATI ON 0 280. 391 13. 159 41. 618 105 69. 0 01200 IMPL. CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 73. 300 07300 OKCOLAC UNCLL DEPENDENCY 0 0 0 0 73. 76. 00 08002 CHRAL HEALTH CLINIC C 0 0 141. 805 141. 805 241. 885 20. 288. 92 231. 850 231. 850 73. 76. 00 08002 CHRAL HEALTH CLINIC C 0 0 141. 805 141. 805 241. 90 231. 830 231. 830	51.00	05100 RECOVERY ROOM	0	321, 047	148, 447	7 469, 494	1, 380	51.00	
60.00 66000 66000 66000 66000 66000 77 15, 242 18. 253 2.022 60.02 65.00 06500 SEEP RATORY THERAPY 0 32.977 15, 248 48, 420 1, 7.67 65.07 66.00 06600 PHSICAL THERAPY 0 20.97 15, 248 48, 410.039 1, 966 66.07 69.00 06000 LECETROCARDIOLOGY 0 17.030 7.875 24.905 1.846 69.00 01.00 OTACID MEDICAL SUPPLIES CHARGED TO PATIENTS 0			0		73, 315		1, 270	52.00	
65.00 06500 RESPIRATORY THERAPY 0 32,977 15,248 48,225 1,767 65. 65.00 06600 PHYSICAL THERAPY 0 280,391 129,648 410,039 1,986 66. 06901 CARDIAC REHABILI TATION 0 170,030 7,875 244,905 164 69. 00 00001 CARDIAC REHABILI TATION 0 284.459 13,159 41,618 1055 69. 10.00 07100 INFL OLS UPARCED TO PATIENTS 0 0 0 77. 76.00 03020 CHEMICAL DEPENDENCY 0 0 0 76. 0 0 76. 0 0 76. 0 0 76. 76. 0 0 76. 0 0 77. 76. 78. </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0						
65.01 06501 SLEEP LAB 0 0 54.307 78 65.60 66.00 06000 PHYSI CAL THERAPY 0 280.391 172,048 410.039 1.89 64.60 69.00 06900 ELECTROCARD IOLOGY 0 17.030 7.875 24.905 164 69. 71.00 0700 MEDI CARL SUPPLIES CHARGED TO PATLENTS 0 0 0 0 73. 00 00 0 73. 00 0 0 73. 00 0 0 0 73. 00 0 0 0 73. 00 0 0 73. 00 0 0 73. 00 0 73. 00 0 73. 00 0 73. 00 0 0 73. 02 23.850 0.0 76. 0 0 73.022 2.069 88. 88.00 08000 RURAL HEALTH CLINIC 11 0 0 73.022 73.022 2.069 88. 89.00			-						
66. 00 06600 PHYSICAL THERAPY 0 280.391 129.648 410.039 1.986 66. 69. 00 06701 CARDIAC REHABILITATION 0 129.648 410.039 7.985 24.905 164 69. 10.00 07100 LECLETROCARDID LOGY 0			0	32, 977				65.00	
69. 00 06900 LECTROCARD I OLOGY 0 17. 030 7. 75 2.4. 905 144 616 65 69. 71. 00 OTOD MEDI CAL, SUPPLIES CHARGED TO PATIENTS 0			0	0				•	
69. 01 064001 CARDIAC REHABILITATION 0 28. 459 13, 159 41, 618 105 69. 71. 00 07200 IMPLIES CHARGED TO PATIENTS 0 0 0 73. 73. 00 07200 IMPLE DEV, CHARGED TO PATIENTS 0 0 0 73. 73. 00 07200 IMPLES CHARGED TO PATIENTS 0 0 0 73. 73. 00 07300 DRUIS CHARGED TO PATIENTS 0 0 0 73. 76. 01 03480 (MCOLOCY 0 0 231, 850 231, 850 76. 76. 01 03480 (MCOLOCY 0 0 141, 805 141, 805 2,119 88. 02 08802 RURAL HEALTH CLINIC 11 0 0 13, 429 282 90. 90.00 13, 429 252 90. 90.01 141, 805 2,119 90. 90.02 90.02 13, 429 252 90. 90.01 141, 907 124, 907 2,251 90. 90. 90.01 141, 904			0						
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 77.300 07300 PRUSC CHARGED TO PATIENTS 0 0 0 0 77.200 07300 PRUSC CHARGED TO PATIENTS 0 0 0 0 0 77.200 0 0 0 0 0 0 77.200 0 0 0 0 0 0 0 77.200 0 0 0 0 0 77.200 0 0 0 0 0 0 0 0 0 0 77.200 0			0						
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 7 73.00 07300 ORUGS CHARGED TO PATIENTS 0 0 0 0 73. 76.00 03020 CHEM CAL DEPENDENCY 0 0 0 73. 07.00 73. 07.00 0 0 73. 07.00 0 0 73. 07.00 0 0 73. 07.00 0 73. 07.00 73. 07.00 73. 07.00 0 73. 07.00 73. 07.00 73. 07.00 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.02 73. 07.0<			0		13, 15	41,018			
73.00 073.00 PRUCS CHARGED TO PATIENTS 0 0 0 0 7 76.00 03480 ONCOLOGY 0 0 231,850 231,850 7 76.01 03480 ONCOLOGY 0 0 231,850 231,850 7 7 88.01 08600 RURAL HEALTH CLINIC II 0 0 141,805 141,805 2,119 8 8 8 0 8800 RURAL HEALTH CLINIC III 0 0 7,3.022 2,069 88 9 9 0 0 7,3.022 7,06,02 8 8 6 9 9 0 0 7,3.022 7,06,04 8 8 9 0 0 0 7,3.022 7,06,04 8 8 9,04 9 9 0 0 7 0 124,907 124,907 2,251 90.0 9 0 0 3,743 91.936 90.0 9 90.0 9 90.0 0			0	s.					
76.00 0 0 0 0 0 0 76.00 00176711ENT SERVICE COST CENTERS 0 0 141.805 231.850 76. 88.00 08800 RURAL HEALTH CLINIC II 0 0 141.805 211.95 88.01 08800 RURAL HEALTH CLINIC II 0 0 136.374 136.374 22.669 88. 80.00 09000 CLINIC - ORTHO 0 3.027 73.022 73.022 2.669 88. 90.01 09001 CLINIC - ORTHO 0 3.027 10.402 13.429 22.669 88. 90.02 09002 CLINIC - DEDS, ENT, FP 0 0 124.907 2.2.769 88. 90. 90.03 199005 CARDI OLCCY 0 0 36.088 36.088 36.908 1.7.22 90.7124.907 2.2.719 90. 2.900 005 CARDI OLCCY 0 0 36.0746 30.746 1.316.90. 1.722 90. 90.001 0100 (MORE HEALTH ACENCY 0 0 0 0 0 0			-	s.					
O 0 231,850 231,850 231,850 76. OUTPATIENT SERVICE COST CENTERS				-			-		
OUTPATLENT SERVICE COST CENTERS OUTPATLENT SERVICE COST CENTERS 0 0 141,805 <th< td=""><td></td><td></td><td></td><td></td><td>231,850</td><td>231, 850</td><td></td><td>1</td></th<>					231,850	231, 850		1	
88.01 0B801 RURAL HEALTH CLINIC III 0 0 136.374 136.374 136.374 2.988 88 88.02 0B802 RURAL HEALTH CLINIC III 0 0 73.022 23.069 88. 90.00 09000 CLINIC - ORTHO 0 0 0.3.027 10.402 13.429 252 90. 90.01 09002 CLINIC - ORTHO 0 0 0.3.048 83.048 697 90. 90.02 09002 CLINIC - PEDS, ENT, FP 0 0.30.746 34.680 1.272 90. 90.04 09004 PSCHATATRY 0 0.30.746 30.746 1.316 90. 90.05 08005 EXENTEN 0 0 0 0 0 0 92. 92. 92.00 0 0 0 0 0 101. 1.316 90. 92. 92.00 0 0 0 0 0 101. 13.14.16.00 114.00 114.00 114.01 114.00 114.00 114.00 114.00 114.00 114.00 114.0		OUTPATIENT SERVICE COST CENTERS		. · · ·					
88.02 088.02 028.02 027.3 022 73.023 73.023	88.00	08800 RURAL HEALTH CLINIC	0	0	141, 805	5 141, 805	2, 119	88.00	
90 9000 CLINIC 0 3,027 10,402 13,429 252 90. 90.01 09001 CLINIC - ORTHO 0 0 0 83,048 83,048 697 90. 90.02 09002 CLINIC - PEDS, ENT, FP 0 0 124,907 124,907 2,251 90. 90.03 09003 INTRAVENOUS THERAPY 0 23,716 10,966 34,682 158 90. 90.05 09005 CARDI OLOGY 0 0 36,908 1,272 90. 91.00 091000 EMERGENCY 0 411,936 190,472 602,408 3,743 91. 92.00 092000 0BESCRATI NO BEDS (NON-DISTINCT PART 0 0 0 0 0 0 92. 92. 92. 92. 92. 92. 92. 92. 92. 92. 92. 92. 92. 92. 92. 92. 92. 93. 93. 93. 93. 93.			0	0	136, 374	136, 374	2, 988	88.01	
90.01 9001 CLINIC - ORTHO 0 83.048 83.048 83.048 677 90. 90.02 09002 CLINIC - PEDS, ENT, FP 0 0 124,907 124,907 2,251 90. 90.03 09003 INTRAVENOUS THERAPY 0 0.30,746 10,966 34,662 158 90. 90.05 09005 CARDIO LOGY 0 0 30,746 1,316 90. 91.00 DERGENCY 0 411,936 190,472 602,408 3,743 91. 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0			0	0	73, 022	2 73, 022	2,069	88.02	
90.02 9002 CLINIC - PEDS, ENT, FP 0 0 124,907 124,907 2,251 90. 90.03 9003 INTRAVENOUS THERAPY 0 23,716 10,966 34,682 158 90. 90.04 9004 PSYCHIATRY 0 0 36,908 30,746 13,16 90. 91.00 90100 ENERGENCY 0 411,936 190,472 602,408 31,743 91. 92.00 085ERVATI ON BEDS (NON-DI STI NCT PART 0			0	3, 027				•	
90.03 90003 INTRAVENUUS THERAPY 0 23,716 10,966 34,682 158 90.90 90.04 90004 PSYCHI ATRY 0 0 36,908 36,908 1,272 90.90 90.05 09005 CARDI OLOGY 0 0 30,746 30,746 1,3716 90.90 91.00 DERREENCY 0 411,936 190,472 602,408 3,743 91.90 92.00 DSEVENTION BEDS (NON-DI STINCT PART 0 114.01 113.00 11300 INTEREST EXPENSE 113.0 114.00 UTI LI ZATION REVI EW-SNF 0 0 0 0 0 114. 118. 114.00 1000 1900.01 190.00 190.00 190.00 190.00 190.00 190.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
90. 04 90004 PSYCHI ATRY 0 0 36, 908 36, 908 1, 272 90. 90. 05 09005 CARDI OLOGY 0 0 30, 746 30, 746 1, 316 90. 90. 90.05 CARDI OLOGY 0 411, 936 1900, 472 602, 408 3, 749 90. 92. 0 0 0 0 0 0 0 0 92. 92. 0 0 0 0 0 0 0 0 92. 0 0 0 0 0 0 0 0 0 10. 10. 10. 10. 10. 10. 10. 10. 10. 11. <t< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td></td><td></td><td></td></t<>			0	-					
90.05 09005 CARDIOLOGY 0 30,746 30,746 1,316 90. 91.00 09100 EMERGENCY 0 411,936 190,472 602,408 3,743 91. 92. 0200 092500 OSERVATION BEDS (NON-DISTINCT PART 0 101. 0 114.00 11300 INTERST EXPENSE 113. 114.00 11400 UTLILIZATION REVIEWSNF 0 0 0 1160. 1160. 102.00 1160.0 102.00 1160.0 102.00 1160.0 <td></td> <td></td> <td>0</td> <td>23, /16</td> <td></td> <td></td> <td></td> <td>•</td>			0	23, /16				•	
91.00 09100 EMERGENCY 0 411,936 190,472 602,408 3,743 91. 92.00 09200 00SERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 0 92.00 0 0 0 92. 0 92. 0 92. 0 0 0 0 0 0 92. 0			0	0					
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 92. OTHER REIMBURSABLE COST CENTERS 0			0	/11 036				•	
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0			0	411, 750	170, 472		5,745	92.00	
101.00 10100 HOME HEALTH AGENCY 0<	12:00							1 /2:00	
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 114.00 UTI LI ZATI ON REVI EW-SNF 116.00 ISOBITIALS (SUM OF LINES 1 through 117) 0 4,611,518 3,220,400 7,831,918 56,743 118. NONREI MBURSABLE COST CENTERS 0 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 194.00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194.01 07951 194.02 07952 COMMUNI TY HEALTH 0 194.03 07953 194.04 07954 EDUCATI ON 0 194.05 07955 MARETI NG 0 194.06 07956 ORTSE MARETI NG 0 194.06 07955 MURTY HEALS 0 194.06 07955 MURTY HEALTH 0 194.06 07955 MURTY 0 <td>101.00</td> <td></td> <td>0</td> <td>0</td> <td>(</td> <td>0 0</td> <td>0</td> <td>101.00</td>	101.00		0	0	(0 0	0	101.00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 0 0 114. 116.00 HOSPI CE 0 0 0 0 116.0 116.0 116.0 116.0 116.0 116.0 116.0 116.0 116.0 116.0 116.0 116.0 116.0 116.0 0 0 0 0 116.0 116									
116.00 116.00 HOSPICE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 4, 611, 518 3, 220, 400 7, 831, 918 56, 743 118. NONRET IMBURSABLE COST CENTERS 0 26, 201 12, 115 38, 316 0 190.00 190.00 0 IFT, FLOWER, COFFEE SHOP & CANTEEN 0 26, 201 12, 115 38, 316 0 192. 194.00 07950 DAYCARE - I NFANT/TODDLER 0 0 0 0 194. 194.01 07951 MOB 0 0 0 0 194. 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 194. 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194. 194.04 07954 EDUCATI ON 0 0 0 0 194. 194.05 07955 MARKETI NG 0 0 0 0 194.								113.00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 4,611,518 3,220,400 7,831,918 56,743 118. NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 26,201 12,115 38,316 0 190. 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 2,110 2,110 0 192. 194.00 07950 DAYCARE-INFANT/TODDLER 0 0 0 0 194. 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 194. 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194. 194.04 07954 EDUCATI ON 0 0 0 0 194. 194.05 07955 MARKETI NG 0 0 0 0 194. 194.06 07954 EULCATI ON 0 0 0 0 194. 194.07								114.00	
NORRE MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 26, 201 12, 115 38, 316 0 190. 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 2, 110 2, 110 0 192. 194.00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 0 194. 194.01 07951 MOB 0 0 0 0 194. 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 194. 194.02 07954 EDUCATI ON 0 0 0 0 194. 194.02 07955 MARKETI NG 0 0 0 0 0 194. 194.04 07955 MARKETI NG 0 0 0 0 194. 194.06 07956 GUEST MEALS 0 0				0	0	0 0		116.00	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 26, 201 12, 115 38, 316 0 190. 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 2, 110 0 192. 194.00 07950 DAYCARE-INFANT/TODDLER 0 0 0 0 194. 194.01 07951 MOB 0 0 0 0 0 194. 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 194. 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194. 194.04 07954 EDUCATI ON 0 0 0 0 0 194. 194.05 07955 MARKETI NG 0 0 0 0 0 194. 194.06 07956 GUEST MEALS 0 0 0 0 0 194. 194.06 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 194.09 07959 URGENT CARE	118.00		0	4, 611, 518	3, 220, 400	7, 831, 918	56, 743	118.00	
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 2,110 2,110 0 192. 194.00 07950 DAYCARE-INFANT/TODDLER 0 0 0 0 194. 194.01 07952 DAYCARE-INFANT/TODDLER 0 0 0 0 194. 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 194. 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194. 194.04 07954 EDUCATI ON 0 0 0 0 194. 194.05 07955 MARKETI NG 0 0 0 0 194. 194.06 07956 GUEST MEALS 0 0 0 0 194. 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 194.08 07958 CANCER CENTER 0 0 0 0 194. 194.09 07959 URGENT CARE 0 0 0 0 194.	100 -							100	
194.00 07950 DAYCARE-INFANT/TODDLER 0 0 0 194. 194.01 07951 MOB 0 0 0 0 194. 194.02 07952 COMMUNITY HEALTH 0 0 0 0 194. 194.03 07953 ASSI STED LI VING/CAMERON WOODS 0 0 0 194. 194.04 07954 EDUCATI ON 0 0 0 0 194. 194.05 07955 MARKETI NG 0 0 0 0 194. 194.06 07956 GUEST MEALS 0 0 0 0 194. 194.06 07956 GUEST MEALS 0 0 0 0 194. 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 194.09 07959 RGENT CARE 0 0 0 0 194. 194.09 07959 UTSI DE LAUNDRY 0 0 0 0 194. 194.09 07959 URGENT CARE <t< td=""><td></td><td></td><td>0</td><td>26, 201</td><td></td><td></td><td></td><td>•</td></t<>			0	26, 201				•	
194.01 07951 MOB 0 0 0 194. 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 194. 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194. 194.04 07954 EDUCATI ON 0 0 0 0 194. 194.05 07955 MARKETI NG 0 0 0 0 194. 194.06 07956 GUEST MEALS 0 0 21,243 21,243 437 194. 194.06 07956 GUEST MEALS 0 0 0 0 194. 194.06 07957 OUSI DE LAUNDRY 0 0 0 0 194. 194.07 07957 OUSI DE LAUNDRY 0 0 0 0 194. 194.08 07958 CANCER CENTER 0 0 0 0 194. 194.10 07600 RHC 0 0 0 0 194. 194.11 07661 OBGYN			0	0	2, 110	2,110			
194. 02 07952 COMMUNI TY HEALTH 0 0 0 194. 194. 03 07953 ASSI STED LI VING/CAMERON WOODS 0 0 0 194. 194. 04 07954 EDUCATI ON 0 0 0 0 194. 194. 04 07954 EDUCATI ON 0 0 0 0 194. 194. 05 07955 MARKETI NG 0 0 0 0 194. 194. 06 07956 GUEST MEALS 0 0 0 0 69 194. 194. 06 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 194. 08 07958 CANCER CENTER 0 0 0 0 194. 194. 09 07959 URGENT CARE 0 0 0 194. 194. 194. 09 07959 URGENT CARE 0 0 0 194. 194. 194. 10 07960 RHC 0 0 0 0 194. 194. 11 07961 G			0	0				•	
194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194. 194. 04 07954 EDUCATI ON 0 0 0 0 194. 194. 05 07955 MARKETI NG 0 0 0 21, 243 21, 243 437 194. 194. 06 07956 GUEST MEALS 0 0 0 0 69 194. 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 194. 08 07958 CANCER CENTER 0 0 0 0 194. 194. 09 07959 URGENT CARE 0 0 0 0 194. 194. 00 07959 BGENT CARE 0 0 0 0 194. 194. 01 07960 RHC 0 0 0 0 194. 194. 10 07959 GEGNN 0 0 0 0 194. 194. 12 07960 RHC 0 0 0 0 194. 194.			0	0					
194.04 07954 EDUCATION 0 0 0 194. 194.05 07955 MARKETING 0 0 21,243 21,243 437 194. 194.06 07956 GUEST MEALS 0 0 0 0 69 194. 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 194.08 07958 CANCER CENTER 0 0 0 194. 194.09 07959 URGENT CARE 0 0 0 194. 194.10 07960 RHC 0 0 0 0 194. 194.11 07961 RHC 0 0 0 0 194. 194.12 07962 TRI NE STUDENT HEALTH 0 0 0 0 243 194.									
194.05 07955 MARKETING 0 21,243 21,243 437 194. 194.05 07956 GUEST MEALS 0 0 0 0 194. 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 194.07 07957 OUTSI DE LAUNDRY 0 0 0 194. 194.08 07959 CANCER CENTER 0 0 0 194. 194.09 07959 URGENT CARE 0 0 0 194. 194.10 07960 RHC 0 0 0 194. 194.10 07960 RHC 0 0 0 194. 194.12 07962 TRI NE STUDENT HEALTH 0 0 0 243 194.									
194.06 07956 GUEST MEALS 0 0 0 69 194. 194.07 07957 OUTSI DE LAUNDRY 0 0 0 194. 194.08 07958 CANCER CENTER 0 0 0 0 194. 194.09 07959 URGENT CARE 0 0 0 0 194. 194.10 07960 RHC 0 0 0 0 194. 194.10 07960 RHC 0 0 0 0 194. 194.12 07962 TRI NE STUDENT HEALTH 0 0 0 0 243 194.			0	0	21 243	21 242		•	
194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 194. 08 07958 CANCER CENTER 0 0 0 194. 194. 09 07959 URGENT CARE 0 0 0 0 194. 194. 09 07959 URGENT CARE 0 0 0 0 194. 194. 10 07960 RHC 0 0 0 0 194. 194. 11 07961 OBGYN 0 0 0 0 194. 194. 12 07962 TRI NE STUDENT HEALTH 0 0 0 243 194.			0	0	21,24) 21, 243		•	
194.08 07958 CANCER CENTER 0 0 0 194. 194.09 07959 URGENT CARE 0 0 0 194. 194.09 07959 URGENT CARE 0 0 0 194. 194.10 07960 RHC 0 0 0 0 194. 194.11 07961 OBGYN 0 0 0 0 194. 194.12 07962 TRI NE STUDENT HEALTH 0 0 0 243 194.			0	0				194.00	
194.09 07959 URGENT CARE 0 0 0 194. 194.10 07960 RHC 0 0 0 194. 194.11 07961 0BGYN 0 0 0 0 194. 194.12 07962 TRI NE STUDENT HEALTH 0 0 0 0 243 194.			0	0				194.07	
194. 10 07960 RHC 0 0 0 194. 194. 11 07961 0BGYN 0 0 0 0 194. 194. 12 07962 TRI NE STUDENT HEALTH 0 0 0 0 243 194.			0	0				194.00	
194.11 07961 0BGYN 0 0 0 194. 194.12 07962 TRI NE STUDENT HEALTH 0 0 0 0 243 194.			0	0				194.10	
194. 12 07962 TRI NE STUDENT HEALTH 0 0 0 0 243 194.			0	0		ol ol		194.11	
			0	0		o o			
174. ISIO 700 000 UTATI VINAL HEALTH I VI VI 17.092 17.092 444 194.		07963 OCCUPATI ONAL HEALTH	0	0	17,692	2 17, 692		194.13	

Health Financial Systems	CAMERON MEMORIAL CO	OMMUNITY HOSPIT	TAL	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 10/01/2020 To 09/30/2021		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
194.14 07964 IMMUNIZATION CLINIC	0	0		0 0	0	194.14
194. 15 07965 FOUNDATI ON	0	5, 963	4,84	6 10, 809	288	194.15
194.1607967 CAMERON FAMILY MEDICINE - NORTH	0	0	(0 0	1, 167	194.16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	0		0 0	1, 120	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	4, 643, 682	3, 278, 40	6 7, 922, 088	60, 511	202.00

	Financial Systems CAME TION OF CAPITAL RELATED COSTS	RON MEMORIAL CC	Provider C	CN: 15-1315 P F	eriod: rom 10/01/2020 o 09/30/2021	u of Form CMS- Worksheet B Part II Date/Time Pre 2/24/2022 4:2	epared
	Cost Center Description	ADMI NI STRATI V		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
00	00500 ADMI NI STRATI VE & GENERAL	785, 296					5.0
00	00700 OPERATION OF PLANT	75, 800	744, 637				7.0
00	00800 LAUNDRY & LINEN SERVICE	1, 582	6,070				8.0
00). 00	00900 HOUSEKEEPI NG 01000 DI ETARY	24, 108 8, 838	1, 029 23, 199		54, 804 1, 207	301, 774	9.0 10.0
	01100 CAFETERI A	8, 386	11, 345		591	0	1
	01300 NURSI NG ADMI NI STRATI ON	12, 021	9, 991	0		0	
	01400 CENTRAL SERVICES & SUPPLY	9, 466	17, 810			0	
	01500 PHARMACY	24, 505	6,601	0		0	
6.00	01600 MEDICAL RECORDS & LIBRARY	11, 882	6, 327	0	0	0	16.0
). 00	03000 ADULTS & PEDIATRICS	73, 546	96, 690	20, 557	17, 925	293, 908	30.0
	03100 I NTENSI VE CARE UNI T	2, 322	6, 744			7, 866	
3.00	04300 NURSERY	575	2, 401	793	674	0	43.0
	ANCI LLARY SERVICE COST CENTERS		(0.7(0	(400	4 077		
	05000 OPERATING ROOM 05100 RECOVERY ROOM	35, 695 18, 962	62, 768 40, 620			0	
	05200 DELIVERY ROOM & LABOR ROOM	15, 910	20, 062			0	
1.00	05400 RADI OLOGY-DI AGNOSTI C	55, 086	48, 062			0	
0. 00	06000 LABORATORY	51, 329	15, 855			0	
5.00	06500 RESPIRATORY THERAPY	17, 959	4, 172			0	
	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	1, 905 24, 030	14, 860 35, 476			0	
	06900 ELECTROCARDI OLOGY	24, 030	2, 155			0	
	06901 CARDI AC REHABI LI TATI ON	1,602	3, 601	0		0	
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 686	0	0	0	0	71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	24, 384	0	0		0	
	07300 DRUGS CHARGED TO PATIENTS	12, 287	0			0	
	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0 21, 964	63, 442			0	
	OUTPATIENT SERVICE COST CENTERS	21,701	007112	100			
	08800 RURAL HEALTH CLINIC	21, 985	38, 803			0	
	08801 RURAL HEALTH CLINIC II	31, 438 15, 883	37, 317			0	
). 02	08802 RURAL HEALTH CLINIC III 09000 CLINIC	2, 755	19, 982 2, 846			0	
	09001 CLINIC- ORTHO	5, 857	22, 725			0	
0. 02	09002 CLINIC - PEDS, ENT, FP	7, 896	34, 179	14	1, 248	0	90.
	09003 I NTRAVENOUS THERAPY	39, 739	3,001	811	541	0	
	09004 PSYCHI ATRY 09005 CARDI OLOGY	3, 754 5, 246	10, 099 8, 413			0	
	09100 EMERGENCY	46, 331	52, 120		000	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART					-	92.
	OTHER REIMBURSABLE COST CENTERS		0				1.01
01.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.
3.00	11300 I NTEREST EXPENSE						113.
4.00	11400 UTILIZATION REVIEW-SNF						114.
	11600 HOSPI CE	0	0) 116.
8.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	730, 526	728, 765	77, 210	54, 613	301, 774	118.
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	511	3, 315	0	0	0	190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	28	577				192.
	07950 DAYCARE-INFANT/TODDLER	0	0	0	0) 194.
		0	0	0	0		194.
	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS	41	0		0) 194.
	07954 EDUCATION	0	0	-	0		194.
4.05	07955 MARKETI NG	16, 107	5, 813		0		194.
4.06	07956 GUEST MEALS	971	0	0	0	0	194.
	07957 OUTSI DE LAUNDRY	0	0	0	0		194.
	07958 CANCER CENTER	0	0	0	0) 194.) 194.
14.09 10 10	07959 URGENT CARE 07960 RHC	0	0		0		194.
	07961 0BGYN	0	0	0	0) 194.
	07962 TRINE STUDENT HEALTH	2, 266	0	0	0		194.
94.13	07963 OCCUPATI ONAL HEALTH	5, 849	4, 841	0	0	0	194.
	07964 I MMUNI ZATI ON CLI NI C	0	0	0	0		194.
4 15	07965 FOUNDATI ON	5, 694 12, 510	1, 326 0) 194.) 194.
	07967 CAMERON FAMILY MEDICINE - NORTH						

Health Fina	ancial Systems CAM	ERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der C		Period:	Worksheet B	
					From 10/01/2020 To 09/30/2021		
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI FTARY	
	cost center bescription	E & GENERAL	PLANT	LINEN SERVICE		DIETART	
		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	0	201.00
202.00	TOTAL (sum lines 118 through 201)	785, 296	744, 637	77,80	8 54, 804	301, 774	202.00

	TI ON OF CAPITAL RELATED COSTS		OMMUNITY HOSPIT Provider CC	CN: 15-1315 Pe	eriod: rom 10/01/2020	u of Form CMS-: Worksheet B Part II Date/Time Pre 2/24/2022 4:2	pared:
	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	
1.00 2.00 4.00 5.00 7.00 8.00 10.00 11.00 13.00 14.00 15.00 16.00	GENERAL SERVICE COST CENTERS OD100 CAP REL COSTS-BLDG & FIXT OD200 CAP REL COSTS-MVBLE EQUIP O0400 EMPLOYEE BENEFITS DEPARTMENT OD500 ADMINISTRATIVE & GENERAL OO700 OPERATION OF PLANT O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING O1000 DI ETARY O1100 CAFETERIA O1300 NURSING ADMINISTRATION O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	152, 099 8, 545 3, 171 2, 843 7, 273		237, 167 1, 065 217	113, 433 0	49, 943	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	INPATIENT ROUTINE SERVICE COST CENTERS	.,	-				1
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	25, 916 593 81	40, 209 920 124	8, 064 0 0	0 0 0	319 12 1	31.00
50.00	ANCI LLARY SERVICE COST CENTERS	7, 929	12, 306	21, 283	0	953	50.00
51.00 52.00 52.00 65.00 65.01 66.00 69.01 71.00 72.00 73.00 76.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06500 RESPIRATORY THERAPY 06500 SLEEP LAB 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHABILITATION 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	5, 605 5, 001 16, 060 12, 188 7, 325 489 8, 856 754 593 0 0 0 0 0 0 0	8, 696 7, 762 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 3, 435 4, 224 46, 894 2, 500 0 569 175 74 44, 297 85, 146 0 0 0	0 0 0 0 0 0 0 0 0 0 0 28, 347 0 0	0 49 8, 368 13, 723 615 308 3, 629 2, 358 933 0 0 0 0 0 0 0 0	51.00 52.00 54.00 60.00 65.00 65.01 66.00
88.00	08800 RURAL HEALTH CLINIC	0	0	519	0	3, 130	88.00
90. 05 91. 00	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 09000 CLINIC 09001 CLINIC - ORTHO 09002 CLINIC - PEDS, ENT, FP 09003 INTRAVENOUS THERAPY 09004 PSYCHIATRY 09005 CARDIOLOGY 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0 4, 903 1, 519 3, 073 4, 661 760 3, 159 1, 922 16, 532	0	4, 082 507 816 554 571 719 41 115 8, 381	0 0 0 85, 086 0 0 0 0	215	90. 01 90. 02 90. 03 90. 04
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) NONREI MBURSABLE COST CENTERS	0 149, 751	0 98, 022	0 234, 248	0 113, 433		113. 00 114. 00 116. 00 118. 00
192.00 194.00 194.02 194.02 194.03 194.04 194.05 194.06 194.06 194.05 194.06 194.10 194.12 194.12 194.12 194.12	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 207952 COMMUNI TY HEALTH 07953 ASSI STED LI VI NG/CAMERON WOODS 107954 EDUCATI ON 07955 MARKETI NG 07956 GUEST MEALS 07957 OUTSI DE LAUNDRY 307958 CANCER CENTER 07959 URGENT CARE 07950 RHC 07961 OBGYN 207962 TRI NE STUDENT HEALTH 307963 OCCUPATI ONAL HEALTH 307965 FOUNDATI ON 07967 CAMERON FAMILY MEDI CI NE - NORTH	0 0 0 0 0 0 1,790 558 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 43 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190.00 192.00 194.01 194.02 194.03 194.03 194.04 194.05 194.06 194.07 194.08 194.09 194.10 194.11 194.12 194.13 194.14 194.15 194.16

Health Financial Systems	CAMERON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 10/01/2020	Worksheet B Part II	
				To 09/30/2021		
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 CAMERON FAMILY MEDICINE - FREMONT	0	0	29	9 0	1, 126	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)	152, 099	98, 022	237, 16	7 113, 433	49, 943	202.00

Heal th	Fi nan	ici al	Syste	ems		
					TED	C

Heal th	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPITAL	L	In Lieu of Form	CMS-2552-1
	ATION OF CAPITAL RELATED COSTS		Provider CCN	: 15-1315	Period: Workshee From 10/01/2020 Part II To 09/30/2021 Date/Tim	
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		<u>2 4.20 pm</u>
	OFNERAL CERVILOE ODOT OFNITERO	24.00	25.00	26.00		
1 00	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
	01500 PHARMACY					15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
30.00	03000 ADULTS & PEDIATRICS	1, 700, 441	0	1, 700, 44	1	30.00
	03100 I NTENSI VE CARE UNI T	97, 277	0	97, 27		31.00
	04300 NURSERY	32, 415	0	32, 41		43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	878, 819	0	878, 81		50.00
	05100 RECOVERY ROOM	551, 695	0	551,69		51.00
	05200 DELIVERY ROOM & LABOR ROOM	287, 351	0	287, 35		52.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	701, 762	0	701, 76		54.00
60.00 65.00	06500 RESPIRATORY THERAPY	327, 555 83, 229	0	327, 55 83, 22		60.00 65.00
65.00	06501 SLEEP LAB	73, 449	0	73, 44		65.0
66.00	06600 PHYSI CAL THERAPY	488,009	o	488, 00		66.00
	06900 ELECTROCARDI OLOGY	33, 323	0	33, 32		69.00
69.01	06901 CARDI AC REHABI LI TATI ON	48, 526	О	48, 52	6	69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	56, 983	0	56, 98		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	109, 530	0	109, 53		72.00
	07300 DRUGS CHARGED TO PATIENTS	40, 634	0	40, 63		73.00
	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0 317, 700	0	317, 70	0	76.00 76.01
70.01	OUTPATIENT SERVICE COST CENTERS	317,700	<u>Ч</u>	517,70		/0.0
88.00	08800 RURAL HEALTH CLINIC	211, 425	0	211, 42	5	88.00
88.01	08801 RURAL HEALTH CLINIC II	213, 282	0	213, 28		88.0
88. 02	08802 RURAL HEALTH CLINIC III	118, 400	0	118, 40	0	88. 02
90.00	09000 CLI NI C	24, 494	0	24, 49		90.00
90.01	09001 CLINIC- ORTHO	119, 383	0	119, 38		90.0
90.02	09002 CLINIC - PEDS, ENT, FP	177, 763	0	177, 76		90.0
	09003 I NTRAVENOUS THERAPY 09004 PSYCHI ATRY	165, 497 56, 740	0	165, 49 56, 74		90. 0 90. 0
	09005 CARDI OLOGY	48, 307	0	48, 30		90.0
	09100 EMERGENCY	784, 056	Ö	784, 05		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	0	0		0	101.00
112 00	SPECIAL PURPOSE COST CENTERS	1				112.00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF					113.00 114.00
	11600 HOSPI CE	0	o		0	116.00
118.00		7, 748, 045	o	7, 748, 04	5	118.00
	NONREI MBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		,, .	- II.	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42, 142	0	42, 14		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 715	0	2, 71	5	192.00
	07950 DAYCARE-INFANT/TODDLER	0	0		0	194.0
	07951 MOB 207952 COMMUNI TY HEALTH	0 41	0	А	0	194.0 194.0
	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS	41			0	194.0
	07954 EDUCATI ON		0		ŏ	194.0
	07955 MARKETI NG	45, 433	ő	45, 43	3	194.0
	07956 GUEST MEALS	1, 598	0	1, 59		194.0
194.07	07957 OUTSI DE LAUNDRY	0	0		0	194.0
	07958 CANCER CENTER	0	0		0	194. 0
	07959 URGENT CARE	0	0		0	194.0
	07960 RHC	0	0		0	194.1
	07961 OBGYN	0	0		0	194.1
	207962 TRINE STUDENT HEALTH 307963 OCCUPATI ONAL HEALTH	2, 602 29, 086	0	2, 60 29, 08		194.12 194.13
	07963 OCCUPATIONAL HEALTH	29,088	0		0	194.1
		, U	V		~I	174.1

Health Financial Systems CAM	ERON MEMORIAL CO	MMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1315	Period: From 10/01/2020 To 09/30/2021		epared: 28 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24.00	25.00	26.00			
194. 15 07965 FOUNDATI ON	18, 117	0	18, 1	17		194.15
194.1607967 CAMERON FAMILY MEDICINE - NORTH	18, 755	0	18, 7	55		194.16
194.1707966CAMERON FAMILY MEDICINE - FREMONT	13, 554	0	13, 5	54		194.17
200.00 Cross Foot Adjustments	0	0	1	0		200.00
201.00 Negative Cost Centers	0	0	1	0		201.00
202.00 TOTAL (sum lines 118 through 201)	7, 922, 088	0	7, 922, 0	88		202.00

	Financial Systems CAME LLOCATION - STATISTICAL BASIS	RON MEMORIAL C	OMMUNITY HOSPIT Provider CO	CN: 15-1315 P	In Lie eriod: rom 10/01/2020	u of Form CMS-: Worksheet B-1	
				T		Date/Time Pre 2/24/2022 4:2	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	1	1				
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	102, 797					1.00
4.00 5.00 7.00 8.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	842 9, 978 10, 094 1, 062	15, 503 10, 094	31, 802, 166	-13, 548, 963 0	58, 923, 956 5, 686, 732 118, 702	4.00 5.00 7.00 8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	180 4, 059			0	1, 808, 962	
11.00	01100 CAFETERI A	4, 059		200, 785 337, 131		663, 134 629, 238	
13.00	01300 NURSI NG ADMI NI STRATI ON	660				901, 973	
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 116				710, 257	
15.00	01500 PHARMACY	1, 155				1, 838, 744	
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	1, 107	589, 511	0	891, 563	16.00
30.00	03000 ADULTS & PEDIATRICS	16, 917	16, 917	3, 026, 742	0	5, 518, 556	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 180				174, 254	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	420	420	10, 641	0	43, 144	43.00
50.00	OSOOO OPERATING ROOM	10, 982	10, 982	888, 029	0	2, 678, 420	50.00
51.00	05100 RECOVERY ROOM	7, 107				1, 422, 798	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 510				1, 193, 827	
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 409				4, 133, 429	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 774		1, 052, 270 928, 492		3, 851, 501 1, 347, 534	
65.01	06501 SLEEP LAB	0				142, 929	
66.00	06600 PHYSI CAL THERAPY	6, 207		1, 043, 565		1, 803, 083	
69. 00 69. 01	06900 ELECTROCARDI OLOGY	377		86, 397		211,008	
71.00	06901 CARDIAC REHABILITATION 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	030		54, 957 0	0	120, 243 951, 912	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1, 829, 666	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	-	0	-	921, 972	
76. 00 76. 01	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0		0		0	
70.01	OUTPATIENT SERVICE COST CENTERS	0	11, 100	0	0	1, 648, 061	70.01
88.00	08800 RURAL HEALTH CLINIC	0	6, 789	1, 113, 407	0	1, 649, 687	88.00
88.01	08801 RURAL HEALTH CLINIC II	0				2, 358, 992	
88. 02 90. 00	08802 RURAL HEALTH CLINIC III 09000 CLINIC	0			0	1, 191, 761 206, 710	
	09001 CLINIC- 0RTH0	67 0					
	09002 CLINIC - PEDS, ENT, FP	0			-		
90.03	09003 I NTRAVENOUS THERAPY	525		82, 840		2, 981, 875	
90. 04 90. 05	09004 PSYCHI ATRY 09005 CARDI OLOGY	0	1, 767 1, 472	668, 436 691, 694		281, 659 393, 611	1
91.00	09100 EMERGENCY	9, 119				3, 476, 454	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0		0		0	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF	-		_			114.00
116.00 118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 102, 085		0 29, 821, 680			116.00
110.00	NONREIMBURSABLE COST CENTERS	102,000	1	27,021,000	13, 540, 703	54, 014, 330	1.10.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	580					190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	101	0	0		192.00
	07950 DAYCARE-INFANT/TODDLER 07951 MOB		0		0		194.00 194.01
	07952 COMMUNITY HEALTH	0	0	0	0		194.02
194.03	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	-		194.03
	07954 EDUCATI ON 07955 MARKETI NG	0	0	0 229, 717	-		194.04
	07955 MARKETING 07956 GUEST MEALS		1, 017 0	229, 717 36, 413		1, 208, 571 72, 845	194.05
	07957 OUTSI DE LAUNDRY	0	0	0			194.07
	07958 CANCER CENTER	0	0	0	0		194.08
	07959 URGENT CARE 07960 RHC	0	0	0	0		194.09 194.10
	07960 RHC 07961 0BGYN	0	0	0	-		194.10
	07962 TRINE STUDENT HEALTH	0			-	170, 053	

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

COST ALLOCA	TION - STATISTICAL BASIS		Provider C		Period: From 10/01/2020	Worksheet B-1	
					To 09/30/2021		
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
		(SQUARE FEET)	(SQUARE FEET)	BENEFI TS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	0.00	SALARIES)		5 00	
104 12 070(2		1.00	2.00	4.00	5A	5.00	104 10
	OCCUPATIONAL HEALTH	0	847	233, 07	3 0	438, 846	
194. 1407964	IMMUNIZATION CLINIC	132	232	151, 45		427, 275	194.14
	CAMERON FAMILY MEDICINE - NORTH	132	232			938, 700	
	CAMERON FAMILY MEDICINE - NORTH	0	0	613, 21 588, 76		809,853	•
200.00	Cross Foot Adjustments	0	0	500,70	0		200.00
200.00	Negative Cost Centers						200.00
202.00	Cost to be allocated (per Wkst. B,	4, 643, 682	3, 278, 406	9, 996, 81	h	13, 548, 963	
202.00	Part I)	4, 043, 002	3, 270, 400	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		13, 340, 703	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	45. 173322	20. 887421	0. 31434	4	0. 229940	203.00
204.00	Cost to be allocated (per Wkst. B,			60, 51	1	785, 296	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0.00190	3	0.013327	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)						l

	Financial Systems CAME LLOCATION - STATISTICAL BASIS	RON MEMORIAL CC	MMUNITY HOSPIT Provider C	CN: 15-1315 F	In Lie Period: From 10/01/2020 To 09/30/2021	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)	2/24/2022 4:2 CAFETERI A (FTES)	
		7.00	8.00	9.00	10.00	11.00	
1.00 2.00 4.00 5.00 7.00	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	130, 283					1.00 2.00 4.00 5.00 7.00
11. 00 13. 00 14. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	1, 062 180 4, 059 1, 985 1, 748 3, 116 1, 155	79, 441 16, 439 7 4 0 0 0 0	6, 586 145 7 0 54	5 16, 651 1 0 0 0 4 0	26, 432 1, 485 551 494	13.00 14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 107	0	(0 0	1, 264	16.00
31.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	16, 917 1, 180 420	20, 991 499 810		434	4, 504 103 14	31.00
50.00	ANCI LLARY SERVI CE COST CENTERS	10, 982	6, 574	514	4 0	1, 378	50.00
51.00 52.00 54.00 60.00 65.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06500 RESPIRATORY THERAPY	7, 107 3, 510 8, 409 2, 774 730	4, 254 1, 122 7, 309 150 60	333 107 427 260 73	3 0 7 0 7 0 3 0	974 869 2, 791 2, 118 1, 273	51.00 52.00 54.00 60.00 65.00
69. 00 69. 01 71. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS	2,600 6,207 377 630 0 0	845 1, 449 0 0 0 0 0	24	1 0 D 0	85 1, 539 131 103 0 0	66.00 69.00 69.01 71.00
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 0 445	(· · ·	0 0 0	76.00 76.01
88. 01 88. 02 90. 00 90. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 09000 CLINIC 09001 CLINIC- ORTHO	6, 789 6, 529 3, 496 498 3, 976	944 1, 080 19 2 453	16 47 217	3 0 5 0 7 0 7 0	0 0 852 264 534	88. 01 88. 02 90. 00 90. 01
90. 03 90. 04 90. 05 91. 00	09002 CLINIC - PEDS, ENT, FP 09003 INTRAVENOUS THERAPY 09004 PSYCHIATRY 09005 CARDIOLOGY 09100 EMERGENCY	5, 980 525 1, 767 1, 472 9, 119	14 828 144 1 14, 387	65	5 0 1 0 0 0		90.05 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			<u> </u>			92.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	101.00
114. 00 116. 00 118. 00	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 127, 506	0 78, 830		-		113.00 114.00 116.00 118.00
190. 00 192. 00 194. 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFICES 07950 DAYCARE-I NFANT/TODDLER 07951 MOB	580 101 0	000000000000000000000000000000000000000	(0 0	190.00 192.00 194.00
194. 02 194. 03 194. 04	07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 079555 MARKETING	0 0 0 1,017	0 0 0 0 0			0 0 0	194. 01 194. 02 194. 03 194. 04 194. 05
194.06 194.07 194.08 194.09	07956 GUEST MEALS 07957 OUTSI DE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE 07960 RHC	0 0 0 0	0 0 0 0			97 0 0 0 0	194.06 194.07 194.08 194.09 194.10
194. 11 194. 12 194. 13 194. 14	07961 OBGYN 07962 TRINE STUDENT HEALTH 07963 OCCUPATIONAL HEALTH 07964 IMMUNIZATION CLINIC 07965 FOUNDATION	0 0 847 0 232	0 0 0 0 0 0 0			0 0 0 0	194. 10 194. 11 194. 12 194. 13 194. 14 194. 15

COST ALLOCA	TI ON - STATI STI CAL BASI S		Provider C		Period: From 10/01/2020 To 09/30/2021	Worksheet B-1 Date/Time Pre 2/24/2022 4:2	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF SERVI C)	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	
		7.00	8.00	9.00	10.00	11.00	
	CAMERON FAMILY MEDICINE - NORTH	0	390	2	3 0		194. 16
	CAMERON FAMILY MEDICINE - FREMONT	0	221		0 0		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, Part I)	6, 994, 325	203, 010	2, 276, 58	8 1, 083, 665	905, 044	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	53. 685631	2. 555481	345. 67081	7 65.081076	34.240466	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	744, 637	77, 808	54, 80	4 301, 774	152, 099	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5. 715535	0. 979444	8. 32128	8 18. 123476	5. 754351	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Cost Center Description Milestic Numeric Networks Compatibility (NetCT Networks) Compatibility (NetCT Networks) Compatibility (NetCT Networks) Compatibility (NetCT Networks) Compatibility (NetCT Networks) Compatibility (NetCT Networks) Compatibility (NetWorks) Compatibility (NetWorks) <thcompatibility (NetWorks) <thcompatibility (</thcompatibility </thcompatibility 	Health Financial Systems CAME COST ALLOCATION - STATISTICAL BASIS	RON MEMORIAL CO	Provider C		In Lie eriod:	u of Form CMS-2552- Worksheet B-1
Cost Contion Description MIRS 160 Admin situation (n incore 13.00 CONTRAL SERVICES 4. (CONTRO PROVIDE 13.00 MIRS 160 (CONTRO (CONTRO PROVIDE 13.00 Description (CONTRO PROVIDE 14.00 MIRS 160 (CONTRO (CONTRO PROVIDE 15.00 MIRS 160 (CONTRO (CONTRO PROVIDE 15.00 MIRS 160 (CONTRO (CONTRO PROVIDE 15.00 MIRS 160 (CONTRO PROVIDE 15.00 MIRS 160 (CONTRO PROVIDE 15.00 MIRS 160 (CONTRO (CONTRO PROVIDE 15.00 MIRS 160 (CONTRO PROVIDE 15.00 MIRS 160 (CONTRO PROVIDE 14.00 MIRS 160 (CONTRO PROVIDE 15.00 MIRS 160 (CONTRO PROVIDE 15.00 <t< th=""><th></th><th></th><th></th><th>F</th><th></th><th>Date/Time Prepared</th></t<>				F		Date/Time Prepared
ENTRAL STRATO CAST CANTERS 0.000100 0001000 00010000 000100000 000100000 00000 00000 000000 000000 000000 000000 0000000000 000000000000 000000000000000000 000000000000000000000000000000000000	Cost Center Description	ADMI NI STRATI O N (DI RECT NRSI NG HR)	SERVI CES & SUPPLY (COSTED REQUI S.)	(COSTED REQUIS.)	RECORDS & LI BRARY (TI ME SPENT)	2/24/2022 4:28 pm
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAPR LC COSTS-BLDG & FIXT 2.00 00200 CAPR LC COSTS-BLDG & FIXT 2.00 00200 CAPR LC COSTS-BLDG & CAPRAL 2.00 00200 CAUROPY & LINEN SERVICE 2.00 00200 CAUROPY & LINEN SERVICE 3.0 00 00200 CAPTERIA 3.0 00 00200 CAPTERIA COST CENTERS 3.0 00 00200 CAUROPY & LINEN SERVICE 3.0 0020	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	
00.000 030000 ADULTS N PED ATRICS 93.660 173.284 0 3.66 04300 DITENSIVE CASE LINIT 2.14.44 173.284 0 0 114 MACLLARY SERVICE COST CENTERS 289 0 0 114 MACLLARY SERVICE COST CENTERS 0 0 0 0 50.00 05200 (DeExity ROW & LABOR ROW 28.671 457.357 0 11.920 51.00 05200 (DELVERY ROW & LABOR ROW 20.259 0 0 0 0 64.00 06400 (LABORATORY 0 10.067.714 0 171.629 65.01 06500 (LABORATORY 0 1.223 0 45.380 69.00 06400 (LABORATORY 0 1.286 0 11.662 71.00 0.04900 (LECRICARDI AL PERAPY 0 1.829 0 0 73.00 0.7000 (ARDICARDAL I LATION 0 1.829 0 0 0 74.00 0.0000 (MEDI CARDICARDI AL PERAPERAL I LATION 0 1.11.00 <td>1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 1300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 10400 MEDICAL RECORDS & LI BRARY</td> <td>0</td> <td>22, 895</td> <td>10, 000</td> <td>624, 481</td> <td>1. C 2. C 4. C 5. C 7. C 8. C 9. C 10. C 11. C 13. C 14. C 15. C 16. C</td>	1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 1300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 10400 MEDICAL RECORDS & LI BRARY	0	22, 895	10, 000	624, 481	1. C 2. C 4. C 5. C 7. C 8. C 9. C 10. C 11. C 13. C 14. C 15. C 16. C
H3. 00 D43200 NURSERV 229 0 0 11 AMULLARY SERVIC COST CENTRES 28, 671 457, 357 0 11, 920 51.00 05100 0F06AT ING. ROOM 20, 259 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 18, 085 73, 811 0 606 60.00 06000 LABORATORY 0 1,007, 776 0 104, 627 60.00 06000 LABORATORY 0 1,007, 776 0 17, 629 65.01 06500 SLEEP LAB 0 0 0 2,23 0 45, 380 69.00 06000 FHVSI CAL THERAPY 0 1,356 0 11, 662 71.00 07100 MED ICAL SUPPLIES CHARED TO PATIENT 0 951, 912 0 0 0 72.00 07200 IMFL DEX, CHARGED TO PATIENTS 0 1, 829 0 0 0 0 73.00 07200 IMFL DEX, CHARGED TO PATIENTS 0 1, 629 0 0 0 0 0 0 0	30. 00 03000 ADULTS & PEDI ATRI CS					30. C
ANCILLARY SERVICE COST CENTERS 00 05000 (DFRATI IK6 NOOM 28, 671 457, 357 0 11, 920 51:00 05100 REGUYERY ROOM 20, 259 0 0 0 52:00 05200 DELVICERY ROOM 18, 085 73, 811 0 008 54:00 05400 RADILOGY-DI AGNOSTI C 0 90, 776 0 104, 622 00 06500 RESPI RATORY THERAPY 0 15, 728 0 7, 692 05:00 D6500 RESPI RATORY THERAPY 0 37, 769 0 29, 478 00 00 D6400 DHUSI CAL THERAPY 0 1, 566 0 11, 662 01 00510 CARDIAC REHABI LITATION 0 1, 566 0 11, 662 07:00 DTOSO DURIS CHARGED TO PATIENTS 0 0 0 0 0 00 000000000000000000000000000000000000						31. C 43. C
51.00 O 50100 PECOVERY ROOM 20, 259 0 0 0 52.00 D5200 DELIVERY ROOM & LABOR ROOM 18, 065 73, 811 0 6608 54.00 D5400 RADIO LOGY-DI AGNOSTI C 0 10, 07, 714 171, 629 65.00 D65500 RESPI RATORY THERAPY 0 53, 728 7, 692 65.01 D6500 LECET LAB 0 0 3, 846 66.00 D6600 FIST CAL THERAPY 0 12, 223 0 45, 380 67.00 D6500 CLECTROCARDIO LOGY 0 3, 769 0 29, 478 67.01 D6500 CLECTROCARDE TO PATI ENTS 0 1, 829, 66 0 0 73.00 07300 DRUGO DRUGC CHARGED TO PATI ENTS 0 1, 829, 66 0 0 0 76.00 33020 DFATOENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ANCILLARY SERVICE COST CENTERS	20 (71	457 257		11 020	FO 0
88.00 08800 RURAL HEALTH CLINIC 0 11,160 0 39,142 88.01 08800 RURAL HEALTH CLINIC III 0 87,724 0 0 90.00 09000 CLINIC 5,488 17,536 0 1,599 90.01 09000 CLINIC - ORTHO 0 11,904 0 14,737 90.02 09001 CLINIC - PEDS, ENT, FP 0 12,262 0 25,455 90.30 90003 INTRAVENOUS THERAPY 0 891 0 16,983 90.04 09004 PSYCHLATRY 0 891 0 16,983 90.05 09005 CARDIOLOGY 0 2,472 0 2,664 91.00 09100 DESERVATION BEDS (NON-DISTINCT PART 59,756 180,094 0 66,767 92.00 DESERVATION REVIENSALE 0 0 0 0 0 113.00 11300 INTREVERSALE COST CENTERS 0 0 0 0 <tr< td=""><td>51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 60.00 06000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 65.01 06501 SLEEP LAB 66.00 06000 ELECTROCARDI OLOGY 69.01 06900 ELECTROCARDI OLOGY 69.01 06901 CARDI AC REHABI LI TATI ON 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 76.00 03020 CHEMI CAL DEPENDENCY 76.01 03480 ONCOLOGY</td><td>20, 259 18, 085 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>0 73, 811 90, 776 1, 007, 714 53, 728 0 12, 223 3, 769 1, 586 951, 912 1, 829, 666 0 0</td><td>0 0 0 0 0 0 0 0 0 2, 499 0 0</td><td>0 608 104, 627 171, 629 7, 692 3, 846 45, 380 29, 478 11, 662 0 0 0 0</td><td>50. 0 51. 0 52. 0 64. 0 65. 0 65. 0 65. 0 69. 0 71. 0 72. 0 73. 0 73. 0 76. 0</td></tr<>	51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 60.00 06000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 65.01 06501 SLEEP LAB 66.00 06000 ELECTROCARDI OLOGY 69.01 06900 ELECTROCARDI OLOGY 69.01 06901 CARDI AC REHABI LI TATI ON 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 76.00 03020 CHEMI CAL DEPENDENCY 76.01 03480 ONCOLOGY	20, 259 18, 085 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 73, 811 90, 776 1, 007, 714 53, 728 0 12, 223 3, 769 1, 586 951, 912 1, 829, 666 0 0	0 0 0 0 0 0 0 0 0 2, 499 0 0	0 608 104, 627 171, 629 7, 692 3, 846 45, 380 29, 478 11, 662 0 0 0 0	50. 0 51. 0 52. 0 64. 0 65. 0 65. 0 65. 0 69. 0 71. 0 72. 0 73. 0 73. 0 76. 0
88.02 08802 RURAL HEALTH CLINIC III 0 10.885 0 23.535 90.00 09000 CLINIC - ORTHO 0 11.904 0 1,599 90.01 09001 CLINIC - ORTHO 0 12.262 0 25.455 90.03 09003 INTRAVENOUS THERAPY 0 15.442 7.501 0 90.04 09004 PSYCHIATRY 0 891 0 16.983 90.05 CARDI OLOGY 0 2,684 0 2,684 91.00 095EVALIATRY 0 0 0 66.767 92.00 09200 085EVATION BEDS (NON-DISTINCT PART 0 0 0 0 01.00 IODO (HERCENCY 0 0 0 0 0 0 11.00 INTER REI MBURSABLE COST CENTERS 0 10.10 10.00 INDER HEATH ACENCY 0 0 0 0	88.00 08800 RURAL HEALTH CLINIC	-				88. C 88. C
90.05 09005 CARDI OLOGY 0 2,472 0 2,684 91.00 09100 EMERGENCY 59,756 180,094 0 66,767 92.00 0925RVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS 114.00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 0 0 116.00 11600 HOSPI CE 0 0 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 228,372 5,033,760 10,000 581,888 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192.00 PYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 194.00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 0 0 194.01 07951 MUNITY HEALTH 0 0 0	88. 02 08802 RURAL HEALTH CLINIC III 90. 00 09000 CLINIC 90. 01 09001 CLINIC- ORTHO 90. 02 09002 CLINIC - PEDS, ENT, FP 90. 03 09003 INTRAVENOUS THERAPY	5, 488 0 0	10, 885 17, 536 11, 904 12, 262 15, 442	0 0 0	23, 535 1, 599 14, 737 25, 455 0	88. C 90. C 90. C 90. C 90. C 90. C 90. C
101.00 10100 HOME HEALTH AGENCY 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 I 1300 I NTEREST EXPENSE 0 0 0 114.00 11400 UTI LI ZATI ON REVIEW-SNF 0 0 0 116.00 HOSPI CE 0 0 0 0 116.00 HOSPI CE 0 0 0 0 SUBTOTALS (SUM OF LINES 1 through 117) 228, 372 5, 033, 760 10, 000 581, 888 NONREL MBURSABLE COST CENTERS 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 194.00 07950 DAYCARE -I NFANT/TODDLER 0 0 0 0 194.01 07951 MOB 0 0 0 0 0 194.02 07952 COMUNI TY HEALTH 0 0 0 0 194.03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0	90. 05 09005 CARDI OLOGY 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0 0 59, 756	2, 472		2, 684	90. 0 91. 0 92. 0
113.00 111300 INTEREST EXPENSE 0 0 0 114.00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 0 0 116.00 HOSPI CE 0 0 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 228,372 5,033,760 10,000 581,888 NORREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 194.00 07950 DAYCARE - I NFANT/TODDLER 0 0 0 0 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 194.02 07954 EDUCATI ON 0 0 0 0 194.03 07955 MARKETI NG 0 0 0 0 194.04 07955 MARKETI NG 0 0 0 0 194.06 07955 GUEST MEALS 0 0 0 0	101.00 10100 HOME HEALTH AGENCY	0	0	0	0	101.0
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 194.00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 0 194.01 07951 MOB 0 0 0 0 0 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 0 194.02 07952 COMMUNI TY HEALTH 0 0 0 0 0 194.02 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 0 194.02 07954 EDUCATI ON 0 0 0 0 0 194.04 07954 EDUCATI ON 0 0 0 0 0 194.05 07955 MARKETI NG 0 916 0 0 0 194.06 07956 GUEST MEALS 0 0 0 0 0 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0	113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 228, 372	0 5, 033, 760	0 10, 000	0 581, 888	113. C 114. C 116. C 118. C
194.04 07954 EDUCATI ON 0 0 0 194.05 07955 MARKETI NG 0 916 0 0 194.05 07955 GUEST MEALS 0 0 0 0 194.07 07957 OUTSI DE LAUNDRY 0 0 0 0 194.08 07958 CANCER CENTER 0 0 0 0 194.08 07959 URGENT CARE 0 0 0 0 194.09 07959 URGENT CARE 0 0 0 0 194.10 07960 RHC 0 0 0 0	190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 DAYCARE-I NFANT/TODDLER 194. 01 07951 MOB 194. 02 07952 COMMUNI TY HEALTH		0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	190. C 192. C 194. C 194. C 194. C 194. C 194. C
194. 12/07962 TRI NE STUDENT HEALTH 0 2,005 0 0 194. 13/07963 OCCUPATI ONAL HEALTH 0 5,588 0 0	194. 04 07954 EDUCATI ON 194. 05 07955 MARKETI NG 194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY 194. 08 07958 CANCER CENTER 194. 09 07959 URGENT CARE 194. 10 07960 RHC 194. 11 07961 OBGYN 194. 12 07962 TRI NE STUDENT HEALTH		916 0 0 0 0 0 0 2,005	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	194. C 194. C 194. C 194. C 194. C 194. C 194. 1 194. 1 194. 1 194. 1 194. 1

Health Finar	ncial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	TAL	In Lie	u of Form CMS-25	52-10
COST ALLOCA	TI ON – STATI STI CAL BASI S		Provider C	1	Period: From 10/01/2020 Fo 09/30/2021	Worksheet B-1 Date/Time Prepa 2/24/2022 4:28	ared:
	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	0	(0 0	10	94.15
194. 16 07967	CAMERON FAMILY MEDICINE - NORTH	0	47, 791	(28, 517	10	94.16
194. 17 07966	CAMERON FAMILY MEDICINE - FREMONT	0	6, 433	(14, 076	10	94.17
200.00	Cross Foot Adjustments					20	00.00
201.00	Negative Cost Centers					20	01.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 254, 062	1, 078, 389	2, 365, 360	1, 200, 267	20	02.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5. 491312	0. 211594	236. 536000	1. 922023	20	03.00
204.00	Cost to be allocated (per Wkst. B, Part II)	98, 022	237, 167	113, 433	3 49, 943	20	04.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 429221	0. 046535	11.343300	0. 079975	20	05.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					20	06.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					20	07.00

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

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pre 2/24/2022 4:2	pared: 8 pm
		1	Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	10, 262, 306		10, 262, 30		0	
	03100 INTENSIVE CARE UNIT	333, 142		333, 14		0	
43.00	04300 NURSERY	107, 769		107, 76	9 0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	4, 402, 656		4, 402, 65		0	
	05100 RECOVERY ROOM	2, 402, 077		2, 402, 07		0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	1, 842, 479		1, 842, 47		0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	6,017,460		6, 017, 46		0	54.00
	06000 LABORATORY	5, 591, 917		5, 591, 91		0	
65.00	06500 RESPIRATORY THERAPY	1, 791, 705	0			0	
	06501 SLEEP LAB	355, 837	0			0	65.01
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	2, 780, 424	0	_,,.		0	
	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON	341, 706		341,70		-	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	207, 992		207,99		0	69.01 71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	1, 372, 214 2, 637, 527		1, 372, 21 2, 637, 52		0	
	07200 TMPL. DEV. CHARGED TO PATIENTS	1, 725, 073		1, 725, 07		0	
	03020 CHEMICAL DEPENDENCY	1, 725, 073			0 0	0	
	03480 ONCOLOGY	2, 624, 410		2, 624, 41	-	0	
70.01	OUTPATIENT SERVICE COST CENTERS	2,024,410		2,024,41	<u> </u>	0	70.01
88.00	08800 RURAL HEALTH CLINIC	2, 562, 330		2, 562, 33	0 0	0	88.00
	08801 RURAL HEALTH CLINIC II	3, 274, 291		3, 274, 29		0	88.01
	08802 RURAL HEALTH CLINIC III	1, 735, 771		1, 735, 77		0	88.02
	09000 CLINIC	343, 187		343, 18		0	90.00
	09001 CLINIC- ORTHO	879, 313		879, 31		0	90.01
	09002 CLINIC - PEDS, ENT, FP	1, 180, 853		1, 180, 85		0	
	09003 I NTRAVENOUS THERAPY	5, 502, 341		5, 502, 34		0	1
	09004 PSYCHI ATRY	493, 630		493, 63		0	90.04
	09005 CARDI OLOGY	594, 091		594, 09		0	90.05
	09100 EMERGENCY	5, 788, 130		5, 788, 13		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 668, 681		2, 668, 68		0	
/2:00	OTHER REIMBURSABLE COST CENTERS	2/000/001		2,000,00	·		1 2.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0			0	0	101.00
113,00	11300 I NTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11600 HOSPI CE	0			o	0	116.00
200.00		69, 819, 312	0	69, 819, 31	2 0		200.00
201.00		2, 668, 681		2, 668, 68			201.00
202.00		67, 150, 631	0				202.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pre 2/24/2022 4:2	pared: 8 pm
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. (+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 367, 577		7, 367, 57			30.00
31.00	03100 INTENSIVE CARE UNIT	374, 500		374, 50			31.00
43.00	04300 NURSERY	424,000		424,00	0		43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	0.745.040	10 107 700	01 040 45	0 001550	0,000000	50.00
50.00	05000 OPERATING ROOM	2, 715, 362	19, 127, 792	21, 843, 15		0.000000	50.00
51.00	05100 RECOVERY ROOM	629, 942	3, 756, 274	4, 386, 21		0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 725, 068	415, 516	2, 140, 58		0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 159, 169	38, 520, 112	40, 679, 28		0.000000	54.00
60.00	06000 LABORATORY	3, 775, 222	22, 696, 318			0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	2, 174, 543	1,016,042	3, 190, 58		0.000000	65.00
65.01	06501 SLEEP LAB	0	1, 108, 271	1, 108, 27		0. 000000	65.01
66.00	06600 PHYSI CAL THERAPY	1, 176, 410	4, 222, 784	5, 399, 19		0.000000	66.00
69.00	06900 ELECTROCARDI OLOGY	713, 705	2,678,362	3, 392, 06		0.000000	69.00
69.01	06901 CARDI AC REHABI LI TATI ON	419	449, 597	450, 01		0.000000	69.01
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	454, 353	2,815,771	3, 270, 12		0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	405, 417	2, 745, 748			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 398, 460	5, 860, 135			0.000000	
76.00	03020 CHEMI CAL DEPENDENCY	0	0		0 0.00000	0.000000	76.00
76.01	03480 ONCOLOGY	0	15, 164, 630	15, 164, 63	0 0. 173061	0.000000	76.01
~~ ~~	OUTPATIENT SERVICE COST CENTERS	10 7/0	4 745 070	1 700 00			
88.00	08800 RURAL HEALTH CLINIC	12, 768	1, 715, 270				88.00
88.01	08801 RURAL HEALTH CLINIC II	0	2, 530, 770	2, 530, 77			88.01
88.02	08802 RURAL HEALTH CLINIC III	630, 687	1, 143, 001	1, 773, 68		0 000000	88.02
90.00	09000 CLINIC	0	591, 561	591, 56		0.00000	90.00
90.01	09001 CLINIC- ORTHO	0	93, 494	93, 49		0.000000	90.01
90.02	09002 CLINIC - PEDS, ENT, FP	0	575, 278	575, 27		0.000000	90.02
90.03	09003 I NTRAVENOUS THERAPY	0	9, 905, 539	9, 905, 53		0.000000	90.03
90.04	09004 PSYCHI ATRY	0	138, 696	138, 69		0.000000	
90.05	09005 CARDI OLOGY	0	20, 769	20, 76		0.000000	
91.00	09100 EMERGENCY	648, 628	26, 793, 754	27, 442, 38		0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	74, 043	3, 818, 344	3, 892, 38	7 0. 685616	0. 000000	92.00
101.00	10100 HOME HEALTH AGENCY	0	0		0		101.00
110.00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF		-				114.00
	11600 HOSPI CE	0	0	10/ 7// 10	0		116.00
200.00		28, 860, 273	167, 903, 828	196, 764, 10	1		200.00
201.00 202.00		28, 860, 273	167, 903, 828	196, 764, 10	1		201. 00 202. 00

Hearth Frhancial Systems CAM	ERON MEMORIAL CON	INUNITY HUSPITAL	In Lieu	J OT FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pro	epared:
			llaani tal	2/24/2022 4:2	28 pm
Cost Conton Deporintion	DDC Innationt	Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 INTENSIVE CARE UNIT					30.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
51. 00 05100 RECOVERY ROOM	0.000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000				52.00
					52.00
	0. 000000				
	0. 000000				60.00
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 REHABI LI TATI ON	0. 000000				69.01
71.00 07100 MEDI CAL 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					
88.00 08800 RURAL HEALTH CLINIC					88.00
88.01 08801 RURAL HEALTH CLINIC II					88.01
88.02 08802 RURAL HEALTH CLINIC III					88.02
90.00 09000 CLINIC	0. 000000				90.00
90. 01 09001 CLINIC- ORTHO	0. 000000				90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	0. 000000				90.02
90. 03 09003 I NTRAVENOUS THERAPY	0. 000000				90.03
90. 04 09004 PSYCHI ATRY	0. 000000				90.04
90. 05 09005 CARDI OLOGY	0. 000000				90.05
91.00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REI MBURSABLE COST CENTERS	1				
101.00 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS	1				110.00
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTILIZATION REVIEW-SNF					114.00
116.00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems CAME	RON MEMORIAL CO	JMMUNITY HUSPI	IAL	In Lie	U OT FORM CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pre 2/24/2022 4:2	pared:
		Ti †I	e XIX	Hospi tal	PPS	
				Costs	110	
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	10, 262, 306		10, 262, 30	6 0	10, 262, 306	30.00
31.00 03100 INTENSIVE CARE UNIT	333, 142		333, 14	2 0	333, 142	31.00
43. 00 04300 NURSERY	107, 769		107, 76	9 0	107, 769	43.00
ANCILLARY SERVICE COST CENTERS						1
50.00 05000 OPERATING ROOM	4, 402, 656		4, 402, 65	6 0	4, 402, 656	50.00
51.00 05100 RECOVERY ROOM	2, 402, 077		2, 402, 07	7 0	2, 402, 077	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 842, 479		1, 842, 47	9 0	1, 842, 479	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 017, 460		6, 017, 46	0 0	6, 017, 460	54.00
60. 00 06000 LABORATORY	5, 591, 917		5, 591, 91	7 0	5, 591, 917	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 791, 705	0	1, 791, 70	5 0	1, 791, 705	65.00
65.01 06501 SLEEP LAB	355, 837	0	355, 83	7 0	355, 837	65.01
66. 00 06600 PHYSI CAL THERAPY	2, 780, 424	0	2, 780, 42	4 0	2, 780, 424	66.00
69. 00 06900 ELECTROCARDI OLOGY	341, 706		341, 70	6 0	341, 706	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	207, 992		207, 99	2 0	207, 992	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 372, 214		1, 372, 21	4 0	1, 372, 214	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,637,527		2, 637, 52		2, 637, 527	•
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 725, 073		1, 725, 07	3 0	1, 725, 073	
76.00 03020 CHEMI CAL DEPENDENCY	0			0 0	0	76.00
76. 01 03480 ONCOLOGY	2, 624, 410		2, 624, 41	0 0	2, 624, 410	76.01
OUTPATIENT SERVICE COST CENTERS		•				1
88.00 08800 RURAL HEALTH CLINIC	2, 562, 330		2, 562, 33	0 0	2, 562, 330	88.00
88.01 08801 RURAL HEALTH CLINIC II	3, 274, 291		3, 274, 29	0 1	3, 274, 291	88.01
88.02 08802 RURAL HEALTH CLINIC III	1, 735, 771		1, 735, 77	1 0	1, 735, 771	88.02
90. 00 09000 CLINIC	343, 187		343, 18	7 0	343, 187	90.00
90. 01 09001 CLINIC- ORTHO	879, 313		879, 31	3 0	879, 313	90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	1, 180, 853		1, 180, 85	3 0	1, 180, 853	90.02
90. 03 09003 I NTRAVENOUS THERAPY	5, 502, 341		5, 502, 34	1 0	5, 502, 341	90.03
90. 04 09004 PSYCHI ATRY	493, 630		493, 63	0 0	493, 630	90.04
90. 05 09005 CARDI OLOGY	594, 091		594, 09	0 1	594, 091	90.05
91.00 09100 EMERGENCY	5, 788, 130		5, 788, 13	0 0	5, 788, 130	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 668, 681		2, 668, 68	1	2, 668, 681	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 UTILIZATION REVIEW-SNF						114.00
116. 00 11600 HOSPI CE	0			0	0	116.00
200.00 Subtotal (see instructions)	69, 819, 312	0	69, 819, 31	2 0	69, 819, 312	200.00
201.00 Less Observation Beds	2, 668, 681		2, 668, 68	1	2, 668, 681	201.00
202.00 Total (see instructions)	67, 150, 631	c	67, 150, 63	0	67, 150, 631	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pre 2/24/2022 4:2	epared:
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 367, 577		7, 367, 57	77		30.00
31. 00 03100 I NTENSI VE CARE UNI T	374, 500		374, 50	00		31.00
43. 00 04300 NURSERY	424,000		424, 00	00		43.00
ANCILLARY SERVICE COST CENTERS			-			
50.00 05000 OPERATING ROOM	2, 715, 362	19, 127, 792	21, 843, 15	0. 201558	0.000000	50.00
51.00 05100 RECOVERY ROOM	629, 942	3, 756, 274	4, 386, 21	0. 547642	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 725, 068	415, 516	2, 140, 58	0. 860737	0.000000	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 159, 169	38, 520, 112	40, 679, 28	0. 147924	0.000000	54.00
60. 00 06000 LABORATORY	3, 775, 222	22, 696, 318	26, 471, 54	0. 211243	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	2, 174, 543	1, 016, 042	3, 190, 58	0. 561560	0.000000	65.00
65.01 06501 SLEEP LAB	0	1, 108, 271	1, 108, 27	0. 321074	0.000000	65.01
66. 00 06600 PHYSI CAL THERAPY	1, 176, 410	4, 222, 784	5, 399, 19	0. 514970	0.000000	66.00
69.00 06900 ELECTROCARDI OLOGY	713, 705	2, 678, 362	3, 392, 06		0.000000	
69. 01 06901 CARDI AC REHABI LI TATI ON	419	449, 597	450, 01		0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	454, 353	2, 815, 771	3, 270, 12		0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	405, 417	2, 745, 748			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 398, 460	5, 860, 135			0.000000	
76.00 03020 CHEMI CAL DEPENDENCY	0	0		0 0.000000	0.000000	
76.01 03480 ONCOLOGY	0	15, 164, 630	15, 164, 63		0.000000	
OUTPATIENT SERVICE COST CENTERS	· · · · ·					
88.00 08800 RURAL HEALTH CLINIC	12, 768	1, 715, 270	1, 728, 03	1. 482797	0.00000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2, 530, 770	2, 530, 77		0.000000	
88.02 08802 RURAL HEALTH CLINIC III	630, 687	1, 143, 001	1, 773, 68		0.000000	
90. 00 09000 CLINIC	0	591, 561	591, 56		0.000000	
90. 01 09001 CLINIC- ORTHO	0	93, 494	93, 49		0.000000	
90. 02 09002 CLINIC - PEDS, ENT, FP	0	575, 278			0.000000	
90. 03 09003 I NTRAVENOUS THERAPY	0	9,905,539	9, 905, 53		0.000000	1
90. 04 09004 PSYCHI ATRY	0	138, 696			0.000000	
90. 05 09005 CARDI OLOGY	0	20, 769	20, 76		0. 000000	
91. 00 09100 EMERGENCY	648, 628	26, 793, 754			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	74,043	3, 818, 344			0. 000000	
OTHER REIMBURSABLE COST CENTERS	11/010	0,010,011	0,0,2,00	01000010	0100000	12100
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>					
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	Ω		0		116.00
200.00 Subtotal (see instructions)	28, 860, 273	167, 903, 828	196, 764, 10	01		200.00
201.00 Less Observation Beds	20,000,273	107, 703, 020	170,704,10			201.00
202.00 Total (see instructions)	28, 860, 273	167, 903, 828	196, 764, 10)1		202.00
	,000,270	, ,, 520	, ,	- I		,

Health Financial Systems CAN	IERUN MEMORIAL CON	MUNITY HUSPITAL	In Lieu	J OF FORM CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Pre	epared:
				2/24/2022 4:2	28 pm
		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	0.001550				1 - 0 - 00
50. 00 O5000 OPERATING ROOM	0. 201558				50.00
51.00 05100 RECOVERY ROOM	0. 547642				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 860737				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 147924				54.00
60. 00 06000 LABORATORY	0. 211243				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 561560				65.00
65.01 06501 SLEEP LAB	0. 321074				65.01
66. 00 06600 PHYSI CAL THERAPY	0. 514970				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 100737				69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 462188				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 419621				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.837001				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 186321				73.00
76.00 03020 CHEMI CAL DEPENDENCY	0. 000000				76.00
76.01 03480 ONCOLOGY	0. 173061				76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	1. 482797				88.00
88.01 08801 RURAL HEALTH CLINIC II	1. 293792				88.01
88.02 08802 RURAL HEALTH CLINIC III	0. 978623				88.02
90. 00 09000 CLINIC	0. 580138				90.00
90. 01 09001 CLINIC- ORTHO	9. 405021				90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	2.052665				90.02
90. 03 09003 I NTRAVENOUS THERAPY	0. 555481				90.03
90. 04 09004 PSYCHI ATRY	3. 559079				90.04
90. 05 09005 CARDI OLOGY	28. 604699				90.05
91.00 09100 EMERGENCY	0. 210919				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 685616				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS	· ·				
113. 00 11300 I NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	1				

Heal th Fina	ncial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lie	eu of Form CMS-	2552-10
	N OF OUTPATIENT SERVICE COST TO CHARGE R		Provider C		Peri od:	Worksheet C	
	FOR MEDICALD ONLY				From 10/01/2020	Part II	
REDUCTIONS					To 09/30/2021		epared:
						2/24/2022 4:2	28 pm
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operati ng	
		(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
		Part I, col.	Part II col.	Capital Cos	t	Reducti on	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
ANCL	LLARY SERVICE COST CENTERS		2.00	0.00		0.00	
	O OPERATING ROOM	4, 402, 656	878, 819	3, 523, 8	37 C	0	50.00
	O RECOVERY ROOM	2, 402, 077	551, 695				
	O DELIVERY ROOM & LABOR ROOM	1, 842, 479					
	0 RADI OLOGY-DI AGNOSTI C	6,017,460				-	
	0 LABORATORY	5, 591, 917	327, 555				
	0 RESPI RATORY THERAPY	1, 791, 705					
65.01 0650	1 SLEEP LAB	355, 837	73, 449	282, 3	88 C	0	65.01
66.00 0660	0 PHYSI CAL THERAPY	2, 780, 424	488, 009	2, 292, 4	15 C	0	66.00
69.00 0690	0 ELECTROCARDI OLOGY	341, 706	33, 323	308, 3	B3 C	0	69.00
69.01 0690	1 CARDI AC REHABI LI TATI ON	207, 992	48, 526	159, 4	66 C	0	69.01
	O MEDICAL SUPPLIES CHARGED TO PATIENT	1, 372, 214				0	71.00
	O I MPL. DEV. CHARGED TO PATIENTS	2, 637, 527	109, 530			-	
	O DRUGS CHARGED TO PATIENTS	1, 725, 073					
	O CHEMI CAL DEPENDENCY	1,725,075					
		-					
		2, 624, 410	317, 700	2, 306, 7	10 C	0	76.01
	ATLENT SERVICE COST CENTERS					-	
	O RURAL HEALTH CLINIC	2, 562, 330					
	1 RURAL HEALTH CLINIC II	3, 274, 291	213, 282				
	2 RURAL HEALTH CLINIC III	1, 735, 771	118, 400	1, 617, 3	71 C	0	88.02
90.00 0900		343, 187	24, 494	318, 6	93 C	0	90.00
90.01 0900	1 CLINIC- ORTHO	879, 313	119, 383	759, 9	30 C	0	90.01
90.02 0900	2 CLINIC - PEDS, ENT, FP	1, 180, 853	177, 763	1,003,0	90 C	0	90.02
	3 INTRAVENOUS THERAPY	5, 502, 341	165, 497	5, 336, 8	44 C	0	90.03
	4 PSYCHI ATRY	493, 630				0	
	5 CARDI OLOGY	594, 091	48, 307			-	
	0 EMERGENCY	5, 788, 130				-	
	O OBSERVATION BEDS (NON-DISTINCT PART	2, 668, 681	442, 195				
	R REIMBURSABLE COST CENTERS	2,000,001	442, 190	2, 220, 4	50 0	0	92.00
		0	0	1	0		101 00
	O HOME HEALTH AGENCY	0	0		0 0	0	101.00
	I AL PURPOSE COST CENTERS			1		1	
	O INTEREST EXPENSE						113.00
	OUTILIZATION REVIEW-SNF						114.00
116.001160		0	0	1	0 0		116.00
200.00	Subtotal (sum of lines 50 thru 199)	59, 116, 095	6, 360, 107	52, 755, 9	38 C	0	200.00
201.00	Less Observation Beds	2, 668, 681	442, 195	2, 226, 4	86 C	0	201.00
202.00	Total (line 200 minus line 201)	56, 447, 414	5, 917, 912	50, 529, 5	D2 0	0	202.00
			•				

ALCULATI O	N OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provider C	CN: 15-1315	Period:	Worksheet C	
EDUCTI ONS	FOR MEDICALD ONLY				From 10/01/2020 To 09/30/2021	Part II	
					To 09/30/2021	Date/Time Pr 2/24/2022 4:	28 pm
			Titl	e XIX	Hospi tal	PPS	20 pm
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to			
		Operati ng	Part I,	Charge Ratio			
		Cost	column 8)	(col. 6 /			
		Reducti on		col. 7)			
		6.00	7.00	8.00			
	LLARY SERVICE COST CENTERS	1					
	O OPERATING ROOM	4, 402, 656					50.0
	O RECOVERY ROOM	2, 402, 077					51.0
	O DELIVERY ROOM & LABOR ROOM	1, 842, 479					52.0
4.00 0540	IO RADI OLOGY-DI AGNOSTI C	6, 017, 460	40, 679, 281	0. 14792	24		54.0
0.00 0600	O LABORATORY	5, 591, 917	26, 471, 540	0. 21124	13		60.0
5.00 0650	0 RESPI RATORY THERAPY	1, 791, 705	3, 190, 585	0. 56150	50		65.0
5.01 0650	1 SLEEP LAB	355, 837	1, 108, 271	0. 3210	74		65.0
6.00 0660	O PHYSI CAL THERAPY	2, 780, 424	5, 399, 194	0. 5149	70		66.0
9.00 0690	0 ELECTROCARDI OLOGY	341, 706	3, 392, 067	0. 10073	37		69.
9.01 0690	1 CARDI AC REHABI LI TATI ON	207, 992	450, 016	0. 46218	38		69.
1.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	1, 372, 214	3, 270, 124	0. 41962	21		71.
2.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	2, 637, 527	3, 151, 165	0. 83700	01		72.0
3.00 0730	O DRUGS CHARGED TO PATIENTS	1, 725, 073	9, 258, 595	0. 18632	21		73.0
6.00 0302	O CHEMI CAL DEPENDENCY	0	0	0.0000	00		76.0
6.01 0348	ONCOLOGY	2, 624, 410	15, 164, 630	0. 1730	51		76.0
OUTP	ATIENT SERVICE COST CENTERS						
	O RURAL HEALTH CLINIC	2, 562, 330	1, 728, 038	1. 48279	97		88. (
8.01 0880	1 RURAL HEALTH CLINIC II	3, 274, 291	2, 530, 770	1. 29379	92		88.0
8. 02 0880	2 RURAL HEALTH CLINIC III	1, 735, 771	1, 773, 688	0. 97862	23		88.
	OCLINIC	343, 187			38		90.
0.01 0900	1 CLINIC- ORTHO	879, 313	93, 494	9. 40502	21		90.
	2 CLINIC - PEDS, ENT, FP	1, 180, 853					90.
	3 INTRAVENOUS THERAPY	5, 502, 341	9, 905, 539				90.
	4 PSYCHI ATRY	493, 630					90.
	5 CARDI OLOGY	594, 091	20, 769				90.
	0 EMERGENCY	5, 788, 130					91.
-	0 OBSERVATION BEDS (NON-DISTINCT PART	2, 668, 681	3, 892, 387				92.
	R REIMBURSABLE COST CENTERS	2/000/001	0/0/2/00/	0.0000			
	O HOME HEALTH AGENCY	0	0	0.0000	00		101.0
	I AL PURPOSE COST CENTERS			0.0000			
	0 INTEREST EXPENSE						113.0
	O UTILIZATION REVIEW-SNF						114.
16.001160		0	0	0. 00000	00		116.
00.00	Subtotal (sum of lines 50 thru 199)	59, 116, 095	-				200.
00.00	Less Observation Beds	2, 668, 681	100, 370, 024 Λ				200.0
			. 0		i i		1201.1

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 10/01/2020		
				To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
			XVIII	Hospi tal	Cost	
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. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	878, 819	21, 843, 154				
51.00 05100 RECOVERY ROOM	551, 695	4, 386, 216				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	287, 351	2, 140, 584				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	701, 762	40, 679, 281				
60. 00 06000 LABORATORY	327, 555	26, 471, 540				
65.00 06500 RESPI RATORY THERAPY	83, 229	3, 190, 585				
65.01 06501 SLEEP LAB	73, 449	1, 108, 271			-	65.01
66.00 06600 PHYSI CAL THERAPY	488, 009	5, 399, 194				
69.00 06900 ELECTROCARDI OLOGY	33, 323	3, 392, 067				69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	48, 526	450, 016				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	56, 983	3, 270, 124				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	109, 530	3, 151, 165				
73.00 07300 DRUGS CHARGED TO PATIENTS	40, 634	9, 258, 595			3, 203	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0	0100000			76.00
76. 01 03480 ONCOLOGY	317, 700	15, 164, 630	0. 02095	0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	211, 425	1, 728, 038				88.00
88.01 08801 RURAL HEALTH CLINIC II	213, 282	2, 530, 770			-	88.01
88.02 08802 RURAL HEALTH CLINIC III	118, 400	1, 773, 688			0	88. 02
90. 00 09000 CLINIC	24, 494	591, 561			0	90.00
90. 01 09001 CLINIC- ORTHO	119, 383	93, 494			0	90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	177, 763	575, 278			0	90.02
90. 03 09003 I NTRAVENOUS THERAPY	165, 497	9, 905, 539			0	90.03
90. 04 09004 PSYCHI ATRY	56, 740	138, 696			0	90.04
90. 05 09005 CARDI OLOGY	48, 307	20, 769			0	90.05
91. 00 09100 EMERGENCY	784, 056	27, 442, 382				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	442, 195	3, 892, 387				92.00
200.00 Total (lines 50 through 199)	6, 360, 107	188, 598, 024	I	4, 022, 754	98, 185	200.00

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPI	TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			То	10/01/2020 09/30/2021	Worksheet D Part IV Date/Time Pre 2/24/2022 4:2	
			XVIII		Hospi tal	Cost	
Cost Center Description	Non Physi ci an		Nursi ng			Allied Health	
	Anestheti st	Program	Program		st-Stepdown		
	Cost	Post-Stepdown		Ac	djustments		
	1.00	Adjustments	0.00			0.00	
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVICE COST CENTERS		0	1		0	0	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	0	0		0	0	0	50.00
	0	0		0	0	0	51.00 52.00
	0	0		0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	
	0	0		0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0			0	0	0	65.00 65.01
65. 01 06501 SLEEP LAB	0	0		0	0	0	
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	66.00 69.00
	0	0		0	0	0	69.00
	0			0	0	0	71.00
	0			0	0	-	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	0	72.00 73.00
73. 00 07300 DR0GS CHARGED TO PATTENTS 76. 00 03020 CHEMI CAL DEPENDENCY	0			0	0	0	76.00
76. 01 03480 0NC0L0GY	0			0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0	0		U	0	0	70.01
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II	0	0		0	0	0	88.01
88. 02 08802 RURAL HEALTH CLINIC III	0			0	0	0	88.02
90. 00 09000 CLINIC	0			0	0	0	90.00
90. 01 09001 CLINIC- ORTHO	0			0	0	0	90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	0			0	0	0	90.02
90. 03 09003 I NTRAVENOUS THERAPY	0			0	0	0	90.03
90. 04 09004 PSYCHI ATRY	0	0		0	0	0	90.04
90. 05 09005 CARDI OLOGY	0	0		0	0	0	90.05
91. 00 09100 EMERGENCY	0	0		0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	ĺ		õ	0	0	92.00
200.00 Total (lines 50 through 199)	0	0		õ	0	-	200.00
······································				-1	0	Ŭ	

	Financial Systems CAME TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF		OMMUNITY HOSPI S Provider C	CN: 15-1315	Peri od:	u of Form CMS-2 Worksheet D	2002 10
THROUG	COSTS				From 10/01/2020	Part IV	
					To 09/30/2021	Date/Time Pre 2/24/2022 4:2	pared: 8 nm
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS			1	01 01 010 151	0.00000	
50.00	05000 OPERATING ROOM	0	-		0 21, 843, 154		
51.00	05100 RECOVERY ROOM	0	0		0 4, 386, 216		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 140, 584	0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 40, 679, 281	0.000000	
60.00	06000 LABORATORY	0	0		0 26, 471, 540	0.000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 3, 190, 585	0.000000	
65.01	06501 SLEEP LAB	0	0		0 1, 108, 271	0.000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 5, 399, 194	0.000000	
	06900 ELECTROCARDI OLOGY	0	0		0 3, 392, 067	0.000000	
	06901 CARDI AC REHABI LI TATI ON	0	0		0 450, 016	0.000000	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 3, 270, 124	0.000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 3, 151, 165	0.000000	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 9, 258, 595	0.000000	
76. 00 76. 01	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0	-		0 0 0 15, 164, 630	0.000000	
76.01	OUTPATIENT SERVICE COST CENTERS	0	0		0 15, 164, 630	0.000000	76.01
88.00	08800 RURAL HEALTH CLINIC	0	0		0 1, 728, 038	0.000000	88.00
88.00	08801 RURAL HEALTH CLINIC	0	-		0 2, 530, 770		
	08802 RURAL HEALTH CLINIC III	0			0 1, 773, 688	0.000000	
90.00	09000 CLINIC	0			0 1, 773, 088	0.000000	
90.00 90.01	09001 CLINIC- ORTHO	0			0 93, 494	0.000000	
	09002 CLINIC - PEDS, ENT, FP	0			0 575, 278	0.000000	
	09003 I NTRAVENOUS THERAPY	0			0 9,905,539		
	09004 PSYCHI ATRY	0			0 138, 696		
90.05	09005 CARDI OLOGY	0			0 20, 769		
	09100 EMERGENCY	0			0 27, 442, 382	0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0 3, 892, 387	0.000000	
.2.00	Total (lines 50 through 199)	0	-		0 188, 598, 024		200.00

MCRI F32 - 17. 2. 173. 2

Health Financial Systems		ERON MEMORIAL CON		TAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider C		Period: From 10/01/2020		
					To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
				XVIII	Hospi tal	Cost	
Cost Center Descr	ription	Outpati ent	I npati 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	
ANCILLARY SERVICE COST	CENTERS						
50.00 05000 OPERATING ROOM		0.000000	606, 005		0 0	0	
51.00 05100 RECOVERY ROOM		0. 000000	103, 969		0 0	0	51.00
52.00 05200 DELIVERY ROOM & L	_ABOR ROOM	0. 000000	450		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOS	STIC	0. 000000	478, 710		0 0	0	54.00
60.00 06000 LABORATORY		0. 000000	842, 734		0 0	0	60.00
65.00 06500 RESPIRATORY THERA	APY	0. 000000	426, 934		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	142, 329		0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	ſ	0.000000	212, 405		0 0	0	69.00
69. 01 06901 CARDI AC REHABILI 1	ΓΑΤΙ ΟΝ	0. 000000	419		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENT	0. 000000	287, 747		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGE	ED TO PATIENTS	0. 000000	122, 884		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO	PATI ENTS	0. 000000	729, 847		0 0	0	73.00
76.00 03020 CHEMI CAL DEPENDEN	NCY	0. 000000	0		0 0	0	76.00
76.01 03480 ONCOLOGY		0.000000	0		0 0	0	76.01
OUTPATIENT SERVICE COS	T CENTERS					· · · · ·	
88.00 08800 RURAL HEALTH CLIN		0,000000	0		0 0	0	1 88.00
88.01 08801 RURAL HEALTH CLIN		0.000000	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLIN		0. 000000	0		0 0	0	
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, EN	NT FP	0.000000	0		0 0	0	90.02
90. 03 09003 I NTRAVENOUS THER		0.000000	0		0 0	0	
90. 04 09004 PSYCHI ATRY		0.000000	0			0	90.04
90. 05 09005 CARDI OLOGY		0.000000	0		0 0	0	90.05
91. 00 09100 EMERGENCY		0.000000	51, 773		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS	(NON_DISTINCT PAPT	0.000000	16, 548		0 0	-	
200.00 Total (lines 50 1		0.000000	4, 022, 754		0 0		200.00
	chi ougir (77)	I I	7,022,704	I	ч -	1 0	200.00

APPORTI ONN	PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C	CN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Worksheet D Part V Date/Time Prepared: 2/24/2022 4:28 pm	
			Title XVIII		Hospi tal	Cost	
				Charges		Costs	
Cost Center Description		Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	I LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	0. 201558		-,,		-	
	00 RECOVERY ROOM	0. 547642					
52.00 052	00 DELIVERY ROOM & LABOR ROOM	0. 860737	0		0 0	0	52.00
	00 RADI OLOGY-DI AGNOSTI C	0. 147924	0			0	54.00
	00 LABORATORY	0. 211243		4, 561, 04	5 0	0	60.00
5.00 065	00 RESPI RATORY THERAPY	0. 561560	0	228, 46	04 0	0	65.00
	01 SLEEP LAB	0. 321074		188, 82	0 0	0	65.01
6.00 066	00 PHYSI CAL THERAPY	0. 514970	0	1, 152, 65	57 0	0	66.00
9.00 069	00 ELECTROCARDI OLOGY	0. 100737	0	567, 48	85 0	0	69.00
9.01 069	01 CARDI AC REHABI LI TATI ON	0. 462188	0	141, 39	9 0	0	69.01
1.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 419621	0	388, 02	.1 0	0	71.00
2.00 072	00 IMPL. DEV. CHARGED TO PATIENTS	0. 837001	0	503, 04	2 0	0	72.00
3.00 073	00 DRUGS CHARGED TO PATIENTS	0. 186321	0	309, 52	.8 0	0	73.00
6. 00 030	20 CHEMI CAL DEPENDENCY	0. 000000	0		0 0	0	76.00
6. 01 034	80 ONCOLOGY	0. 173061	0	5, 555, 90	02 0	0	76.01
OUTI	PATIENT SERVICE COST CENTERS						1
38.00 088	OO RURAL HEALTH CLINIC						88.00
88. 01 088	01 RURAL HEALTH CLINIC II						88.01
88. 02 088	02 RURAL HEALTH CLINIC III						88.02
0.00 090	00 CLINIC	0. 580138	0	216, 16	01 0	0	90.00
0. 01 090	01 CLINIC- ORTHO	9. 405021	0	44, 20	04 0	0	90.01
	02 CLINIC - PEDS, ENT, FP	2.052665	0			0	90.02
	03 I NTRAVENOUS THERAPY	0. 555481	0			0	90.03
	04 PSYCHI ATRY	3. 559079	0			0	90.04
	05 CARDI OLOGY	28. 604699				0	
	00 EMERGENCY	0. 210919				-	
	00 OBSERVATION BEDS (NON-DISTINCT PART	0. 685616					1
200.00	Subtotal (see instructions)	0.000010		38, 014, 99		-	200.00
201.00	Less PBP Clinic Lab. Services-Program		Ĭ	00,014,77	0 0		200.00
	Only Charges					1	
1	Net Charges (line 200 - line 201)	1	1	38, 014, 99	1	1	202.00

	RON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lieu	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C		Period: From 10/01/2020 To 09/30/2021	Worksheet D Part V Date/Time Pr 2/24/2022 4:	
		Title	XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)	-			
ANCI LLARY SERVICE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	699, 035	0				50.00
51. 00 05100 RECOVERY ROOM	272, 816		1			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 187, 383	0				54.00
60. 00 06000 LABORATORY	963, 489					60.00
65. 00 06500 RESPIRATORY THERAPY	128, 296	0				65.00
65. 01 06501 SLEEP LAB	60, 625	0				65.01
66. 00 06600 PHYSI CAL THERAPY	593, 584	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	57, 167	0				69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	65, 353	0				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	162, 822	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	421, 047	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	57,672	0				73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0				76.00
76. 01 03480 0NC0L0GY	961, 510					76.01
OUTPATIENT SERVICE COST CENTERS	,,,,,,,,		1			
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
88.02 08802 RURAL HEALTH CLINIC III						88.02
90. 00 09000 CLINIC	125, 403	0				90.00
90. 01 09001 CLINIC- ORTHO	415, 740	0				90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	114, 473		1			90.02
90. 03 09003 I NTRAVENOUS THERAPY	3, 637, 810	2, 403				90.03
90. 04 09004 PSYCHI ATRY	115, 471	0				90.04
90. 05 09005 CARDI OLOGY	281, 556					90.05
91.00 09100 EMERGENCY	947, 206	17, 778				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	704, 211	0				92.00
200.00 Subtotal (see instructions)	11, 972, 669	20, 181				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	20,701				201.00
202.00 Net Charges (line 200 - line 201)	11, 972, 669	20, 181				202.00

Health Financial Systems CA	MERON MEMORIAL C	RON MEMORIAL COMMUNITY HOSPITAL			In Lieu of Form CMS-2		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provider (Peri od:	Worksheet D		
				From 10/01/2020			
				To 09/30/2021	Date/Time Pre 2/24/2022 4:2	epared:	
		Ti +	le XIX	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem		
oust center beschiption	Related Cost	Adjustment	Capi tal	Days	(col. 3 /		
	(from Wkst.	/ aj as tillorre	Related Cost		col. 4)		
	B, Part II,		(col . 1 -		001. 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, 700, 441	222, 669	9 1, 477, 77	2 4, 682	315.63	30.00	
31.00 INTENSIVE CARE UNIT	97, 277		97, 27	7 126	772.04	31.00	
43.00 NURSERY	32, 415		32, 41	5 426	76.09	43.00	
200.00 Total (lines 30 through 199)	1, 830, 133		1, 607, 46	4 5, 234		200.00	
Cost Center Description	Inpatient	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	23	7, 259	9			30.00	
31.00 INTENSIVE CARE UNIT	0	(31.00	
43.00 NURSERY	7	533				43.00	
200.00 Total (lines 30 through 199)	30	7, 792	2			200.00	

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 10/01/2020	Worksheet D	
						narod
				To 09/30/2021	2/24/2022 4:2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)				5 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	070_010	01 040 154	0.04007	0.054	224	
50. 00 05000 OPERATING ROOM	878, 819					
51.00 05100 RECOVERY ROOM	551, 695					
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	287, 351					52.00 54.00
60. 00 06000 LABORATORY	701, 762 327, 555					60.00
65. 00 06500 RESPIRATORY THERAPY	83, 229					65.00
65. 01 06500 RESPIRATORY THERAPY	73, 449				275	65.00
66. 00 06600 PHYSI CAL THERAPY	488, 009				0	66.00
69. 00 06900 ELECTROCARDI OLOGY	33, 323				-	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	48, 526				0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	56, 983				86	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	109, 530				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	40, 634				93	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0				0	76.00
76. 01 03480 ONCOLOGY	317, 700	-			0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	211, 425	1, 728, 038	0. 12235	0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	213, 282			6 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	118, 400	1, 773, 688	0. 06675	4 0	0	88.02
90. 00 09000 CLINIC	24, 494	591, 561	0. 04140	6 0	0	90.00
90. 01 09001 CLINIC- ORTHO	119, 383	93, 494	1. 27690	5 0	0	90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	177, 763	575, 278	0. 30900	4 0	0	90.02
90. 03 09003 I NTRAVENOUS THERAPY	165, 497	9, 905, 539	0. 01670	0 8	0	90.03
90. 04 09004 PSYCHI ATRY	56, 740	138, 696	0. 40909	6 0	0	90.04
90. 05 09005 CARDI OLOGY	48, 307	20, 769			0	90.05
91.00 09100 EMERGENCY	784, 056				204	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	442, 195					92.00
200.00 Total (lines 50 through 199)	6, 360, 107	188, 598, 024	l	145, 327	9, 124	200.00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	CAMERON MEMORIAL CO			Period:	u of Form CMS- Worksheet D	2002 1
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OF	IER PASS THROUGH CUS	is provider c		From 10/01/2020	Part III	
				To 09/30/2021	Date/Time Pre	•nared·
					2/24/2022 4:2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adj ustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
43.00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	: Per Diem	I npati ent	
	Adj ustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	-	col. 6)		
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	4, 68	2 0.00	23	30.00
31.00 03100 INTENSIVE CARE UNIT		0	12	6 0.00	0	31.00
43.00 04300 NURSERY		0	42	6 0.00	7	43.00
200.00 Total (lines 30 through 199)		0	5, 23	4	30	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.0
31.00 03100 INTENSIVE CARE UNIT	0					31.0
43. 00 04300 NURSERY	0					43.0
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2									
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS	S Provider C	CN: 15-1315		eriod: com 10/01/2020 o 09/30/2021				
		Ti tl	e XIX		Hospi tal	PPS			
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health			
	Anestheti st	Program	Program		Post-Stepdown				
	Cost	Post-Stepdown			Adjustments				
		Adjustments							
	1.00	2A	2.00		3A	3.00			
ANCILLARY SERVICE COST CENTERS									
50.00 05000 OPERATI NG ROOM	0	0		0	0	0	50.00		
51.00 05100 RECOVERY ROOM	0	0		0	0	0	51.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00		
60. 00 06000 LABORATORY	0	0		0	0	0	60.00		
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00		
65. 01 06501 SLEEP LAB	0	0		0	0	0	65.01		
66. 00 06600 PHYSI CAL THERAPY	0			0	0	0	66.00		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00		
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0		0	0		69.00		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0		71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	72.00		
73. 00 07200 TMPL. DEV. CHARGED TO PATTENTS	0	0		0	0		73.00		
	0	0		0	0	0			
76.00 03020 CHEMI CAL DEPENDENCY	0	0		0	0	0	76.00		
76.01 03480 ONCOLOGY	0	0		0	0	0	76.01		
OUTPATIENT SERVICE COST CENTERS	0	0	1	0	0				
88.00 08800 RURAL HEALTH CLINIC	0	-		0	0		88.00		
88. 01 08801 RURAL HEALTH CLINIC II	0	0		0	0	-	88.01		
88. 02 08802 RURAL HEALTH CLINIC III	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, FP	0	0		0	0	0	90.02		
90. 03 09003 I NTRAVENOUS THERAPY	0	0		0	0	0	90.03		
90. 04 09004 PSYCHI ATRY	0	0		0	0	0	90.04		
90. 05 09005 CARDI OLOGY	0	0		0	0	0	90.05		
91.00 09100 EMERGENCY	0	0		0	0	0	91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00		
200.00 Total (lines 50 through 199)	0	0		0	0	0	200.00		

Health Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS			CN: 15-1315	Period: From 10/01/2020 Fo 09/30/2021	Worksheet D	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0) (21, 843, 154	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0) (4, 386, 216	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(2, 140, 584	0.000000	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(40, 679, 281	0.000000	54.00
60. 00 06000 LABORATORY	0	0	(26, 471, 540	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(3, 190, 585	0.00000	65.00
65.01 06501 SLEEP LAB	0	0	(1, 108, 271	0.00000	65.01
66.00 06600 PHYSI CAL THERAPY	0	0		5, 399, 194	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		3, 392, 067	0.000000	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0		450, 016	0.000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		3, 270, 124	0.000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		3, 151, 165	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		9, 258, 595	0.000000	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0	0		0 0	0.000000	76.00
76. 01 03480 ONCOLOGY	0	0		15, 164, 630		
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(1, 728, 038	0.00000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		2, 530, 770	0.000000	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0		1, 773, 688	0.000000	
90, 00 09000 CLINIC	0	0		591, 561	0,000000	
90. 01 09001 CLINIC- ORTHO	0	0		93, 494	0.000000	90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	0	0		575, 278		
90. 03 09003 I NTRAVENOUS THERAPY	0	0		9, 905, 539		
90, 04 09004 PSYCHI ATRY	0	0		138, 696		
90. 05 09005 CARDI OLOGY	0	0		20, 769		90.05
91.00 09100 EMERGENCY	0	0		27, 442, 382		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			3, 892, 387	0.000000	
200.00 Total (lines 50 through 199)	0			188, 598, 024		200.00

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Health Financial Systems CAME	RON MEMORIAL COM	MUNITY HOSPI	ΓAL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 10/01/2020 To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		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 SERVICE COST CENTERS			-		-	
50.00 05000 OPERATING ROOM	0. 000000	8, 054		0 0	0	
51.00 05100 RECOVERY ROOM	0. 000000	4, 194		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	52, 374		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	11, 653		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	23, 404		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	10, 559		0 0	0	65.00
65.01 06501 SLEEP LAB	0. 000000	0	1	0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 219		0 0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 945		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	21, 084		0 0	0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0. 000000	0		0 0	0	76.00
76.01 03480 ONCOLOGY	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS			ı			
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	1 88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.02
90. 00 09000 CLINIC	0, 000000	0		0 0	0	90.00
90. 01 09001 CLI NI C- ORTHO	0, 000000	0		0 0	0	90.01
90. 02 09002 CLINIC - PEDS, ENT, FP	0. 000000	0		0 0	0	90.02
90. 03 09003 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
90. 04 09004 PSYCHI ATRY	0. 000000	0		0 0	0	90.04
90. 05 09005 CARDI OLOGY	0. 000000	0		0 0	0	90.05
91. 00 09100 EMERGENCY	0, 000000	7, 141		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	700		0 0		
200.00 Total (lines 50 through 199)		145, 327		0 0		200.00
······································	1 I	, 02,	1			1 2 2 . 50

CAMERON MEMORIAL COMMUNITY HOSPITAL

	Financial Systems CAMERON MEMORIAL COMM	IUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1315	Period:	Worksheet D-1	
			From 10/01/2020 To 09/30/2021	Date/Time Pre	pare
				2/24/2022 4:2	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
. 00	Inpatient days (including private room days and swing-bed day			6, 107	1.
. 00	Inpatient days (including private room days, excluding swing-			4, 682	
. 00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.
00	do not complete this line.			2 201	
. 00 . 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	3, 281 123	4. 5.
. 00	reporting period	through becen		125	J.
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	490	6.
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	177	7.
00	reporting period		01	()5	
. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	635	8.
. 00	Total inpatient days including private room days applicable t	o the Program (excludin	a swing_bed and	840	9.
. 00	newborn days) (see instructions)		ig sinnig bed and	010	
0.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	101	10.
	through December 31 of the cost reporting period (see instruc		-		
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	512	11.
2 00	December 31 of the cost reporting period (if calendar year, e		to room dovo)	0	12
2.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including priva	ite room days)	0	12
3.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room davs)	0	13
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr			0	
	Total nursery days (title V or XIX only)			0	
6.00	Nursery days (title V or XIX only)			0	16.
7 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	cos through December 21	of the cost		17
7.00	reporting period	thi bugh becember 51	of the cost		''.
8.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	of the cost	216.95	19
	reporting period		44	21/ 05	0
0.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter December 31 or	the cost	216.95	20.
1.00	Total general inpatient routine service cost (see instruction	is)		10, 262, 306	21.
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		
	5 x line 17)	·			
3.00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line 6	0	23.
4 00	x line 18)			20, 400	24
4.00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	ar at of the cost report	ing period (inne	38, 400	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	137, 763	25
	x line 20)		5 m		
6.00	Total swing-bed cost (see instructions)			1, 343, 830	
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 918, 476	27
0 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abconvetion had a	horaco	0	1 20
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	a and observation bed c	narges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	30
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
1.00	Average per diem private room charge differential (line 32 mi		icti ons)	0.00	
5.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 2 x line 25)	ne 31)		0.00	
5.00 7.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost of	lifferential (line	0 8, 918, 476	36
,	27 minus line 36)	and private room cost c		0, 710, 470	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			1, 904. 84	
	Program general inpatient routine service cost (line 9 x line			1, 600, 066	
0.00	Medically necessary private room cost applicable to the Progr			0 1, 600, 066	40
	Total Program general inpatient routine service cost (line 39				. 41

	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 10/01/2020	Worksheet D-1	
					To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
			Title	e XVIII	Hospi tal	Cost	.0 pi
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42
00	INTENSIVE CARE UNIT	333, 142	126	2, 643. 9	8 52	137, 487	43
00	CORONARY CARE UNIT	000,112	120	2,0101,	0 02	107,107	44
00	BURN INTENSIVE CARE UNIT						45
00	SURGI CAL I NTENSI VE CARE UNI T						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1 00	-
00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)	-		1.00 1,144,791	48
00	Total Program inpatient costs (sum of lines			ons)		2, 882, 344	
	PASS THROUGH COST ADJUSTMENTS	······································				_,,	
00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50
00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51
00	and IV)	EQ and E1)				_	
00 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non rh	veician anact	hatist and	0	
00	medical education costs (line 49 minus line		a a teu, non-ph	ysi ci an anest	notist, anu		33
	TARGET AMOUNT AND LIMIT COMPUTATION	/					1
00	Program di scharges					0	54
00	Target amount per discharge					0.00	55
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	0	
00	Bonus payment (see instructions)					0	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59
00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the	markat baskat		0.00	60
00	If line 53/54 is less than the lower of line					0.00	
00	which operating costs (line 53) are less that					0	
	amount (line 56), otherwise enter zero (see		- (
00	Relief payment (see instructions)	,				0	62
00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	192, 389	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	a neriod (See	975, 278	65
00	instructions) (title XVIII only)				g period (See	775,270	
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	II only). For	1, 167, 667	66
	CAH (see instructions)		·		3,		
00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67
00	(line 12 x line 19)						
00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 or	the cost rep	orting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU			· · · · · · · · · · · · · · · · · · ·		0	1 "
00	Skilled nursing facility/other nursing facil)		70
00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71
00	Program routine service cost (line 9 x line						72
00	Medically necessary private room cost application	0	•				73
00	Total Program general inpatient routine serv	•			Dont II I		74
00	Capital-related cost allocated to inpatient 26, line 45)	outine service	CUSIS (Trom	wurksneet B,	raitii, column		75
00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces	• •					79
00	Total Program routine service costs for comp		ost limitatio	n (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem limi		`				81
00	Inpatient routine service cost limitation (I						82
00 00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in		5)				83
00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ins)				84
00	Total Program inpatient operating costs (sum	•					86
55	PART IV - COMPUTATION OF OBSERVATION BED PASS						
00	Total observation bed days (see instructions					1, 401	87
	Adjusted general inpatient routine cost per		line 2)			1, 904. 84	
00	Observation bed cost (line 87 x line 88) (se					2, 668, 681	

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 10/01/2020 To 09/30/2021		nared
					2/24/2022 4:2	
		Title	XVIII	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, 700, 441	10, 262, 306	0. 16569	8 2, 668, 681	442, 195	90.00
91.00 Nursing Program cost	0	10, 262, 306	0.00000	0 2, 668, 681	0	91.00
92.00 Allied health cost	0	10, 262, 306	0.00000	0 2, 668, 681	0	92.00
93.00 All other Medical Education	0	10, 262, 306	0.00000	0 2, 668, 681	0	93.00

CAMERON MEMORIAL COMMUNITY HOSPITAL

Heal th	Financial Systems CAMERON MEMORIAL COM	MUNITY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1315	Peri od:	Worksheet D-1	
			From 10/01/2020 To 09/30/2021	Date/Time Pre	pared:
		Title XIX	lloonital	2/24/2022 4:2	8 pm
	Cost Center Description		Hospi tal	PPS	
	•			1.00	
	PART I - ALL PROVIDER COMPONENTS				-
	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs excluding newborn)		6, 107	1.00
2.00	Inpatient days (including private room days, excluding swing			4, 682	2.00
3.00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3.00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation	had dave)		3, 281	4.00
4.00 5.00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost		5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	490	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	177	7.00
7.00	reporting period	on days) through becenbe	1 51 01 the cost	177	/.00
8.00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	635	8.00
0.00	reporting period (if calendar year, enter 0 on this line)		a and an least and	22	
9.00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excludin	g swing-bed and	23	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instru				11 00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12.00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar	5 (51	<i>,</i>	0	13.00
14.00	Medically necessary private room days applicable to the Prog			0	14.00
	Total nursery days (title V or XIX only)			426	
16.00	Nursery days (title V or XIX only)			7	16.00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		17.00
17.00	reporting period	ces through becember 51	of the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18.00
10.00	reporting period	an through December 21 a	f the east	214 05	10.00
19.00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through becember 31 0	T the cost	216. 95	19.00
20.00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	216. 95	20.00
01 00	reporting period			10 0/0 00/	01 00
	Total general inpatient routine service cost (see instructio Swing-bed cost applicable to SNF type services through Decem		ting period (line	10, 262, 306 0	21.00 22.00
22.00	5 x line 17)	ber at of the cost repor	ting period (init		22.00
23.00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23.00
24 00	x line 18) Swing-bed cost applicable to NF type services through Decemb	or 21 of the cost report	ing pariod (line	38, 400	24 00
24.00	7 x line 19)	el 31 Ul the cost report	ring period (inne	38,400	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	137, 763	25.00
24 00	x line 20)			1 242 020	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 343, 830 8, 918, 476	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			0, 710, 170	27.00
	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29.00
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	30.00 31.00
	Average private room per diem charge (line 29 ÷ line 3)	20)		0.00	
	Average semi-private room per diem charge (line 30 \div line 4)			0.00	
	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l	, (ctions)	0.00	
	Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00	35.00 36.00
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	IUSTMENTS			-
	Adjusted general inpatient routine service cost per diem (se			1, 904. 84	38.00
	Program general inpatient routine service cost (line 9 x lin			43, 811	39.00
	Medically necessary private room cost applicable to the Prog			0	
41.00	Total Program general inpatient routine service cost (line 3	9 + line 40)		43, 811	41.00

MPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1315	Period: From 10/01/2020	Worksheet D-1	
					To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
		1		e XIX	Hospi tal	PPS	-0 pm
	Cost Center Description	Total I npati ent	Total I npati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	-
. 00	NURSERY (title V & XIX only)	1.00	426			1, 771	42.
	Intensive Care Type Inpatient Hospital Units						
00	INTENSIVE CARE UNIT	333, 142	126	2, 643. 98	3 0	0	
00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T						44.
00	SURGI CAL I NTENSI VE CARE UNI T						46.
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	. line 200)			69, 710	48
00	Total Program inpatient costs (sum of lines			ons)		115, 292	
00	PASS THROUGH COST ADJUSTMENTS		1				1 50
00	Pass through costs applicable to Program inp	atient routine	services (Troi	n WKST. D, SUN	I OT Parts I and	7, 792	50
00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	um of Parts II	9, 124	51
<i>.</i> .	and IV)						
00 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated per st		otict and	16, 916 98, 376	
00	medical education costs (line 49 minus line		rateu, non-pri	ysi ci all'allesti	ietist, anu	90, 370	53
	TARGET AMOUNT AND LIMIT COMPUTATION	-					
00	Program discharges					0	
00 00	Target amount per discharge Target amount (line 54 x line 55)					0.00 0	
00	Difference between adjusted inpatient operat	line 53)	0				
00	Bonus payment (see instructions)	,	0				
00	Lesser of lines 53/54 or 55 from the cost re	mpounded by the	0.00	59			
00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport un	dated by the	markat backat		0.00	60
00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
~~	amount (line 56), otherwise enter zero (see	instructions)				0	
00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym		0				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	neriod (See	0	65
	instructions) (title XVIII only)				perrou (bee	0	
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line (65)(title XVII	l only). For	0	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67
. 00	(line 12 x line 19)	e costs through	December 31	SI THE COST IE	porting period	0	
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino coste (lino 67 - lin	5 69)		0	69
00	PART III - SKILLED NURSING FACILITY, OTHER N					0	09
00	Skilled nursing facility/other nursing facil						70
00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71
00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(lino 14 v li	ino 25)			72
00	Total Program general inpatient routine serv	0					74
00	Capital-related cost allocated to inpatient				Part II, column		75
00	26, line 45) Der diem capital related costs (line 75 , li	no 3)					_,
00 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces	s costs (from p					79
00	Total Program routine service costs for comp		ost limitation	n (line 78 mir	nus line 79)		80
00 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81
00	Reasonable inpatient routine service cost (83
00	Program inpatient ancillary services (see in		-				84
00	Utilization review - physician compensation						85
00	Total Program inpatient operating costs (sum		rough 85)				86
00	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions					1, 401	87
	Adjusted general inpatient routine cost per		line 2)			1, 904. 84	
00	naj do tod gonor dr inpatrione roati no oboti por						

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 10/01/2020 To 09/30/2021		parod
				10 097 307 2021	2/24/2022 4: 2	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 700, 441	10, 262, 306	0. 16569	8 2, 668, 681	442, 195	90.00
91.00 Nursing Program cost	0	10, 262, 306	0.00000	0 2, 668, 681	0	91.00
92.00 Allied health cost	0	10, 262, 306	0.00000	0 2, 668, 681	0	92.00
93.00 All other Medical Education	0	10, 262, 306	0.00000	0 2, 668, 681	0	93.00

Health Financial Systems CAMERON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1315	Peri od:	Worksheet D-3	3
			From 10/01/2020		
			To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
bost benter bescription		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			ondriges	col . 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 300, 450		30.00
31. 00 03100 INTENSIVE CARE UNIT			156,000		31.00
43. 00 04300 NURSERY			,		43.00
ANCI LLARY SERVICE COST CENTERS		1			
50. 00 05000 OPERATING ROOM		0. 2015	58 606, 005	122, 145	50.00
51.00 05100 RECOVERY ROOM		0. 5476			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.8607			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1479			
60. 00 06000 LABORATORY		0. 2112			
65. 00 06500 RESPI RATORY THERAPY		0. 56150			
65. 01 06501 SLEEP LAB		0. 3210			
66. 00 06600 PHYSI CAL THERAPY		0. 5149			
69. 00 06900 ELECTROCARDI OLOGY		0. 1007:			
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 4621			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 41962			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 8370			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1863			
76. 00 03020 CHEMI CAL DEPENDENCY		0.0000			
76. 01 03480 ONCOLOGY		0. 1730			
OUTPATIENT SERVICE COST CENTERS		0.1730		<u>/</u> 0	70.01
88.00 08800 RURAL HEALTH CLINIC		0.0000	20	0	88.00
88.01 08801 RURAL HEALTH CLINIC II		0.0000		0	
88. 02 08802 RURAL HEALTH CLINIC III		0.0000		0	
90. 00 09000 CLINIC		0. 5801			
90. 01 09001 CLINIC- ORTHO		9. 40502			
90. 02 09002 CLINIC - PEDS, ENT, FP		2.0526			
90. 03 09003 I NTRAVENOUS THERAPY		0. 5554			
90. 04 09004 PSYCHI ATRY		3. 5590		-	
90. 05 09005 CARDI 0L0GY		28.6046			
90. 05 09005 CARDI 0L0GY 91. 00 09100 EMERGENCY		0. 2109		-	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.2109			
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.0850	4, 022, 754		
200.00 Total (sum of fines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charg	$\log (\lim_{n \to \infty} (1))$		4, 022, 754		200.00
201.00 [Less PBP CITIC Laboratory Services-Program only charg 202.00] Net charges (line 200 minus line 201)	jes (ITHE OT)		-		201.00
zuz. ou piver charges (inne zuo minus inne zui)		I.	4, 022, 754	1	202.00

NPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1315	Peri od:	Worksheet D-3	3
		Component	CCN: 15-Z315	From 10/01/2020 To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
		Title	e XVIII	Swing Beds - SNI		
	Cost Center Description	· •	Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x	
			1.00	2.00	col. 2) 3.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	-
	ADULTS & PEDIATRICS					30.
1.00 03100	INTENSIVE CARE UNIT					31.
3.00 04300	NURSERY					43.
	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 2015	58 C	0	50.
	RECOVERY ROOM		0. 5476			
	DELIVERY ROOM & LABOR ROOM		0.8607		-	
	RADI OLOGY-DI AGNOSTI C		0. 1479			
			0. 2112			
	RESPIRATORY THERAPY		0. 5615			
	SLEEP LAB		0.3210		-	
	PHYSI CAL THERAPY ELECTROCARDI OLOGY		0. 5149 0. 1007			
	CARDI AC REHABI LI TATI ON		0. 1007			
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4021		-	
	IMPL. DEV. CHARGED TO PATIENTS		0. 8370			
	DRUGS CHARGED TO PATIENTS		0. 1863		-	
	CHEMI CAL DEPENDENCY		0.0000			
	ONCOLOGY		0. 1730		0	
	TI ENT SERVICE COST CENTERS			- I		
	RURAL HEALTH CLINIC		0.0000		0	88.
	RURAL HEALTH CLINIC II		0.0000		0	
	RURAL HEALTH CLINIC III		0.0000		0	
	CLINIC		0. 5801		-	
	CLINIC- ORTHO		9.4050		, s	1
	CLINIC - PEDS, ENT, FP		2.0526		-	
	INTRAVENOUS THERAPY		0. 5554		-	
	PSYCHI ATRY		3.5590		-	
	CARDI OLOGY EMERGENCY		28. 6046 0. 2109		-	
	OBSERVATION BEDS (NON-DISTINCT PART		0.2109			
2.00 09200 00.00	Total (sum of lines 50 through 94 and 96 th	rough (19)	0. 0856	844, 906		
00.00	Less PBP Clinic Laboratory Services-Program			844, 900		200.
02.00	Net charges (line 200 minus line 201)	only charges (The OT)		844, 906		201.

Health Financial Systems CAMERON MEMORIAL COM				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1315	Period: From 10/01/2020	Worksheet D-3	
			To 09/30/2021		
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	10.0(0	1	1 20 00
30. 00 03000 ADULTS & PEDIATRICS			19, 968		30.00
31. 00 03100 I NTENSI VE CARE UNI T			3, 431		31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			13, 154		43.00
50. 00 05000 OPERATING ROOM		0. 2015	58 8, 054	1, 623	50.00
51. 00 05100 RECOVERY ROOM		0. 5476			•
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 8607			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14792			•
60. 00 06000 LABORATORY		0. 2112			•
65. 00 06500 RESPIRATORY THERAPY		0. 5615			•
65. 01 06501 SLEEP LAB		0. 3210			65.01
66. 00 06600 PHYSI CAL THERAPY		0. 5149		0	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1007			
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 4621		0	69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 41962		-	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 8370		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1863		-	
76.00 03020 CHEMI CAL DEPENDENCY		0.0000			76.00
76. 01 03480 ONCOLOGY		0.1730			76.01
OUTPATIENT SERVICE COST CENTERS				. · · · · ·	
88.00 08800 RURAL HEALTH CLINIC		1. 4827	97 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II		1. 2937	92 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III		0. 9786	23 0	0	88.02
90. 00 09000 CLINIC		0. 5801	38 0	0	90.00
90. 01 09001 CLINIC- ORTHO		9. 4050	21 0	0	90.01
90. 02 09002 CLINIC - PEDS, ENT, FP		2.0526	5 0	0	90.02
90. 03 09003 I NTRAVENOUS THERAPY		0. 5554	31 0	0	90.03
90. 04 09004 PSYCHI ATRY		3. 5590	79 0	0	90.04
90. 05 09005 CARDI OLOGY		28.6046	99 0	0	90.05
91. 00 09100 EMERGENCY		0. 2109		1, 506	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 6856			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			145, 327	69, 710	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			145, 327		202.00

	Financial Systems CAMERON MEMORIAL COMMUN			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	rovider CCN: 15-1315	Period: From 10/01/2020 To 09/30/2021	Date/Time Pre	
		Title XVIII	Hospi tal	2/24/2022 4:2 Cost	8 pm
			nospi tui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			11, 992, 850	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2.00
3.00 4.00	OPPS payments Outlier payment (see instructions)			0	3.00 4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	i ons)		0.000	5.00 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			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. IV Organ acquisitions	, col. 13, line 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			11, 992, 850	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13.00
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 pa	yment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for	payment for services		0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17 00
18.00	Total customary charges (see instructions)			0.000000	18.00
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds l	ine 11) (see	0	19.00
20.00	instructions) Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds I	ine 18) (see	0	20. 00
21.00	instructions) Lesser of cost or charges (see instructions)			12, 112, 779	21.00
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23.00 24.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			72, 609	25.00
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) $\rm pl$			6, 502, 861 5, 537, 309	
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	le 50)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			5, 537, 309	
	Primary payer payments Subtotal (line 30 minus line 31)			4, 361 5, 532, 948	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		0,002,710	02100
	Composite rate ESRD (from Wkst. I-5, line 11)			0 E72 E12	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			573, 512 372, 783	
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		417, 325	36.00
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			5, 905, 731 0	37.00 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			_	39.50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	d devices (see instru	ctions)	0	39.97 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			5, 905, 731	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	40. 01 40. 02
40.03	Sequestration adjustment-PARHM pass-throughs			Ū	40.03
	Interim payments			6, 111, 744	
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			Ū	42.01
43.00	Balance due provider/program (see instructions)			-206, 013	
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	43.01 44.00
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.00 92.00
92.00 93.00	Time Value of Money (see instructions)			0.00	
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 10/01/2020 To 09/30/2021		
		Title		Hospi tal	Cost	
		Inpatient	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2, 820, 75	i9	6, 111, 744	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	L I				
3. 01	ADJUSTMENTS TO PROVIDER	07/14/2021	323, 80	00	0	3.01
3. 02				0	0	3.02
3. 03				0	0	3.03
3.04				0	0	3.04
3. 05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53				0	0	3.53
3.54 3.99	Subtatal (sum of lines 2.01.2.40 minus sum of lines			-	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		323, 80	JU	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 144, 55	0	6, 111, 744	4.00
1.00	(transfer to Wkst. E or Wkst. E-3, line and column as		0, 111, 00		0, 111, 711	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	_				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVIDER			0	0	5.01 5.02
5.02 5.03				0	0	5.02
5.05	Provider to Program			U	0	5.03
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	Ő	5.5
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER			0	0	6.0
6.02	SETTLEMENT TO PROGRAM		487, 38		206, 013	6.02
7.00	Total Medicare program liability (see instructions)		2, 657, 17	Contractor	5,905,731 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		0		1.00	2.00	
	Name of Contractor	0		1.00	2.00	8.00

ANALY	n Financial Systems CAMERON MEMORIAL CO SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	DMMUNITY HOSPIT Provider CO Component (Period: From 10/01/2020 To 09/30/2021		epared:
		Title	XVIII	Swing Beds - SN		o piii
		Inpatien			rt 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		1, 567, 8	50 0	000	
	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	07/14/2021	160, 2	00	0	3.01
3. 02				0	0	
3.03				0	0	
3.04				0	0	
3. 05	Provider to Program			0	0	3.05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	
3. 52				0	0	3. 52
3.53				0	0	
3.54				0	0	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		160, 2		0	
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)		1, 728, 0	50	0	4.00
	TO BE COMPLETED BY CONTRACTOR				1	
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
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50 5.51	TENTATI VE TO PROGRAM			0	0	
5.51				0		
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5. 01	SETTLEMENT TO PROVIDER			0	0	
5. 02	SETTLEMENT TO PROGRAM		249, 0		0	
7.00	Total Medicare program liability (see instructions)		1, 479, 0		0	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems CAMERON MEMORIAL CO	MMUNITY HOSPITAL	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1315	Period: From 10/01/2020	Worksheet E- Part II	1	
			To 09/30/2021	Date/Time Pr 2/24/2022 4:		
		Title XVIII	Hospi tal	Cost		
	TO BE COMPLETED BY CONTRACTOR FOR MONETANDARD COST DEPORTS			1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-	
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00			1.00			
2.00						
4.00	Total inpatient days from S-3, Pt. 1 col. 8, sum of lines 1	9 through 12 and 22			3.00	
		, o through 12, and 32.			5.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	Line 20				
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of line 168 $$	certified Hil 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 sequestratio	n (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00	

ALCUL	Financial Systems CAMERON MEMORIAL COMMUNIT ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	vider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet E-2	
		nponent CCN: 15-Z315	From 10/01/2020 To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
. 00	Inpatient routine services - swing bed-SNF (see instructions)		1, 179, 344	0	1.0
. 00	Inpatient routine services - swing bed-NF (see instructions)		.,,	-	2.0
. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-t			0	3.0
. 01	instructions) Nursing and allied health payment-PARHM (see instructions)				3.0
. 00	Per diem cost for interns and residents not in approved teaching	program (see		0.00	4.0
	instructions)				
. 00	Program days		613	0	5.0
. 00	Interns and residents not in approved teaching program (see instr Utilization review - physician compensation - SNF optional method		0	0	6.0 7.0
. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	i oni y	1, 488, 310	0	8.0
. 00	Primary payer payments (see instructions)		1, 400, 510	0	9.0
0.00	Subtotal (line 8 minus line 9)		1, 488, 310	0	10.0
1.00	Deductibles billed to program patients (exclude amounts applicabl	e to physician	0	0	11.0
	professional services)				
2.00	Subtotal (line 10 minus line 11)		1, 488, 310	0	12.0
3.00	Coinsurance billed to program patients (from provider records) (ϵ for physician professional services)	exclude collisurance	9, 275	0	13.0
4.00	80% of Part B costs (line 12 x 80%)			0	14.0
5.00	Subtotal (see instructions)		1, 479, 035	0	15.0
6.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.0
6.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.5
6.55	Rural community hospital demonstration project (§410A Demonstrati	on) payment	0		16.5
(00	adjustment (see instructions)				44.0
6.99 7.00	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	16.9 17.0
7.00	Adjusted reimbursable bad debts (see instructions)		0	0	17.0
8.00	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)	0	0	
9.00	Total (see instructions)	,	1, 479, 035	0	19.0
9.01	Sequestration adjustment (see instructions)		0	0	19.0
9. 02	Demonstration payment adjustment amount after sequestration)		0	0	19.0
9.03	Sequestration adjustment-PARHM pass-throughs				19.0
9.25 0.00	Sequestration for non-claims based amounts (see instructions) Interim payments		0 1, 728, 050	0	19.2 20.0
0.00	Interim payments-PARHM		1, 728, 050	0	20.0
1.00	Tentative settlement (for contractor use only)		0	0	21.0
1.01	Tentative settlement-PARHM (for contractor use only)			-	21.0
2.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 1	9.25, 20, and 21)	-249, 015	0	22.0
2.01	Balance due provider/program-PARHM (see instructions)				22.0
3.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23.0
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstrati	on) Adjustment			
	Is this the first year of the current 5-year demonstration period				200. 0
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
01.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst	. D-1, Pt. II, line			201.0
02 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from Wk	ct D 2 col 2 li	20		202.0
.02.00	200 (title XVIII swing-bed SNF))	St. D-3, COL 3, TH	le		202.0
03.00	Total (sum of lines 201 and 202)				203.0
	Medicare swing-bed SNF discharges (see instructions)				204.0
	Computation of Demonstration Target Amount Limitation (N/A in fir	st year of the curre	ent 5-year demons	tration	
	period)				
	Medicare swing-bed SNF target amount	1100 204)			205.0
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				206. 0
	Program reimbursement under the §410A Demonstration (see instruct				207.0
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, c	-	1		208.0
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	ons)			209. 0
	Reserved for future use				210. 0
	Comparision of PPS versus Cost Reimbursement	alua () == 010) ()			01F 0
15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 instructions)	prus rine 210) (see			215.0

	Financial Systems CAMERON MEMORIA ATION OF REIMBURSEMENT SETTLEMENT	L COMMUNITY HOSPITAL Provider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 10/01/2020 To 09/30/2021	Part V Date/Time Pre	epai
		Title XVIII	Hospi tal	2/24/2022 4:2 Cost	.0
				1.00	
00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR ME Inpatient services	DICARE PART A SERVICES - COS	ST REIMBURSEMENT	2 002 244	1.
00	Nursing and Allied Health Managed Care payment (see ins	tructions)		2, 882, 344 0	
00	Organ acquisition			0	
00	Subtotal (sum of lines 1 through 3)			2, 882, 344	
00	Primary payer payments			23, 961	
00	Total cost (line 4 less line 5). For CAH (see instructi	ons)		2, 887, 206	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				4
00	Routine service charges			0	
00 00	Ancillary service charges Organ acquisition charges, net of revenue			0	
	Total reasonable charges			0	
. 00	Customary charges			0	1'
. 00	Aggregate amount actually collected from patients liabl	e for payment for services or	n a charge basis	0	1 1
	Amounts that would have been realized from patients lia			0	1
	had such payment been made in accordance with 42 CFR 41	3.13(e)	-		
	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)			0	
00	Excess of customary charges over reasonable cost (compl	ete only if line 14 exceeds l	ine 6) (see	0	1
. 00	instructions) Excess of reasonable cost over customary charges (compl	ata anly if line 6 avcords li	no 14) (soo	0	1
. 00	instructions)	ete only if the o exceeds if	110 14) (300	0	1'
. 00	Cost of physicians' services in a teaching hospital (se COMPUTATION OF REIMBURSEMENT SETTLEMENT	ee instructions)		0	1
. 00	Direct graduate medical education payments (from Worksh	neet E-4, line 49)		0	1 1
	Cost of covered services (sum of lines 6, 17 and 18)			2, 887, 206	
. 00	Deductibles (exclude professional component)			248, 100	2
	Excess reasonable cost (from line 16)			0	
	Subtotal (line 19 minus line 20 and 21)			2, 639, 106	
	Coinsurance			1,408	
	Subtotal (line 22 minus line 23)		`	2, 637, 698	
	Allowable bad debts (exclude bad debts for professional Adjusted reimbursable bad debts (see instructions)	services) (see instructions,)	29, 961 19, 475	
	Allowable bad debts for dual eligible beneficiaries (see	e instructions)		19, 475	
	Subtotal (sum of lines 24 and 25, or line 26)			2, 657, 173	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2,007,170	
	Pioneer ACO demonstration payment adjustment (see instr	ructions)		0	
	Recovery of accelerated depreciation.			0	2
	Demonstration payment adjustment amount before sequestr	ation		0	
	Subtotal (see instructions)			2, 657, 173	
	Sequestration adjustment (see instructions)			0	
	Demonstration payment adjustment amount after sequestra	ITI ON		0	
	Sequestration adjustment-PARHM			3, 144, 559	3
. 00	Interim payments Interim payments-PARHM			3, 144, 339	3
. 00				0	
. 01				0	3
	Bal ance due provi der/program (line 30 minus lines 30.01	, 30.02, 31, and 32)		-487, 386	
	Balance due provider/program-PARHM (lines 2, 3, 18, and		1, and 32.01)		3
		accordance with CMS Pub. 15-2,		0	3

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1315	Peri od:	Worksheet E-3	2552
			From 10/01/2020 To 09/30/2021	Part VII Date/Time Pre	par
		Title XIX	Hocni tal	2/24/2022 4:2 PPS	8 p
			Hospi tal	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0	0	
00 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		0	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		0	0	1 '
	Reasonable Charges				
00	Routi ne servi ce charges		36, 553		18
00	Ancillary service charges		145, 327	0	9
. 00	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		181, 880	0	12
~~	CUSTOMARY CHARGES	<u> </u>			
8.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
. 00	basis Amounts that would have been realized from patients liable for	navment for services	on 0	0	14
r. 00	a charge basis had such payment been made in accordance with 4		0	0	'-
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 011 3413. 13(0)	0. 000000	0,000000	15
	Total customary charges (see instructions)		181, 880	0	16
	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	181, 880	0	17
	line 4) (see instructions)	-			
3.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds li	ne 0	0	18
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instr		0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	2
00	Other than outlier payments		126, 306	0	22
	Outlier payments		120, 300	0	23
	Program capital payments		0	0	24
	Capital exception payments (see instructions)		0		2
	Routine and Ancillary service other pass through costs		0	0	20
7.00	Subtotal (sum of lines 22 through 26)		126, 306	0	27
	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)		126, 306	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		-		
	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	126, 306	0	
	Deducti bl es Coi nsurance		0 261	0	32
	Allowable bad debts (see instructions)		201	0	
	Utilization review		0	0	35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	126, 045	0	36
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	~	0	0	3
	Subtotal (line 36 ± line 37)		126, 045	0	38
0. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)		126, 045	0	
	Interim payments		126, 045	0	41
<u>.</u> 00	Balance due provider/program (line 40 minus line 41)		0	0	
	Protested amounts (nonallowable cost report items) in accordar	and with CMC Dub 1E 0	0	0	43

	SHEET (If you are nonproprietary and do not maintain per accounting records, complete the General Fund column	Provider C	CN: 15-1315 P	eriod: rom 10/01/2020	Worksheet G	
nly)	pe accounting records, comprete the General Fund cordinin			o 09/30/2021	Date/Time Pre 2/24/2022 4:2	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
C	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	25, 528, 017	0	0	0	1 1
	Temporary investments	23, 320, 017	0	0	0	2
	Notes receivable	0	0	0	0	3
	Accounts receivable	11, 034, 516	-	0	0	
	Other receivable	889, 990		0	0	
	Allowances for uncollectible notes and accounts receivable	007,770	0	0	0	6
	Inventory	1, 529, 187		0	0	
	Prepai d expenses	890, 001	1	0	0	8
	Other current assets	0	0	0	0	9
	Due from other funds	0	0	0	0	10
	Total current assets (sum of lines 1-10)	39, 871, 711	0	0	0	
-	FIXED ASSETS		-	-		
-	Land	2, 019, 703	0	0	0	1 12
3. 00 1	Land improvements	0	0	0	0	13
	Accumulated depreciation	0	0	0	0	14
	Buildings	59, 461, 729	0	0	0	15
6. OO 🛛	Accumulated depreciation	-28, 215, 380		0	0	16
	Leasehold improvements	0	0	0	0	17
8. OO 🖌	Accumulated depreciation	0	0	0	0	18
9.00 F	Fixed equipment	0	0	0	0	19
D. 00 🛛	Accumulated depreciation	0	0	0	0	20
	Automobiles and trucks	0	0	0	0	21
	Accumulated depreciation	0	0	0	0	22
3.00 1	Major movable equipment	19, 429, 417	0	0	0	23
	Accumulated depreciation	-15, 380, 045	0	0	0	24
5.00 1	Minor equipment depreciable	0	0	0	0	25
5. OO A	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	28
1	Minor equipment-nondepreciable	0	0	0	0	
	Total fixed assets (sum of lines 12-29)	37, 315, 424	0	0	0	
	OTHER ASSETS					
	Investments	30, 433, 600	0	0	0	31
2.00 [Deposits on Leases	0	0	0	0	32
	Due from owners/officers	0	0	0	0	33
4.00 0	Other assets	1, 016, 678	0	0	0	34
5. 00 1	Total other assets (sum of lines 31-34)	31, 450, 278		0	0	35
	Total assets (sum of lines 11, 30, and 35)	108, 637, 413		0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	2, 922, 951	0	0	0	37
3.00	Salaries, wages, and fees payable	6, 461, 032	0	0	0	38
	Payroll taxes payable	0	0	0	0	39
	Notes and loans payable (short term)	8, 315, 942	0	0	0	40
	Deferred income	0	0	0	0	
	Accelerated payments	0				42
	Due to other funds	0	0	0	0	43
	Other current liabilities	951, 567	0	0	0	44
5.00	Total current liabilities (sum of lines 37 thru 44)	18, 651, 492		0	0	45
	LONG TERM LIABILITIES		· · · · · ·			
	Mortgage payable	0	0	0	0	1 46
	Notes payable	0	0	0	0	47
	Unsecured Loans	0	0	0	0	
	Other long term liabilities	40, 957, 959	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	40, 957, 959	1	0	0	
	Total liabilities (sum of lines 45 and 50)	59, 609, 451	1	-	0	
	CAPITAL ACCOUNTS	2., 007, 101				1
	General fund balance	49,027,962				52
	Specific purpose fund	, 02.7, 702	0			53
	Donor created - endowment fund balance - restricted		Ĭ	0		54
1	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant			0	0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	"
	Total fund balances (sum of lines 52 thru 58)	49,027,962	0	0	0	59
	Total liabilities and fund balances (sum of lines 51 and	108, 637, 413		-	0	
				0		

STATE	Financial Systems CAMER IENT OF CHANGES IN FUND BALANCES	RON MEMORIAL CO	Provider CC	CN: 15-1315	Perio From To	od: 10/01/2020 09/30/2021	Date/Time F	Prep	
		General	Fund	Speci al	Purpo	se Fund	2/24/2022 Endowment Fund		3 pm
		1.00	2.00	3.00		4.00	5.00	-	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 00 35, 298, 814 13, 729, 148 49, 027, 962 0 49, 027, 962 0	5.00		0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment Fund	49, 027, 962 Pl ant	Fund		0	0		19.00
		6.00	7.00	8,00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0	0.00	0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0	0 0 0 0 0 0 0		000				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

AIEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CO	CN: 15-1315	Period: From 10/0 To 09/3	1/2020 0/2021	Worksheet G-2 Parts I & II Date/Time Pre 2/24/2022 4:2	pared
	Cost Center Description		I npati ent	Outpat	ient	Total	
			1.00	2.0	0	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
00	Hospi tal		8, 345, 4	53		8, 345, 453	
00	SUBPROVIDER - IPF						2.0
00	SUBPROVIDER - IRF						3.0
00	SUBPROVIDER						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					0 0 15 150	9.0
00	Total general inpatient care services (sum of lines 1-9)		8, 345, 4	53		8, 345, 453	10.0
00	Intensive Care Type Inpatient Hospital Services		274 5	20		274 500	1 1 1 0
	INTENSIVE CARE UNIT		374, 5	50		374, 500	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						12.0 13.0
	SURGICAL INTENSIVE CARE UNIT						14.0
	OTHER SPECIAL CARE (SPECIFY)						14.0
00	Total intensive care type inpatient hospital services (sum o	flipos	374, 5	20		374, 500	
00	11-15)	1 THES	374, 5	50		374, 500	10.0
00	Total inpatient routine care services (sum of lines 10 and 1	6)	8, 719, 9	53		8, 719, 953	17.0
00	Ancillary services	0)	18, 787, 9		71, 947	149, 059, 907	
	Outpati ent servi ces		703, 8		47, 888	32, 951, 745	
	RURAL HEALTH CLINIC		12, 7	-	15, 270		
	RURAL HEALTH CLINIC II		, .		30, 770	2, 530, 770	
	RURAL HEALTH CLINIC III		630, 6		43,001	1, 773, 688	
	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
	HOME HEALTH AGENCY				0	0	
00	AMBULANCE SERVICES						23.0
	CMHC						24.0
00	AMBULATORY SURGICAL CENTER (D. P.)						25.0
00	HOSPICE			0	0	0	26.0
00	NON REIMBURSABLE		13, 1	40 2,4	16, 787	2, 429, 927	27.0
01	PROFESSIONAL FEES		176, 6	50 3, 4	02, 564	3, 579, 214	27.0
00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	29, 045, 0	15 173, 7	28, 227	202, 773, 242	28.0
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
	Operating expenses (per Wkst. A, column 3, line 200)				19, 129		29.0
00	ADD (SPECIFY)			0			30.
00				0			31.
00				0			32.
00				0			33.
00				0			34.
00				0	~		35.
00	Total additions (sum of lines 30-35)			0	0		36. 37.
00 00	DEDUCT (SPECIFY)			0			37.
00				0			38. 39.
				0			
00				0			40.
00	Total deductions (sum of lines 27 41)			U	_		41.
	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line	(12)(+romofered)		01 /	10 100		42.
00	to Wkst. G-3, line 4)	42) (transfer		81,6	19, 129		43.

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1315	Peri od:	Worksheet G-3	
			From 10/01/2020		
			To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
			-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		202, 773, 242	1.00
2.00	Less contractual allowances and discounts on patients' accour			118, 014, 739	2.00
3.00	Net patient revenues (line 1 minus line 2)			84, 758, 503	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		81, 619, 129	
5.00	Net income from service to patients (line 3 minus line 4)	10)		3, 139, 374	5.00
0.00	OTHER INCOME			011071071	0.00
6.00	Contributions, donations, bequests, etc			279, 311	6.00
7.00	Income from investments			4, 748, 167	7.00
B. 00	Revenues from telephone and other miscellaneous communication	n servi ces		0	•
9.00	Revenue from television and radio service			0	
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			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.0
17.00	Revenue from sale of drugs to other than patients			0	17.0
18.00	Revenue from sale of medical records and abstracts			0	18.0
19.00				0	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.0
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
	Governmental appropriations			0	23.00
	OTHER OPERATING INCOME			1, 273, 961	24.00
24.01	CONTRI BUTI ONS			0	24.0
	GAIN/LOSS ON DISPOSAL OF PROPERTY			-6, 046	
	COVI D-19 PHE Fundi ng			4, 294, 381	
25.00				10, 589, 774	
26.00	Total (line 5 plus line 25)			13, 729, 148	
	OTHER EXPENSES (SPECIFY)			0	27.0
28.00	Total other expenses (sum of line 27 and subscripts)			0	
29.00	Net income (or loss) for the period (line 26 minus line 28)			13, 729, 148	29.0

		RON MEMORIAL CO			In Lie	U OT FORM CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315	Peri od:	Worksheet M-1	
			Component	CCN: 15-8530	From 10/01/2020 To 09/30/2021	Date/Time Pre	norod.
			component	CCN: 15-8530	10 09/30/2021	2/24/2022 4:2	
					RHC I	Cost	o piii
		Compensati on	Other Costs	Total (col	1 Reclassi fi cat		
		compensation	other costs	+ col. 2)	ions	Tri al Balance	
				+ COI. 2)	10113	(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physician	416, 521	2, 353	418, 87	4 0	418, 874	1.00
2.00	Physician Assistant	410, 521	2, 353	410, 07	0 0	410, 0/4	2.00
		222 550	0	222 55	0	-	
3.00	Nurse Practitioner	233, 559	0	233, 55	9 0	233, 559	3.00
4.00	Visiting Nurse	015 110	0	045 44	0 0	0	4.00
5.00	Other Nurse	315, 143	0	315, 14	3 0	315, 143	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	17, 998	0	17, 99	8 0	17, 998	
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	42, 188	0				
10.00	Subtotal (sum of lines 1 through 9)	1,025,409	2, 353	1, 027, 76	2 0	1, 027, 762	
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	8, 257	8, 25	7 0	8, 257	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	8, 257	8, 25	7 0	8, 257	21.00
22.00	Total Cost of Health Care Services (sum of	1,025,409	10, 610	1, 036, 01	9 0	1, 036, 019	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	28.00
	through 27)						
	FACILITY OVERHEAD						1
29.00	Facility Costs	0	209	20	9 0	209	29.00
30.00	Administrative Costs	87, 997	33, 664	121, 66	1 0	121, 661	30.00
31.00	Total Facility Overhead (sum of lines 29 and		33, 873			121, 870	
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 113, 406	44, 483	1, 157, 88	9 0	1, 157, 889	32.00
	and 31)						
	[and 31]						I

Heal th	Financial Systems CAMER	RON MEMORIAL CO	DMMUNITY HOSPI	AL	In Lieu	i of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315	Peri od:	Worksheet M-1	1
			Component	CCN: 15-8530	From 10/01/2020 To 09/30/2021	Date/Time Pre	-nared
			oomponente	. 10 0000	10 07/00/2021	2/24/2022 4:2	
					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS		110.074				1
1.00	Physi ci an	0	418, 874				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	233, 559				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	315, 143				5.00
6.00	Clinical Psychologist	0	17 000				6.00
7.00 8.00	Clinical Social Worker	0	17, 998				7.0
8.00 9.00	Laboratory Technician	0	40 100				9.0
9.00 10.00	Other Facility Health Care Staff Costs	0	42, 188 1, 027, 762				
10.00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	0	1,027,762				10.0
12.00	Physician Supervision Under Agreement	0	0				12.0
12.00	5	0	0				13.0
14.00	Other Costs Under Agreement	0	0				14.0
14.00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	8, 257				14.0
16.00	Transportation (Health Care Staff)	0					16.0
17.00	Depreciation-Medical Equipment	0	0				17.0
18.00	Professional Liability Insurance	0	0				18.0
19.00	Other Health Care Costs	0					19.0
	Allowable GME Costs	0	0				20.0
20.00	Subtotal (sum of lines 15 through 20)	0	8, 257				21.0
22.00	Total Cost of Health Care Services (sum of	0	1, 036, 019				22.0
22.00	lines 10, 14, and 21)	0	1,000,017				22.0
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23.0
24.00	Dental	0	0				24.0
25.00	Optometry	0	0				25.0
25. 01	Tel eheal th	0	0				25.0
25. 02	Chronic Care Management	0	0				25.0
26.00	All other nonreimbursable costs	0	0				26.0
27.00	Nonallowable GME costs						27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.0
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	209				29.0
30.00	Administrative Costs	0	121, 661				30.0
31.00	Total Facility Overhead (sum of lines 29 and	0	121, 870				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1, 157, 889				32.00

Hearth	FI nanci ai Systems Camei	RON MEMORIAL CO	JMMUNITY 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 10/01/2020 To 09/30/2021	Date/Time Pre	narod
			component	CCN. 13-6345	10 09/30/2021	2/24/2022 4:2	
					RHC II	Cost	
		Compensation	Other Costs	Total (col	1 Recl assi fi cat		
		oomponou er on	00000	+ col . 2)	ions	Tri al Balance	
					1 0110	(col. 3 +	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS		2.00	0.00		0,00	
1.00	Physi ci an	511, 113	60, 903	572, 0	16 0	572, 016	1.00
2.00	Physician Assistant	138, 922	00, 700				2.00
3.00	Nurse Practitioner	273, 651	0	273, 6			3.00
4.00	Visiting Nurse	273,031	0	275,0	0 0		4.00
4.00 5.00	Other Nurse	228, 768	0	228, 7	-	228, 768	
6.00	Clinical Psychologist	220, 700	0	220, 7	0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0		7.00
7.00 8.00	Laboratory Technician	0	0		0 0	0	8.00
8.00 9.00	Other Facility Health Care Staff Costs	178, 959	0	178, 9			9.00
			-				
10.00	Subtotal (sum of lines 1 through 9)	1, 331, 413	60, 903	1, 392, 3	0	1, 392, 316	
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	83, 696	83, 6	96 0		
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	83, 696			83, 696	
22.00	Total Cost of Health Care Services (sum of	1, 331, 413	144, 599	1, 476, 0	12 0	1, 476, 012	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0		23.00
24.00	Dental	0	0		0 0		24.00
25.00	Optometry	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	28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	962	9	62 0	962	29.00
30.00	Administrative Costs	238, 938	13, 076	252, 0	14 0	252, 014	30.00
31.00	Total Facility Overhead (sum of lines 29 and	238, 938	14, 038	252, 9	76 0	252, 976	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 570, 351	158, 637	1, 728, 9	88 0	1, 728, 988	32.00
	and 31)						
	-						-

MALVC	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C				-2552- 1
ANALYS	IS OF HUSPITAL-BASED RHC/FUHC CUSTS		Provi der C	JN: 15-1315	Period: From 10/01/2020	Worksheet M-	I
			Component	CCN: 15-8545	To 09/30/2021	Date/Time Pro	
					RHC II	2/24/2022 4:: Cost	28 pm
		Adjustments	Net Expenses			0031	
		naj ao imorrio	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
. 00	Physi ci an	0	572,016				1 1.
. 00	Physician Assistant	0					2.
3.00	Nurse Practitioner	0	273, 651				3.
1.00	Visiting Nurse	0	0				4.
5.00	Other Nurse	0	228, 768				5.
. 00	Clinical Psychologist	0	0				6.
. 00	Clinical Social Worker	0	0				7.
8.00	Laboratory Techni ci an	0	0				8.
. 00	Other Facility Health Care Staff Costs	0	178, 959				9.
0.00	Subtotal (sum of lines 1 through 9)	0					10.
1.00	Physician Services Under Agreement	0	0				111.
2.00	Physician Supervision Under Agreement	0	0				12.
3.00	Other Costs Under Agreement	0	0				13.
4.00	Subtotal (sum of lines 11 through 13)	0	-				14.
5.00	Medical Supplies	0	-				15.
6.00	Transportation (Health Care Staff)	0	03,070				16.
7.00	Depreciation-Medical Equipment	0	0				17.
	Professional Liability Insurance	0	0				18.
9.00	Other Heal th Care Costs	0	0				19.
20.00	Allowable GME Costs	0					20.
1.00	Subtotal (sum of lines 15 through 20)	0	83, 696				21.
2.00	Total Cost of Health Care Services (sum of	0					22.
2.00	lines 10, 14, and 21)	0	1, 470, 012				22.
	COSTS OTHER THAN RHC/FQHC SERVICES						
3.00	Pharmacy	0	0				23.
4.00	Dental	0	-				24.
5.00	Optometry	0	0				25.
5. 01	Tel eheal th	0	0				25.
25.02	Chronic Care Management	0	0				25.
26.00	All other nonreimbursable costs	0	0				26.
7.00	Nonallowable GME costs	0	0				27.
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.
0.00	through 27)	0					20.
	FACILITY OVERHEAD						
9.00	Facility Costs	0	962				29.
0.00	Administrative Costs	0					30.
1.00	Total Facility Overhead (sum of lines 29 and	0					31.
	30)	0					"
32.00	Total facility costs (sum of lines 22, 28	0	1, 728, 988				32.
		0	.,,,,00				1 0

	5	TON WEWORTAL CO	JIVIIVIUNI II IIUJEI				
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Period: From 10/01/2020	Worksheet M-1	
			Component		To 09/30/2021		
					RHC III	Cost	
		Compensati on	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		050			(17.000	1
1.00	Physi ci an	666, 987	952	667, 93			1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	156, 654	0	156, 65	4 0	156, 654	3.00
4.00	Visiting Nurse	07.0(1	0	07.0/	0 0	0	4.00
5.00	Other Nurse	87, 361	0	87, 36	0	87, 361	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	102,020	0	102.02	0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	103, 829					9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 014, 831	952	1, 015, 78	3 0	1,010,700	
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00 13.00	Physician Supervision Under Agreement Other Costs Under Agreement	0	0		0 0		12.00
13.00	5	0	0		0 0		13.00
14.00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	6, 533	6, 53		6, 533	
16.00	Transportation (Health Care Staff)	0	0, 555	0, 53	0 0	0,555	16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0			0 0		17.00
19.00	Other Health Care Costs	0					19.00
20.00	Allowable GME Costs	0	0		0 0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	6, 533	6, 53	3 0	6, 533	
22.00	Total Cost of Health Care Services (sum of	1,014,831	7, 485				
22.00	lines 10, 14, and 21)	1,014,001	7,400	1,022,31	0	1, 022, 310	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
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	28.00
	through 27)						
	FACILITY OVERHEAD					-	
29.00	Facility Costs	0	_, •		0 0	2, 720	29.00
30.00	Administrative Costs	72, 521	108, 992				
31.00	Total Facility Overhead (sum of lines 29 and	72, 521	111, 712	184, 23	3 0	184, 233	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1,087,352	119, 197	1, 206, 54	.9 0	1, 206, 549	32.00
	and 31)					I	

		CON MEMORIAL CO	DMMUNITY HOSPI			J OF FORM CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1315	Period: From 10/01/2020	Worksheet M-1	1
			Component (CCN: 15-8546	To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
					RHC III	Cost	- 1
		Adjustments	Net Expenses				
		-	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						1
. 00	Physi ci an	-347, 902	320, 037				1.(
. 00	Physician Assistant	0	0				2.0
. 00	Nurse Practitioner	-81, 710	74, 944				3.
. 00	Visiting Nurse	0	0				4.0
. 00	Other Nurse	0	87, 361				5.
. 00	Clinical Psychologist	0	0				6.
. 00	Clinical Social Worker	0	0				7.
. 00 . 00	Laboratory Technician Other Facility Health Care Staff Costs	0	103, 829				8. 9.
0.00	Subtotal (sum of lines 1 through 9)	-429, 612	586, 171				10.
1.00	Physician Services Under Agreement	-429,012	0				11.
2.00	Physician Supervision Under Agreement	0	0				12.
2.00	Other Costs Under Agreement	0	0				12.
4.00	Subtotal (sum of lines 11 through 13)	0	0				14.
4.00 5.00	Medical Supplies	0	6, 533				14.
6.00	Transportation (Health Care Staff)	0	0, 555				16.
7.00	Depreciation-Medical Equipment	0	0				17.
	Professional Liability Insurance	0	0				18.
9.00	Other Heal th Care Costs	0	0				19.
	Allowable GME Costs	0	0				20.
	Subtotal (sum of lines 15 through 20)	0	6, 533				21.
2.00	Total Cost of Health Care Services (sum of	-429, 612	592, 704				22.
2.00	lines 10, 14, and 21)	127,012	0,2,,01				
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
3.00	Pharmacy	0	0				23.
4.00	Dental	0	0				24.
5.00	Optometry	0	0				25.
5.01	Tel eheal th	0	0				25.
5.02	Chronic Care Management	0	0				25.
6.00	All other nonreimbursable costs	0	0				26.
7.00	Nonallowable GME costs						27.
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	2, 720				29.
0.00	Administrative Costs	0	181, 513				30.
31.00	Total Facility Overhead (sum of lines 29 and	0	184, 233				31.
	30)						
32.00	Total facility costs (sum of lines 22, 28	-429, 612	776, 937				32.
	and 31)						

	Financial Systems CAME ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC	ERON MEMORIAL CO			Period:	u of Form CMS-2 Worksheet M-2			
ALLUCA	ATTON OF OVERHEAD TO HOSPITAL-DASED RHC/FUHC	SERVICES	Provider C		From 10/01/2020		-		
			Component		o 09/30/2021				
		_	_	_	RHC I	Cost			
		Number of FTE	Total Visits		Mi ni mum	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	0.68	3, 646	4, 200	2, 856		1.0		
. 00	Physician Assistant	0.00	0	2, 100	0 0		2.0		
. 00	Nurse Practitioner	1.56	5, 318	2, 100	3, 276		3.0		
. 00	Subtotal (sum of lines 1 through 3)	2.24	8, 964	-	6, 132	8, 964	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. 28	90			90	7.0		
. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.0		
. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7.0		
	onl y)								
8.00	Total FTEs and Visits (sum of lines 4	2.52	9, 054	-		9, 054	8.0		
	through 7)								
9.00	Physician Services Under Agreements		0)		0	9.0		
	DETERMINATION OF ALLOWABLE COST APPLICABLE					1.00			
0.00	Total costs of health care services (from W			RVICES		1, 036, 019	1 10 0		
1.00	Total nonreimbursable costs (from Wkst. M-1						11.0		
2.00						-			
2.00	Cost of all services (excluding overhead) (9		1, 036, 019						
	Ratio of hospital -based RHC/FQHC services (1.000000 121,870						
4.00 5.00		Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) Parent provider overhead allocated to facility (see instructions)							
		ity (see instru	ctions)			1, 404, 441			
	Total overhead (sum of lines 14 and 15)					1, 526, 311			
						0	1		
	Enter the amount from line 16		ing 12 v ling	10)		1, 526, 311			
	Overhead applicable to hospital-based RHC/F					1, 526, 311			

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 2,562,330
 20.00

	Financial Systems CAM	ERON MEMORIAL C	Provi der C		Period:	u of Form CMS-2 Worksheet M-2	
	TION OF OVERTIEND TO HOST THE BASED RECTORE	JERVICED			From 10/01/2020		
			Component		Го 09/30/2021		
			_		RHC II	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	1		-	-	
1.00	Physi ci an	1.45					1.00
2.00	Physician Assistant	0. 81					2.0
3.00	Nurse Practitioner	1.84					3.0
1.00	Subtotal (sum of lines 1 through 3)	4. 10			11, 655	14, 236	4.0
5.00	Visiting Nurse	0.00	0			0	5.0
. 00	Clinical Psychologist	0.00				0	6.0
7.00	Clinical Social Worker	0.00	0			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	4. 10	14, 236			14, 236	8.0
	through 7)						
9.00	Physician Services Under Agreements		388			388	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL - BAS	ED RHC/EOHC SE	RVICES		1.00	
0.00	Total costs of health care services (from W					1, 476, 012	100
1.00							11.0
2.00	Cost of all services (excluding overhead) (,			1, 476, 012	
3.00	Ratio of hospital-based RHC/FQHC services (1.000000				
4.00	Total hospital-based RHC/FQHC overhead - (f		252, 976				
5.00	Parent provider overhead allocated to facil	1, 545, 303					
6.00			51.51.5/			1, 798, 279	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					1, 798, 279	-
	Overhead applicable to hospital-based RHC/F	OHC services ()	ine 13 x line	18)		1, 798, 279	
						1, 1, 5, 217	

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 3, 274, 291
 20.00

Component CCN: 15-8546 From 10/01/2020 To 09/30/2021 Date/Time Prepared 2/24/2022 4:28 pm Number of FTE Personnel Total Visits Productivity Minimum Visits (col. 1 x col. 3) Greater of col. 2 or col. 4 VISITS AND PRODUCTIVITY Positions Number of FTE Personnel Total Visits Productivity Minimum Visits (col. 1 x col. 3) Greater of col. 2 or col. 4 00 Physician 0.54 1,929 4,200 2.268 1.0 00 Physician 0.54 1,929 4,200 2.268 1.0 00 Physician 0.45 1,913 2,100 945 3.0 00 Visiting Nurse 0.00 0 3.213 3.842 3.213 3.842 4.0 00 Clinical Social Worker 0.00 0 0 0 7.0 00 Diabetes Self Management Training (FQHC 0.00 0 0 7.0 0.00 Total Orstal FTEs and Visits (sum of lines 4 0.99 3.842 3.842 8.0 0.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, li			ERON MEMORIAL CO			Period:	u of Form CMS-2 Worksheet M-2	
Component CCN: 15-8546 To 09/30/2021 Date/Time Prepared 2/24/2022 4: 28 pm Number of FTE Personnel Total Visits Productivity Minimum Visits (col. 2 or col. 4 Greater of col. 2 or col. 4 Greater of col. 2 or col. 4 1.00 2.00 3.00 4.00 5.00 - Positions	ALLUCA	ATTON OF OVERHEAD TO HOSPITAL-BASED RHC/FUHC	SERVICES	Provi der C				
Number of FTE Personnel Total Visits Productivity Standard (1) Minimum Visits (col. 1 x col. 3) Greater of col. 4 VISITS AND PRODUCTIVITY 1 x col. 3) 1 x col. 3) col. 4 - Positions 1 x col. 3) 3.00 4.00 5.00 - Physician Assistant 0.00 0 2.100 2.68 1.00 00 Physician Assistant 0.00 0 2.100 945 3.00 00 Nurse Practitioner 0.45 1,913 2,100 945 3.0 00 Clinical Social Worker 0.00 0 0 0.54 0.00 0 0.5 00 Clinical Social Worker 0.00 0 0 0.7.0 0 0 0.0 0 0.7.0 0.01 Diabetes Self Management Training (FOHC only) 0.00 0 0 0 7.0 0 9.0 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.9 0.0 0				Component			Date/Time Pre	
Personnel Standard (1) Visits (col. 1 x col.3) col.2 or col.4 1.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY			_			RHC III	Cost	
Image: Note of the second se			Number of FTE	Total Visits	Producti vi ty	Minimum	Greater of	
I.00 2.00 3.00 4.00 5.00 VISITS AND PRODUCTIVITY Positions 1.00 2.00 3.00 4.00 5.00 Physician 0.54 1.929 4.200 2.268 1.0 000 Physician Assistant 0.00 0 2.100 0 2.00 001 Wirse Practitioner 0.45 1.913 2.100 945 3.213 3.842 4.00 5.00 001 Subtotal (sum of lines 1 through 3) 0.99 3.842 3.213 3.842 4.00 5.00 001 Clinical Social Worker 0.00 0 0 0 6.00 011 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7.00 020 Diabetes Self Management Training (FOHC only) 0.00 0 0 7.00 030 Total FTEs and Visits (sum of lines 4 0.99 3.842 3.842 8.00 040 Total costs of heal th care services (from Wkst. M-1, col. 7, line 22) 1.00 92.00			Personnel		Standard (1)	Visits (col.	col. 2 or	
VISITS AND PRODUCTIVITY Positions Positions 0 00 Physician Assistant 0.00 0 2,100 0 00 Nurse Practitioner 0.45 1,912 2,100 0 00 Nurse Practitioner 0.45 1,913 2,100 945 3,842 4,00 00 Nurse Practitioner 0.45 1,913 2,100 945 3,842 4,00 00 Visiting Nurse 0.00 0 0 5,00 0 5,00 5,00 0,00 0 5,00 7,00 5,00 5,00 7,00 5,00 7,00 7,00 7,00 7,00 7,00 7,00 7,00 7,00 7,00 7,00 1,00								
Positions			1.00	2.00	3.00	4.00	5.00	
.00 Physician 0.54 1,929 4,200 2,268 1.0 .00 Physician Assistant 0.00 0 2,100 0 2.00 0 2.00 0 2.00 0 2.00 0 2.000 0 2.00 0.00 0 2.00 945 3.01 3.842 3.213 3.842 4.00 2.00 945 3.01 0.00 0<								
00 Physician Assistant 0.00 0 2,100 0 2.00 00 Nurse Practitioner 0.45 1,913 2,100 945 3.0 00 Subtotal (sum of lines 1 through 3) 0.99 3,842 3,213 3,842 4.0 0.00 Clinical Psychologist 0.00 0 0 6.00 0 0 6.00 0 0 0 6.00 0			-	-	-	-	-	
Nurse Practitioner 0.45 1,913 2,100 945 3,213 3,842 4,00 00 Subtotal (sum of lines 1 through 3) 0.99 3,842 3,213 3,842 4,00 00 Visiting Nurse 0.00 0 0 5,00 0,00 0 0 5,00 00 Clinical Psychologist 0.00 0 0 5,00 0,00 0 0 5,00 0,00 0 0 5,00 0,00 0 0,00 0 0,00 0 0,00 0 0,7,00 0,00 0 0,7,00 0,7,00 0,00 0 0,7,00 0,00 <t< td=""><td>I. 00</td><td></td><td></td><td></td><td></td><td></td><td></td><td>1.00</td></t<>	I. 00							1.00
00 Subtotal (sum of lines 1 through 3) 0.99 3,842 3,213 3,213 3,842 4.0 00 Visiting Nurse 0.00 0 0 0 0 5.0 000 Clinical Psychologist 0.00 0 0 0 6.0 001 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7.0 011 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7.0 010 Diabetes Self Management Training (FOHC 0.00 0 0 7.0 0.00 Total FTEs and Visits (sum of lines 4 0.99 3,842 3,842 3,842 8.0 0.00 Physician Services Under Agreements 0 0 0 9.0 9.0 0.00 Physician Services (Inder Agreements 0 0 9.0 9.0 9.0 9.0 9.0 0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1.00 0 10.0 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 10.00000 10.0 10.00000	2.00							2.00
00 Visiting Nurse 0.00 0 0 5.00 00 Clinical Psychologist 0.00 0 0 6.00 00 Clinical Social Worker 0.00 0 0 6.00 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7.0 02 Diabetes Self Management Training (FOHC 0.00 0 0 7.0 0.00 Total FTEs and Visits (sum of lines 4 0.99 3,842 3,842 3,842 0.00 Physician Services Under Agreements 0 0 9.0 9.0 0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 0 9.0 11.00 0.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 11.00 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 592,704 10.0 11.00 3.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.0000000 13.00 4.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 184,233 14.00 5.00	3.00							3.00
0.00 Clinical Psychologist 0.00 0	4.00					3, 213	3, 842	4.0
C00 Clinical Social Worker 0.00 0 0 7.0 .01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7.0 .02 Diabetes Self Management Training (FOHC only) 0.00 0 0 7.0 .02 Diabetes Self Management Training (FOHC only) 0.00 0 0 7.0 .00 Total FTEs and Visits (sum of lines 4 0.99 3,842 3,842 3,842 3,842 0.00 Physician Services Under Agreements 0<	5.00						0	5.0
Netical Nutrition Therapist (FOHC only)0.0000007.00Diabetes Self Management Training (FOHC only)0.0000007.00StoreTotal FTEs and Visits (sum of lines 4 through 7)0.993,8423,8423,8428.0Store0Physician Services Under Agreements009.009.00Detremination00009.00Detremination00009.00Detremination00009.00Detremination00009.00Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination00000Detremination0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td>6.0</td></t<>							0	6.0
1.02 Diabetes Self Management Training (FOHC 0.00 0 0 0 7.0 0.1 y) Total FTEs and Visits (sum of lines 4 0.99 3,842 3,842 3,842 8.0 1.00 Physician Services Under Agreements 0 0 0 0 9.00 2.00 Physician Services Under Agreements 0 0 0 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 0 0 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 28) 0 11.00 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 592,704 12.00 3.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 4.00 Total nospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 184,233 14.00 5.00 Parent provider overhead allocated to facility (see instructions) 958,834 15.00 6.00 Total overhead (sum of lines 14 and 15)							0	7.0
onl y) Total FTEs and Visits (sum of lines 4 through 7)0.993,8423,8423,8428.00Physician Services Under Agreements009.00DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES09.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)592,70410.01.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)011.02.00Cost of all services (excluding overhead) (sum of lines 10 and 11)592,70412.03.00Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12)1.00000013.04.00Total nonprimbursable coverhead - (from Worksheet. M-1, col. 7, line 31)184,23314.05.00Parent provider overhead allocated to facility (see instructions)958,83415.001,143,0676.00Total overhead (sum of lines 14 and 15)1,143,06718.07.00Allowable GME overhead (see instructions)017.08.00Enter the amount from line 161,143,06718.0	7.01	1 37					0	7.0
t. 00Total FTEs and Visits (sum of lines 4 through 7) Physician Services Under Agreements0.993,842 3,8423,8423,8428.0009.009.0009.009.00009.0009.00009.00009.0009.0009.0009.0009.0009.0009.0009.0009.0009.0009.0009.0009.0001.000010.00010.0010.010.01.00010.0010.010.01.0001.000010.01.0001.0001.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01.0010.01	. 02		0.00	0			0	7.0
through 7) Physician Services Under Agreements009.00DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES1.000Total costs of health care services (from Wkst. M-1, col. 7, line 22)592,70410.01.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)011.002.00Cost of all services (excluding overhead) (sum of lines 10 and 11)592,70412.003.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.00000013.004.00Total nonprimeter provider overhead allocated to facility (see instructions)958,83415.006.00Total overhead (sum of lines 14 and 15)1,143,06716.007.00Allowable GME overhead (see instructions)017.008.00Enter the amount from line 161,143,06718.00								
Description Physician Services Under Agreements 0 0 9.00 Detremination Detremination 0 0 9.00 Detremination Detremination 0 0 9.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 0 10.00 11.00 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 592,704 12.00 3.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 4.00 Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 184,233 14.00 5.00 Parent provider overhead allocated to facility (see instructions) 958,834 15.00 6.00 Total overhead (sum of lines 14 and 15) 1,143,067 16.00 7.00 Allowable GME overhead (see instructions) 0 17.00 8.00 Enter the amount from line 16 1,143,067 18.00	3.00		0.99	3, 842			3, 842	8.0
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 592,704 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 592,704 3.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.00000 4.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 184,233 5.00 Parent provider overhead allocated to facility (see instructions) 1,143,067 6.00 Total overhead (sum of lines 14 and 15) 1,143,067 7.00 Allowable GME overhead (see instructions) 0 8.00 Enter the amount from line 16 1,143,067								
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES0.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)592,7041.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)02.00Cost of all services (excluding overhead) (sum of lines 10 and 11)592,7043.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.0000004.00Total nonreimbursable coverhead - (from Worksheet. M-1, col. 7, line 31)184,2335.00Parent provider overhead allocated to facility (see instructions)958,8346.00Total overhead (sum of lines 14 and 15)1,143,0677.00Allowable GME overhead (see instructions)08.00Enter the amount from line 161,143,067	9.00	Physician Services Under Agreements		0			0	9.0
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES0.00Total costs of health care services (from Wkst. M-1, col. 7, line 22)592,7041.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)02.00Cost of all services (excluding overhead) (sum of lines 10 and 11)592,7043.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.0000004.00Total nonreimbursable coverhead - (from Worksheet. M-1, col. 7, line 31)184,2335.00Parent provider overhead allocated to facility (see instructions)958,8346.00Total overhead (sum of lines 14 and 15)1,143,0677.00Allowable GME overhead (see instructions)08.00Enter the amount from line 161,143,067							1.00	
0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 592,704 10.0 1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.0 2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 592,704 12.0 3.00 Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.0 4.00 Total noverhead allocated to facility (see instructions) 958,834 15.00 6.00 Total overhead (sum of lines 14 and 15) 1,143,067 16.0 7.00 Allowable GME overhead (see instructions) 0 17.0 8.00 Enter the amount from line 16 1,143,067 18.0		DETERMINATION OF ALLOWARLE COST ADDITION					1.00	
1.00Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)011.02.00Cost of all services (excluding overhead) (sum of lines 10 and 11)592, 70412.03.00Ratio of hospital -based RHC/FOHC services (line 10 divided by line 12)1.00000013.04.00Total hospital -based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)184, 23314.05.00Parent provider overhead allocated to facility (see instructions)958, 83415.006.00Total overhead (sum of lines 14 and 15)1,143, 06716.007.00Allowable GME overhead (see instructions)017.008.00Enter the amount from line 161,143, 06718.00	0 00		<u> </u>		RVICES		E02 704	10.0
2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 592,704 12.0 3.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.0 4.00 Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 184,233 14.0 5.00 Parent provider overhead allocated to facility (see instructions) 958,834 15.00 6.00 Total overhead (sum of lines 14 and 15) 1,143,067 16.00 7.00 Allowable GME overhead (see instructions) 0 17.00 8.00 Enter the amount from line 16 1,143,067 18.00								
3.00Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12)1.00000013.04.00Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)184,23314.05.00Parent provider overhead allocated to facility (see instructions)958,83415.06.00Total overhead (sum of lines 14 and 15)1,143,06716.07.00Allowable GME overhead (see instructions)017.08.00Enter the amount from line 161,143,06718.0								
4.00Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31)184,23314.05.00Parent provider overhead allocated to facility (see instructions)958,83415.06.00Total overhead (sum of lines 14 and 15)1,143,06716.07.00Allowable GME overhead (see instructions)017.08.00Enter the amount from line 161,143,06718.0								
5.00Parent provider overhead allocated to facility (see instructions)958,83415.06.00Total overhead (sum of lines 14 and 15)1,143,06716.07.00Allowable GME overhead (see instructions)017.08.00Enter the amount from line 161,143,06718.0								
6.00 Total overhead (sum of lines 14 and 15) 1,143,067 16.0 7.00 Allowable GME overhead (see instructions) 0 17.0 8.00 Enter the amount from line 16 1,143,067 18.0								
7.00 Allowable GME overhead (see instructions) 0 17.0 8.00 Enter the amount from line 16 1,143,067 18.0			ty (see institu					
8.00 Enter the amount from line 16 1,143,067 18.0								
							-	
	18.00		NHC somulass (1	ino 12 v lino	10)			

 19.00
 Overhead applicable to hospital-based RHC/FQHC services (sum of lines 10 and 19)
 1, 143, 007 17.00

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 1, 735, 771

	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider C		Period:	Worksheet M-3	
ERVI C	ES	Component		From 10/01/2020 To 09/30/2021	Date/Time Pre	
		Title	XVIII	RHC I	2/24/2022 4:2 Cost	8 pili
		intro			0031	
					1.00	
00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES		11.20		2 5 (2 2 2 2 2	1 1 0
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro Cost of injections/infusions and their administration (from W				2, 562, 330 30, 742	
. 00	Total allowable cost excluding injections/infusions (line 1 m				2, 531, 588	
. 00	Total Visits (from Wkst. M-2, column 5, line 8)		/		9, 054	
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)			0	5.0
. 00	Total adjusted visits (line 4 plus line 5)				9, 054	
. 00	Adjusted cost per visit (line 3 divided by line 6)		0-1		279.61	7.0
			L Card	culation of Limi	τ (Ι)	
			Prior to Jan	On or After	On or After	
			1 (Rate	Jan. 1 (Rate	Apr. 1 (Rate	
			Period 1)	Period 2)	Period 3)	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your	1.00 0.0	2.00 0 0.00	3.00	8.0
. 00	contractor)	. o or your	0.0	0.00	207.03	0.0
. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		279.6			1
0.00	Program covered visits excluding mental health services (from records)	contractor	31	7 282	720	10.0
1.00	Program cost excluding costs for mental health services (line 10)	9 x line	88, 63	6 78, 850	194, 134	11.0
2.00	Program covered visits for mental health services (from contr records)	actor		1 2	0	12.0
3.00	Program covered cost from mental health services (line 9 x li	ne 12)	28	0 559	0	13.0
	Limit adjustment for mental health services (see instructions		28	0 559	0	
5.00	Graduate Medical Education Pass Through Cost (see instruction					15.0
6.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 362, 459		16.0
6. 01 6. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov records)			224, 943 6, 517		16.0 16.0
6.03	Total program preventive costs ((line 16.02/line 16.01) times	line 16)		10, 501		16.0
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 times .80) (Titles V and XIX see instructions.)			259, 308		16. (
6. 05	Total program cost (see instructions)			0 269, 809		16. (
7.00	Primary payer amounts			0		17.0
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from		27, 823		18.0
9.00	contractor records) Beneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from		38, 122		19.0
0.00	contractor records) Net Medicare cost excluding vaccines (see instructions)			269, 809		20.0
1. 00	Program cost of vaccines and their administration (from Wkst. 16)	M-4, line		6, 685		21.0
2.00	Total reimbursable Program cost (line 20 plus line 21)			276, 494		22.0
3.00	Allowable bad debts (see instructions)			0		23.0
3.01	Adjusted reimbursable bad debts (see instructions)			0		23.0
4.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0		24.
5.00 5.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	e)		0		25. 25.
5. 50 5. 99	Demonstration payment adjustment amount before sequestration	3)		0		25. 25.
5.00	Net reimbursable amount (see instructions)			276, 494		26.
5. 01	Sequestration adjustment (see instructions)			0		26.
5. 02	Demonstration payment adjustment amount after sequestration			0		26.
7.00	Interim payments			250, 905		27.
~ ~ ~	Tentative settlement (for contractor use only)			0		28.0
	Palance due component/program (Line 24 minus Lines 24 01 24	02 27 004				
8.00 9.00	Balance due component/program (line 26 minus lines 26.01, 26. 28)	02, 27, and		25, 589		29.0

	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC			Period:	Worksheet M-3	
SERVI C	ES	Component		From 10/01/2020 To 09/30/2021		
		Title	XVIII	RHC II	Cost	
	DETERMINATION OF RATE FOR MOCRETAL RACER RUG (FOMO OFRICA				1.00	
. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M_2	Line 20)		3, 274, 291	1 1.0
2.00	Cost of injections/infusions and their administration (from W				0	
3.00	Total allowable cost excluding injections/infusions (line 1 m				3, 274, 291	3.0
1.00	Total Visits (from Wkst. M-2, column 5, line 8)				14, 236	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)			388	
b. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)				14, 624	
. 00	Aujusted cost per visit (inne s divided by inne o)		Cal	culation of Limi	223.90 t (1)	7.0
			Prior to Jan	On or After	On or After	
			1 (Rate	Jan. 1 (Rate		
			Period 1)	Peri od 2)	Period 3)	
			1.00	2.00	3.00	
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 contractor)	.6 or your	0. C			8.00
	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		223. 9			
	Program covered visits excluding mental health services (from records)					
1.00	Program cost excluding costs for mental health services (line 10)		44, 10			
	Program covered visits for mental health services (from contr records)			0 0	_	
	5			0 0	-	
	5			0 0	0	14. C
6.00	5 , , , , , , , , , , , , , , , , ,			0 198, 256		16.0
	Total program charges (see instructions)(from contractor's re			171, 025		16.0
6. 02	02 Total program preventive charges (see instructions)(from provider's records)			840		16. C
	Total program preventive costs ((line 16.02/line 16.01) times			974		16.0
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 times .80) (Titles V and XIX see instructions.)	3 and 18)		141, 602		16.0
6. 05	Total program cost (see instructions)			0 142, 576		16.0
	Primary payer amounts			0		17.0
8.00	Less: Beneficiary deductible for RHC only (see instructions)	(from		20, 279		18.0
9.00	contractor records) Beneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from		29, 983		19.0
	contractor records)			27,700		
	Net Medicare cost excluding vaccines (see instructions)			142, 576		20.0
1.00	Program cost of vaccines and their administration (from Wkst. 16)	M-4, line		0		21.0
2.00	Total reimbursable Program cost (line 20 plus line 21)			142, 576		22.0
	Allowable bad debts (see instructions)			28		23.0
	Adjusted reimbursable bad debts (see instructions)			18		23.0
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0		24.0
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		25.0
	Pioneer ACO demonstration payment adjustment (see instruction	S)		0		25.
	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions) 142,		142, 594		26.0	
	Sequestration adjustment (see instructions)			0		26.0
6. 02			0		26.0	
	0 Interim payments			118, 019		27.0
7.00	57		0	1	28.0	
27.00 28.00		00 07		04 575		1 20 0
27.00	Balance due component/program (line 26 minus lines 26.01, 26. 28)	02, 27, and		24, 575		29.0

	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider C		Period:	Worksheet M-3	
ERVIC	ES	Component		From 10/01/2020 To 09/30/2021	Date/Time Pre 2/24/2022 4:2	
		Title	XVIII	RHC III	Cost	
					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro		,		1, 735, 771	1.
. 00 . 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m				0 1, 735, 771	2.
. 00	Total Visits (from Wkst. M-2, column 5, line 8))		3, 842	
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)			0,012	5.
. 00	Total adjusted visits (line 4 plus line 5)				3, 842	
. 00	Adjusted cost per visit (line 3 divided by line 6)				451.79	7.
			Calid	ulation of Limi	t (1)	
			Prior to Jan.	On or After	On or After	
			1 (Rate	Jan. 1 (Rate	Apr. 1 (Rate	
			Period 1)	Period 2)	Period 3)	
00	Den visit neveret linit (from CNC Dub 100.04 shorter 0. 520	/	1.00	2.00	3.00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 contractor)	.6 or your	0.0			8.
. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		451.7		303.92	
0. 00	Program covered visits excluding mental health services (from records)	contractor	2		45	10
. 00	Program cost excluding costs for mental health services (line 10)	9 x line	9, 48	8 9, 939	13, 676	11
2.00	Program covered visits for mental health services (from contr records)	actor		0 0	0	12
3.00	Program covered cost from mental health services (line 9 x li	ne 12)		0 0	0	13
4.00	Limit adjustment for mental health services (see instructions)		0 0	0	14
5.00	Graduate Medical Education Pass Through Cost (see instruction					15
5.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 33, 103		16
5. 01 5. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov			18, 126 2, 225		16 16
(02	records)	1		4.0(2		11
6. 03 6. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			4, 063 22, 358		16 16
(0F	times . 80) (Titles V and XIX see instructions.)			0 0/ 101		
5.05 7.00	Total program cost (see instructions)			0 26, 421		16
B. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from		1, 093		18
5.00	contractor records)	(TTOM		1,073		
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instructio contractor records)	ns) (from		2, 962		19
D. 00	Net Medicare cost excluding vaccines (see instructions)			26, 421		20
1.00	Program cost of vaccines and their administration (from Wkst. 16)	M-4, line		0		21
2.00	Total reimbursable Program cost (line 20 plus line 21)			26, 421		22
	Allowable bad debts (see instructions)			0		23
3. 01	Adjusted reimbursable bad debts (see instructions)			0		23
1.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0		24
6.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		25
5.50	Pioneer ACO demonstration payment adjustment (see instruction	S)		0		25
5.99	Demonstration payment adjustment amount before sequestration			0		25
5.00 5.01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			26, 421		26 26
5. 01	Demonstration payment adjustment amount after sequestration			0		20
7.002	Interim payments			21, 765		27
3.00	Tentative settlement (for contractor use only)			21, , 05		28
9.00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and		4, 656		29
	28)					1
	Protested amounts (nonallowable cost report items) in accorda					

	Financial Systems CAMERON MEMORIAL C				u of Form CMS-2	
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider C		Period: From 10/01/2020	Worksheet M-4	
		Component (CCN: 15-8530	To 09/30/2021		pared:
		•			2/24/2022 4:2	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2.01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 027, 762	1, 027, 76	2 1, 027, 762	1, 027, 762	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 000440	0. 00214	.8 0. 000000	0. 000000	
3.00	Injection/infusion health care staff cost (line 1 x line 2)	452	2, 20	0 8	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	5, 343	4,42	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5, 795	6, 63	5 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 036, 019	1, 036, 01	9 1, 036, 019	1, 036, 019	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1, 526, 311			1, 526, 311	
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 005594	0. 00640	0. 000000	0. 000000	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8, 538			0	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	14, 333			0	10100
11.00	Total number of injections/infusions (from your records)	51	24		0	
12.00	Cost per injection/infusion (line 10/line 11)	281.04				12.00
13.00	Number of injection/infusion administered to Program beneficiaries	13	4	.6 0	0	
	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3, 654	3, 03	1 0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		30, 74	2		15.00
16. 00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		6, 68	5		16.00

Heal th	Financial Systems CAMERON MEMORIAL CO	MMUNITY HOSPITAL	In Lie	u of Form CMS-2	552-10
	IS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Provi der CCN: 15-1315	Peri od:	Worksheet M-5	
	ES RENDERED TO PROGRAM BENEFICIARIES		From 10/01/2020		
02.001.0		Component CCN: 15-8530	To 09/30/2021		pared:
			5110	2/24/2022 4: 28	3 pm
			RHC I	Cost	
				t B	
			mm/dd/yyyy 1.00	Amount	
1 00	Tatal interim poyments paid to been tal based DUC (FOUC		1.00	2.00 250,905	1 00
1.00 2.00	Total interim payments paid to hospital-based RHC/FQHC Interim payments payable on individual bills, either submi-	ttad as to be submitted to		250, 905	1.00 2.00
2.00	the contractor for services rendered in the cost reporting			0	2.00
	"NONE" or enter a zero	perrou. In none, write			
3.00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3.00
5.00	revision of the interim rate for the cost reporting period.				5.00
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		250, 905	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR		_		
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
F 04	Program to Provider				F 01
5.01				0	5.01
5.02				0	5.02
5.03	Provider to Program			0	5.03
5.50	Provider to Program			0	5.50
5.50 5.51				0	5.50 5.51
5.51				0	5.51
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the			Ű	6.00
6.01	SETTLEMENT TO PROVIDER			25, 589	6.01
6.02	SETTLEMENT TO PROGRAM			23, 307	6.02
7.00	Total Medicare program liability (see instructions)			276, 494	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

Heal th	Financial Systems CAMERON MEMORIAL CO	MMUNITY HOSPITAL	In Lie	u of Form CMS-2	552-10
ANALYSI'S OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR Provider CCN: 15-1315			Peri od:	Worksheet M-5	
	ES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8545	From 10/01/2020 To 09/30/2021		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			118, 019	1.00
2.00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting			0	2.00
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
1	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	ster to Worksheet M-3, line		118, 019	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03	Dravidor to Dragnom			0	5.03
	Provider to Program				E EO
5.50				0	5.50
5.51				0	5. 51 5. 52
5.52 5.99	Subtotal (cum of lines E 01 E 40 minus cum of lines E 50 E	08)		0	5.52 5.99
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the				5.99 6.00
6.00 6.01	SETTLEMENT TO PROVIDER	e cost report. (1)		24, 575	6.00 6.01
6.01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			24, 575	6.01 6.02
6.02 7.00	Total Medicare program liability (see instructions)			142, 594	6.02 7.00
7.00			Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	Ū.	1.00	2.00	8.00
			I	I I	

Heal th	Financial Systems CAMERON MEMORIAL CO	OMMUNI TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR Provider CCN: 15-1315 F				Worksheet M-5	
SERVI C	ES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8546	From 10/01/2020 To 09/30/2021	Date/Time Prep 2/24/2022 4:28	pared:
			RHC III	Cost	
		· ·	Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			21, 765	1.00
2.00	Interim payments payable on individual bills, either submi-	tted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3.00
	revision of the interim rate for the cost reporting period.	. Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	9	21, 765	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
F F0	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52		22)		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.99
6.00	Determined net settlement amount (balance due) based on the	e cost report. (I)		4 / 5 /	6.00
6.01	SETTLEMENT TO PROVIDER			4,656	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)		Contract	26, 421	7.00
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
8.00	Name of Contractor	0	1.00	2.00	8.00
0.00		I	I		0.00