This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1315 Worksheet S Peri od: From 10/01/2021 Parts I-III AND SETTLEMENT SUMMARY 09/30/2022 Date/Time Prepared: 2/22/2023 3:06 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 2/22/2023 3:06 pm] Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
(1) As Submitted
(2) Settled without Audit
(3) Settled with Audit
(4) Final Report for this Provider CCN
(5) Settled with Audit
(6) Date Received:
(7) 02/25/2022
(8) Date Received:
(9) 02/25/2022
(9) 08/001
(1) NPR Date:
(9) 08/001
(1) Contractor's Vendor Code:
(9) Settled with Audit
(9) [N] Initial Report for this Provider CCN
(1) NPR Date:
(2) Settled without Audit
(3) Settled with Audit
(4) NPR Date:
(5) NPR Date:
(6) Date Received:
(8) NPR Date:
(9) Contractor use only (3) Settled with Audit (4) Reopened (5) Amended

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CAMERON MEMORIAL COMMUNITY HOSPITAL (15-1315) for the cost reporting period beginning 10/01/2021 and ending 09/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

SI GNATURE 0	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	An	gie Logan	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2 Signatory F	Printed Name	Angi e Logan			2
3 Signatory T	Title	PRESIDENT / CEO			3
4 Date		02/22/2023 03:06:39 PM			4

Encryption Information

ECR: Date: 2/22/2023 Time: 3:06 pm

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		Title XVIII				
	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	52, 697	-8, 988	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	89, 758	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		-6, 484		0	10.00
10.01 RURAL HEALTH CLINIC II	0		-16, 640		0	10. 01
10.02 RURAL HEALTH CLINIC III	0		359		0	10. 02
200. 00 Total	0	142, 455	-31, 753	0	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1315 Peri od: Worksheet S-2 From 10/01/2021 To 09/30/2022 Part I Date/Time Prepared: 2/22/2023 3:06 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 416 E MAUMEE STREET 1.00 PO Box: 1.00 State: IN 2.00 City: ANGOLA Zip Code: 47803-County: STEUBEN 2.00 Component Name Payment System (P, CCN CBSA Provi der Date T, 0, or N)
/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 CAMERON MEMORIAL 151315 99915 02/01/2003 Ν 0 3.00 COMMUNITY HOSPITAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF CAMERON MEMORIAL 157315 99915 N 02/01/2003 Ν 0 7.00 7.00 COMMUNI TY 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14 00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC CAMERON FAMILY MEDICINE 158530 99915 12/31/2016 Ν 0 0 15.00 Hospital-Based Health Clinic - RHC CAMERON URGENT CARE 99915 15.01 158545 11/26/2019 0 0 15.01 Hospital -Based Health Clinic - RHC CAMERON OB/GYN 158546 99915 0 15.02 15.02 11/25/2019 0 N $\Pi\Pi$ Hospital-Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2021 09/30/2022 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22. 01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to Ν N N 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provi der CC		Peri od:	TII LI CC		eet S-2	
				From 10/0	1/2021 0/2022	Part I Date/T		pared:
In-S	State	In-State	Out-of	Out-of	Medi ca		023 3.0 1ther	O pili
	cai d	Medi cai d	State	State	HMO da	- I	di cai d	
pai d	days	el i gi bl e	Medi cai d	Medi cai d		'	days	
		unpai d days	paid days	el i gi bl e unpai d				
1.	00	2. 00	3. 00	4. 00	5. 00		5. 00	-
24.00 If this provider is an IPPS hospital, enter the	0	0		0		0		24.00
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.								05.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	0	0	0	0		0		25.00
Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid days in column 3, out-of-state								
Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
nino para ana errgibre but unpara days in corunin 5.				Urban/R	Rural S	Date of	Geogr	
26.00 Enter your standard geographic classification (not wage)	status	at the he	ginning of	1. (00	26.00
cost reporting period. Enter "1" for urban or "2" for rur	al.		0					
27.00 Enter your standard geographic classification (not wage)				st	2			27. 00
reporting period. Enter in column 1, "1" for urban or "2" enter the effective date of the geographic reclassificati			ррі і сарі е,					
35.00 If this is a sole community hospital (SCH), enter the num			CH status i	n	0			35.00
effect in the cost reporting period.				D		F . P		
				Begi ni		Endi 2.		_
36.00 Enter applicable beginning and ending dates of SCH status	. Subs	cript line	36 for num					36.00
of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the	numbo	r of porio	de MDU etat					37.00
is in effect in the cost reporting period.	Hullibe	i oi perro	us won stat	us	٩			37.00
37.01 Is this hospital a former MDH that is eligible for the MD								37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" for ye	s or "	N" for no.	(see					
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates of	MDH st	atus. If L	ine 37 is					38.00
greater than 1, subscript this line for the number of per								
enter subsequent dates.				Y/	'NI	Y	/NI	
				1. (2.		-
39.00 Does this facility qualify for the inpatient hospital pay	ment a	djustment	for low vol	ume N		1		39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i), (i				mn				
1 "Y" for yes or "N" for no. Does the facility meet the m accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)?	ıı reage Enter	requireme in column	nts in 2 "Y" for v	es				
or "N" for no. (see instructions)			,					
40.00 Is this hospital subject to the HAC program reduction adj					I	1	I	40.00
"N" for no in column 1, for discharges prior to October 1 no in column 2, for discharges on or after October 1. (se			yes or "N"	for				
ine in condimit 27 for an estimating content of a feet account in the		. 401. 0.10)			V	XVIII		
Prospective Payment System (PPS)-Capital					1.00	2.00	3. 00	
45.00 Does this facility qualify and receive Capital payment fo	r di sp	roporti ona	te share in	accordance	e N	N	N	45.00
with 42 CFR Section §412.320? (see instructions)	6					, , ,	, .	47.00
46.00 Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L,			,		N	N	N	46. 00
Pt. III.		ii uiu iiks		i im ough				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capit					N	N	N	47. 00
48.00 Is the facility electing full federal capital payment? E Teaching Hospitals	nter "	Y" for yes	or "N" for	no.	N	N	N	48. 00
56.00 Is this a hospital involved in training residents in appr	oved G	ME program	s? Enter "Y	" for ves o	or N	Т	Τ	56.00
"N" for no in column 1. For column 2, if the response to								
was involved in training residents in approved GME progra					,			
year, and are you are impacted by CR 11642 (or applicable Enter "Y" for yes; otherwise, enter "N" for no in column		WA direct	GME payment	reduction?				
57.00 If line 56 is yes, is this the first cost reporting perio	d duri							57.00
GME programs trained at this facility? Enter "Y" for yes								
is "Y" did residents start training in the first month of for yes or "N" for no in column 2. If column 2 is "Y", c								
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if				£ 13				
58.00 If line 56 is yes, did this facility elect cost reimburse			ans' servic	es as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, comp			. D. I					59.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, co	mplete	- Wkst. D-2	. PT. I.		l N			1 37.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	·ΤΑ	Provi der Co	F	eriod: rom 10/01/2021 o 09/30/2022	Worksheet S-2 Part I Date/Time Pre	
			NAHE 413. 85 Y/N	Worksheet A Line #	2/22/2023 3:0 Pass-Through Qualification Criterion	
			1.00	2. 00	Code 3. 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 colis "Y", are you impacted by CR 11642 (or subsequent (adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	ee If column 1	N	2.00	5. 66	60.00
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2. 00	3. 00	4. 00	5. 00	
51.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
51.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.03
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
51.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61. 05
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Prog	gram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME				0.00	0.00	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.				0.00	0.00	61. 20

	Enter in column 2, the program code. Enter in column					
	3, the IME FTE unweighted count. Enter in column 4,					
	the direct GME FTE unweighted count.					
					1. 00	
	ACA Provisions Affecting the Health Resources and Se	rvices Administration	(HRSA)			
62.00	62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which					62.00
]	your hospital received HRSA PCRE funding (see instru	ctions)				
62. 01	Enter the number of FTE residents that rotated from a	a Teaching Health Cen	ter (THC) into	your hospital	0. 00	62.01
	during in this cost reporting period of HRSA THC pro	gram. (see instructio	ns)			
	Teaching Hospitals that Claim Residents in Nonprovid	ler Settings				
63.00	Has your facility trained residents in nonprovider so	ettings during this c	ost reporting	period? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through	67. (see instr	uctions)		

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COM		ATA Provide	r CCN: 15-1315	In Lie Period: From 10/01/2021 To 09/30/2022		pared:
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	2/22/2023 3:0 Ratio (col. 1/ (col. 1 + col. 2))	6 pm
			Si te 1.00	2. 00	3.00	
Section 5504 of the ACA Base Yo						
period that begins on or after 64.00 Enter in column 1, if line 63 in the base year period, the nu resident FTEs attributable to a settings. Enter in column 2 the resident FTEs that trained in a of (column 1 divided by (column)	s yes, or your facili umber of unweighted no rotations occurring in me number of unweighte your hospital. Enter i in 1 + column 2)). (see	ty trained resider n-primary care all nonprovider d non-primary care n column 3 the rat instructions)	e i o			64.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			O. (Unwei ghted	0.000000 Ratio (col.	65. 00
			FTEs	FTEs in	1/ (col . 1 +	
			Nonprovi der Si te	Hospi tal	col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Curren		n Nonprovider Sett	tingsEffective	for cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi	beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					66.00
	Program Name	Program Code	Unwei ghted FTEs	Unwei ghted FTEs in	Ratio (col. 3/ (col. 3 +	
			Nonprovi der Si te		col . 4))	
	1.00	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all	2		0. (0.00	0. 000000	67.00

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)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1315 Peri od: Worksheet S-2 From 10/01/2021 To 09/30/2022 Part I Date/Time Prepared: 2/22/2023 3:06 pm 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75 00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 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) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 $\S413.40(f)(1)(ii)$? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. N 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94.00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train 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)

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CO		eriod: rom 10/01/2021		
		To	09/30/2022	Date/Time Pi 2/22/2023 3	
			V 1. 00	XI X 2. 00	
08.00 s this a rural hospital qualifying for an exception to the CR	NA fee sche	edul e? See 42	N N	2.00	108.0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	1
	1. 00	2. 00	3. 00	4.00	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 0
				1.00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Works applicable.	for yes or	"N" for no. I	f yes,	N	110. 0
			1.00	2. 00	
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	reporting mn 1 is Y, cipating in	period? Enter enter the column 2.	N		111.0
		1. 00	2. 00	3.00	
12.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting pe 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 cease participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	riod? Y", enter	N N	2.00	3.00	112.0
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub.15-1, chapter 22, §2208.1.	or E only) percent cludes	N			0115.0
16.00 s this facility classified as a referral center? Enter "Y" fo	r yes or	N			116.0
"N" for no. 17.00 s this facility legally-required to carry malpractice insuran	ce? Enter	Υ			117. 0
"Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence polic if the policy is claim-made. Enter 2 if the policy is occurren	y? Enter 1	1			118. 0
		Premi ums	Losses	Insurance	
		1.00	2. 00	3.00	
18.01 List amounts of malpractice premiums and paid losses:		163, 275		D	0 118. 0
			1. 00	2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.			N		118.0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y ifies for t	" for yes or he Outpatient	N	N	119. C
21.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.		3	Y		121.0
22.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included. Transplant Center Information			Y	5. 00	122.0
25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125.0
yes, enter certification date(s) (mm/dd/yyyy) below.	r the certi	fication date			126. 0
26.00 If this is a Medicare certified kidney transplant center, ente					127.0
in column 1 and termination date, if applicable, in column 2.	the certif	ication date			1127.0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.					127.0
in column 1 and termination date, if applicable, in column 2. 27.00 f this is a Medicare certified heart transplant center, enter	the certif	ication date			128. 0

Health Financial Systems	CAMERON MEMORIA	AL COMMUNITY HOSPIT	AL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provi der CC	N: 15-1315		l: 10/01/2021	Worksheet S-2 Part I	2
					9/30/2022	Date/Time Pro	
						2/22/2023 3:0	Jo pili
130.00 f this is a Medicare certified p	ancreas transplant cer	nter enter the cer	ti fi cati o	n	1. 00	2.00	130.00
date in column 1 and termination date, if applicable, in column 2.							
131.00 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							
132.00 If this is a Medicare certified i	slet transplant center	r, enter the certif	ication da	ate			132. 00
in column 1 and termination date, 133.00 Removed and reserved	if applicable, in col	umn 2.					133. 00
134.00 If this is an organ procurement o	3 , , ,	ter the OPO number	in column	1			134.00
and termination date, if applicab	le, in column 2.						+
140.00 Are there any related organizatio					Υ		140. 00
chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th				osts			
1.00		2. 00		. ' '	3.00		
If this facility is part of a cha office and enter the home office			ugh 143 t	he name a	nd address	of the home	
141. 00 Name:	Contractor's Nam		Contr	actor's N	umber:		141. 00
142.00 Street: 143.00 Ci ty:	PO Box: State:		Zip C	ode:			142. 00 143. 00
			-: P -:				
144.00 Are provider based physicians' co	sts included in Worksh	neet A?				1. 00 Y	144. 00
145.00 of costs for renal services are c	laimed on Wkst A lir	ne 74 are the cost	s for		1. 00	2. 00	145. 00
inpatient services only? Enter "Y	" for yes or "N" for r	no in column 1. If	column 1 i				
no, does the dialysis facility in period? Enter "Y" for yes or "N"		ation for this cost	reportin	g			
146.00 Has the cost allocation methodolo	gy changed from the pr				Υ	07/07/2022	146. 00
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/		Pub. 15-2, chapter	40, §4020,) [
				'		1.00	
147.00 Was there a change in the statist	ical basis? Enter "Y"	for yes or "N" for	no.			1. 00 Y	147. 00
148.00 Was there a change in the order o	f allocation? Enter "\	/" for yes or "N" f	or no.			N	148. 00
149.00 Was there a change to the simplif	ied cost finding metho	Part A	es or "N" Part		Title V	N Title XIX	149. 00
		1. 00	2. 00		3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155. 00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF		N N	N N		N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER							158. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00
161. 00 CMHC			N		N	N	161. 00
						1.00	
Mul ti campus				ee.	ODCA O		1/5 62
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one or more camp	uses in di	ifferent (CBSAs?	N	165. 00
	Name	County	State	Zi p Code		FTE/Campus	
166.00 If line 165 is yes, for each	0	1. 00	2.00	3. 00	4. 00	5. 00	0166.00
campus enter the name in column							
0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
Health Information Technology (HI	T) inconting in the A-	mori can Booksey	d Poi pus-	tmont Ast		1. 00	
167.00 Is this provider a meaningful use	r under §1886(n)? Ent	ter "Y" for yes or	"N" for n	D.		Y	167. 00
168.00 If this provider is a CAH (line 1	O5 is "Y") and is a me	eaningful user (lin	e 167 is '	"Y"), ente	er the		168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	not a meaningful user,	does this provide			rdshi p	N	168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful					ontor the	0.0	0169. 00
transition factor. (see instruction		, and is not a CAN	CITTLE 103	13 N);	circa tile]	9107.00

Health Financial Systems	CAMERON MEMORIAL COM	In Lie	In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE CO				Worksheet S-2 Part I	!
			To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the E period respectively (mm/dd/yyy			170.00		
			1. 00	2.00	
171.00 If line 167 is "Y", does this	N	C	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. If column 1 is yes,	enter the number of secti	on		
1876 Medicare days in column 2	2. (see instructions)				

	Financial Systems CAMERON MEMORIAL CO AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-1315	Peri od: From 10/01/2021 To 09/30/2022	u of Form CMS- Worksheet S-: Part II Date/Time Pro 2/22/2023 3:0	2 epared:
				Y/N	Date	ļ
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	Tor all NU r	esponses. Ent	er all dates in	tne	
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c		instructions			1.0
			1. 00	Date 2.00	V/I 3. 00	+
2. 00	Has the provider terminated participation in the Medicare P	Program? If	1.00 N	2.00	3.00	2.0
2. 00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				2.0
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and other	offices, drug der or its of the board	Y			3.00
	relationships? (see instructions)	:i Silliiai				
	Transmiper (see That detraine)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
1. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	12/20/2022	4.0
5. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N	Legal Oper.	
				1. 00	2. 00	
5. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, i	s the provide	er N		6.0
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		N		7.0
3. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		· ·			8.0
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	n N		9.0
10. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10.0
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11.0
					Y/N	
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			cost reporting	Y N	12. 0 13. 0
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	f yes, see ir	nstructi ons.	N	14.00
15. 00	Bed Complement Did total beds available change from the prior cost reporti		yes, see ins	structions.	N T B	15. 0
			Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16.00
17. 00	instructions) Was the cost report prepared using the PS&R Report for	Υ	01/31/2023	Υ	01/31/2023	17.0

16.00	Was the cost report prepared using the PS&R Report only?	N		N		16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 (see instructions)					
17 00	Was the cost report prepared using the PS&R Report for	V	01/31/2023	V	01/31/2023	17. 00
17.00	totals and the provider's records for allocation? If	'	01/31/2023	'	01/31/2023	17.00
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
19 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
17.00	Report data for corrections of other PS&R Report	.,				17.00
	information? If yes, see instructions.					

Heal th	Financial Systems CAMERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS	S-2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-1315	Peri od: From 10/01/2021 To 09/30/2022	Worksheet S Part II Date/Time P 2/22/2023 3	repared:	
			i pti on	Y/N	Y/N		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00	
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00	
		Y/N	Date	Y/N	Date		
01.00	lw	1.00	2.00	3.00	4. 00	01.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, se			sing the cost	N	22. 00 23. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprai	sais made du	ring the cost	N	23.00	
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost r	eporting period?	N	24. 00	
25.00	Have there been new capitalized leases entered into during	, the cost repo	orting period	? If yes, see	N	25. 00	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ina period?	lf ves. see	N	26.00	
	instructions.	·	0.				
27. 00	Has the provider's capitalization policy changed during the copy.	ne cost reporti	ng period? I	r yes, submit	N	27. 00	
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	t reporting	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Reserve Fund)	Υ	29. 00			
	treated as a funded depreciation account? If yes, see inst	•					
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.	s, see	N	30.00			
31. 00	Has debt been recalled before scheduled maturity without i instructions.	N	31.00				
22.00	Purchased Services	6		441	V	22.00	
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ied through c	ontractual	Υ	32.00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to compet	itive bidding? If	Υ	33.00	
	no, see instructions. Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an a	ırrangement wit	h provi der-b	ased physicians?	Υ	34.00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	kistina aareeme	ents with the	provi der-based	Υ	35.00	
	physicians during the cost reporting period? If yes, see i				D-+-		
				Y/N 1. 00	2. 00		
	Home Office Costs						
36.00	•			N		36.00	
37. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office	?		37.00	
38. 00	If line 36 is yes , was the fiscal year end of the home of			f		38.00	
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			5.		39.00	
	see instructions.	·	,			40.00	
40. 00	00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions.						
	1.00 2.						
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	DAVI D		GOODMAN		41.00	
42. 00	respectively. Enter the employer/company name of the cost report	WIPFLI LLP				42.00	
12 00	preparer.	609 270 2042		DCOODMAN@WLDE	I COM	42.00	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	608. 270. 2962		DGOODMAN@WI PFL	I. CUM	43.00	

Heal th	Financial Systems CAMERON MEMORIAL	COMM	IUNITY HOSPITAL	_		In Lieu	of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN:	: 15-1315		riod: om 10/01/2021	Worksheet S-2 Part II	!
					To			pared:
					L		2/22/2023 3:0	6 pm
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	CP.	A					41.00
	held by the cost report preparer in columns 1, 2, and 3,							
	respecti vel y.							
42.00	Enter the employer/company name of the cost report							42.00
	preparer.							
43.00	Enter the telephone number and email address of the cost							43.00
	report preparer in columns 1 and 2, respectively.							

Heal th Fi nancial SystemsCAMERON MEMORHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA In Lieu of Form CMS-2552-10 Peri od: Worksheet S-3 From 10/01/2021 Part I To 09/30/2022 Date/Ti me Prepared: 2/22/2023 3:06 pm Provider CCN: 15-1315

						077 007 2022	2/22/2023 3:0	6 pm
							I/P Days /	
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		23	8, 395	79, 344. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4. 00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			23	8, 395	79, 344. 00	0	7. 00
	beds) (see instructions)			_			_	
8.00	INTENSIVE CARE UNIT	31. 00		2	730	2, 822. 40	0	8. 00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00					0	12.00
13.00	NURSERY	43.00		0.5	0.405	00 1// 10	0	13.00
14.00	Total (see instructions)			25	9, 125	82, 166. 40	0	14.00
15.00	CAH visits						0	15.00
16. 00 17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF							16. 00 17. 00
18.00	SUBPROVI DER - TRF							18.00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101, 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					· ·	23. 00
24. 00	HOSPI CE	116. 00		0	0			24.00
24. 10	HOSPICE (non-distinct part)	30. 00		Ü	Ŭ			24. 10
25. 00	CMHC - CMHC	55. 55						25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01					0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02					0	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			25				27. 00
28.00	Observation Bed Days						0	28.00
29.00	Ambul ance Trips							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-1315

Peri od: Worksheet S-3 From 10/01/2021 Part I To 09/30/2022 Date/Time Prepared:

2/22/2023 3:06 pm I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Total All Component Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 3, 697 1,007 61 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 1, 353 2.00 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 0 4 00 4 00 5.00 Hospital Adults & Peds. Swing Bed SNF 552 0 1, 262 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 95 6.00 7.00 Total Adults and Peds. (exclude observation 1,559 61 5,054 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8 00 36 130 8 00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12 00 13.00 NURSERY 13.00 13 344 14.00 Total (see instructions) 1, 595 78 5, 528 0.00 415.70 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 0 0 0 0.00 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 0.00 24.00 0 0 0 0.00 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 RURAL HEALTH CLINIC 26.00 1, 160 0 9,558 0.00 10.09 26.00 RURAL HEALTH CLINIC II 18, 746 26.01 1, 201 0 0.00 13.85 26.01 RURAL HEALTH CLINIC III 5, 617 8.76 26 02 125 0 0 00 26 02 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26. 25 0 0 0 0.00 26.25 27.00 Total (sum of lines 14-26) 0.00 448.40 27.00 28.00 Observation Bed Days 0 1,816 28.00 Ambul ance Trips 29 00 0 29 00 Employee discount days (see instruction) 30.00 0 30.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 32.00 0 96 32.00 0 32.01 32.01 0 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

| Peri od: | Worksheet S-3 | From 10/01/2021 | Part | To 09/30/2022 | Date/Time Prepared: Heal th Fi nancial SystemsCAMERON MEMORHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA CAMERON MEMORIAL COMMUNITY HOSPITAL Provider CCN: 15-1315

				T	0 09/30/2022	Date/Time Pre 2/22/2023 3:00	
		Full Time		Disch	arges	272272023 3.0	O pili
		Equi val ents			9		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	277	19	1, 133	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			326	0		2. 00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO I RF Subprovi der				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospi tal Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions)						8. 00
9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	277	19	1, 133	
15. 00	CAH visits	0.00	O	2,,,	17	1, 100	15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0. 00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 01	RURAL HEALTH CLINIC II	0. 00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29.00	Ambulance Trips						29. 00 30. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)						31.00
32. 00	Total ancillary labor & delivery room						32. 00 32. 01
J∠. UI	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
		1		1	'	'	

OSPITAL-BASED RHC/FQHC STATISTICAL	DATA		Provi der (CCN: 15-1315	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8530	From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
					RHC I	Cost	
							4
Clinic Address and Identificat	·l on					00	
00 Street	.1 011				1500 W MAUMEE	STREET	1
20 120.20.2			C	i ty	State	ZIP Code	
				. 00	2.00	3. 00	
00 City, State, ZIP Code, County			ANGOLOA		IN	46703	2
						1. 00	
00 HOSPITAL-BASED FQHCs ONLY: Des	signation - Enter '	"R" for rur	al or "U" for	urban		0	3
					nt Award	Date	
0.51.15.1					1. 00	2. 00	
Source of Federal Funds Community Health Center (Secti	on 330(d) DHS Ac-	+)		<u> </u>			4
00 Migrant Health Center (Section							5
OO Health Services for the Homele	ess (Section 340(d)), PHS Act)					1
OO Appalachian Regional Commission	on						
00 Look-Alikes							8
00 OTHER (SPECIFY)							9
					1.00	2. 00	
.00 Does this facility operate as yes or "N" for no in column 1. 2. (Enter in subscripts of line hours.)	If yes, indicate	number of	other operation	ons in column	N	0	10
Tiour 3.)		Sur	nday	l N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3.00	4. 00	5. 00	
Facility hours of operations (.1)		I	08: 00	16: 30	08: 00	11
OO CEINIC				08.00	10. 30	06.00	-
					1.00	2. 00	
.00 Have you received an approval .00 Is this a consolidated cost re 30.8? Enter "Y" for yes or "N" number of providers included i numbers below.	eport as defined in ' for no in column	n CMS Pub. 1. If yes,	100-04, chapte enter in colu	er 9, section umn 2 the	N N	0	12 13
Trumber 3 ber ow.				Prov	ider name	CCN number	
					1. 00	2. 00	
.00 RHC/FQHC name, CCN number		\/ (N)	1 ,,	20/11/	VI V	T	14
		1. 00	V 2.00	3. 00	XI X 4. 00	Total Visits 5.00	
00 Have you provided all or subst	tantially all	1.00	2.00	3.00	4.00	5.00	15
GME cost? Enter "Y" for yes or column 1. If yes, enter in col 4 the number of program visits Intern & Residents for titles XIX, as applicable. Enter in commber of total visits for thi (see instructions)	"N" for no in umns 2, 3 and s performed by V, XVIII, and column 5 the						
				unty			
00 01 + 01 + 1 7 1 5 0 1 1 0				. 00			
OO City, State, ZIP Code, County		Tuesday	STEUBEN	nesday	Thur	sday	2
		to	from	1 10	trom	l to	
		6. 00	7.00	8. 00	from 9.00	to 10.00	

Health Financial Systems	CAMERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1315	Peri od:	Worksheet S-8	
		Component	CCN: 15-8530	From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12: 00				11.00

SPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 15-1315	Peri od:	Worksheet S-	8
		Component	CCN: 15-8545	From 10/01/202 To 09/30/202	22 Date/Time Pr	
				RHC II	2/22/2023 3: Cost	00 pi
				I I I I I I I I I I I I I I I I I I I	1 0031	
					1. 00	
Clinic Address and Identification				1201 N. WAVNE	CTDEET	1
00 Street		C	i ty	1381 N. WAYNE State	ZIP Code	1
			. 00	2. 00	3.00	
00 City, State, ZIP Code, County		ANGOLA		I	N 46703	2
					1.00	
00 HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rur	al or "U" for	urban			0 3
				nt Award	Date	
Source of Federal Funds				1. 00	2. 00	
Community Health Center (Section 330(d), PHS	Act)					4
Migrant Health Center (Section 329(d), PHS A						5
Health Services for the Homeless (Section 34)	O(d), PHS Act)					6
Appalachian Regional Commission						7
OO Look-Alikes OO OTHER (SPECIFY)						8
OU UTHER (SPECIFT)						+ 9
				1. 00	2. 00	
OD Does this facility operate as other than a horyes or "N" for no in column 1. If yes, indicated 2. (Enter in subscripts of line 11 the type or hours.)	ate number of	other operation	ons in column			0 10
Tiours.)	Sur	day	l N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2.00	3. 00	4. 00	5. 00	
Facility hours of operations (1) .00 CLINIC	09: 00	17: 30	08: 00	19: 30	00.00	
OU CLINIC	09:00	17: 30	08: 00	19: 30	08: 00	11
				1. 00	2. 00	
 Have you received an approval for an exception Is this a consolidated cost report as defined 8? Enter "Y" for yes or "N" for no in colon number of providers included in this report. 	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	er 9, section umn 2 the	N N		0 13
Trumber's berow.			Provi	ider name	CCN number	
				1. 00	2. 00	
00 RHC/FQHC name, CCN number		1				14
	Y/N 1. 00	V 2.00	3. 00	XI X 4. 00	Total Visits	
00 Have you provided all or substantially all	1.00	2.00	3.00	4.00	5. 00	15
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					1	
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.						
4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the		Co	untv			
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.			unty .00			
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)		4	. 00			2
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)	Tuesday	4 Wedr	. 00 nesday		ursday	2
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)	Tuesday to 6.00	4	. 00	Thu from 9.00	ursday to 10.00	2

Health Financial Systems CAM	MERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1315	Peri od:	Worksheet S-8	
		Component	CCN: 15-8545	From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
				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

		RON MEMORIAL CO			In Li	eu of Form CMS-	
HOSPI TA	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CCN: 15-1315	Peri od: From 10/01/202	Worksheet S-8	3
			Component	CCN: 15-8546	To 09/30/202		epared:
						2/22/2023 3:0	
					RHC III	Cost	
							-
	Clini - Add d-n+i+fi+i					1. 00	
1. 00	Clinic Address and Identification Street				204 E MALIMEE	STREET SUITE	1.00
1.00	311 661				101	. SINLLI SUITL	1.00
			Ci	ity	State	ZIP Code	
				. 00	2.00	3. 00	
2. 00	City, State, ZIP Code, County		ANGOLA		1	N 46703	2.00
2 00	HOCOLTAL BACED FOLICE ONLY Deel meeting. Fort	"D"	-1 "!!"			1.00	2 00
8. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er k for rura	al or U for		nt Award	Date 0	3.00
					1. 00	2.00	
	Source of Federal Funds				1.00	2.00	
1.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5. 00	Migrant Health Center (Section 329(d), PHS A						5.00
. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
. 00	Appalachian Regional Commission						7.00
3. 00 9. 00	Look-Alikes OTHER (SPECIFY)						9.00
. 00	OTHER (SPECIFT)						9.00
					1. 00	2. 00	
0. 00	Does this facility operate as other than a h	ospi tal -based f	RHC or FQHC? E	nter "Y" for			10.00
	yes or "N" for no in column 1. If yes, indic	ate number of o	other operatio	ons in column			
	2. (Enter in subscripts of line 11 the type o	f other operati	ion(s) and the	operating			
	hours.)			1 .	_	+	
		Sun			Monday	Tuesday from	
		from 1.00	to 2. 00	3.00	4. 00	5. 00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
1. 00	CLINIC			08: 00	16: 30	08: 00	11.00
					1. 00	2. 00	
	Have you received an approval for an excepti				N		12.00
3. 00	Is this a consolidated cost report as define	din (MS Puh 1	100-04, chapte	er 9, section	N	1 0	
				2 41			
	30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,					
	number of providers included in this report.	umn 1. If yes,					
		umn 1. If yes,		ders and	ider name	CCN number	
	number of providers included in this report. numbers below.	umn 1. If yes,		ders and Provi	ider name 1.00	CCN number	13.00
4. 00	number of providers included in this report.	umn 1. If yes, List the names	s of all provi	ders and Provi	1. 00	2. 00	13.00
4.00	number of providers included in this report. numbers below.	umn 1. If yes, List the names	s of all provi	Provi	1. 00 XIX	2.00 Total Visits	13.00
	number of providers included in this report. numbers below. RHC/FOHC name, CCN number	umn 1. If yes, List the names	s of all provi	ders and Provi	1. 00	2. 00	14.00
	number of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all	umn 1. If yes, List the names	s of all provi	Provi	1. 00 XIX	2.00 Total Visits	14.00
	number of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	umn 1. If yes, List the names	s of all provi	Provi	1. 00 XIX	2.00 Total Visits	14.00
	number of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all	umn 1. If yes, List the names	s of all provi	Provi	1. 00 XIX	2.00 Total Visits	14. 00
	number of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	umn 1. If yes, List the names	s of all provi	Provi	1. 00 XIX	2.00 Total Visits	14. 00
	number of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 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	umn 1. If yes, List the names	s of all provi	Provi	1. 00 XIX	2.00 Total Visits	14. 00
	number of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	umn 1. If yes, List the names	s of all provi	Provi	1. 00 XIX	2.00 Total Visits	14. 00
	number of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 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	umn 1. If yes, List the names	V 2.00	Provi	1. 00 XIX	2.00 Total Visits	14. 00
	number of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	umn 1. If yes, List the names	V 2.00	Provi	1. 00 XIX	2.00 Total Visits	14. 00
5.00	number of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	umn 1. If yes, List the names	V 2.00	Provi	1. 00 XIX	2.00 Total Visits	13. 0C
5.00	number of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	umn 1. If yes, List the names Y/N 1.00	V 2.00	Provi	1. 00 XI X 4. 00	2.00 Total Visits	13.00
15.00	number of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	umn 1. If yes, List the names	V 2.00	Provi	1. 00 XI X 4. 00	2.00 Total Visits 5.00	13. 00 14. 00 15. 00
5.00	number of providers included in this report. numbers below. RHC/FOHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	umn 1. If yes, List the names Y/N 1.00 Tuesday	V 2.00	XVIII 3.00 unty .00	1. 00 XI X 4. 00	Z.00 Total Visits 5.00	13.00

Health Financial Systems CA	MERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1315	Peri od:	Worksheet S-8	1
		Component	CCN: 15-8546	From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	12: 00				11.00

Heal th	Financial Systems CAMERON MEMORIAL COMMU	INI TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-13		eri od:	Worksheet S-1	
			Fr To	om 10/01/2021 0 09/30/2022	Date/Time Pre	narod:
				09/30/2022	2/22/2023 3:0	
					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 line 202	col umn	8)	0. 333759	1.00
2 00	Medicaid (see instructions for each line)				10 255 251	2 00
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				10, 355, 351 Y	2. 00 3. 00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	ntal payments from	Medi cai	d?	Ϋ́	4. 00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f				0	5.00
6.00	Medi cai d charges				35, 530, 239	6.00
7. 00	Medicaid cost (line 1 times line 6)				11, 858, 537	7.00
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum	of line	s 2 and 5; if	1, 503, 186	8. 00
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions f</pre>	for each line)				
9. 00	Net revenue from stand-alone CHIP	or cach fille)			0	9. 00
10.00	Stand-alone CHIP charges				0	10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 minus lin	ne 9; if	< zero then	0	12.00
	enter zero) Other state or local government indigent care program (see ins	tructions for each	lino)			
13. 00	Net revenue from state or local indigent care program (Not inc				0	13. 00
14. 00	Charges for patients covered under state or local indigent car				0	
	10)	1 3 (
15.00	State or local indigent care program cost (line 1 times line 1				0	15.00
16. 00	Difference between net revenue and costs for state or local in	ndigent care progra	am (line	15 minus line	0	16. 00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CH	IIP and state/Incal	i ndi de	nt care progra	ims (see	
	instructions for each line)	iri and state/rocar	That ge	iit care progra	1113 (366	
17. 00	1				0	
18.00	Government grants, appropriations or transfers for support of			(6 11	0	18.00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	ii indigent care pr	rograms	(sum of fines	1, 503, 186	19.00
	·	Uni ns		Insured	Total (col. 1	
		patie 1.0		pati ents 2.00	+ col . 2) 3.00	
	Uncompensated Care (see instructions for each line)	1.0	00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fa	ncility	163, 633	0	163, 633	20. 00
	(see instructions)					
21. 00	Cost of patients approved for charity care and uninsured disco	ounts (see	54, 614	0	54, 614	21. 00
22. 00	instructions) Payments received from patients for amounts previously writter	off as	0	0	0	22. 00
22.00	charity care	1 011 43	J	J	Ü	22.00
23. 00	Cost of charity care (line 21 minus line 22)		54, 614	0	54, 614	23. 00
					4 00	
24 00	Does the amount on line 20 column 2, include charges for patie	ont days boyond a L	onath o	f ctay limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care		engtii	1 Stay IIIII t	IV	24.00
25. 00	If line 24 is yes, enter the charges for patient days beyond t		orogram'	s length of	0	25. 00
24 00	stay limit	octructions)			4 120 025	24 00
26. 00 27. 00	Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex	,	ns)		4, 139, 025 317, 582	26. 00 27. 00
27. 00	Medicare allowable bad debts for the entire hospital complex (•	13)		488, 588	
28. 00	Non-Medicare bad debt expense (see instructions)				3, 650, 437	28. 00
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	opense (see instruc	ctions)		1, 389, 372	
	Cost of uncompensated care (line 23 column 3 plus line 29)	! 20)			1, 443, 986	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus I	rne 30)			2, 947, 172	31.00

Heal th	Financial Systems CAME	RON MEMORIAL CON	MUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der Co	CN: 15-1315	Period: From 10/01/2021	Worksheet A	
						Date/Time Pre 2/22/2023 3:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fi ed	Pill
	· ·			+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
		1. 00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS				11.00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		4, 868, 847				
2.00	00200 CAP REL COSTS-MVBLE EQUIP	4/1 700	1, 917, 367				1
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	461, 709 6, 571, 920	10, 933, 249 7, 969, 292				
7. 00	00700 OPERATION OF PLANT	1, 120, 084	3, 537, 134				
8. 00	00800 LAUNDRY & LINEN SERVICE	0	37, 968				1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	924, 700	603, 186 522, 618				
11. 00	01100 CAFETERI A	522, 978 0	0 0	1, 045, 59	5 -52, 280 0 0		1
13. 00	01300 NURSING ADMINISTRATION	597, 961	154, 296	752, 25		1	1
14.00	01400 CENTRAL SERVICES & SUPPLY	221, 337	201, 960			423, 297	1
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	495, 971 729, 925	5, 221, 984 224, 389			1	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	127, 723	224, 307	754, 51	+ 0	754, 514	10.00
30.00	03000 ADULTS & PEDIATRICS	4, 214, 584	1, 979, 359	6, 193, 94	-142, 022	6, 051, 921	30.00
31.00	03100 NTENSI VE CARE UNI T	0	0		93, 341		
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	0		16, 263	16, 263	43.00
50. 00	05000 OPERATING ROOM	1, 657, 924	1, 367, 686	3, 025, 61	-782, 325	2, 243, 285	50.00
51.00	05100 RECOVERY ROOM	0	0		782, 325	782, 325	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	52, 289	2, 750				
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	2, 265, 781 1, 152, 331	1, 160, 728 2, 227, 713				
65. 00	06500 RESPIRATORY THERAPY	973, 615	511, 089				
65. 01	06501 SLEEP LAB	0	0		70, 666		
66. 00	06600 PHYSI CAL THERAPY	1, 172, 707	65, 513			,	1
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON	61, 777	4, 894 8, 058			1	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	01,777	2, 471, 029				
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		1, 570, 686		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		2, 124, 164	l	
76. 00 76. 01	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0	0 2, 021, 885	2, 021, 88	5 0	0 2, 021, 885	
	03030 DI ABETI C EDUCATI ON	o	85, 051				1
	OUTPATIENT SERVICE COST CENTERS						1
88. 00 88. 01	08800 RURAL HEALTH CLINIC	1, 085, 301	111, 857				1
88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	1, 577, 593 1, 120, 051	267, 283 305, 770		· ·		
90.00	09000 CLI NI C	109, 090	16, 438			1	
90. 01	09001 CLINIC- ORTHO	327, 585	1, 045, 835				
	09002 CLINIC - PEDS ENT FP 09003 INTRAVENOUS THERAPY	1, 116, 107	61, 454 17, 349				
	09004 PSYCHI ATRY	91, 327 710, 808	28, 381				
	09005 CARDI OLOGY	1, 162, 689	65, 363				
	09100 EMERGENCY	2, 449, 765	373, 878	2, 823, 64	0	2, 823, 643	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		1, 324, 269	1, 324, 26	-1, 324, 269		113.00
	11400 UTILIZATION REVIEW-SNF 11600 HOSPICE	0	0			l .	114. 00 116. 00
118.00		32, 947, 909	51, 715, 922	84, 663, 83	-433, 778		
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0		190.00
	19200 PHYSICIANS PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER	0	0		0		192. 00 194. 00
	07950 DATCARE-TNPANT/TODDLER	0	0				194.00
	07952 COMMUNITY HEALTH	64, 400	27, 260	91, 66	0	l e	194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0		0		194. 03
	07954 EDUCATI ON 07955 MARKETI NG	0 430	0 452 270	733, 80	0	l .	194.04
	07956 GUEST MEALS	80, 430	653, 370 0	/33,80	114, 293 52, 280		194. 05
194.07	07957 OUTSI DE LAUNDRY		0		0		194. 07
194. 08	07958 CANCER CENTER	0	0]	0	0	194. 08
	07959 URGENT CARE	0	0	!	0	l	194.09
	07960 RHC 07961 OBGYN		0		0		194. 10 194. 11
	07961 OBGTN 07962 TRI NE STUDENT HEALTH	136, 310	5, 553	141, 86	3 0	141, 863	
194. 13	07963 OCCUPATI ONAL HEALTH	291, 786	179, 584	471, 37	18, 813	490, 183	194. 13
194. 14	07964 I MMUNI ZATI ON CLINI C	0	0		0	0	194. 14

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	pared:
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		, p
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4.00	5. 00	
194. 15 07965 FOUNDATI ON	144, 816	163, 394	308, 210	808	309, 018	194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	822, 339	88, 718	911, 057	158, 327	1, 069, 384	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	614, 925	69, 222	684, 147	89, 257	773, 404	194. 17
200.00 TOTAL (SUM OF LINES 118 through 199)	35, 102, 915	52, 903, 023	88, 005, 938	0	88, 005, 938	200.00

 Health Financial
 Systems
 CAMERON MEMORIA

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-1315

Peri od: Worksheet A From 10/01/2021 To 09/30/2022 Date/Time Prepared:

			To	
Cost Center Description	Adjustments	Net Expenses	, , , , , , , , , , , , , , , , , , , ,	.
	(See A-8)	For		
	6. 00	Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-194, 902	4, 862, 991		1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	-139, 747	2, 994, 791		2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-226, 924	9, 995, 189		4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-2, 791, 774	11, 543, 317		5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	0 0	4, 657, 218 180, 689		7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG		1, 385, 165		9.00
10. 00 01000 DI ETARY	-268, 979	724, 337		10.00
11. 00 01100 CAFETERI A	0	o		11.00
13.00 01300 NURSING ADMINISTRATION	0	752, 257		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	-3, 300	419, 997		14.00
15. 00 01500 PHARMACY	-11, 696	939, 792		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	-899	953, 415		16.00
30. 00 03000 ADULTS & PEDIATRICS	-867, 878	5, 184, 043		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	93, 341		31.00
43. 00 04300 NURSERY	0	16, 263		43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM	-672, 558	1, 570, 727		50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0 0	782, 325 87, 457	l .	51.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	3, 426, 509	·	54.00
60. 00 06000 LABORATORY	-3, 335	3, 376, 709	·	60.00
65. 00 06500 RESPIRATORY THERAPY	o	1, 279, 234		65.00
65. 01 06501 SLEEP LAB	0	70, 666	·	65. 01
66. 00 06600 PHYSI CAL THERAPY	-3, 025	1, 235, 195	·	66.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHABI LI TATI ON	1 247	139, 698	·	69. 00 69. 01
69. 01 06901 CARDIAC REHABILITATION 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-1, 247 0	68, 588 900, 343	l control of the cont	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 570, 686		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	2, 124, 164		73.00
76. 00 03020 CHEMI CAL DEPENDENCY	O	o		76.00
76. 01 03480 ONCOLOGY	-32, 168	1, 989, 717		76. 01
76. 02 03030 DI ABETI C EDUCATION OUTPATIENT SERVICE COST CENTERS	0	85, 051		76. 02
88. 00 08800 RURAL HEALTH CLINIC	ol	1, 368, 541		88. 00
88. 01 08801 RURAL HEALTH CLINIC II	Ö	2, 062, 553		88. 01
88.02 08802 RURAL HEALTH CLINIC III	-293, 044	1, 280, 290		88. 02
90. 00 09000 CLI NI C	0	125, 528		90.00
90. 01 09001 CLI NI C - ORTHO	-1, 171, 691	230, 512		90. 01
90. 02 09002 CLINIC - PEDS ENT FP 90. 03 09003 NTRAVENOUS THERAPY	-766, 428 0	667, 749 2, 687, 609		90. 02 90. 03
90. 04 09004 PSYCHI ATRY	-517, 034	298, 195		90.03
90. 05 09005 CARDI OLOGY	-776, 769	532, 161		90.05
91. 00 09100 EMERGENCY	o	2, 823, 643		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	ol	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		101.00
113. 00 11300 NTEREST EXPENSE	0	0		113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114. 00
116. 00 11600 HOSPI CE	0 740 000	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-8, 743, 398	75, 486, 655		118. 00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	ol	0		190. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	o	o		192.00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	0		194. 00
194. 01 07951 MOB	0	0		194. 01
194. 02 07952 COMMUNITY HEALTH	0	91, 660		194. 02 194. 03
194. 03 07953 ASSISTED LIVING/CAMERON WOODS 194. 04 07954 EDUCATION	0	0		194. 03
194. 05 07955 MARKETI NG		848, 093		194.04
194. 06 07956 GUEST MEALS		52, 280		194.06
194. 07 07957 OUTSI DE LAUNDRY	0	o		194. 07
194. 08 07958 CANCER CENTER	0	o		194. 08
194. 09 07959 URGENT CARE	0	0		194. 09
194. 10 07960 RHC 194. 11 07961 OBGYN	0	0		194. 10 194. 11
194. 11 07961 0BGYN 194. 12 07962 TRINE STUDENT HEALTH		141, 863		194. 11
194. 13 07963 OCCUPATI ONAL HEALTH	o	490, 183		194. 12
194. 14 07964 I MMUNI ZATI ON CLINI C	o	0		194. 14
194. 15 07965 FOUNDATI ON	o	309, 018		194. 15

Health Financial Systems	CAMERON MEMORIAL CO	MMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TR	AL BALANCE OF EXPENSES	Provi der CCN: 15-1315	Peri od: From 10/01/2021	Worksheet A
			To 09/30/2022	Date/Time Prepared: 2/22/2023 3:06 pm
Cost Center Description	Adiustments	Net Expenses		

			2/22/2023 3.00	PIII
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	0	1, 069, 384	1	94. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	773, 404	11	94. 17
200.00 TOTAL (SUM OF LINES 118 through 199)	-8, 743, 398	79, 262, 540	2	00.00

Provider CCN: 15-1315

| Peri od: | From 10/01/2021 | To 09/30/2022 | Worksheet A-6 | To 09/30/2022 | Date/Time Prepared: | 2/22/2023 3:06 pm

					2/22/2023	3: 06 pi
	Cook Cooks	Increases	Callaria	0+1		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - LABOR AND DELIVERY	3.00	4.00	3.00		
00	NURSERY	43.00	10, 166	6, 097		1
00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	2 <u>0, 2</u> 65	1 <u>2, 1</u> 53		2
	TOTALS		30, 431	18, 250		
00	B - PROPERTY INSURANCE	4 00	ما	74 700		
00	CAP REL COSTS BLDG & FLXT	1. 00	0	71, 729		1 2
00	CAP REL COSTS-MVBLE EQUIP TOTALS			1 <u>3, 3</u> 73 85, 102		2
	C - CAFETERIA		<u> </u>	05, 102		
00	GUEST MEALS	194. 06	26, 149	26, 131		1
	TOTALS		26, 149	26, 131		
	D - INTEREST EXPENSE					
00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 318, 618		'
00	CAP REL COSTS-MVBLE EQUIP			<u>5, 651</u>		:
	TOTALS E - DEPRECIATION EXPENSE		0	1, 324, 269		
00	CAP REL COSTS-MVBLE EQUIP	2.00	O	1, 198, 147		-
,0	TOTALS			- 1, 198, 147 1, 198, 147		
	F - ICU		<u> </u>	1, 170, 117		
00	INTENSIVE CARE UNIT	31.00	79, 191	14, 150		
	TOTALS		79, 191	14, 150		
	G - PROPERTY TAX					
00	CAP REL COSTS-BLDG & FLXT			<u>5, 918</u>		
	TOTALS		0	5, 918		
20	H - SLEEP LAB - EKG SLEEP LAB	4F 01	20 021	20 025		
00 00	ELECTROCARDI OLOGY	65. 01 69. 00	30, 831 22, 659	39, 835 21, 146		
50	TOTALS		53, 490	60, 981		
	I - PUBLIC RELATIONS		55, 176	00, 701		
00	MARKETI NG	194. 05	0	114, 293		
	TOTALS			114, 293		
	J - RECOVERY ROOM					
00	RECOVERY ROOM	<u>51.</u> 00	78 <u>2, 3</u> 25	0		
	TOTALS		782, 325	0		
00	K - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72.00	ol	1 570 (0)		
00	PATIENTS	72.00	٥	1, 570, 686		
	TOTALS			1, 570, 686		
	L - FOUNDATION RECLASS					
00	FOUNDATI ON	194. 15	808	0		
	TOTALS		808	0		
	M - IMMUNIZATION CLINIC RECLA		ما	(0.070		
00	CLINIC - PEDS ENT FP	9002	0	6 <u>3, 370</u> 63, 370		
	N - DRUGS RECLASS		U	03, 370		
0	DRUGS CHARGED TO PATIENTS	73. 00	0	4, 703, 097		
	TOTALS			4, 703, 097		
	O - IV THERAPY					
00	I NTRAVENOUS THERAPY	90. 03	0	2, 578, 933		
	TOTALS		0	2, 578, 933		
	P - EKG HST RECLASS		00.005			
00	ELECTROCARDI OLOGY	<u>69.00</u>	90, 999	0		
	TOTALS Q - OFFSITE DEPRECIATION		90, 999	0		
00	CAMERON FAMILY MEDICINE -	194. 16	ol	5, 232		
	NORTH	174.10	J	0, 202		
00	CAMERON FAMILY MEDICINE -	194. 17	O	3, 840		
	FREMONT					
	TOTALS		0	9, 072		
	R - PROVIDER BENEFITS	20.00		150 744		
0	RURAL HEALTH CLINIC	88. 00	0	153, 741		
0	RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III	88. 01 88. 02	0	217, 677 147, 513		
0	CLINIC- ORTHO	90. 01	0	28, 783		
0	CLINIC - PEDS ENT FP	90. 02	0	193, 246		
00	PSYCHI ATRY	90. 04	Ö	93, 682		
00	CARDI OLOGY	90. 05	О	80, 878		
00	OCCUPATI ONAL HEALTH	194. 13	О	18, 813		
00	CAMERON FAMILY MEDICINE -	194. 16	0	153, 095		
00	NORTH	404.4		05 447		_
.00	CAMERON FAMILY MEDICINE - FREMONT	194. 17	0	85, 417		1
	TOTALS	+				
			UI	1, 1/2, 043		1

Heal th	Financial Systems	CAME	ERON MEMORIAL (COMMUNITY HOSPI	TAL	In Lie	u of Form CMS-	2552-10
RECLASS	SI FI CATI ONS			Provi der	CCN: 15-1315	Peri od: From 10/01/2021	Worksheet A-	6
							Date/Time Pro 2/22/2023 3:	epared: 06 pm
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
	S - PSYCH PROVIDER TIME							
1.00	RURAL HEALTH CLINIC	88. 00	17, 642	0)			1.00
	TOTALS		17, 642)			
	T - LAUNDRY RECLASS							
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	142, 721				1.00
	TOTALS		0	142, 721				
500.00	Grand Total: Increases		1, 081, 035	13, 087, 965	i [500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1315

					10	09/30/2022 Date/lime 2/22/2023	
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00 A - LABOR AND DELIVERY	7. 00	8. 00	9. 00	10. 00		
1.00	ADULTS & PEDIATRICS	30.00	30, 431	18, 250	0		1.00
2.00		0.00	0	0	0		2. 00
	TOTALS		30, 431	18, 250			
1. 00	B - PROPERTY I NSURANCE ADMI NI STRATI VE & GENERAL	5. 00	o	85, 102	12		1.00
2. 00	A SEIVER OF A SEIV	0.00	o	00, 102	12		2. 00
	TOTALS			85, 102			
1 00	C - CAFETERIA	10.00	24 140	24 121	0		1 00
1. 00	TOTALS — — — — —	10.00	26, 149 26, 149	2 <u>6, 1</u> 31 26, 131			1.00
	D - INTEREST EXPENSE		20, 117	20, 101			
1.00	INTEREST EXPENSE	113. 00	0	1, 324, 269			1.00
2. 00		0.00		0			2. 00
	TOTALS E - DEPRECIATION EXPENSE		<u> </u>	1, 324, 269			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 198, 147	9		1.00
	TOTALS		0	1, 198, 147			
1 00	F - ICU	20.00	70 101	14 150	0		1 00
1. 00	ADULTS & PEDIATRICS	3000		1 <u>4, 1</u> 50 14, 150			1.00
	G - PROPERTY TAX		77, 171	11, 100			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>5, 9</u> 18	13		1. 00
	TOTALS		0	5, 918			
1. 00	H - SLEEP LAB - EKG RESPI RATORY THERAPY	65. 00	53, 490	60, 981	0		1.00
2. 00		0.00	0	00, 701	o		2. 00
	TOTALS		53, 490	60, 981			
1 00	I - PUBLIC RELATIONS	F 00		114 202	0		1 00
1. 00	ADMI NI STRATI VE & GENERAL TOTALS			11 <u>4, 2</u> 93 114, 293			1.00
	J - RECOVERY ROOM		<u> </u>	111, 270			
1.00	OPERATI NG ROOM	50.00	782, 325	0	0		1.00
	TOTALS K - IMPLANTABLE DEVICES		782, 325	0			
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 570, 686	0		1.00
	PATI ENT	1					
	TOTALS		0	1, 570, 686			
1. 00	L - FOUNDATION RECLASS ADMINISTRATIVE & GENERAL	5. 00	808	0	0		1.00
1.00	TOTALS		808	— — <u> </u>	— — —		1.00
	M - IMMUNIZATION CLINIC RECLA						
1. 00	PHARMACY	1500	•	6 <u>3, 3</u> 70 63, 370			1.00
	TOTALS N - DRUGS RECLASS		0	63, 370			
1. 00	PHARMACY	15. 00	0	4, 703, 097	0		1.00
	TOTALS		0	4, 703, 097			
1. 00	O - IV THERAPY DRUGS CHARGED TO PATIENTS	72 00	O	2, 578, 933	0		1.00
1.00	TOTALS			2,578,933 2,578,933			1.00
	P - EKG HST RECLASS						
1. 00	RESPI RATORY THERAPY	6500	90, 999	0	0		1.00
	TOTALS Q - OFFSITE DEPRECIATION		90, 999	0			
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	9, 072	9		1.00
2. 00		0.00		0	9		2. 00
	TOTALS		0	9, 072			
1. 00	R - PROVIDER BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 172, 845	O		1.00
2. 00	LWFLOTEL BENEFIT TO DEPARTMENT	0.00	0	1, 172, 645	0		2.00
3.00		0. 00	0	0	O		3. 00
4.00		0. 00	0	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0	0		5. 00 6. 00
7. 00		0.00	ol	0	0		7.00
8.00		0. 00	ō	O	Ö		8. 00
9.00		0.00	0	0	0		9.00
10. 00		0.00		0 1, 172, 845	0		10.00
	S - PSYCH PROVIDER TIME		J	1, 172, 043			
1.00	PSYCHI ATRY	90. 04	17, 642	0	0		1.00
	TOTALS		17, 642	0			

Heal th Financial Systems

CAMERON MEMORIAL COMMUNITY HOSPITAL

Provider CCN: 15-1315

Period:
From 10/01/2021
To 09/30/2022

Date/Time Prepared:
2/22/2023 3: 06 pm

						2/22/2023 3:	<u>06 pm</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	T - LAUNDRY RECLASS						
1.00	HOUSEKEEPI NG	9. 00	0	142, 721	1		1.00
	TOTALS — — — — —			142, 721	1		
500.00	Grand Total: Decreases	-	1, 081, 035	13, 087, 965	5		500.00
000.00	por arra i o carri Door oacoo		.,,	10,007,700	-1	T. Control of the con	1000.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS | Peri od: | Worksheet A-7 | From 10/01/2021 | Part I | To 09/30/2022 | Date/Time Prepared: Provider CCN: 15-1315

Beginning Balances Acquisitions Donation Total Disposals and Retirements	1.00
Ball ances Reti rements	1. 00
	1. 00
	1. 00
1.00 2.00 3.00 4.00 5.00	1. 00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES	1.00
1. 00 Land 2, 019, 703 0 0 0 0	
2.00 Land mprovements 0 0 0 0	2.00
3.00 Buildings and Fixtures 59,461,729 1,690,398 0 1,690,398 0	3.00
4.00 Building Improvements 0 0 0 0	4.00
5.00 Fixed Equipment 0 0 0 0	5.00
6.00 Movable Equipment 19,429,417 1,010,155 0 1,010,155 676,650	6.00
7.00 HIT designated Assets 0 0 0 0	7.00
8. 00 Subtotal (sum of lines 1-7) 80, 910, 849 2, 700, 553 0 2, 700, 553 676, 650	8.00
9.00 Reconciling Items 0 0 0 0	9.00
10. 00 Total (line 8 minus line 9) 80, 910, 849 2, 700, 553 0 2, 700, 553 676, 650	10.00
Ending Fully	
Bal ance Depreciated	
Assets	
6.00 7.00	
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 61,152,127 0	3.00
4.00 Building Improvements 0 0	4. 00
5.00 Fixed Equipment 0 0	5.00
6.00 Movable Equipment 19,762,922 0	6.00
7.00 HIT designated Assets 0 0	7. 00
8.00 Subtotal (sum of lines 1-7) 82,934,752 0	8.00
9.00 Reconciling Items 0 0	9. 00
10.00 Total (line 8 minus line 9) 82,934,752 0	10.00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-					2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-1315	Peri od: From 10/01/2021 To 09/30/2022	Worksheet A-7 Part II Date/Time Pre 2/22/2023 3:0	pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9. 00	10. 00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	CAP REL COSTS-BLDG & FLXT	4, 868, 847			0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 917, 367		0	0	2.00
3. 00	Total (sum of lines 1-2)	4, 868, 847	· · · · · · · · · · · · · · · · · · ·		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	4, 868, 847	1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 917, 367	•			2.00
3. 00	Total (sum of lines 1-2)	0	6, 786, 214				3.00

Health Financial Systems CAM	ERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 10/01/2021	Worksheet A-7	
				To 09/30/2022		pared:
	1	DUTATION OF DA	TI 00	111001T10N 0F	2/22/2023 3:0	6 pm
	COMI	PUTATION OF RAT	1105	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	col . 2)	4.00	F 00	
PART III - RECONCILIATION OF CAPITAL COSTS	1.00	2. 00	3.00	4. 00	5. 00	
1.00 CAP REL COSTS-BLDG & FLXT	61, 152, 127	1 0	61, 152, 12	7 0. 755757	0	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	19, 762, 921		19, 762, 92		_	2.00
3.00 Total (sum of lines 1-2)	80, 915, 048		80, 915, 048			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
DART III DECONOLILIATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1.00 PART III - RECONCILIATION OF CAPITAL COSTS	LENTERS 0		ıl ,	3, 661, 628	0	1.00
2. 00 CAP REL COSTS-BLDG & FIXT		1		1, 059, 235		2.00
3.00 Total (sum of lines 1-2)	0			0 4, 720, 863		3.00
or or protein (dam or prince in 2)		Sl	JMMARY OF CAPI		1,717,007	0.00
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11. 00	12.00	13.00	instructions)	15. 00	
DADT III DECONCILIATION OF CADITAL COSTS		12.00	13.00	14.00	15.00	

1, 123, 716 4, 816 1, 128, 532

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

Total (sum of lines 1-2)

71, 729 13, 373 85, 102

5, 918 5, 918 4, 862, 991 1. 00 2, 994, 791 2. 00 7, 857, 782 3. 00

0 0 0

1. 00 2. 00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-1315 Peri od: Worksheet A-8 From 10/01/2021 09/30/2022 Date/Time Prepared: 2/22/2023 3:06 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL Α -194, 902 CAP REL COSTS-BLDG & FIXT 1.00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL -835 CAP REL COSTS-MVBLE EQUIP Α 2.00 11 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0 0.00 3.00 Α (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by -10, 579 ADMINISTRATIVE & GENERAL 6.00 5.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0 00 7.00 stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 Provi der-based physici an -4, 775, 693 10.00 A-8-2 10.00 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 -399, 436 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 14.00 Cafeteria-employees and guests -246, 334 DI ETARY 10.00 В 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than В -11, 696 PHARMACY 15.00 17.00 pati ents Sale of medical records and -899 MEDICAL RECORDS & LIBRARY 18.00 R 16.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 0 education (tuition, fees, books, etc.) 20.00 Vending machines В -4, 373 DI ETARY 10 00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY A-8-3 66.00 24.00 therapy costs in excess of limitation (chapter 14) OUTILIZATION REVIEW-SNF 25.00 25.00 Utilization review 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** 28.00 Non-physician Anesthetist 19.00 28.00 Physicians' assistant 29 00 0.00 29 00 Adjustment for occupational 0 *** Cost Center Deleted *** 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

Provi der CCN: 15-1315 Peri od: Worksheet A-8 From 10/01/2021 | To 09/30/2022 | Date/Time Prepared:

					0 09/30/2022	2/22/2023 3:0	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					-		
	Coot Contor Deceriation	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	Cost Center Description	(2)	Amount	Cost Center	Line #	Ref.	
		1, 00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		*** Cost Center Deleted ***	68. 00	3.00	31.00
01.00	pathology costs in excess of	7. 0 0		Soot conton bon stea	551.55		01100
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	LOBBYING EXPENSES	Α	-5, 547	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	MEALS ON WHEELS	В	-18, 272	DI ETARY	10. 00	0	33. 01
33. 02	RENTAL INCOME OFFSET - CANCER	В	-32, 168	ONCOLOGY	76. 01	0	33. 02
	CENTER						
33. 03	ATM SURCHARGE REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	00.00
33. 04	RHC OB PHYSICIAN & MIDLEVELS	Α	-293, 044	RURAL HEALTH CLINIC III	88. 02	0	33. 04
	OFFSET						
33. 05	MEDICALD HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33.05
33. 06 33. 07	PHYSICIAN RECRUITMENT MISC REVENUE	A B		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06 33. 07
33. 07		B B	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33.07
33.08	OTHER PHYSICIAL THERAPY REVENUE	В	-3, 025	PHYSI CAL THERAPY	66. 00	U	33.08
33. 09	CARDIAC REHAB FITNESS REVENUE	В	_1 247	CARDIAC REHABILITATION	69. 01	0	33. 09
33. 10	OTHER ADJUSTMENTS (SPECIFY)	Ь	-1, 247	CARDIAC REHADIELIATION	0.00	0	33. 10
55. 10	(3)				0.00	O	33. 10
33. 11	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 11
	(3)				3.00	3	
50.00	TOTAL (sum of lines 1 thru 49)		-8, 743, 398				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

TATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND F FFICE COSTS ider CCN: 15-1315 | Period: From 10/01/2

Data (Time December)

OFFICE	. (0515			110111 10/01/2021		
				To 09/30/2022	Date/Time Pre	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	, o p
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CMO AND MOB RENTAL	868, 816	1, 007, 728	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - CAMERON WOODS	0	193, 475	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 PHARMAC	0	33, 449	4.01
5.00	TOTALS (sum of lines 1-4).			868, 816	1, 268, 252	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

6.00	С	CAMERON MEDICAL	100.00	0. 00	6.00
7.00			0.00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Health Financial Systems				CAMERON MEMORIAL COMMUNITY HOSPITAL							In Lieu of Form CMS-2552-10					
STATEME	NT OF COSTS OF	SERVICES FRO	M RELAT	ED ORGANIZ	ZATI ONS	AND HO	ME Pi	ovi der	CCN:	15-1315	Peri			Workshe	et A-8	3-1
OFFICE	COSTS											10/01/2		D . I . /T'		
											То	09/30/2	022	Date/Ti 2/22/20	me Pr∈ 123 3.(eparea: Na nm
	Net	Wkst. A-7 Ref	:						_					2/22/20	25 5.0	о рііі
	Adjustments															
	(col. 4 minus															
	col. 5)*															
	6. 00	7. 00														
	A. COSTS INCUR	RED AND ADJUS	TMENTS	REQUIRED A	AS A RE	SULT OF	TRANS	ACTI ONS	WITH	RELATED	ORGAN	I ZATI ONS	OR (CLAI MED	HOME	
	OFFICE COSTS:															
1.00	-138, 912	(9													1.00
2.00	-193, 475		0													2.00
3.00	-26, 850		0													3.00
3. 01	-3, 300		0													3. 01
4.00	-3, 450)	0												1	4.00
4. 01	-33, 449		o													4. 01

5.00 -399, 436 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s)		
and/or Home Office		
		4
Type of Business		
6. 00		
 B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	6.00
7. 00	7.00
8. 00	8.00
9. 00	9.00
10.00	10.00
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.
- 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
- 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.

Provider CCN: 15-1315

						0 09/30/2022	2 Date/IIme Pro 2/22/2023 3:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	867, 878	867, 878	3 0	0	0	1.00
2.00	50.00	OPERATING ROOM	672, 558	672, 558	0	0	0	2.00
3.00	60.00	LABORATORY	10, 106	3, 335	6, 771	0	0	3.00
4.00	90. 01	CLINIC- ORTHO	1, 171, 691	1, 171, 691	0	0	0	4.00
5.00	90. 02	CLINIC - PEDS ENT FP	766, 428	766, 428	0	0	0	5. 00
6.00	90. 04	PSYCHI ATRY	517, 034	517, 034	1 0	0	0	6. 00
7.00	90. 05	CARDI OLOGY	776, 769	776, 769	9 0	0	0	7. 00
8. 00	0.00		0	1	0	0	0	8.00
9. 00	0.00		0		0	0	0	9. 00
10.00	0.00		0		0	0	0	10.00
200.00			4, 782, 464	4, 775, 693	6, 771	· -	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Education	12		
	1. 00	2. 00	8. 00	9. 00	12.00	13. 00	14.00	
1. 00	30. 00	ADULTS & PEDIATRICS	0	C	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	C	0	0	0	2.00
3.00	60.00	LABORATORY	0	C	0	0	0	3.00
4.00	90. 01	CLINIC- ORTHO	0	C	0	0	0	4.00
5.00	90. 02	CLINIC - PEDS ENT FP	0	C	0	0	0	5.00
6.00	90. 04	PSYCHI ATRY	0	C	0	0	0	6.00
7.00	90. 05	CARDI OLOGY	0	C	0	0	0	7. 00
8.00	0.00		0	C	0	0	0	8. 00
9.00	0.00		0	C	0	0	0	9. 00
10.00	0.00		0	C	0	0	0	10.00
200.00			0	C	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0		1	867, 878		1.00
2.00		OPERATING ROOM	0		,	672, 558		2.00
3. 00		LABORATORY	0	·)	3, 335		3. 00
4. 00		CLINIC- ORTHO	0	(0	1, 171, 691		4. 00
5. 00		CLINIC - PEDS ENT FP	0	(0	766, 428	•	5. 00
6.00		PSYCHI ATRY	0	C	0	517, 034	•	6. 00
7. 00		CARDI OLOGY	0	[C	0	776, 769		7. 00
8. 00	0. 00		0	C	0	0		8. 00
9. 00	0. 00		0	[C	0	0		9. 00
10.00	0. 00		0	l c	0	0		10.00
200.00			0	(0	4, 775, 693		200.00

| Peri od: | Worksheet B | From 10/01/2021 | Part | | To 09/30/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1315

				-	Го 09/30/2022		
			CAPI TAL REI	ATED COSTS		2/22/2023 3:0	o piii
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	BLDG & FIXI	MARTE ECOLA	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS			2.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT	4, 862, 991	4, 862, 991	0 004 70			1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 994, 791 9, 995, 189	39, 832	2, 994, 79° 20, 53°			2. 00 4. 00
5. 00	00500 ADMINI STRATI VE & GENERAL	11, 543, 317	404, 236	268, 462		14, 522, 548	5.00
7. 00	00700 OPERATION OF PLANT	4, 657, 218	477, 514	192, 598	393, 164	5, 720, 494	7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE	180, 689	50, 240		1	251, 192	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 385, 165 724, 337	8, 515 280, 955			1, 721, 696 1, 293, 004	
11. 00	01100 CAFETERI A	0	0	(0	11.00
	01300 NURSING ADMINISTRATION	752, 257	31, 222	33, 353		1, 026, 724	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	419, 997 939, 792	147, 408 54, 639	59, 459 22, 038		704, 552 1, 190, 561	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	953, 415	0 0 0 0	21, 122		1, 190, 301	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 184, 043 93, 341				7, 864, 520	
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	16, 263	55, 822 19, 869	22, 515 8, 014		199, 475 47, 714	1
	ANCILLARY SERVICE COST CENTERS	10, 200	17,007	0,01	0,000	17,711	10.00
	05000 OPERATING ROOM	1, 570, 727	519, 523			2, 607, 138	1
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	782, 325 87, 457	336, 209 83, 023	135, 605 33, 486		1, 528, 745 229, 433	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 426, 509	397, 802	160, 44		4, 780, 077	54.00
60.00	06000 LABORATORY	3, 376, 709	131, 229			3, 965, 350	1
65. 00	06500 RESPIRATORY THERAPY	1, 279, 234	34, 534	13, 929		1, 618, 731	65.00
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	70, 666 1, 235, 195		49, 609 120, 436		131, 097 2, 065, 866	
69. 00	06900 ELECTROCARDI OLOGY	139, 698	17, 835			204, 621	69.00
69. 01	06901 CARDIAC REHABILITATION	68, 588	29, 803	12, 02°		132, 097	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	900, 343	0		-	900, 343	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	1, 570, 686 2, 124, 164	0		-	1, 570, 686 2, 124, 164	73.00
76. 00	03020 CHEMI CAL DEPENDENCY	0	0	(0	0	76. 00
76. 01	03480 ONCOLOGY	1, 989, 717	0			2, 201, 510	
76. 02	03030 DIABETIC EDUCATION OUTPATIENT SERVICE COST CENTERS	85, 051	0		0	85, 051	76. 02
88. 00	08800 RURAL HEALTH CLINIC	1, 368, 541	0	129, 53	7 139, 899	1, 637, 977	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 062, 553	0	124, 570		2, 426, 097	88. 01
88. 02 90. 00	08802 RURAL HEALTH CLINIC III 09000 CLINIC	1, 280, 290 125, 528	0 18, 923	66, 70! 15, 850		1, 423, 700 198, 599	
90. 00	09001 CLI NI C- 0RTH0	230, 512	10, 423	75, 864		366, 453	1
90. 02	09002 CLINIC - PEDS ENT FP	667, 749	0	114, 10 ⁻	1 89, 650	871, 500	90. 02
	09003 I NTRAVENOUS THERAPY	2, 687, 609	56, 768	22, 89		2, 799, 331	
90. 04	09004 PSYCHI ATRY 09005 CARDI OLOGY	298, 195 532, 161	0	33, 715 28, 086		387, 156 692, 979	
	09100 EMERGENCY	2, 823, 643	451, 496			4, 317, 142	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	· ·	0 0	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	J			<u> </u>		101.00
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF	0	0	,		0	114.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	75, 486, 655	4, 829, 309	2, 941, 804	9, 694, 639	75, 039, 073	116. 00 118. 00
	NONREI MBURSABLE COST CENTERS	707 1007 000	17 02 77 00 7	2/ / 11/ 00	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	70,007,070	
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	27, 438			38, 505	1
	19200 PHYSICIANS PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER	0	0	1, 92			192. 00 194. 00
	07951 MOB	0	0				194. 01
	07952 COMMUNITY HEALTH	91, 660	0	(22, 605	114, 265	
	07953 ASSISTED LIVING/CAMERON WOODS	0	0				194.03
	07954 EDUCATI ON 07955 MARKETI NG	848, 093) n	19, 40!	5 28, 232	895, 730	194. 04 194. 05
194.06	07956 GUEST MEALS	52, 280	0	.,, ,,,	9, 179	61, 459	194. 06
	07957 OUTSI DE LAUNDRY	0	0	(0		194. 07
	O7958 CANCER CENTER O7959 URGENT CARE	0	0	() 0		194. 08 194. 09
	07960 RHC	0	0				194. 10
194. 11	07961 OBGYN	0	0	(ol ol	0	194. 11

Health Financial Systems	CAMERON MEMORIAL COMM	In Lieu of Form CMS-255				
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1315	From 10/01/2021			
				Part Date/Time Prepared		

			10	09/30/2022	2/22/2023 3:0	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	col. 7)	1. 00	2.00	4. 00	4A	
194. 12 07962 TRINE STUDENT HEALTH	141, 863	1.00	2.00	4, 00	189, 710	194 12
194. 13 07963 OCCUPATI ONAL HEALTH	490, 183	Ö	16, 161	70, 536	· ·	1
194.14 07964 IMMUNIZATION CLINIC	0	0	0	0	0	194. 14
194. 15 07965 FOUNDATI ON	309, 018	6, 244	4, 427	51, 116	370, 805	194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	1, 069, 384	0	0	72, 133	1, 141, 517	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	773, 404	0	0	59, 265	832, 669	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)	79, 262, 540	4, 862, 991	2, 994, 791	10, 055, 552	79, 262, 540	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1315

Period: Worksheet B From 10/01/2021 Part I To 09/30/2022 Date/Time Prepared:

2/22/2023 3:06 pm Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL **PLANT** LINEN SERVICE 9. 00 5.00 7.00 10.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 14, 522, 548 5.00 7.00 00700 OPERATION OF PLANT 1, 283, 227 7,003,721 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 56, 348 89, 274 396, 814 8.00 00900 HOUSEKEEPI NG 386 213 15, 131 2 123 040 9 00 9 00 0 10.00 01000 DI ETARY 290, 048 499, 245 0 78, 211 2, 160, 508 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 230, 316 55, 481 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 158, 046 261, 938 7.309 14 00 0 14.00 0 15.00 01500 PHARMACY 267, 068 97, 092 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 276, 083 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 2, 120, 384 03000 ADULTS & PEDIATRICS 1, 764, 182 1, 569, 609 366, 413 696, 230 31.00 03100 INTENSIVE CARE UNIT 44, 746 99, 193 6, 934 21, 928 40, 124 31.00 10, 703 18, 347 43 00 43.00 04300 NURSERY 35, 306 145, 459 0 ANCILLARY SERVICE COST CENTERS 50 00 584, 836 50.00 05000 OPERATING ROOM 923, 170 0 262, 776 0 05100 RECOVERY ROOM 342, 930 597, 430 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 51, 467 147, 529 5, 120 29, 238 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1,072,272 706, 879 0 131, 571 0 54.00 60.00 06000 LABORATORY 889, 511 233, 188 0 78, 942 0 60.00 65.00 06500 RESPIRATORY THERAPY 363, 115 61, 365 0 18, 274 0 65.00 06501 SLEEP LAB 5, 848 29.408 0 65.01 0 65.01 0 66.00 06600 PHYSI CAL THERAPY 463, 417 530,600 63, 958 0 66.00 06900 ELECTROCARDI OLOGY 45, 901 31, 691 0 69.00 69.00 0 0 69.01 06901 CARDIAC REHABILITATION 29, 632 52, 959 0 0 69.01 201, 966 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 352, 338 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 476, 495 8,040 0 73.00 0 76.00 03020 CHEMI CAL DEPENDENCY 0 0 76.00 03480 ONCOLOGY 493.845 0 76.01 C 1,096 0 76.01 03030 DIABETIC EDUCATION 76.02 19,079 0 76.02 OUTPATIENT SERVICE COST CENTERS 367, 433 88.00 08800 RURAL HEALTH CLINIC 0 0 17, 177 0 88.00 08801 RURAL HEALTH CLINIC II 0 88.01 544, 225 365 0 88.01 319, 366 88.02 08802 RURAL HEALTH CLINIC III 0 2, 193 0 88.02 90.00 09000 CLI NI C 44, 550 33, 625 0 9,868 0 90.00 09001 CLINIC- ORTHO 09002 CLINIC - PEDS ENT FP 90 01 82, 203 0 66, 516 90.01 0 0 90.02 195, 496 66, 151 0 90.02 09003 I NTRAVENOUS THERAPY 627, 949 100, 875 0 0 90.03 90.03 90.04 09004 PSYCHI ATRY 86, 847 0 0 0 90.04 29, 238 09005 CARDLOLOGY 0 90.05 90.05 155, 450 0 09100 EMERGENCY 91.00 968, 426 802, 289 0 374, 246 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 116. 00 11600 HOSPI CE \cap 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 160, 508 118. 00 13, 575, 137 6, 943, 869 396, 814 2, 114, 634 NONREI MBURSABLE COST CENTERS 0 190 00 190.00 1900 GIFT FLOWER COFFEE SHOP & CANTEEN 8.637 48.756 192.00 19200 PHYSICIANS PRIVATE OFFICES 432 0 0 0 192.00 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194.00 0 0 194. 01 07951 MOB 0 0 0 0 0 0 0 0 0 0 0 194. 01 0 0 0 194. 02 07952 COMMUNITY HEALTH 25.632 C 0 194.02 194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 194.03 194. 04 07954 EDUCATI ON 0 194.04 194. 05 07955 MARKETI NG 200, 931 0 194.05 0 0 194.06 07956 GUEST MEALS 0 13, 787 C 0 194, 06 194. 07 07957 OUTSLDE LAUNDRY 0 194. 07 194.08 07958 CANCER CENTER 0 0 0 0 194.08 194. 09 07959 URGENT CARE 0 C 0 0 194, 09 0 194. 10 194. 10 07960 RHC 0 C 0 194. 11 07961 OBGYN 0 0 194. 11 0 194. 12 07962 TRI NE STUDENT HEALTH 42, 556 C 0 0 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 0 0 194. 13 129, 406 0 C 194. 14 07964 IMMUNIZATION CLINIC 0 0 0 194. 14 C 194. 15 07965 FOUNDATI ON 0 0 194. 15 83.179 11,096 194. 16 07967 CAMERON FAMILY MEDICINE - NORTH 0 8.406 0 194. 16 256 066

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-131	Period: Worksheet B From 10/01/2021 Part I To 09/30/2022 Date/Time Prepared:

						2/22/2023 3:0	76 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	
194. 17 07966	CAMERON FAMILY MEDICINE - FREMONT	186, 785	0	0	0	0	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)	14, 522, 548	7, 003, 721	396, 814	2, 123, 040	2, 160, 508	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1315 Peri od:

Peri od: Worksheet B From 10/01/2021 Part I To 09/30/2022 Date/Time Prepared:

In Lieu of Form CMS-2552-10

2/22/2023 3:06 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & RECORDS & **SUPPLY** LI BRARY Ν 15.00 11 00 13.00 16.00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 0 13.00 13.00 1, 312, 521 01400 CENTRAL SERVICES & SUPPLY 14.00 1, 131, 845 14 00 15.00 01500 PHARMACY 0 C 7,559 1, 562, 280 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 365 1, 507, 198 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 16, 500 30.00 03000 ADULTS & PEDIATRICS 0 470, 108 97, 288 30.00 03100 INTENSIVE CARE UNIT 0 31 00 8,970 0 210 31.00 04300 NURSERY 43.00 0 0 0 43.00 1, 665 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 102, 108 50.00 146, 581 18, 783 05100 RECOVERY ROOM 0 o 51.00 89, 698 51.00 C 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 8, 218 0 1.711 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C r 35, 567 210, 552 54.00 60.00 06000 LABORATORY 0 0 0 1, 796 0 327, 815 60.00 0 65.00 06500 RESPIRATORY THERAPY 111, 739 16, 128 48, 444 65.00 0 06501 SLEEP LAB 65.01 0 953 65 01 66.00 06600 PHYSI CAL THERAPY 156, 660 4, 423 0 81, 418 66.00 06900 ELECTROCARDI OLOGY 0 0 0 5, 980 0 69.00 1, 138 56, 100 69.00 11, 581 o 06901 CARDIAC REHABILITATION 22. 181 69.01 515 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 (8, 201 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 600,057 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 0 705, 682 0 73.00 03020 CHEMI CAL DEPENDENCY 76 00 Ω 0 76 00 0 03480 ONCOLOGY 76.01 0 0 0 29, 707 76.01 03030 DIABETIC EDUCATION 0 76.02 76.02 73 0 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 9 030 71 129 0 0 88.01 08801 RURAL HEALTH CLINIC II 0 C 67,098 0 144, 802 88.01 08802 RURAL HEALTH CLINIC III 0 0 88.02 4, 691 48, 182 88.02 0 90.00 09000 CLI NI C 13, 239 6 162 0 27, 111 90 00 09001 CLINIC- ORTHO 90.01 4, 912 0 27, 584 90.01 C 09002 CLINIC - PEDS ENT FP 0 5, 126 0 65, 396 90.02 90.02 0 90.03 09003 I NTRAVENOUS THERAPY 10, 982 5, 934 856, 598 16, 352 90.03 09004 PSYCHI ATRY 90 04 33, 993 90 04 461 0 90.05 09005 CARDI OLOGY 0 44,638 644 0 13, 124 90.05 91.00 09100 EMERGENCY 278, 600 91, 597 0 134, 718 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 116. 00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 312, 521 1, 115, 346 1, 562, 280 1, 398, 430 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 190 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 192.00 0 194.00 194. 00 07950 DAYCARE-I NFANT/TODDLER 000000000000000 0 0 0 0 194. 01 07951 MOB 0 0 0 194, 01 194. 02 07952 COMMUNI TY HEALTH C 57 0 194.02 194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 194.03 0 0 0 194. 04 07954 EDUCATI ON 0 0 0 194.04 194. 05 07955 MARKETI NG 0 194, 05 C 38 194.06 07956 GUEST MEALS C 0 0 194.06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 0 194. 07 194. 08 07958 CANCER CENTER C 0 0 194, 08 194.09 07959 URGENT CARE 0 C 0 194.09 194. 10 07960 RHC 0 194. 10 0 0 0 0 194. 11 07961 OBGYN 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 18, 939 194. 12 0 1.288 0 194. 13 07963 OCCUPATI ONAL HEALTH 0 0 194. 13 1.762 194. 14 07964 IMMUNIZATION CLINIC 0 194. 14 0 194. 15 07965 FOUNDATI ON 0 194. 15 241

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1315

| Peri od: | Worksheet B | From 10/01/2021 | Part | | Date/Time Prepared: | 2/22/2023 3:06 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	
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	0	0	8, 136	0	60, 564	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	0	4, 977	0	29, 265	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)	0	1, 312, 521	1, 131, 845	1, 562, 280	1, 507, 198	202. 00

| Period: | Worksheet B | From 10/01/2021 | Part | To 09/30/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1315

Cost Center Description						To 09/30/2022 Date/Time Pr	
Cost & Post Stephan		Cost Center Description	Subtotal		Total	2/22/2023 3.	U6 piii
Stepdom Adjustments Adju							
EMERICAL SURVICE COST CENTERS 1,00 26,00				Stepdown			
EXERTAL SERVICE COST CENTERS 1 00 0000 CARE DE COSTS-SERVE A FIXTO 4 00 0000 CARE DE COSTS-SERVE SERVET S			24. 00		26. 00	_	
2.00					I		1.00
4. 00							•
0.0000 ORDING OF PEANT	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
8.00 0 0800 (AUNDRY & U. NEN SERVICE 9.00 0 0900) (DISSECTED WEST 9.00 0 0		1					
10.00 01000 DETARY							
11.0 0 01400 CAFETERIA 11.0 0 13.0 0 14.0 0 INSIN KA MAN INSTRATION 13.0 0 13.0 0 14.0 0 INSIN KA MAN INSTRATION 14.0 0 1							•
14.00 01400 FARTMAN 14.00 15							
15. 00							
INPATI ENT ROUTINE SERVICE COST CENTERS 14, 965, 234 0 14, 965, 234 0 33.00 0 30.00 MULTIS & PEDIATRIC S 14, 965, 234 0 247, 580 31.00 33.00 30.00 MUSERY PC CARE UNIT 421, 580 0 421, 580 31.00 430.00 430.00 MUSERY PC CARE UNIT 421, 580 0 421, 580 31.00 430.00							
30.00 03000 ADULTS & PEDIATRICS 14,965,234 0 14,965,234 30,00 31,00 310,00	16. 00						16. 00
31.00 03100 INTERSIVE CARE LINIT	30. 00		14, 965, 234	0	14, 965, 23	34	30.00
MACILLARY SERVICE COST CENTERS	31.00	03100 INTENSIVE CARE UNIT	421, 580	0	421, 58	30	31.00
50.00	43. 00		259, 194	0	259, 19	04	43.00
S2.00 GS200 DELIVERY ROOM & LABOR ROOM	50.00	O5000 OPERATING ROOM	4, 645, 392	0	4, 645, 39	02	50.00
54.00							
65.00 0c500 RESPIRATORY THERAPY 2, 237, 796 0 2, 237, 796 0 6.5.00							
65. 01 0e501 SLEEP LAB			1				•
69. 00 069000 064000 064000 064000 06400 06900 06400 06900 064000 06900 06400 06900 06400 06400 06900 06400			1				
69-01 06901 CARDIJAC REHABILITATION 248, 965 0 248, 965 0 9. 01			i	_			
71.00 07100 MZDI CAL SUPPLIES CHARGED TO PATIENT 1,110,510 0 1,110,510 71.00 72.00 72.00 72.00 72.00 72.00 73.				_	,		
73.00 07300 DRUGS CHARGED TO PATIENTS 3, 314, 381 0 3, 314, 381 73, 30 76, 00 3020 CHEMICAL DEPENDENCY 0 0 76, 600 76, 6	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 110, 510		1, 110, 51	0	71.00
76. 00 03020 CHEMI CAL DEPENDENCY 0 0 76. 00 76			1	_			•
76. 02 03030 DIABETIC EDUCATION 104, 203 0 104, 203 76. 02 0	76.00	03020 CHEMI CAL DEPENDENCY	0	0	5,5,5.	0	76. 00
DUTPATIENT SERVICE COST CENTERS							
88 01 08801 RURAL HEALTH CLINIC II 3, 182, 587 0 3, 182, 587 88 01 88 02 08802 RURAL HEALTH CLINIC III 1, 798, 132 0 1, 798, 132 0 90. 00 09000 01, 1000 01, 1000 01, 1000 00, 00 90. 01 09001 01, 101 0- PEDS ENT FP 1, 203, 669 0 1, 203, 669 90, 02 90. 02 09002 01, 101 0- PEDS ENT FP 1, 203, 669 0 1, 203, 669 90, 02 90. 03 09003 10, 102 0- PEDS ENT FP 1, 203, 669 0 1, 203, 669 90, 02 90. 03 09003 10, 102 0- PEDS ENT FP 1, 203, 669 0 1, 203, 669 90, 02 90. 04 09004 PSYCHI ATRY 508, 457 0 508, 457 0 508, 457 90, 04 90. 05 09005 0, 0000 0, 0000 0, 000 0, 00 91. 00 09100 EMERGENCY 0, 36, 073 0 936, 073 0 936, 073 90, 05 91. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 91. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 91. 00 09100 0 0 0 0 0 0 0 0 0		OUTPATIENT SERVICE COST CENTERS					
88 02 08802 RIPAL HEALTH CLINIC III							
90. 01 09001 CLI NI C - ORTHO 547, 668 0 547, 668 99. 01 90. 02 09002 CLI NI C - PEDS ENT FP 1, 203, 669 0 1, 203, 669 99. 02 90. 03 09003 INTRAVENOUS THERAPY 4, 418, 021 0 4, 418, 021 90. 03 90. 04 09004 PSYCHI ATRY 508, 457 0 508, 457 90. 04 90. 05 09005 CARDI LOGY 936, 073 0 936, 073 90. 05 91. 00 09100 EMERGENCY 6, 967, 018 0 6, 967, 018 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTI NCT PART 92. 00 07 09200 OBSERVATI ON BEDS (NON-DISTI NCT PART 92. 00 08 09001 ORTHOR REI MBURSABLE COST CENTERS 92. 00 114. 00 11000 HOME HEALTH AGENCY 0 0 0 0 115. 00 11000 HOME HEALTH AGENCY 0 0 0 0 116. 00 11600 HOSPI CE SUBSTOTALIS (SUM OF LINES 1 through 117) 73, 898, 137 0 73, 898, 137 0 73, 898, 137 0 116. 00 118. 00 SUBITOTALIS (SUM OF LINES 1 through 117) 73, 898, 137 0 73, 898, 137 0 73, 898, 137 0 190. 00 192. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 95, 898 0 95, 898 190. 00 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194. 01 194. 01 07952 COMMUNITY HEALTH 139, 954 0 139, 954 194. 02 194. 02 07952 COMMUNITY HEALTH 139, 954 0 139, 954 194. 02 194. 03 07953 ASSISTED LIVI NG/CAMERON WOODS 0 0 0 194. 04 194. 04 07955 MARKETI NG 1, 096, 699 0 1, 096, 699 194. 05 194. 06 07955 MARKETI NG 75, 246 0 75, 246 194. 07 194. 08 07958 CANCER CENTER 0 0 0 0 194. 07 194. 08 07959 MARKETI NG 0 0 0 0 194. 07 194. 08 07959 GANCER CENTER 0 0 0 0 194. 07 194. 10 07960 RHC 1007960 RHC 1007960 TRICKED 1007960	88. 02	08802 RURAL HEALTH CLINIC III	1, 798, 132				88. 02
90. 02 09002 CLINIC - PEDS ENT FP							1
90. 04 09004 PSYCHI ATRY 508, 457 0 508, 457 90. 04 90. 05 09005 CARDI OLOGY 936, 073 0 936, 073 99. 05 91. 00 09100 EMERGENCY 6, 967, 018 0 6, 967, 018 0 92. 00 09200 OBSERVATI ON BDS (NON-DI STI NCT PART 0 0 0 THER REI MURSABLE COST CENTERS 101. 00 1300 NORTHER REI MURSABLE COST CENTERS 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 73, 898, 137 0 73, 898, 137 0 NONREI MURSABLE COST CENTERS 118. 00 190. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 2, 359 0 2, 359 192. 00 194. 01 07951 MOB AYCARE-I NFANT/TODDLER 0 0 0 0 194. 01 07951 MOB SASI STEED LI VI NG/CAMERON WOODS 0 0 0 194. 02 07952 (COMMUNI TY HEALTH 139, 954 0 139, 954 194. 02 194. 05 07955 MARKETI NG 1, 096, 699 0 1, 096, 699 194. 05 194. 06 07956 (BEST MEALS 75, 246 0 0 0 0 194. 07 07957 (OUTS) ENTIRED 1 VI NG/CAMERON WOODS 0 0 0 194. 08 07956 (BEST MEALS 75, 246 0 75, 246 0 194. 05 194. 08 07956 (BEST MEALS 75, 246 0 0 0 0 0 194. 09 07959 (BROTT CARE 0 0 0 0 0 194. 08 07956 (BROTT CARE 0 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE 0 0 0 0 194. 10 07966 (BRC CREET CARE CARE CARE CARE CARE CARE CARE CARE			· · ·	_			1
90. 05 99005 CARDI OLOGY 936, 073 0 936, 073 91. 00 91. 00 9200 DEREGENCY 0 92. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0							
91. 00 09100 EMERGENCY 6, 967, 018 0 6, 967, 018 92. 00 9200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 0 0 0 0 0 0 0 0 0		09005 CARDI OLOGY			936, 07	73	
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS	91.00	09100 EMERGENCY			6, 967, 01	8	•
101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	92.00			0			92.00
113.00	101.00	10100 HOME HEALTH AGENCY	0	0		0	101.00
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 73,898,137 0 73,898,137 116. 00 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 95,898 0 95,898 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 2,359 0 2,359 192. 00 194. 00 194. 01 07950 DAYCARE-I NFANT/TODDLER 0 0 0 0 194. 00 194. 01 07951 MOB 0 0 0 0 194. 00 194. 01 194. 02 07952 COMMUNI TY HEALTH 139,954 0 139,954 194. 02 194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194. 03 194. 04 194. 05 07955 MARKETI NG 1,096,699 0 1,096,699 194. 05 194. 05 194. 06 07956 GUEST MEALS 75,246 0 75,246 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 08 194. 09 07959 URGENT CARE 0 0 0 0 194. 10 194. 09 194. 10 07960 RHC 0 0 0 0 194. 10 194. 10 194. 12 19762 TRI NE STUDENT HEALTH 252,493 0 252,493 194. 12	113.00						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 73,898,137 0 73,898,137 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 1900 1900 1910				0			
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 95,898 0 95,898 190. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 194. 01 194. 01 194. 01 194. 02 194. 01 194. 02 194. 03 194. 04 194. 02 194. 03 194. 04 194. 04 194. 04 194. 04 194. 04 194. 04 194. 05 194. 05 194. 05 194. 05 194. 06 194. 07 194. 07 194. 08 194. 07 194. 08 194. 08 194. 08 194. 08 194. 09 194. 08 194. 09 194. 08 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 10 194. 09 194. 10 194			73, 898, 137		l .	0 37	
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES 2, 359 0 2, 359 192. 00 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194. 01 07951 MOB 0 0 0 194. 01 194. 01 194. 02 07952 COMMUNI TY HEALTH 139, 954 0 139, 954 194. 02 194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 194. 03 194. 04 07954 EDUCATI ON 0 0 0 0 194. 04 194. 05 07955 MARKETI NG 1, 096, 699 0 1, 096, 699 194. 05 194. 06 07956 GUEST MEALS 75, 246 0 75, 246 194. 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. 10 194. 11 107961 OBGYN 0 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 252, 493 0 252, 493	400.00	NONREI MBURSABLE COST CENTERS					
194. 00 07950 DAYCARE-INFANT/TODDLER 0 0 0 0 194. 00 194. 01 194. 01 194. 01 194. 02 17951 MOB 0 0 0 0 194. 01 194. 01 194. 02 17952 COMMUNI TY HEALTH 139, 954 0 139, 954 194. 02 17953 ASSI STED LI VI NG/CAMERON WOODS 0 0 194. 04 17954 EDUCATI ON 0 0 0 0 194. 04 194. 05 07955 MARKETI NG 1, 096, 699 0 1, 096, 699 194. 05 17956 GUEST MEALS 75, 246 0 75, 246 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 0 194. 06 194. 07 194. 08 07958 CANCER CENTER 0 0 0 0 194. 08 194. 09 07959 RHC 0 0 0 0 194. 08 194. 09 07959 RHC 0 0 0 0 194. 09 194. 10 17960 RHC 0 0 0 0 194. 10 17961 OBGYN 0 0 0 0 194. 11 17961 OBGYN 0 0 0 0 194. 11 17961 OBGYN 0 0 0 0 194. 11 194. 12 12 178 TRI NE STUDENT HEALTH 252, 493 0 252, 493							
194. 02 07952 COMMUNITY HEALTH 139, 954 0 139, 954 194. 02 194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 194. 03 194. 04 07954 ASSISTED LIVING/CAMERON WOODS 0 0 194. 04 194. 05 07955 MARKETING 1,096, 699 0 1,096, 699 194. 06 07956 GUEST MEALS 75, 246 0 75, 246 194. 06 194. 07 07957 OT957 OT957 OT957 OT957 UTSIDE LAUNDRY 0 0 0 194. 07 194. 08 07958 CANCER CENTER 0 0 0 194. 08 194. 09 07959 URGENT CARE 0 0 0 0 194. 08 194. 10 07960 RHC 0 0 0 194. 10 194. 11 107961 OBGYN 0 0 0 194. 11 194. 12 07962 TRINE STUDENT HEALTH 252, 493 0 252, 493	194.00	07950 DAYCARE-I NFANT/TODDLER					194. 00
194. 03 07953 ASSI STED LI VI NG/CAMERON WOODS 0 0 0 194. 03 194. 04 07954 EDUCATI ON 0 0 194. 04 194. 05 07955 MARKETI NG 1, 096, 699 0 1, 096, 699 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 07 194. 08 07958 OUTSI DE LAUNDRY 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. 10 194. 11 107961 OBGYN 0 0 0 252, 493 194. 12			0 139 954	_	•	0 54	
194. 05 07955 MARKETI NG 1, 096, 699 0 1, 096, 699 194. 05 194. 06 07956 GUEST MEALS 75, 246 0 75, 246 194. 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 07960 RHC 0 0 0 0 194. 11 07961 OBGYN 0 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 252, 493 0 252, 493	194. 03	07953 ASSISTED LIVING/CAMERON WOODS	0			0	194. 03
194. 06 07956 GUEST MEALS 75, 246 0 75, 246 194. 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 0 194. 08 07958 CANCER CENTER 0 0 0 194. 09 07959 ORDENT CARE 0 0 194. 10 07960 ORDENT CARE 0 0 194. 10 07960 ORDENT CARE 0 0 194. 11 07961 ORDENT CARE 0 0 194. 12 07962 TRI NE STUDENT HEALTH 252, 493 194. 12			1 096 699			0	
194. 08 07958 CANCER CENTER 0 0 0 194. 08 194. 09 07959 URGENT CARE 0 0 0 194. 09 194. 10 07960 RHC 0 0 0 194. 10 194. 11 07961 OBGYN 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 252, 493 0 252, 493 194. 12	194.06	07956 GUEST MEALS		0			194. 06
194. 09 07959 URGENT CARE 0 0 0 194. 09 194. 10 07960 RHC 0 0 0 194. 10 194. 11 07961 OBGYN 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 252, 493 0 252, 493 194. 12			0	0		0	
194. 10 07960 RHC 0 0 0 194. 10 194. 11 07961 0BGYN 0 0 0 194. 11 194. 12 07962 TRI NE STUDENT HEALTH 252, 493 0 252, 493 194. 12			o	0		0	•
194. 12 07962 TRI NE STUDENT HEALTH 252, 493 0 252, 493 194. 12	194. 10	07960 RHC	0	_		0	
			252, 493		•	93	
				0			194. 13

Health Financial Systems	CAMERON MEMORIAL COMMU	JNI TY HOSPI	TAL	In Lieu of Form CMS-2552-10				
COST ALLOCATION - GENER	RAL SERVICE COSTS		Provi der C			10/01/2021 09/30/2022		Prepared:

					2/22/2023 3: 0	6 pm
	Cost Center Description	Subtotal	Intern &	Total		
			Resi dents			
			Cost & Post			
			Stepdown			
			Adjustments			
		24. 00	25. 00	26. 00		
194. 14 07964	IMMUNIZATION CLINIC	0	0	0		194. 14
194. 15 07965	FOUNDATI ON	465, 321	0	465, 321		194. 15
194. 16 07967	CAMERON FAMILY MEDICINE - NORTH	1, 474, 689	0	1, 474, 689		194. 16
194. 17 07966	CAMERON FAMILY MEDICINE - FREMONT	1, 053, 696	0	1, 053, 696		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)	79, 262, 540	0	79, 262, 540		202.00

| Peri od: | Worksheet B | From 10/01/2021 | Part | I | To | 09/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315

					To	09/30/2022	Date/Time Pre 2/22/2023 3:0	
				CAPI TAL REI	LATED COSTS		2/22/2023 3.0	o piii
		Cost Contan Departmen	Di rectly	DIDC 0 FLVT	MVBLE EQUIP	Cubtatal	EMDL OVEE	
		Cost Center Description	Assigned New	BLDG & FIXT	MARTE EGOLA	Subtotal	EMPLOYEE BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
		AL SERVICE COST CENTERS	U	1.00	2.00	ZN	4.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0	39, 832	20, 531	60, 363	60, 363	2.00 4.00
5. 00		ADMINISTRATIVE & GENERAL	0	404, 236		672, 698	13, 850	5.00
7.00		OPERATION OF PLANT	0	477, 514		670, 112	2, 360	7.00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	50, 240 8, 515		70, 503 11, 949	0 1, 948	8. 00 9. 00
10.00		DI ETARY	0	280, 955		394, 274	1, 047	
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	0	0 31, 222	_	0 64, 575	0 1, 260	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	147, 408		206, 863	466	14.00
15. 00		PHARMACY	0	54, 639		76, 677	1, 045	15. 00
16. 00		MEDICAL RECORDS & LIBRARY IENT ROUTINE SERVICE COST CENTERS	0	0	21, 122	21, 122	1, 538	16. 00
30.00		ADULTS & PEDIATRICS	0	883, 312	356, 270	1, 239, 582	8, 649	30.00
31.00		INTENSIVE CARE UNIT	0	55, 822		78, 337	167	31.00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	19, 869	8, 014	27, 883	21	43.00
50.00	05000	OPERATING ROOM	0	519, 523		729, 064	1, 845	50. 00
51. 00 52. 00		RECOVERY ROOM	0	336, 209		471, 814	1, 648	•
54.00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	83, 023 397, 802		116, 509 558, 249	153 4, 774	
60.00	06000	LABORATORY	0	131, 229	52, 929	184, 158	2, 428	60.00
65. 00 65. 01		RESPIRATORY THERAPY SLEEP LAB	0	34, 534 0		48, 463 49, 609	1, 747 65	65. 00 65. 01
66. 00		PHYSI CAL THERAPY	0	298, 600		419, 036	2, 471	66.00
69. 00		ELECTROCARDI OLOGY	0	17, 835		25, 028	239	69. 00
69. 01 71. 00		CARDIAC REHABILITATION MEDICAL SUPPLIES CHARGED TO PATIENT	0	29, 803 0		41, 824 0	130	69. 01 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	1	ő	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 76. 01		CHEMI CAL DEPENDENCY ONCOLOGY	0	0		211, 793	0	76. 00 76. 01
76. 02	03030	DIABETIC EDUCATION	0			0	0	76. 02
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0	129, 537	129, 537	840	88. 00
88. 01	1	RURAL HEALTH CLINIC II	0	0		124, 576	1, 434	
88. 02		RURAL HEALTH CLINIC III	0	0	,	66, 705	460	88. 02
90. 00 90. 01		CLINIC CLINIC- ORTHO	0	18, 923 0		34, 779 75, 864	230 361	90. 00 90. 01
90. 02	1	CLINIC - PEDS ENT FP	0	0		114, 101	538	90. 02
90. 03		I NTRAVENOUS THERAPY PSYCHI ATRY	0	56, 768		79, 665	192	90. 03 90. 04
90. 04 90. 05		CARDI OLOGY	0	0	33, 715 28, 086	33, 715 28, 086	797	
91.00	09100	EMERGENCY	0	451, 496	182, 104	633, 600	5, 162	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS				0		92.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						112 00
		UTILIZATION REVIEW-SNF						113. 00 114. 00
116.00	11600	HOSPI CE	0		О	0		116.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4, 829, 309	2, 941, 804	7, 771, 113	58, 197	118. 00
190.00		IMBURSABLE COST CENTERS GIFT FLOWER COFFEE SHOP & CANTEEN	0	27, 438	11, 067	38, 505	0	190. 00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	1, 927	1, 927	0	192. 00
194. 00 194. 01	1	DAYCARE-I NFANT/TODDLER	0	0	0	0		194. 00 194. 01
		COMMUNITY HEALTH	0	0	0	0		194.01
194. 03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194. 03
		EDUCATION MARKETING	0	0	0 19, 405	0 19, 405		194. 04 194. 05
		GUEST MEALS	0	0	19, 403	17, 403		194. 05
		OUTSI DE LAUNDRY	0	0	0	O		194. 07
		CANCER CENTER URGENT CARE	0	0	0	0 nl		194. 08 194. 09
194. 10	07960	RHC	O	Ö	o o	ő	0	194. 10
		OBGYN TRINE STUDENT HEALTH	0	0	- 1	0		194. 11 194. 12
174.12	101902	INTINE STODENT REALTH	ı O	ı	ا	·	287	1174. 12

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1315	Peri od:	Worksheet B
			From 10/01/2021	
			To 00 /20 /2022	Doto/Time Dropored.

					10 09/30/2022	2/22/2023 3:0	
			CAPI TAL REL	ATED COSTS			
Co	ost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2.00	2A	4. 00	
194. 13 07963 00	CCUPATI ONAL HEALTH	0	0	16, 16	16, 161	423	194. 13
194. 14 07964 I N	MMUNIZATION CLINIC	0	0	(0	0	194. 14
194. 15 07965 FC	OUNDATI ON	0	6, 244	4, 42	7 10, 671	307	194. 15
194. 16 07967 CA	AMERON FAMILY MEDICINE - NORTH	0	0	(0	433	194. 16
194. 17 07966 CA	AMERON FAMILY MEDICINE - FREMONT	0	0	(0	356	194. 17
200. 00 Cr	ross Foot Adjustments				0		200.00
201. 00 Ne	egative Cost Centers		0	(0	0	201.00
202.00 TO	OTAL (sum lines 118 through 201)	l ol	4, 862, 991	2, 994, 79	1 7, 857, 782	60, 363	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1315

Peri od: Worksheet B From 10/01/2021 Part II To 09/30/2022 Date/Time Prepared:

2/22/2023 3:06 pm Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL **PLANT** LINEN SERVICE 9. 00 5.00 7. 00 10.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 686, 548 5.00 7.00 00700 OPERATION OF PLANT 60, 666 733, 138 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 2,664 9, 345 82, 512 8.00 00900 HOUSEKEEPI NG 18. 259 1, 584 33, 740 9 00 9 00 0 10.00 01000 DI ETARY 13, 712 52, 260 0 1, 243 462, 536 10.00 01100 CAFETERI A 0 11.00 0 11.00 13.00 01300 NURSING ADMINISTRATION 10,888 5,808 0 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 27, 419 0 14 00 7.472 116 0 14.00 0 15.00 01500 PHARMACY 12,626 10, 163 0 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 13.052 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 453, 946 30.00 30.00 03000 ADULTS & PEDIATRICS 83.384 164.304 76, 190 11.064 2, 115 31.00 03100 INTENSIVE CARE UNIT 10, 383 1,442 348 8,590 31.00 43 00 43.00 04300 NURSERY 506 3,696 3,815 2, 312 0 ANCILLARY SERVICE COST CENTERS 50 00 27, 649 50.00 05000 OPERATING ROOM 96, 636 O 4, 176 0 05100 RECOVERY ROOM 16, 212 62, 538 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 2, 433 15, 443 1, 065 465 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 73, 995 54.00 50, 693 0 2.091 0 54.00 60.00 06000 LABORATORY 42,053 24, 410 0 1, 255 0 60.00 17, 167 65.00 06500 RESPIRATORY THERAPY 6, 424 0 290 0 65.00 06501 SLEEP LAB 1.390 0 93 65.01 0 65.01 0 66.00 06600 PHYSI CAL THERAPY 21, 909 55, 542 1,016 0 66.00 2, 170 06900 ELECTROCARDI OLOGY 3, 317 0 69.00 69.00 0 69.01 06901 CARDIAC REHABILITATION 1, 401 5, 544 0 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 9.548 C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 16, 657 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 22, 527 0 128 0 73.00 0 76.00 03020 CHEMI CAL DEPENDENCY 0 0 76.00 0 03480 ONCOLOGY 23, 347 0 17 76.01 C 0 76.01 03030 DIABETIC EDUCATION 76.02 902 0 76.02 OUTPATIENT SERVICE COST CENTERS 17, 371 88.00 08800 RURAL HEALTH CLINIC 0 0 273 0 88.00 08801 RURAL HEALTH CLINIC II 0 88.01 88.01 25, 729 C 0 15, 098 88.02 08802 RURAL HEALTH CLINIC III 0 35 0 88.02 90.00 09000 CLI NI C 2, 106 3,520 0 157 0 90.00 09001 CLINIC- ORTHO 09002 CLINIC - PEDS ENT FP 90 01 3.886 0 1 057 Ω 90.01 Γ 9, 242 0 90.02 1,051 0 90.02 09003 I NTRAVENOUS THERAPY 29, 687 10, 559 0 0 90.03 90.03 0 90.04 09004 PSYCHI ATRY 4, 106 0 0 0 90.04 90.05 09005 CARDLOLOGY 0 90.05 7 349 465 0 91.00 09100 EMERGENCY 45, 783 83, 982 0 5, 948 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 641, 759 726, 872 82, 512 462, 536 118. 00 33, 606 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 1900 GIFT FLOWER COFFEE SHOP & CANTEEN 408 5.104 192.00 19200 PHYSICIANS PRIVATE OFFICES 20 0 0 0 192.00 194. 00 07950 DAYCARE-I NFANT/TODDLER 0 0 0 194.00 0 0 194. 01 07951 MOB 0 0 0 0 0 0 0 0 0 0 0 194. 01 0 0 οĺ 194. 02 07952 COMMUNITY HEALTH 1, 212 Ω 0 194.02 194. 03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 0 194.03 194. 04 07954 EDUCATI ON 0 0 0 194.04 194. 05 07955 MARKETI NG 9, 499 0 0 194.05 0 194.06 07956 GUEST MEALS 0 652 C 0 194, 06 194. 07 07957 OUTSLDE LAUNDRY 0 194. 07 0 194.08 07958 CANCER CENTER 0 0 0 194.08 194. 09 07959 URGENT CARE 0 C 0 0 194, 09 194. 10 07960 RHC 0 194. 10 0 C 0 194. 11 07961 OBGYN 0 0 194. 11 0 0 194. 12 07962 TRI NE STUDENT HEALTH 2,012 C 0 0 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 0 0 0 194. 13 6, 118 C 0 194. 14 07964 IMMUNIZATION CLINIC 0 0 194. 14 0 C 194. 15 07965 FOUNDATI ON 0 0 194. 15 3.932 1, 162 194. 16 07967 CAMERON FAMILY MEDICINE - NORTH 12, 106 0 134 0 194. 16

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1315	Period: Worksheet B From 10/01/2021 Part II To 09/30/2022 Date/Time Prepared:

						2/22/2023 3:0	וווע סכ
	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	
194. 17 07966	CAMERON FAMILY MEDICINE - FREMONT	8, 830	0	0	0	0	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)	686, 548	733, 138	82, 512	33, 740	462, 536	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-1315

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 10/01/2021 | Part II |
| To 09/30/2022 | Date/Time Prepared: 2/29/2023 3:06 pm

				09/30/2022	2/22/2023 3:0	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	MEDICAL RECORDS &	
		N N	SUPPLY		LI BRARY	
CENEDAL CEDALOE COCT CENTEDO	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	0					11.00
13.00 01300 NURSING ADMINISTRATION	0	82, 531				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	242, 336	100 100		14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	0		1, 618 78	102, 129	35, 790	15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS			70	<u> </u>	33, 770	10.00
30. 00 03000 ADULTS & PEDIATRICS	0	29, 560	20, 830	0	392	30.00
31.00 03100 INTENSIVE CARE UNIT	0		0	0	5	31.00
43. 00 04300 NURSERY	0	0	0	0	40	43.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	4 401	31, 384	ol	446	FO 00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	0		31, 384	0	440	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	517	Ö	o	41	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	7, 615	О	5, 000	54.00
60. 00 06000 LABORATORY	0	0	385	0	7, 784	60.00
65. 00 06500 RESPI RATORY THERAPY	0	7, 026	3, 453	0	1, 150	65.00
65. 01 06501 SLEEP LAB 66. 00 06600 PHYSI CAL THERAPY	0	0 9, 851	0 947	0	23 1, 933	65. 01 66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1	244	0	1, 933	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	Ö	728	110	Ö	527	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1, 756	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	128, 477	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	46, 132	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY 76. 01 03480 ONCOLOGY	0		0	0	705	76. 00 76. 01
76. 02 03030 DI ABETI C EDUCATI ON	o o	- 1	16	o	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0		1, 933	0	1, 689	88. 00
88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III	0	0	14, 366	0	3, 438 1, 144	88. 01 88. 02
90. 00 09000 CLINIC	0	832	1, 004 1, 319	0	644	90.00
90. 01 09001 CLI NI C - ORTHO	Ö	0	1, 052	o	655	90. 01
90. 02 09002 CLINIC - PEDS ENT FP	0	0	1, 098	О	1, 553	90. 02
90. 03 09003 I NTRAVENOUS THERAPY	0	691	1, 270	55, 997	388	90. 03
90. 04 09004 PSYCHI ATRY 90. 05 09005 CARDI OLOGY	0	0	99	0	807	90.04
90. 05 09005 CARDI OLOGY 91. 00 09100 EMERGENCY	0	2, 807 17, 518	138 19, 611	0	312 3, 199	90. 05 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		17,510	17,011	J	5, 177	92.00
OTHER REIMBURSABLE COST CENTERS				1		
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						112 00
114.00 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
116. 00 11600 HOSPI CE	0	0	0	o	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	82, 531	238, 803	102, 129	33, 207	
NONREI MBURSABLE COST CENTERS	_					
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS PRIVATE OFFICES	0		0	0		190. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 194. 00 07950 DAYCARE-INFANT/TODDLER	0		0	0		194.00
194. 01 07951 MOB	0	0	0	0		194. 00
194. 02 07952 COMMUNI TY HEALTH	0	o	12	Ö		194. 02
194.03 07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194. 03
194. 04 07954 EDUCATI ON	0	0	0	0		194. 04
194. 05 07955 MARKETI NG	0	0	8	0		194. 05 194. 06
194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY	0			0		194. 06 194. 07
194. 08 07958 CANCER CENTER	0			0		194. 07
194. 09 07959 URGENT CARE	Ö	0	o	Ö		194. 09
194. 10 07960 RHC	0	0	0	o		194. 10
194. 11 07961 OBGYN	0	0	0	0		194. 11
194. 12 07962 TRI NE STUDENT HEALTH 194. 13 07963 OCCUPATI ONAL HEALTH	0	0	276 377	0		194. 12 194. 13
194. 13 07963 OCCUPATIONAL HEALTH	0		377	0		194. 13
194. 15 07965 FOUNDATION	ő	1	52	Ö		194. 15
			<u>'</u>			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS CAMERON MEMORIAL COMMUNITY HOSPITAL Provider CCN: 15-1315

						2/22/2020 0.0	O PIII
	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. 16 0796	7 CAMERON FAMILY MEDICINE - NORTH	0	0	1, 742	0	1, 438	194. 16
194. 17 0796	6 CAMERON FAMILY MEDICINE - FREMONT	0	0	1, 066	0	695	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)	0	82, 531	242, 336	102, 129	35, 790	202. 00

| Period: | Worksheet B | From 10/01/2021 | Part II | To 09/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315

				To 09/30/2022 Date/Ti me 2/22/2023	
Cost Center Description	Subtotal	Intern &	Total	2/22/2023	3.00 piii
		Residents			
		Cost & Post Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT			1		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE			•		7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON					11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16. 00
30. 00 03000 ADULTS & PEDIATRICS	2, 087, 901	0	2, 087, 9	901	30, 00
31. 00 03100 I NTENSI VE CARE UNI T	101, 951	0			31.00
43. 00 04300 NURSERY	38, 273	0	38, 2	273	43.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	897, 621	0	897, 6	21	50.00
51. 00 05100 RECOVERY ROOM	557, 852	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	136, 626	0	1		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	702, 417	0			54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	262, 473 85, 720	0			60.00 65.00
65. 01 06501 SLEEP LAB	51, 180	0			65. 01
66. 00 06600 PHYSI CAL THERAPY	512, 705	0	512, 7	705	66. 00
69. 00 06900 ELECTROCARDI OLOGY	32, 706	0	, .		69.00
69. 01 06901 CARDIAC REHABILITATION 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	50, 264 11, 304	0	1		69. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	145, 134	0	1		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	68, 787	0	, .		73. 00
76. 00 03020 CHEMI CAL DEPENDENCY 76. 01 03480 ONCOLOGY	0 235, 862	0	ł	0	76. 00 76. 01
76. 02 03030 DI ABETI C EDUCATI ON	918	0		918	76.01
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	151, 643 169, 549	0			88. 00 88. 01
88. 02 08802 RURAL HEALTH CLINIC III	84, 446	0			88. 02
90. 00 09000 CLINIC	43, 587	0			90.00
90. 01 09001 CLINIC- ORTHO	82, 875	0	, -		90. 01
90. 02 09002 CLINI C - PEDS ENT FP 90. 03 09003 NTRAVENOUS THERAPY	127, 583 178, 449	0			90.02
90. 04 09004 PSYCHI ATRY	39, 059	0			90.03
90. 05 09005 CARDI OLOGY	39, 954				90. 05
91. 00 09100 EMERGENCY	814, 803	0		303	91. 00 92. 00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0			92.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE			1		112 00
114.00 11400 UTILIZATION REVIEW-SNF					113. 00 114. 00
116. 00 11600 HOSPI CE	0	0		О	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 711, 642	0	7, 711, 6	542	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	44, 017	0	44, 0	017	190, 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	1, 947	0	1		192.00
194. 00 07950 DAYCARE-I NFANT/TODDLER	O	0	1	O	194. 00
194. 01 07951 MOB 194. 02 07952 COMMUNITY HEALTH	1 240	0	1	0	194. 01 194. 02
194.03 07953 ASSISTED LIVING/CAMERON WOODS	1, 360 0	0	1, 3	0	194. 02
194. 04 07954 EDUCATI ON	o	Ö		0	194. 04
194. 05 07955 MARKETI NG	29, 081	0	29, 0		194. 05
194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY	707	0	·	707 0	194. 06 194. 07
194. 08 07958 CANCER CENTER		0		ŏ	194. 07
194. 09 07959 URGENT CARE	O	Ö		0	194. 09
194. 10 07960 RHC	0	0	1	0	194. 10
194. 11 07961 OBGYN 194. 12 07962 TRINE STUDENT HEALTH	0 3, 025	0	3, 0	025	194. 11 194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	23, 079		1		194. 13

Health Financial Systems	CAMERON MEMORIAL COMM	JNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1315	Peri od: From 10/01/2021	Worksheet B
				Date/Time Prepared:

					2/22/	2023 3:06 pm
	Cost Center Description	Subtotal	Intern &	Total		
			Resi dents			
			Cost & Post			
			Stepdown			
			Adjustments			
		24. 00	25. 00	26.00		
194. 14 07964	IMMUNIZATION CLINIC	0	0	C		194. 14
194. 15 07965	FOUNDATI ON	16, 124	0	16, 124		194. 15
194. 16 07967	CAMERON FAMILY MEDICINE - NORTH	15, 853	0	15, 853		194. 16
194. 17 07966	CAMERON FAMILY MEDICINE - FREMONT	10, 947	0	10, 947	1	194. 17
200. 00	Cross Foot Adjustments	0	0	C		200.00
201. 00	Negative Cost Centers	0	0	[c		201.00
202. 00	TOTAL (sum lines 118 through 201)	7, 857, 782	0	7, 857, 782		202.00

Heal th	Financial Systems CAME LLOCATION - STATISTICAL BASIS	RON MEMORIAL C	OMMUNITY HOSPIT		In Lie Period:	worksheet B-1	
C031 F	ELUCATION - STATISTICAL BASIS		Frovider C	F	From 10/01/2021 o 09/30/2022		epared:
		CAPI TAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1. 00	2.00	SALARI ES) 4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	JA.	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	102, 797					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0.43	156, 956				2.00
4. 00 5. 00	OO4OO	842 8, 545				64, 739, 992	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	10, 094				5, 720, 494	1
8.00	00800 LAUNDRY & LINEN SERVICE	1, 062		1	-	,	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	180 5, 939	l control of the cont			, , , , , , , , , , , , , , , , , , , ,	1
11. 00	01100 CAFETERI A	3, 939		1			1
13.00	01300 NURSING ADMINISTRATION	660	1, 748			.,	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 116					1
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 155					
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		1,107	127, 723	,,	1,230,730	10.00
30.00	03000 ADULTS & PEDIATRICS	18, 672					1
31.00	03100 INTENSIVE CARE UNIT	1, 180		1			1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	420	420	10, 166	0	47, 714	43.00
50.00	05000 OPERATING ROOM	10, 982	10, 982	875, 599	0	2, 607, 138	50.00
51.00	05100 RECOVERY ROOM	7, 107					1
52. 00 54. 00	05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	1, 755 8, 409		1			
60.00	06000 LABORATORY	2, 774					1
65.00	06500 RESPI RATORY THERAPY	730	l l			,	1
65. 01	06501 SLEEP LAB	0	_,	1			1
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	6, 312 377				_, -,,	
69. 01	06901 CARDI AC REHABI LI TATI ON	630	l control of the cont	1		1	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1			1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0			0	,	1
76.00	03020 CHEMI CAL DEPENDENCY						1
76. 01	03480 ONCOLOGY	0	,				1
76. 02	03030 DIABETIC EDUCATION OUTPATIENT SERVICE COST CENTERS	0) 0	(0	85, 051	76. 02
88. 00	08800 RURAL HEALTH CLINIC	Ιο	6, 789	398, 559) 0	1, 637, 977	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0	6, 529	680, 795		2, 426, 097	88. 01
	08802 RURAL HEALTH CLINIC III	400					
	09000 CLI NI C 09001 CLI NI C- ORTHO	400	831 3, 976			366, 453	
90. 02	09002 CLINIC - PEDS ENT FP	0	5, 980			871, 500	1
	09003 I NTRAVENOUS THERAPY	1, 200				2, 799, 331	
90. 04 90. 05	09004 PSYCHI ATRY 09005 CARDI OLOGY	0	1 .,			387, 156 692, 979	
91.00	09100 EMERGENCY	9, 544					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0		0	1	101.00
101.00	SPECIAL PURPOSE COST CENTERS		,		,,		101.00
	11300 INTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF 11600 HOSPI CE	0				0	114. 00 116. 00
118.00		102, 085	1	27, 619, 072	-14, 522, 548		
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	580	l .		1		190. 00 192. 00
	07950 DAYCARE-INFANT/TODDLER		l l				194.00
	07951 MOB	0	0	(0	l .	194. 01
	07952 COMMUNITY HEALTH	0	0	64, 400			
	07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION				0	l .	194. 03 194. 04
194.05	07955 MARKETI NG		1, 017	80, 430		895, 730	
	07956 GUEST MEALS	0	0	26, 149	0		194.06
	07957 OUTSLDE LAUNDRY 07958 CANCER CENTER	0	0		0		194. 07 194. 08
	07959 URGENT CARE				1		194.00
194. 10	07960 RHC	0		(0	194. 10
194. 11	07961 OBGYN	0	0	(0	0	194. 11

| Peri od: | Worksheet B-1 | From 10/01/2021 | To 09/30/2022 | Date/Time Prepared: Provider CCN: 15-1315

				'	0 077 007 2022	2/22/2023 3:0	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1. 00	2. 00	SALARI ES) 4. 00	5A	5. 00	
104 1007045	TRINE STUDENT HEALTH	1.00	2.00				104 10
	OCCUPATIONAL HEALTH	0	847	136, 310		189, 710 576, 880	1
	I I MMUNI ZATI ON CLINI C	0	847	200, 951	0	•	194. 13
194. 15 07965	l .	132	232	145, 624	0	370, 805	
	CAMERON FAMILY MEDICINE - NORTH	132	232	205, 499		1, 141, 517	1
4	CAMERON FAMILY MEDICINE - FREMONT	0	0	168, 839		832, 669	1
200. 00	Cross Foot Adjustments	J	O	100,037	0	•	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	4, 862, 991	2, 994, 791	10, 055, 552		14, 522, 548	•
202.00	Part 1)	4,002,771	2, // 7, // 1	10, 033, 332		14, 322, 340	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	47. 306740	19. 080449	0. 351013		0. 224321	203.00
204. 00	Cost to be allocated (per Wkst. B,			60, 363		686, 548	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 002107		0. 010605	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

	LLOCATION - STATISTICAL BASIS	TOTAL INCIDENTAL OF	Provi der C	CN: 15-1315 P	eri od:	Worksheet B-1	
					rom 10/01/2021 o 09/30/2022	Date/Time Pre 2/22/2023 3:0	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (PATI ENT	HOUSEKEEPING (HOURS OF S ERVIC)	DI ETARY (PATI ENT DAYS)	CAFETERI A (FTES)	
		7. 00	DAYS) 8. 00	9.00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT	83, 316					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 062	1				8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG	180	l .	5, 809			9.00
11. 00	01000 DI ETARY 01100 CAFETERI A	5, 939		214		0	10.00
	01300 NURSING ADMINISTRATION	660	Ō	Ö	0	0	1
	01400 CENTRAL SERVICES & SUPPLY	3, 116	l .	20		0	
15.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 155 0	l .	0		0	
10.00	I NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	10.00
	03000 ADULTS & PEDIATRICS	18, 672		1, 905	6, 870	0	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 180		1		0	
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	420	344	398	0	0	43.00
50. 00	05000 OPERATING ROOM	10, 982	0	719	0	0	50.00
51.00	05100 RECOVERY ROOM	7, 107	l .			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 755	l .	l .		0	52.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	8, 409 2, 774		360 216		0	54. 00 60. 00
	06500 RESPIRATORY THERAPY	730		50		0	65.00
65. 01	06501 SLEEP LAB	0	_			0	
66. 00 69. 00	06600 PHYSI CAL THERAPY	6, 312		175 0		0	66.00
69. 00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON	377 630		0		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		Ö		0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	-	0	72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 CHEMI CAL DEPENDENCY	0	0	22 0		0	73. 00 76. 00
	03480 ONCOLOGY		0	3		0	1
	03030 DI ABETI C EDUCATI ON	0				0	1
00.00	OUTPATIENT SERVICE COST CENTERS		1 0				00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0		•	0	0	
88. 02	08802 RURAL HEALTH CLINIC III	Ö	-	6		0	1
90.00	09000 CLI NI C	400	0	27		0	90.00
90. 01 90. 02	09001 CLI NI C - ORTHO	0	0	182 181		0	
	09003 I NTRAVENOUS THERAPY	1, 200	0	0		0	1
90.04	09004 PSYCHI ATRY	0	0	0	0	0	
	09005 CARDI OLOGY	0 544		1		0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 544	0	1, 024	0	0	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						1 /2:00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11600 HOSPI CE	0	0	0	0		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	82, 604	7, 440	5, 786	7, 000	0	118.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	580	0	0	0	0	190.00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0		O		0	192. 00
	07950 DAYCARE-INFANT/TODDLER	0	0	0	1		194.00
	07951 MOB 07952 COMMUNITY HEALTH	0	0	0	0		194. 01 194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	Ö	Ö	0		194. 03
	07954 EDUCATI ON	0	0	0	0	0	194. 04
	07955 MARKETI NG	0	0	0	0		194.05
	07956 GUEST MEALS 07957 OUTSI DE LAUNDRY	0	0		0	0	194. 06 194. 07
	07958 CANCER CENTER	0	Ö	Ö	o o		194. 08
	07959 URGENT CARE	0	0	0	0		194. 09
	07960 RHC 07961 0BGYN	0	0	0	0		194. 10 194. 11
	07961 OBGTN 07962 TRINE STUDENT HEALTH	0	0	0	-		194. 11
194. 13	07963 OCCUPATI ONAL HEALTH	0		O	0	0	194. 13
194. 14	07964 IMMUNIZATION CLINIC	0	0	0	0	0	194. 14

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPIT	AL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CC	CN: 15-1315	Peri od:	Worksheet B-1

					rom 10/01/2021		
				T	o 09/30/2022	Date/Time Pre 2/22/2023 3:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	555 5511 55 555 FT 511		LINEN SERVICE		(PATI ENT	(FTES)	
		(SQUARE FEET)	(PATI ENT	ERVIC)	DAYS)	(1123)	
		(SQS/IIIC TEET)	DAYS)	Litti 0)	<i>D</i> /(10)		
		7. 00	8.00	9. 00	10.00	11. 00	
194. 15 07	7965 FOUNDATION	132	0	0	0	0	194. 15
194. 16 07	7967 CAMERON FAMILY MEDICINE - NORTH	0	0	23	0	0	194. 16
194. 17 07	7966 CAMERON FAMILY MEDICINE - FREMONT	0	0	0	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,	7, 003, 721	396, 814	2, 123, 040	2, 160, 508	0	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	84. 062137	53. 335215	365. 474264	308. 644000	0.000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	733, 138	82, 512	33, 740	462, 536	0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	8. 799486	11. 090323	5. 808229	66. 076571	0.000000	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	CAMER	ON MEMORIAL CO	<u>MMUNITY H</u> OSPIT	AL	<u>I</u> n Lieu	u of Form CMS-	<u>255</u> 2-10
COST ALLOCATION - STATISTICAL BASIS			Provi der CC	F	eriod: rom 10/01/2021 o 09/30/2022	Worksheet B-1 Date/Time Pre 2/22/2023 3:0	pared:
Cost Center Description		NURSI NG ADMI NI STRATI O N (DI RECT NRS I NG HR) 13. 00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
GENERAL SERVICE COST CENTERS	V=				Т		
1. 00 00100 CAP REL COSTS-BLDG & FI 2. 00 00200 CAP REL COSTS-MVBLE EQL 4. 00 00400 EMPLOYEE BENEFITS DEPAF 5. 00 00500 ADMINISTRATI VE & GENERA 7. 00 00700 OPERATI ON OF PLANT 8. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINISTRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPF 15. 00 01500 PHARMACY 10. 00 01600 MEDI CAL RECORDS & LI BRA INPATI ENT ROUTI NE SERVI CE CO	JI P RTMENT NL : : : PLY	273, 924 0 0 0	2, 962, 670 19, 785 955 254, 657	10, 000			1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT		98, 112 1, 872	254, 657	0			31.00
43. 00 04300 NURSERY		0	Ő	0			43. 00
43. 00	ED TO PATIENT PATIENTS ITS	21, 310 18, 720 1, 715 0 0 23, 320 32, 695 1, 248 2, 417 0 0 0 0 0 0 0 2, 763 0 0 0 2, 763 0 0 0 0 0 0 0 0	383, 685 0 93, 100 4, 701 42, 215 0 11, 578 2, 980 1, 347 21, 467 1, 570, 686 175, 632 12, 279 16, 130 12, 858 13, 418 15, 532 1, 206 1, 687 239, 760	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9, 102 0 829 102, 033 158, 858 23, 476 462 39, 455 27, 186 10, 749 0 0 0 14, 396 70, 171 23, 349 13, 138 13, 367 31, 691 7, 924 16, 473 6, 360		43.00 50.00 51.00 52.00 54.00 65.01 66.00 69.00 69.01 71.00 72.00 73.00 76.00 76.01 76.02 88.01 88.02 90.00 90.01 90.02 90.03 90.04 90.05 91.00
OTHER REIMBURSABLE COST CENTI	ERS	ol	0	0	O		101.00
SPECIAL PURPOSE COST CENTERS		<u> </u>	0	0	. 0		1.51.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES NONREI MBURSABLE COST CENTERS	5 1 through 117)	0 273, 924	0 2, 919, 484	0 10, 000	0 677, 677		113. 00 114. 00 116. 00 118. 00
NONREL MBURSABLE COST CENTERS	CES	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 149 0 100 0 0 0 0 0 3, 372 4, 611	0 0 0 0 0 0 0 0 0 0 0 0	,		190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 05 194. 06 194. 06 194. 07 194. 08 194. 09 194. 10 194. 11 194. 12 194. 13

Health Financial Systems	CAMERON MEMORIAL COMMUN	ITY HOSPITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	P	rovider CCN: 15-1315	From 10/01/2021	Worksheet B-1
			To 09/30/2022	Date/Time Prepared: 2/22/2023 3:06 pm

				10	09/30/2022	2/22/2023 3:0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	2/22/2023 3.0	o piii
	oost oditer bescription	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &		
		N	SUPPLY	REQUIS.)	LI BRARY		
		(DI RECT NRS	(COSTED		(TIME SPENT)		
		ING HR)	REQUIS.)		`		
		13. 00	14. 00	15. 00	16. 00		
194. 14 07964	IMMUNIZATION CLINIC	0	0	0	0		194. 14
194. 15 07965	FOUNDATI ON	0	630	0	0		194. 15
194. 16 07967	CAMERON FAMILY MEDICINE - NORTH	0	21, 297	0	29, 349		194. 16
194. 17 07966	CAMERON FAMILY MEDICINE - FREMONT	0	13, 027	0	14, 182		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,	1, 312, 521	1, 131, 845	1, 562, 280	1, 507, 198		202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	4. 791552	0. 382035	156. 228000	2. 063564		203. 00
204. 00	Cost to be allocated (per Wkst. B,	82, 531	242, 336	102, 129	35, 790		204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 301292	0. 081796	10. 212900	0. 049001		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)						1

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-1315	Peri od:	Worksheet C	
				From 10/01/2021	Part I	
				To 09/30/2022	Date/Time Pre	pared:
					2/22/2023 3:0	6 pm
		litle	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	14, 965, 234		14, 965, 23	4 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	421, 580		421, 58	0 0	0	31.00
43. 00 04300 NURSERY	259, 194		259, 19	4 0	0	43.00
ANCILLARY SERVICE COST CENTERS]
50. 00 05000 OPERATING ROOM	4, 645, 392		4, 645, 39	2 0	0	50.00
51.00 05100 RECOVERY ROOM	2, 558, 803		2, 558, 80	3 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	472, 716		472, 71		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 936, 918		6, 936, 91	-	0	54.00
60. 00 06000 LABORATORY	5, 496, 602		5, 496, 60		0	60.00
65. 00 06500 RESPI RATORY THERAPY	2, 237, 796	0			0	65.00
					0	
65. 01 06501 SLEEP LAB	167, 306	0	167, 30			65. 01
66. 00 06600 PHYSI CAL THERAPY	3, 366, 342	0	3, 366, 34		0	66.00
69. 00 06900 ELECTROCARDI OLOGY	345, 431		345, 43		0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	248, 965		248, 96		0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 110, 510		1, 110, 51		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 523, 081		2, 523, 08	1 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 314, 381		3, 314, 38	1 0	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0			o o	0	76.00
76. 01 03480 0NC0L0GY	2, 726, 158		2, 726, 15	8 0	0	76. 01
76. 02 03030 DI ABETI C EDUCATION	104, 203		104, 20		0	76. 02
OUTPATIENT SERVICE COST CENTERS				-,		
88. 00 08800 RURAL HEALTH CLINIC	2, 102, 746		2, 102, 74	6 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	3, 182, 587		3, 182, 58		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	1, 798, 132		1, 798, 13		Ö	88. 02
90. 00 09000 CLI NI C	333, 154		333, 15		0	90.00
90. 01 09001 CLI NI C- ORTHO	547, 668		547, 66		0	90.00
90. 02 09002 CLINI C - PEDS ENT FP	1				0	90.01
	1, 203, 669		1, 203, 66		_	
90. 03 09003 I NTRAVENOUS THERAPY	4, 418, 021		4, 418, 02		0	90.03
90. 04 09004 PSYCHI ATRY	508, 457		508, 45		0	90.04
90. 05 09005 CARDI OLOGY	936, 073		936, 07		0	90.05
91. 00 09100 EMERGENCY	6, 967, 018		6, 967, 01		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 005, 824		4, 005, 82	4	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0			0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116. 00 11600 HOSPI CE	0			ol	0	116.00
200.00 Subtotal (see instructions)	77, 903, 961	0	77, 903, 96	1 0	0	200.00
201.00 Less Observation Beds	4, 005, 824	_	4, 005, 82			201.00
202.00 Total (see instructions)	73, 898, 137	0				202.00
1.222. (222.1102.402.010)		·	, , 10	١		,

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1315 Peri od: Worksheet C From 10/01/2021 Part I 09/30/2022 Date/Time Prepared: 2/22/2023 3:06 pm Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 11, 920, 860 30.00 03000 ADULTS & PEDIATRICS 11, 920, 860 30.00 31.00 03100 INTENSIVE CARE UNIT 393,000 393,000 31.00 340, 000 04300 NURSERY 340,000 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 1, 791, 339 12, 430, 402 14, 221, 741 0.326640 0.000000 50.00 05000 OPERATING ROOM 945, 664 51.00 05100 RECOVERY ROOM 5, 403, 943 6, 349, 607 0.402986 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 113, 200 20, 289 1, 133, 489 0.417045 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 48, 142, 915 0.144090 2.414.241 45, 728, 674 0.000000 54.00 54.00 3, 820, 917 28, 904, 883 0. 190162 0.000000 60.00 06000 LABORATORY 25, 083, 966 60 00 65.00 06500 RESPIRATORY THERAPY 2, 392, 119 1, 276, 588 3, 668, 707 0.609969 0.000000 65.00 65.01 06501 SLEEP LAB 1, 118, 233 1, 118, 233 0.149616 0.000000 65.01 4, 584, 724 06600 PHYSI CAL THERAPY 1, 663, 921 6, 248, 645 0.538732 0.000000 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 165, 573 3, 135, 103 3, 300, 676 0.104655 0.000000 69.00 539, 342 69 01 06901 CARDIAC REHABILITATION 539, 342 0.461609 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 881, 067 0.000000 6, 848, 157 7, 729, 224 0.143677 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 336,600 2, 476, 530 2, 813, 130 0.896895 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 3, 350, 969 7, 104, 061 0.317013 0.000000 73.00 10, 455, 030 73.00 76.00 03020 CHEMI CAL DEPENDENCY 0 0.000000 0.000000 76.00 03480 ONCOLOGY 76.01 21, 506, 696 21, 506, 696 0.126759 0.000000 76.01 76.02 03030 DIABETIC EDUCATION 6,500 57, 504 64,004 1.628070 0.000000 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2, 169, 275 2, 179, 947 88.00 10.672 08801 RURAL HEALTH CLINIC II 3, 729, 278 3, 729, 278 88 01 88.01 88.02 08802 RURAL HEALTH CLINIC III 740, 113 1, 255, 961 1, 996, 074 88.02 09000 CLI NI C 90.00 0 542, 397 542, 397 0.614225 0.000000 90.00 31, 487 09001 CLINIC- ORTHO 0 31, 487 17. 393464 0.000000 90.01 90.01 09002 CLINIC - PEDS ENT FP 0 567, 986 567, 986 2.119188 90.02 0.000000 90.02 90.03 09003 I NTRAVENOUS THERAPY 0 8, 775, 477 8, 775, 477 0.503451 0.000000 90.03 90.04 09004 PSYCHI ATRY 0 251, 879 251, 879 2.018656 0.000000 90.04 90.05 09005 CARDI OLOGY 0 28, 951 28, 951 32 333011 0.000000 90.05 09100 EMERGENCY 30, 665, 969 91.00 916, 462 31, 582, 431 0. 220598 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 107, 728 2, 767, 521 2, 875, 249 1.393209 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 33, 310, 945 188, 100, 393 221, 411, 338 200.00 201.00 Less Observation Beds 201.00 33, 310, 945 188, 100, 393 202.00 Total (see instructions) 221, 411, 338 202.00

Cost Center Description
Cost Center Description
NPATLENT ROUTINE SERVICE COST CENTERS 1.00
IMPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.
30.00 03000 ADULTS & PEDIATRICS 31.00 43.00
31.00 03100 INTENSIVE CARE UNIT
43.00
ANCILLARY SERVICE COST CENTERS 50.00
SO 00 05000 05000 05000 05000 05000 05100 05100 05100 05100 05100 05100 05100 05100 05100 05100 05200 05100 05200 05100 05200 05100 05200 05100 05200 05100 05200 05100 05200 05100 05200 05100 05200 051000 051000 051000 051000 051000 051000 051000 051000 051000 051000 051000 0510000 0510000 0510000 0510000 0510000 0510000 0510000 0510000 05100000 05100000 05100000 05100000 051000000 05100000 051000000 051000000 0510000000 051000000 05100
51.00 05100 RECOVERY ROOM 0.000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 06500 RESPIRATORY THERAPY 0.000000 65.01 06501 SLEEP LAB 0.000000 65.01 06501 SLEEP LAB 0.000000 65.01 06500 CELETRICOARDI OLOGY 0.000000 65.01 06501 SLEEP LAB 0.000000 65.01 06900 CELETRICOARDI OLOGY 0.000000 65.01 06901 CARDI AGNOSTI CELETRICOARDI OLOGY 0.000000 069.01 06901 CARDI AGNOSTI CELETRICOARDI OLOGY 0.000000 069.01 06901 06
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 552.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000
60. 00 06000 LABORATORY 0.000000 065. 00 06500 RESPI RATORY THERAPY 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000
65. 00 06500 RESPIRATORY THERAPY 0. 000000 65. 01 66. 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 CARDIA C REHABI LI TATI ON 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 76. 01 03400 00COLOGY 0. 000000 76. 00 76. 01 03400 00COLOGY 0. 000000 76. 01 76. 02 03300 DIABETI C EDUCATI ON 0. 000000 76. 01 76. 02 03300 DIABETI C EDUCATI ON 0. 000000 76. 01 88. 00 08800 RURAL HEALTH CLINI C 11 88. 02 09000 CLINI C - PEDS ENT FP 0. 000000 90. 01 90. 01 09001 CLINI C - PEDS ENT FP 0. 000000 90. 01 90. 03 09003 INTAVENOUS THERAPY 0. 000000 90. 01 90. 04 09004 PSYCHI ATRY 0. 000000 90. 01 90. 05 09005 CARDIO LOGY 90. 04 90. 06 09005 CARDIO LOGY 90. 04 90. 07 09000 00000 00000 00000 00000 91. 00 09100 EMERGENCY 0. 000000 90. 04 90. 01 09100 EMERGENCY 0. 000000 90. 05 91. 00 09100 EMERGENCY 0. 000000 90. 05 92. 00 09200 DISERVATI ON BEDS (NON-DISTINCT PART 0. 000000 90. 05 92. 00 09200 DISERVATI ON BEDS (NON-DISTINCT PART 0. 000000 90. 01 91. 00 01000 INTEREST EXPENSE 101. 00
65. 01 06501 SLEEP LAB
66. 00 06600 PHYSI CAL THERAPY 0. 000000 69. 00 69. 00 69.00 66.00 69.
69. 00
69. 01 06901 CARDIAC REHABILITATION 0.000000 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 171. 00 172. 00 172. 00 07200 IMPLD DEV. CHARGED TO PATIENTS 0.000000 172. 00 172. 00 173. 00 1
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 000000 72. 00 72. 00 72. 00 73. 00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 75. 00 03200 CHEM CAL DEPENDENCY 0. 000000 76. 00 03480 ONCOLOGY 0. 000000 76. 01 03480 ONCOLOGY 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 75. 00 03020 CHEMI CAL DEPENDENCY 0.000000 76. 01 03480 ONCOLOGY 0.000000 76. 01 76. 02 03030 DI ABETI C EDUCATI ON 0.000000 76. 01 03030 DI ABETI C EDUCATI ON 0.000000 76. 02 0000000 76. 02 00000000 76. 02 00000000 76. 02 0000000000000000000000000000000000
73. 00
76. 00 03020 CHEMI CAL DEPENDENCY 0. 000000 76. 01 03480 ONCOLOGY 0. 000000 76. 01 76. 01 76. 02 03030 DI ABETI C EDUCATI ON 0. 000000 76. 01 76. 02 000000 00000 00000 00000 0. 0000000 0. 000000
76. 01 03480 ONCOLOGY 0.000000 76. 01 76. 02 03030 DI ABETI C EDUCATION 0.000000 76. 02 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 888. 01 08801 RURAL HEALTH CLINI C III 88. 02 08802 RURAL HEALTH CLINI C III 88. 02 08902 RURAL HEALTH CLINI C III 88. 02 09000 CLINI C 0.000000 90. 01 09001 CLINI C 0.000000 90. 01 09001 CLINI C 0.000000 90. 01 09001 CLINI C 0.000000 90. 02 09002 CLINI C 0.000000 90. 02 09002 CLINI C 0.000000 90. 03 09003 INTRAVENOUS THERAPY 0.000000 90. 03 09003 INTRAVENOUS THERAPY 0.000000 90. 03 09005 CARDI OLOGY 0.000000 90. 04 09004 PSYCHI ATRY 0.000000 90. 05 09005 CARDI OLOGY 0.000000 90. 05 090005 CARDI OLOGY 0.000000 90. 05 09005
76. 02 03030 DI ABETI C EDUCATI ON 0.000000 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 88. 00 88. 01 08801 RURAL HEALTH CLINI C 111 88. 02 08802 RURAL HEALTH CLINI C 111 88. 02 08802 RURAL HEALTH CLINI C 111 88. 01 88. 00 09000 CLINI C 0.000000 90. 01 09000 CLINI C 0.000000 90. 01 09001 CLINI C - PEDS ENT FP 0.000000 90. 02 09002 CLINI C - PEDS ENT FP 0.000000 90. 03 09003 INTRAVENOUS THERAPY 0.000000 90. 04 09004 PSYCHI ATRY 0.000000 90. 05 09005 CARDI OLOGY 0.000000 90. 06 09005 CARDI OLOGY 0.000000 90. 07 09100 EMERGENCY 0.000000 90. 08 09100 EMERGENCY 0.000000 90. 00 09200 DISSERVATI ON BEDS (NON-DI STINCT PART 0.000000) 91. 00 09100 HOME HEALTH AGENCY 0.000000 101. 00 10100 HOME HEALTH AGENCY 113. 00 11300 INTEREST EXPENSE
SECOND S
88. 00
88. 01
88. 02
90. 00 09000 CLINI C 0.000000 0.000000 90. 01 09001 CLINI C - ORTHO 0.000000 90. 01 09001 CLINI C - PEDS ENT FP 0.000000 90. 02 09002 CLINI C - PEDS ENT FP 0.000000 90. 02 09003 NTRAVENOUS THERAPY 0.000000 90. 03 09003 NTRAVENOUS THERAPY 0.000000 90. 03 09003 CARDI OLOGY 0.000000 90. 03 09005 CARDI OLOGY 0.000000 90. 05 09005 CARDI OLOGY 0.000000 91. 00 09100 EMERGENCY 0.000000 91. 00 09200 095ERVATI ON BEDS (NON-DI STINCT PART 0.000000 092. 00 09200 095ERVATI ON BEDS (NON-DI STINCT PART 0.000000 092. 0
90. 01
90. 02
90. 03
90. 04
90. 05
91. 00
92. 00
OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113. 00
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
116. 00 11600 HOSPI CE 116. 00
200.00 Subtotal (see instructions) 200.00
201.00 Less Observation Beds 201.00
202.00 Total (see instructions) 202.00

Health Financial Systems	CAMERON MEMORIAL COMMUNI	ITY HOSPITAL	In Lie	u of Form CMS-2552-10
	_			

Health Financial Systems CAME	RON MEMORIAL CO	JMMUNITY HOSPI	IAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 10/01/2021 To 09/30/2022	Worksheet C Part I Date/Time Pre 2/22/2023 3:0	
		Ti tl	e XIX	Hospi tal	PPS	-
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•					
30. 00 03000 ADULTS & PEDIATRICS	14, 965, 234		14, 965, 23	4 0	14, 965, 234	30.00
31.00 03100 INTENSIVE CARE UNIT	421, 580		421, 58	o o	421, 580	31.00
43. 00 04300 NURSERY	259, 194		259, 19	4 0	259, 194	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	4, 645, 392		4, 645, 39	2 0	4, 645, 392	50.00
51.00 05100 RECOVERY ROOM	2, 558, 803		2, 558, 80	3 0	2, 558, 803	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	472, 716		472, 71	6 0	472, 716	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 936, 918		6, 936, 91	8 0	6, 936, 918	54.00
60. 00 06000 LABORATORY	5, 496, 602		5, 496, 60	2 0	5, 496, 602	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 237, 796	0	2, 237, 79	6 0	2, 237, 796	65.00
65. 01 06501 SLEEP LAB	167, 306	0	167, 30	6 0	167, 306	65. 01
66. 00 06600 PHYSI CAL THERAPY	3, 366, 342	0			3, 366, 342	66.00
69. 00 06900 ELECTROCARDI OLOGY	345, 431		345, 43		345, 431	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	248, 965		248, 96		248, 965	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 110, 510	l e	1, 110, 51	o o	1, 110, 510	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 523, 081		2, 523, 08		2, 523, 081	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 314, 381		3, 314, 38		3, 314, 381	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0			o o	0	76.00
76. 01 03480 0NC0L0GY	2, 726, 158		2, 726, 15	8 0	2, 726, 158	76. 01
76. 02 03030 DI ABETI C EDUCATION	104, 203		104, 20	3 0	104, 203	76. 02
OUTPATIENT SERVICE COST CENTERS		•				1
88. 00 08800 RURAL HEALTH CLINIC	2, 102, 746		2, 102, 74	6 0	2, 102, 746	88. 00
88.01 08801 RURAL HEALTH CLINIC II	3, 182, 587		3, 182, 58	7 0	3, 182, 587	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	1, 798, 132		1, 798, 13	2 0	1, 798, 132	88. 02
90. 00 09000 CLI NI C	333, 154		333, 15		333, 154	
90. 01 09001 CLI NI C- ORTHO	547, 668		547, 66		547, 668	1
90. 02 09002 CLINIC - PEDS ENT FP	1, 203, 669		1, 203, 66		1, 203, 669	
90. 03 09003 INTRAVENOUS THERAPY	4, 418, 021		4, 418, 02		4, 418, 021	
90. 04 09004 PSYCHI ATRY	508, 457		508, 45		508, 457	90.04
90. 05 09005 CARDI OLOGY	936, 073		936, 07		936, 073	
91. 00 09100 EMERGENCY	6, 967, 018	l e	6, 967, 01		6, 967, 018	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 005, 824		4, 005, 82		4, 005, 824	
OTHER REIMBURSABLE COST CENTERS		l				
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS				- 1		
113. 00 11300 NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF			1			114.00
116. 00 11600 H0SPI CE	0			ol l	0	116.00
200.00 Subtotal (see instructions)	77, 903, 961	0	77, 903, 96	1 0	77, 903, 961	
201.00 Less Observation Beds	4, 005, 824		4, 005, 82		4, 005, 824	
202.00 Total (see instructions)	73, 898, 137	0				
	· ·					-

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1315 Peri od: Worksheet C From 10/01/2021 Part I 09/30/2022 Date/Time Prepared: 2/22/2023 3:06 pm Title XIX Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 11, 920, 860 30.00 03000 ADULTS & PEDIATRICS 11, 920, 860 30.00 31.00 03100 INTENSIVE CARE UNIT 393,000 393,000 31.00 340, 000 04300 NURSERY 340,000 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 1, 791, 339 12, 430, 402 14, 221, 741 0.326640 0.000000 50.00 05000 OPERATING ROOM 945, 664 51.00 05100 RECOVERY ROOM 5, 403, 943 6, 349, 607 0.402986 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 113, 200 20, 289 1, 133, 489 0.417045 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 48, 142, 915 0.144090 2.414.241 45, 728, 674 0.000000 54.00 54.00 3, 820, 917 28, 904, 883 0. 190162 0.000000 60.00 06000 LABORATORY 25, 083, 966 60 00 65.00 06500 RESPIRATORY THERAPY 2, 392, 119 1, 276, 588 3, 668, 707 0.609969 0.000000 65.00 65.01 06501 SLEEP LAB 1, 118, 233 1, 118, 233 0.149616 0.000000 65.01 4, 584, 724 06600 PHYSI CAL THERAPY 1, 663, 921 6, 248, 645 0.538732 0.000000 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 165, 573 3, 135, 103 3, 300, 676 0.104655 0.000000 69.00 539, 342 69 01 06901 CARDIAC REHABILITATION 539, 342 0.461609 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 881, 067 6, 848, 157 7, 729, 224 0.143677 0.000000 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72 00 336, 600 2, 476, 530 2, 813, 130 0.896895 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 3, 350, 969 7, 104, 061 0.317013 0.000000 73.00 10, 455, 030 73.00 76.00 03020 CHEMI CAL DEPENDENCY 0 0.000000 0.000000 76.00 03480 ONCOLOGY 76.01 21, 506, 696 21, 506, 696 0.126759 0.000000 76.01 76.02 03030 DIABETIC EDUCATION 6,500 57, 504 64,004 1.628070 0.000000 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2, 169, 275 2, 179, 947 0. 964586 0.000000 88.00 10.672 08801 RURAL HEALTH CLINIC II 3, 729, 278 3, 729, 278 88 01 0.853406 0.000000 88 01 88.02 08802 RURAL HEALTH CLINIC III 740, 113 1, 255, 961 1, 996, 074 0.900834 0.000000 88.02 09000 CLI NI C 90.00 0 542, 397 542, 397 0.614225 0.000000 90.00 31, 487 09001 CLINIC- ORTHO 0 31, 487 17. 393464 0.000000 90.01 90.01 09002 CLINIC - PEDS ENT FP 0 567, 986 567, 986 90.02 2.119188 0.000000 90.02 90.03 09003 I NTRAVENOUS THERAPY 0 8, 775, 477 8, 775, 477 0.503451 0.000000 90.03 90.04 09004 PSYCHI ATRY 0 251, 879 251, 879 2.018656 0.000000 90.04 90.05 09005 CARDI OLOGY 0 28, 951 28 951 32 333011 0.000000 90.05 09100 EMERGENCY 30, 665, 969 91.00 916, 462 31, 582, 431 0. 220598 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 107, 728 2, 767, 521 2, 875, 249 1.393209 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114 00 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 33, 310, 945 188, 100, 393 221, 411, 338 200.00 201.00 Less Observation Beds 201.00

33, 310, 945

188, 100, 393

221, 411, 338

202.00

202.00

Total (see instructions)

			To 09/30/2022	Date/Time Prepared: 2/22/2023 3:06 pm
		Title XIX	Hospi tal	PPS PPS
Cost Center Description	PPS Inpatient			
	Ratio			
INDATIENT DOUTINE SERVICE COST CENTERS	11. 00			
30.00 O3000 ADULTS & PEDIATRICS				30.00
31. 00 03100 NTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				43.00
50. 00 05000 OPERATING ROOM	0. 326640			50.00
51. 00 05100 RECOVERY ROOM	0. 402986			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 417045			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 144090			54.00
60. 00 06000 LABORATORY	0. 190162			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 609969			65.00
65. 01 06501 SLEEP LAB	0. 149616			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 538732			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 104655			69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 461609			69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 143677			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 896895			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 317013			73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000			76. 00
76. 01 03480 ONCOLOGY	0. 126759			76. 01
76. 02 03030 DI ABETI C EDUCATION	1. 628070			76. 02
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 964586			88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0. 853406			88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0. 900834			88. 02
90. 00 09000 CLI NI C	0. 614225			90.00
90. 01 09001 CLINI C- ORTHO	17. 393464			90. 01
90. 02 09002 CLINIC - PEDS ENT FP	2. 119188			90. 02
90. 03 09003 I NTRAVENOUS THERAPY	0. 503451			90. 03
90. 04 09004 PSYCHI ATRY	2. 018656			90.04
90. 05 09005 CARDI OLOGY	32. 333011			90. 05
91. 00 09100 EMERGENCY	0. 220598			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	1. 393209			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
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

Heal th Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Peri od: Worksheet C From 10/01/2021 Part II To 09/30/2022 Date/Time Prepared: Provi der CCN: 15-1315

				10	09/30/2022	Date/lime Pre 2/22/2023 3:0	
			Ti +I	e XIX	Hospi tal	PPS	о рііі
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	oost center bescription	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col . 1 -		Amount	
		20)	20)	col . 2)		7 11110 01111	
		1, 00	2.00	3.00	4. 00	5. 00	
ANCI L	LARY SERVICE COST CENTERS						
	OPERATING ROOM	4, 645, 392	897, 621	3, 747, 771	0	0	50.00
51.00 05100	RECOVERY ROOM	2, 558, 803		2, 000, 951	ol	0	51.00
	DELIVERY ROOM & LABOR ROOM	472, 716			o	0	52.00
	RADI OLOGY-DI AGNOSTI C	6, 936, 918	•		o	0	1
	LABORATORY	5, 496, 602	262, 473		0	0	
	RESPI RATORY THERAPY	2, 237, 796			o	0	
	SLEEP LAB	167, 306			0	0	65. 01
	PHYSI CAL THERAPY	3, 366, 342	512, 705		o o	0	
	ELECTROCARDI OLOGY	345, 431	32, 706		0	0	1
	CARDI AC REHABI LI TATI ON	248, 965			o o	0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	1, 110, 510			0	0	1
	IMPL. DEV. CHARGED TO PATIENTS	2, 523, 081	145, 134		0	0	72.00
	DRUGS CHARGED TO PATTENTS	3, 314, 381	68, 787		0	0	1
	CHEMI CAL DEPENDENCY	3, 314, 301	00, 707		0	0	1
	ONCOLOGY	2, 726, 158	_	-	0	0	
	DI ABETI C EDUCATI ON	104, 203	918		0	0	1
	TIENT SERVICE COST CENTERS	104, 203	910	103, 263	<u> </u>	0	76.02
	RURAL HEALTH CLINIC	2, 102, 746	151, 643	1, 951, 103	o	0	88. 00
	RURAL HEALTH CLINIC II	3, 182, 587	169, 549		0	0	
	RURAL HEALTH CLINIC III	1, 798, 132			0	0	
	CLINIC	333, 154			0	0	1
	CLINIC- ORTHO	547, 668			0	0	1
	CLINIC - PEDS ENT FP	1, 203, 669			0	0	
	I NTRAVENOUS THERAPY	4, 418, 021	178, 449		0	0	1
	PSYCHIATRY	508, 457	39, 059		0	0	90.03
	CARDI OLOGY		•		٥	0	
	CARDI OLOGY EMERGENCY	936, 073			O O	0	1
		6, 967, 018	•		0	0	
	OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	4, 005, 824	558, 881	3, 446, 943	U	0	92.00
	HOME HEALTH AGENCY	0	0	ı	ما		101 00
	AL PURPOSE COST CENTERS	0	0	0	0	0	101.00
	INTEREST EXPENSE			I	T		113.00
	UTILIZATION REVIEW-SNF						114.00
116. 00 11600			_			^	116.00
200.00	Subtotal (sum of lines 50 thru 199)	42 257 052	4 042 200	U E4 21E EEE	0		200.00
200.00	Less Observation Beds	62, 257, 953			0		200.00
		4, 005, 824	•		0		
202. 00	Total (line 200 minus line 201)	58, 252, 129	5, 483, 517	52, 768, 612	0	0	202.00

Heal th Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 10/01/2021 | To 09/30/2022 | Date/Time Prepared: | 2/22/2023 3: 06 pm Provider CCN: 15-1315

					2/22/2023 3:06 pm
		Ti tl	e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,	Cost to		
	Operati ng	Part I,	Charge Ratio	()	
	Cost	column 8)	(col. 6 /		
	Reducti on		col. 7)		
	6. 00	7.00	8. 00		
ANCILLARY SERVICE COST CENTERS	<u>.</u>			<u>.</u>	
50. 00 05000 OPERATING ROOM	4, 645, 392	14, 221, 741	0. 32664	0	50.00
51.00 05100 RECOVERY ROOM	2, 558, 803	6, 349, 607	0. 40298	6	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	472, 716	1, 133, 489	0. 41704	5	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 936, 918	48, 142, 915	0. 14409	0	54.00
60. 00 06000 LABORATORY	5, 496, 602	28, 904, 883	0. 19016	2	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 237, 796	3, 668, 707	0. 60996	9	65. 00
65. 01 06501 SLEEP LAB	167, 306				65. 01
66. 00 06600 PHYSI CAL THERAPY	3, 366, 342				66.00
69. 00 06900 ELECTROCARDI OLOGY	345, 431				69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	248, 965				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 110, 510				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 523, 081				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 314, 381				73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0,011,001				76. 00
76. 01 03480 ONCOLOGY	2, 726, 158	-			76. 01
76. 02 03030 DI ABETI C EDUCATI ON	104, 203				76. 02
OUTPATIENT SERVICE COST CENTERS	101, 200	01,001	1. 02007	<u> </u>	70.02
88. 00 08800 RURAL HEALTH CLINIC	2, 102, 746	2, 179, 947	0. 96458	6	88.00
88. 01 08801 RURAL HEALTH CLINIC II	3, 182, 587				88. 01
88. 02 08802 RURAL HEALTH CLINIC III	1, 798, 132				88. 02
90. 00 09000 CLINIC	333, 154				90.00
90. 01 09001 CLI NI C- ORTHO	547, 668				90. 01
90. 02 09002 CLINIC - PEDS ENT FP	1, 203, 669				90. 02
90. 03 09003 NTRAVENOUS THERAPY	4, 418, 021				90.03
90. 04 09004 PSYCHI ATRY	508, 457				90.04
90. 05 09005 CARDI OLOGY	936, 073				90.05
91. 00 09100 EMERGENCY	6, 967, 018				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 005, 824				92.00
OTHER REIMBURSABLE COST CENTERS	4,003,024	2,073,247	1. 37320	7	72.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0.00000	0	101.00
SPECIAL PURPOSE COST CENTERS			0.00000	O _I	101.00
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
116. 00 11600 HOSPI CE		0	0. 00000	0	116.00
200.00 Subtotal (sum of lines 50 thru 199)	62, 257, 953	_			200.00
201.00 Less Observation Beds	4, 005, 824				200.00
202.00 Total (line 200 minus line 201)	58, 252, 129				201.00
202. 00 Total (Title 200 IIII Hus Title 201)	00, 202, 129	200, 131, 478	I	1	J202.00

In Lieu of Form CMS-2552-10 Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-1315 Peri od: Worksheet D From 10/01/2021 Part II 09/30/2022 Date/Time Prepared: 2/22/2023 3:06 pm Title XVIII Hospi tal Cost Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 4. 00 5. 00 3.00 ANCILLARY SERVICE COST CENTERS 50 00 897, 621 370, 481 50 00 05000 OPERATING ROOM 14, 221, 741 0.063116 23.383 05100 RECOVERY ROOM 557, 852 6, 349, 607 0.087856 122, 770 51.00 51.00 10, 786 05200 DELIVERY ROOM & LABOR ROOM 52.00 136, 626 1, 133, 489 0.120536 52.00 05400 RADI OLOGY-DI AGNOSTI C 592, 437 54.00 702, 417 48, 142, 915 0.014590 8,644 54.00 60.00 06000 LABORATORY 262, 473 28, 904, 883 0.009081 811, 712 7, 371 60.00 65.00 06500 RESPIRATORY THERAPY 85, 720 3, 668, 707 0.023365 362, 791 8, 477 65.00 06501 SLEEP LAB 51, 180 1, 118, 233 0.045769 65.01 65.01 0 512, 705 66.00 06600 PHYSI CAL THERAPY 6, 248, 645 0.082051 243. 182 19, 953 66,00 69.00 06900 ELECTROCARDI OLOGY 32, 706 3, 300, 676 0.009909 40, 298 399 69.00 06901 CARDIAC REHABILITATION 50, 264 539, 342 0.093195 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 11, 304 7, 729, 224 0.001463 294, 469 431 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.051592 110, 470 5, 699 72.00 145.134 2, 813, 130 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 68, 787 10, 455, 030 0.006579 719, 664 4,735 73.00 03020 CHEMI CAL DEPENDENCY 76.00 0 0.000000 0 0 76.00 03480 ONCOLOGY 235, 862 21, 506, 696 0.010967 76.01 Ω 76.01 76.02 03030 DIABETIC EDUCATION 918 64,004 0.014343 6, 400 92 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 2, 179, 947 0.069563 0 88.00 151, 643 08801 RURAL HEALTH CLINIC II 3, 729, 278 88.01 169, 549 0.045464 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC III 84, 446 1, 996, 074 0.042306 0 0 88.02 09000 CLI NI C 0 90.00 43, 587 542, 397 0.080360 0 90.00 09001 CLINIC- ORTHO 09002 CLINIC - PEDS ENT FP 31, 487 90 01 82.875 2.632039 0 Ω 90.01 567, 986 0 90.02 127, 583 0.224623 0 90.02 90. 03 09003 I NTRAVENOUS THERAPY 178, 449 8, 775, 477 0.020335 0 0 90.03 ol 90.04 09004 PSYCHI ATRY 39,059 251, 879 0.155070 0 90.04 90. 05 09005 CARDI OLOGY 39, 954 28, 951 1 380056 0 90.05 0 91. 00 | 09100 | EMERGENCY 814, 803 31, 582, 431 0.025799 135, 004 3, 483 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 558, 881 2, 875, 249 0.194377 0 92.00 200.00 Total (lines 50 through 199) 6, 042, 398 208, 757, 478 3, 809, 678 93, 453 200. 00

 Heal th Financial
 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1315
 | Peri od: | Worksheet D | From 10/01/2021 | Part IV | To 09/30/2022 | Date/Time Prepared: THROUGH COSTS

					10 077 007 2022	2/22/2023 3: 0	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0)	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0)	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0)	0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
65. 01	06501 SLEEP LAB	0	0)	0 0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0)	0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0)	0 0	0	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	0		0 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73.00
76.00	03020 CHEMI CAL DEPENDENCY	0	0	1	0	0	76. 00
76. 01	03480 ONCOLOGY	0	0		0 0	0	76. 01
76. 02	03030 DIABETIC EDUCATION	0	0		0 0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	1	0	0	00.00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	1	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	1	0	0	88. 02
90.00	09000 CLI NI C	0	0	1	0	0	90.00
90. 01	09001 CLI NI C- 0RTH0	0	0	1	0	0	90. 01
	09002 CLINIC - PEDS ENT FP	0	0	1	0	0	90. 02
90. 03	09003 I NTRAVENOUS THERAPY	0	0		0 0	0	90. 03
90.04	09004 PSYCHI ATRY	0	0	1	0	0	90. 04
90.05	09005 CARDI OLOGY	0	0)	0 0	0	90.05
91.00	09100 EMERGENCY	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	200. 00

| Peri od: | Worksheet D | From 10/01/2021 | Part IV | To | 09/30/2022 | Date/Time Prepared:
 Heal th Financial
 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

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

					0 09/30/2022	2/22/2023 3:0	parea: 6 pm
			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	C, Part I,	(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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C		0. 000000	l
51.00	05100 RECOVERY ROOM	0	0	(6, 349, 607	0.000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(1, 133, 489	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(48, 142, 915	0.000000	54.00
60.00	06000 LABORATORY	0	0	C	28, 904, 883	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	3, 668, 707	0.000000	65.00
65. 01	06501 SLEEP LAB	0	0	C	1, 118, 233	0.000000	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0	C	6, 248, 645	0.000000	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	3, 300, 676	0.000000	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	0	C	539, 342	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	7, 729, 224	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	2, 813, 130	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	10, 455, 030	0.000000	73.00
76.00	03020 CHEMI CAL DEPENDENCY	0	0		0	0.000000	76. 00
76.01	03480 ONCOLOGY	0	0		21, 506, 696	0.000000	76. 01
76.02	03030 DI ABETI C EDUCATION	0	0	(64, 004	0.000000	76. 02
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	C	2, 179, 947	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	C	3, 729, 278	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	C	1, 996, 074	0.000000	88. 02
90.00	09000 CLI NI C	0	0	C	542, 397	0.000000	90.00
90. 01	09001 CLI NI C- 0RTH0	0	0	C	31, 487	0. 000000	90. 01
90. 02	09002 CLINIC - PEDS ENT FP	0	0	C	567, 986	0.000000	90. 02
90.03	09003 I NTRAVENOUS THERAPY	0	0	C	8, 775, 477	0.000000	90.03
90.04	09004 PSYCHI ATRY	0	0	C	251, 879	0.000000	90.04
90.05	09005 CARDI OLOGY	0	0	C	28, 951	0.000000	90.05
91.00	09100 EMERGENCY	0	0	C	31, 582, 431	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	2, 875, 249	0. 000000	92.00
200.00	Total (lines 50 through 199)	0	0	C	208, 757, 478		200. 00

| Peri od: | Worksheet D | From 10/01/2021 | Part IV | To | 09/30/2022 | Date/Time Prepared:
 Heal th Financial
 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

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

				10 09/30/2022	2/22/2023 3:0	
		Title XVIII		Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS			,	_		
50.00 05000 OPERATING ROOM	0. 000000	370, 481		0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	122, 770		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	592, 437		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	811, 712		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	362, 791		0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	243, 182		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	40, 298		0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	294, 469		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	110, 470		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	719, 664		0	0	73.00
76.00 03020 CHEMI CAL DEPENDENCY	0. 000000	0		0	0	76. 00
76. 01 03480 ONCOLOGY	0. 000000	0		0	0	76. 01
76. 02 03030 DI ABETI C EDUCATI ON	0. 000000	6, 400		0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0	0	88. 02
90. 00 09000 CLI NI C	0. 000000	0		0	0	90.00
90. 01 09001 CLI NI C- ORTHO	0. 000000	0		0	0	90. 01
90. 02 09002 CLI NI C - PEDS ENT FP	0. 000000	0		0	0	90. 02
90. 03 09003 I NTRAVENOUS THERAPY	0. 000000	0		0	0	90. 03
90. 04 09004 PSYCHI ATRY	0. 000000	0		0	0	90. 04
90. 05 09005 CARDI OLOGY	0. 000000	0		0	0	90. 05
91. 00 09100 EMERGENCY	0. 000000	135, 004		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		3, 809, 678		0	0	200.00
			•			•

In Lieu of Form CMS-2552-10 Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1315 Peri od: Worksheet D From 10/01/2021 To 09/30/2022 Part V Date/Time Prepared: 2/22/2023 3:06 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 663, 482 0. 326640 50.00 05100 RECOVERY ROOM 0 51.00 0.402986 775, 720 51.00 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 417045 0 1, 150 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.144090 10, 350, 488 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0.190162 4, 753, 976 0 60.00 06500 RESPIRATORY THERAPY 65.00 0.609969 228, 802 0 65.00 65.01 06501 SLEEP LAB 0.149616 227, 827 0 65.01 66.00 06600 PHYSI CAL THERAPY 0. 538732 1, 126, 854 0 66.00 06900 ELECTROCARDI OLOGY 0. 104655 631, 824 0 69.00 69.00 06901 CARDIAC REHABILITATION 0.461609 187,063 69.01 69.01 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.143677 359, 313 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 460, 066 0 72.00 0.896895 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73 00 0.317013 2, 012, 940 0 03020 CHEMI CAL DEPENDENCY 76.00 0.000000 0 0 0 76.00 76. 01 03480 ONCOLOGY 0. 126759 4, 229, 722 0 76.01 03030 DIABETIC EDUCATION 76.02 1.628070 0 76.02 0 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 90 00 09000 CLI NI C 0.614225 222, 951 0 90.00 0 90.01 09001 CLINIC- ORTHO 17. 393464 27, 842 0 0 90.01 90.02 09002 CLINIC - PEDS ENT FP 2. 119188 47, 520 0 90.02 09003 I NTRAVENOUS THERAPY 0.503451 3, 579, 036 90.03 90.03 7,722 0 09004 PSYCHI ATRY 2.018656 90.04 90.04 32, 674 0 0 90.05 09005 CARDI OLOGY 32. 333011 15, 592 0 90.05 126, 997 91. 00 09100 EMERGENCY 0. 220598 0 4, 815, 512 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 290, 302 92.00 1.393209 0 Ω 200.00 Subtotal (see instructions) 38, 040, 656 134, 719 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 38, 040, 656 0 202.00 202.00 Net Charges (line 200 - line 201) 134, 719

In Lieu of Form CMS-2552-10 Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1315 Peri od: Worksheet D From 10/01/2021 To 09/30/2022 Part V Date/Time Prepared: 2/22/2023 3:06 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 870, 000 50.00 05100 RECOVERY ROOM 312, 604 51.00 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 480 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 491, 402 0 54.00 60.00 06000 LABORATORY 904, 026 60.00 65.00 06500 RESPIRATORY THERAPY 139, 562 0 65.00 06501 SLEEP LAB 65.01 34, 087 0 65.01 66.00 06600 PHYSI CAL THERAPY 607, 072 66.00 66, 124 0 69.00 06900 ELECTROCARDI OLOGY 69.00 06901 CARDIAC REHABILITATION 86, 350 0 69.01 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 51, 625 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 412, 631 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 638, 128 73 00 03020 CHEMI CAL DEPENDENCY 76.00 0 76.00 76. 01 03480 ONCOLOGY 536, 155 0 76.01 03030 DIABETIC EDUCATION 76.02 0 76.02 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 88. 01 08801 RURAL HEALTH CLINIC II 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 90 00 09000 CLI NI C 136, 942 0 90 00 90.01 09001 CLINIC- ORTHO 484, 269 0 90.01 90. 02 09002 CLINIC - PEDS ENT FP 100, 704 90.02 09003 I NTRAVENOUS THERAPY 90.03 1, 801, 869 3, 888 90.03 65, 958 90. 04 09004 PSYCHI ATRY 90.04 0 90.05 09005 CARDI OLOGY 504, 136 90.05 91. 00 09100 EMERGENCY 1,062,292 28, 015 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 797, 660 92.00 200.00 Subtotal (see instructions) 12, 104, 076 31, 903 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

12, 104, 076

31, 903

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der CO		Peri od:	Worksheet D	
				From 10/01/2021 To 09/30/2022	Part Date/Time Pre	nared:
			'	07/30/2022	2/22/2023 3:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			1
30.00 ADULTS & PEDIATRICS	2, 087, 901	391, 260				1
31.00 INTENSIVE CARE UNIT	101, 951		101, 951		784. 24	1
43. 00 NURSERY	38, 273		38, 273		111. 26	1
200.00 Total (lines 30 through 199)	2, 228, 125		1, 836, 865	5, 987		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00 ADULTS & PEDIATRICS	61	18, 773				30.00
31.00 INTENSIVE CARE UNIT	4	3, 137				31.00
43. 00 NURSERY	13					43.00
200.00 Total (lines 30 through 199)	78	23, 356				200. 00

Provider CON: 15-1315 Peri od: From 1/O/1/2021 Part II Part II Part II Part II Part II Port II Part II Port II Part II Par	Health Financial Systems CAME	ERON MEMORIAL CO	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
Capital Related Cost (From Wast. (Crown Wast. Column 4) Column	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS			From 10/01/2021 To 09/30/2022	Part II Date/Time Pre 2/22/2023 3:0	
Related Cost (From Wist. C, Part I, col. 8)							
CFrom Wikst B, Part II, col . 20	Cost Center Description						
B. Part II, col 26)							
COL . 26) 1.00 2.00 3.00 4.00 5.00					Charges	column 4)	
ANCILLARY SERVICE COST CENTERS			col. 8)	col . 2)			
ANCILLARY SERVICE COST CENTERS Service S							
50.00 0500		1. 00	2.00	3. 00	4. 00	5. 00	
51. 00 05100 RECOVERY ROOM 557,852 6,349,607 0.087856 10,648 935 51. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 136,626 1,133,489 0.120536 13,950 1,681 52. 00 60. 00 06400 RADI OLOGY-DI AGNOSTI C 702,417 48,142,915 0.014590 52,158 761 54. 00 60. 00 06500 RESPI RATORY THERAPY 262,473 28,904,883 0.009081 71,179 646 60. 00 65. 01 06501 SLEEP LAB 51,180 1,118,233 0.045769 0 0 65. 01 66. 00 06600 BRESPI RATORY THERAPY 512,705 6,248,645 0.082051 3,698 303 66. 00 66. 00 06600 BRESPI RATORY THERAPY 512,705 6,248,645 0.082051 3,698 303 66. 00 66. 00 06600 PHYSI CAL THERAPY 512,705 6,248,645 0.082051 3,698 303 66. 00 69. 01 06901 CLECTROCABIO LOGY 32,706 33,00 0.09309 3,960 39		1		1		1	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 136,626 1,133,489 0.120536 13,950 1,681 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 702,417 48,142,915 0.014590 52,158 761 54.00 65. 00 06500 RESPI RATORY THERAPY 262,473 28,904,883 0.009081 71,179 646 60.00 65. 01 06501 RESPI RATORY THERAPY 85,720 3,668,707 0.023365 26,818 627 65.00 65. 01 06500 RESPI RATORY THERAPY 512,705 6,248,645 0.082051 3,698 303 66.00 69. 00 06600 PHYSI CAL THERAPY 512,705 6,248,645 0.082051 3,698 303 66.00 69. 01 06901 CARDI ACR EHABI LITATION 50,264 539,342 0.093195 0 0 71.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 145,134 2,813,130 0.051592 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 68,787 10,455,030 0.06579				•			
54.00 05400 RADI OLOGY - DI AGNOSTI C 702, 417 48, 142, 915 0.014590 52, 158 761 54. 00							
60.00 06000 LABORATORY 262, 473 28, 904, 883 0.009081 71, 179 646 60.00 65.00 06500 RESPI RATORY THERAPY 85, 720 3, 668, 707 0.023365 26, 818 627 65.00 06501 SLEEP LAB 51, 180 1, 118, 233 0.045769 0 0 065.01 0.0650							
65. 00 06500 RESPI RATORY THERAPY 85,720 3,668,707 0.023365 26,818 627 65.00 65.01 06501 SLEEP LAB 51,180 1,118,233 0.045769 0 0 65.01 66.00 06600 PHYSI CAL THERAPY 512,705 6,248,645 0.082051 3,698 303 66.00 69.00 06900 ELECTROCARDI OLOGY 32,706 3,300,676 0.009909 3,960 39 69.00 69.01 06901 CARDI AC REHABI LI TATI ON 50,264 539,342 0.093195 0 0 69.01 71.00 7100 MBDI CAL SUPPLIES CHARGED TO PATI ENT 11,304 7,729,224 0.001463 0 0 71.00 72.00 73.00 07200 MPL. DEV. CHARGED TO PATI ENTS 145,134 2,813,130 0.051592 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 68,787 10,455,030 0.006579 65,081 428 73.00 76.00 03020 CHEMI CAL DEPENDENCY 0 0 0 0.000000 0 0 76.01 03480 0NCOLOGY 235,862 21,506,696 0.010967 0 0 76.01 76.02 03030 DABETI C EDUCATI ON 918 64,004 0.014343 0 0 76.02 0000000000000000000000000000000000				l .			
65. 01 06501 SLEEP LAB 51, 180 1, 118, 233 0. 045769 0 0 65. 01 66. 00 06600 PHYSI CAL THERAPY 512, 705 6, 248, 645 0. 082051 3, 698 303 66. 00 69. 01 06900 ELECTROCARDI OLOGY 32, 706 33, 300, 676 0. 009909 3, 960 39 69. 00 69. 01 06901 CARDI AC REHABI LITATI ON 50, 264 539, 342 0. 093195 0 0. 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 11, 304 7, 729, 224 0. 001463 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 145, 134 2, 813, 130 0. 051592 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 145, 134 2, 813, 130 0. 051592 0 0 72. 00 76. 01 03480 ONCOLOGY 235, 862 21, 506, 696 0. 010967 0 0 76. 01 76. 02 03030 DIABETI C EDUCATI ON 918 64, 004 0. 014343 0 0 76. 02 0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 1 169, 549 3, 729, 278 0. 045464 0 0 88. 01 88. 01 08801 RURAL HEALTH CLINIC 1 1 169, 549 3, 729, 278 0. 045464 0 0 0 0. 00 90. 01 09001 CLINIC - ORTHO 82, 875 31, 487 2, 632039 0 0 90. 01 90. 02 09002 CLINIC - DETENS 17, 849 8, 775, 477 0. 020335 0 0 90. 02 90. 03 09003 INTRAVENOUS THERAPY 39, 059 251, 879 0. 155070 0 0 90. 02 90. 04 09004 PSYCHI ATRY 39, 954 28, 951 1. 380056 0 0 90. 05 91. 00 09100 GLERGENCY 814, 803 31, 582, 431 0. 025799 42, 841 1, 105 91. 00 92. 00 09000							
66. 00 06600 PHYSI CAL THERAPY 512, 705 6, 248, 645 0. 082051 3, 698 303 66. 00 69. 00 06900 ELECTROCARDI OLOGY 32, 706 3, 300, 676 0. 009909 3, 960 39 69. 00 06901 CARDI AC REHABI LI TATI ON 50, 264 539, 342 0. 093195 0 0. 69. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 11, 304 7, 729, 224 0. 001463 0 0. 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 145, 134 2, 813, 130 0. 051592 0 0. 72. 00 0. 0000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000							
69. 00 06900 ELECTROCARDI OLOGY 32, 706 3, 300, 676 0.009909 3, 960 39 69. 00 69. 01 06901 CARDI AC REHABI LITATION 50, 264 539, 342 0.093195 0 0.69. 01 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 11, 304 7, 729, 224 0.001463 0 0 71. 00 072.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 145, 134 2, 813, 130 0.051592 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 68, 787 10, 455, 030 0.006579 65, 081 428 73. 00 0.000000 0 0 0.000000 0							
69. 01 06901 CARDIAC REHABILITATION 50, 264 539, 342 0. 093195 0 0 69. 01 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 11, 304 7, 729, 224 0. 001463 0 0 71. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 145, 134 2, 813, 130 0. 051592 0 0 72. 00 7300 DRUGS CHARGED TO PATIENTS 68, 787 10, 455, 030 0. 006579 65, 081 428 73. 00 73. 00 03020 CHEMI CAL DEPENDENCY 0 0 0. 0000000 0 0 0 76. 00 76. 00 03480 ONCOLOGY 235, 862 21, 506, 696 0. 010967 0 0 76. 01 76. 02 0000000 DIABETIC EDUCATION 918 64, 004 0. 014343 0 0 76. 02 000000000 DIABETIC EDUCATION 918 64, 004 0. 014343 0 0 76. 02 0000000000000000000000000000000000							
71. 00							
72. 00						1	
73. 00 07300 DRUGS CHARGED TO PATIENTS 68, 787 10, 455, 030 0.006579 65, 081 428 73. 00 76. 00 03020 CHEMI CAL DEPENDENCY 0 0 0.000000 0 0 76. 00 76. 01 03480 ONCOLOGY 235, 862 21, 506, 696 0.010967 0 0 76. 01 76. 02 03030 DI ABETI C EDUCATION 918 64, 004 0.014343 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 11 169, 549 3, 729, 278 0.045464 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC 111 84, 446 1, 996, 074 0.042306 0 0 88. 02 90. 00 09000 CLINIC 0RTHO 82, 875 31, 487 2.632039 0 0 0 90. 01 90. 01 09001 CLINIC - PEDS ENT FP 127, 583 567, 986 0.224623 0 0 90. 02 90. 02 09002 CLINIC - PEDS ENT FP 127, 583 567, 986 0.224623 0 0 90. 02 90. 03 09003 INTRAVENOUS THERAPY 178, 449 8, 775, 477 0.020335 0 0 90. 03 90. 04 09004 PSYCHIATRY 39, 059 251, 879 0.155070 0 0 90. 03 90. 05 09005 CARDI OLOGY 39, 954 28, 951 1.380056 0 0 0 90. 05 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 558, 881 2, 875, 249 0.194377 0 0 0 92. 00						1	
76. 00						_	
76. 01		· ·					
76. 02 03030 DI ABETI C EDUCATI ON 918 64, 004 0. 014343 0 0 0 76. 02 0000 DUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 1 151, 643 2, 179, 947 0. 069563 0 0 88. 00 8801 RURAL HEALTH CLINIC II 169, 549 3, 729, 278 0. 045464 0 0 88. 01 08801 RURAL HEALTH CLINIC III 84, 446 1, 996, 074 0. 042306 0 0 88. 01 090. 00 09000 CLINIC 43, 587 542, 397 0. 080360 0 0 90. 00 90. 01 09001 CLINIC - ORTHO 82, 875 31, 487 2. 632039 0 0 0 90. 01 090. 01 09001 CLINIC - PEDS ENT FP 127, 583 567, 986 0. 224623 0 0 0 90. 02 090. 03 09003 INTRAVENOUS THERAPY 178, 449 8, 775, 477 0. 020335 0 0 0 90. 03 09004 PSYCHIATRY 39, 059 251, 879 0. 155070 0 0 90. 04 090. 05 09005 CARDI OLOGY 39, 954 28, 951 1. 380056 0 0 0 90. 05 090. 09100 EMERGENCY 814, 803 31, 582, 431 0. 025799 42, 841 1, 105 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 558, 881 2, 875, 249 0. 194377 0 0 0 92. 00						0	
SECTION SERVICE COST CENTERS SERVICE CO						_	
88. 00 08800 RURAL HEALTH CLINIC 151, 643 2, 179, 947 0.069563 0 0 88. 00 88. 01 88. 01 08801 RURAL HEALTH CLINIC II 169, 549 3, 729, 278 0.045464 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC II 84, 446 1, 996, 074 0.042306 0 0 0 88. 02 90. 00 09000 CLINIC 43, 587 542, 397 0.080360 0 0 90. 00 90. 01 09001 CLINIC - ORTHO 82, 875 31, 487 2.632039 0 0 90. 01 90. 02 90. 02 CLINIC - PEDS ENT FP 127, 583 567, 986 0.224623 0 0 90. 02 90. 03 09003 INTRAVENOUS THERAPY 178, 449 8, 775, 477 0.020335 0 0 90. 03 90. 04 99040 PSYCHIATRY 39, 059 251, 879 0.155070 0 0.05 90. 05 09005 CARDI OLOGY 39, 954 28, 951 1.380056 0 0.90. 05 91. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 558, 881 2, 875, 249 0.194377 0 0 92. 00 92. 00 92. 00 92. 00 0.05 0		918	64, 004	0. 01434	.3 0	0	76. 02
88. 01 08801 RURAL HEALTH CLINIC II 169, 549 3, 729, 278 0.045464 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 84, 446 1, 996, 074 0.042306 0 0 0 88. 02 90. 00 09000 CLINIC 09001 CLINIC 09001 CLINIC 09001							
88. 02 08802 RURAL HEALTH CLINIC III 84, 446 1, 996, 074 0.042306 0 0 88. 02 09000 CLINIC 111 84, 446 1, 996, 074 0.080360 0 0 90. 00 90. 00 90. 01 09001 CLINIC - ORTHO 82, 875 31, 487 2.632039 0 0 90. 01 90. 02 09002 CLINIC - PEDS ENT FP 127, 583 567, 986 0.224623 0 0 90. 02 90. 03 NTRAVENOUS THERAPY 178, 449 8, 775, 477 0.020335 0 0 90. 03 90. 04 99004 PSYCHIATRY 39, 059 251, 879 0.155070 0 0.90. 04 09004 PSYCHIATRY 39, 954 28, 951 1.380056 0 0.90. 05 91. 00 09100 EMERGENCY 814, 803 31, 582, 431 0.025799 42, 841 1, 105 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 558, 881 2, 875, 249 0.194377 0 0 92. 00						-	
90. 00 09000 CLINI C 43, 587 542, 397 0.080360 0 0 90.00 90. 01 09001 CLINI C - ORTHO 82, 875 31, 487 2.632039 0 0 90.01 90. 02 09002 CLINI C - PEDS ENT FP 127, 583 567, 986 0.224623 0 0 90.02 90. 03 09003 INTRAVENOUS THERAPY 178, 449 8, 775, 477 0.020335 0 0 90.03 90. 04 09004 PSYCHI ATRY 39, 959 251, 879 0.155070 0 0 90.04 90. 05 09005 CARDI OLOGY 39, 954 28, 951 1.380056 0 0 90.05 91. 00 09100 EMERGENCY 814, 803 31, 582, 431 0.025799 42, 841 1, 105 91.00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 558, 881 2, 875, 249 0.194377 0 0 92.00						-	
90. 01						0	
90. 02 09002 CLI NI C - PEDS ENT FP 127, 583 567, 986 0.224623 0 0 90. 02 09003 INTRAVENOUS THERAPY 178, 449 8, 775, 477 0.020335 0 90. 03 09004 PSYCHI ATRY 39, 059 251, 879 0.155070 0 90. 04 09004 PSYCHI ATRY 39, 954 28, 951 1.380056 0 90. 05 09100 EMERGENCY 814, 803 31, 582, 431 0.025799 42, 841 1, 105 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 558, 881 2, 875, 249 0.194377 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 558, 881 2, 875, 249 0.194377 0 0 92. 00 0920				•		_	
90. 03 09003 INTRAVENOUS THERAPY 178, 449 8, 775, 477 0. 020335 0 0 90. 03 90. 04 09004 PSYCHI ATRY 39, 059 251, 879 0. 155070 0 90. 04 90. 05 09005 CARDI OLOGY 39, 954 28, 951 1. 380056 0 0 90. 05 91. 00 09100 EMERGENCY 814, 803 31, 582, 431 0. 025799 42, 841 1, 105 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 558, 881 2, 875, 249 0. 194377 0 0 92. 00 09200						0	
90. 04 09004 PSYCHI ATRY 39, 059 251, 879 0. 155070 0 90. 04 90. 05 09005 CARDI OLOGY 39, 954 28, 951 1. 380056 0 90. 05 91. 00 09100 EMERGENCY 814, 803 31, 582, 431 0. 025799 42, 841 1, 105 91. 00 92. 00 9200 0BSERVATI ON BEDS (NON-DI STI NCT PART 558, 881 2, 875, 249 0. 194377 0 0 92. 00				•		0	
90. 05 09005 CARDI OLOGY 39, 954 28, 951 1. 380056 0 0 90. 05 09100 EMERGENCY 814, 803 31, 582, 431 0. 025799 42, 841 1, 105 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART 558, 881 2, 875, 249 0. 194377 0 0 92. 00 09200				l .		0	
91. 00 09100 EMERGENCY						0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 558, 881 2, 875, 249 0. 194377 0 0 92. 00						1	
				•		1, 105	
200.00 Total (lines 50 through 199) 6,042,398 208,757,478 310,054 7,770 200.00						1	
	200.00 Total (lines 50 through 199)	6, 042, 398	208, 757, 478		310, 054	7, 770	200.00

	RON MEMORIAL CO			In Lie	u of Form CMS-	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	epared: 06 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(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	5, 51	0.00	61	30.00
31.00 03100 INTENSIVE CARE UNIT		0	13	0.00	4	31.00
43. 00 04300 NURSERY		0	34	4 0.00	13	43.00
200.00 Total (lines 30 through 199)		0	5, 98	7	78	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	l .				30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

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 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1315
 Peri od: Worksheet D From 10/01/2021 Part IV To 09/30/2022 Date/Time Prepared: THROUGH COSTS

					2/22/2023 3:0	6 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0)	0	0	50.00
51.00 05100 RECOVERY ROOM	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 RESPI RATORY THERAPY	0	0)	0 0	0	65.00
65. 01 06501 SLEEP LAB	0	0)	0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0		0 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 0	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0		0 0	0	76.00
76. 01 03480 ONCOLOGY	0	0		0 0	0	76. 01
76. 02 03030 DI ABETI C EDUCATI ON	0	0		0 0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
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	0	88. 02
90. 00 09000 CLI NI C	0	0		0 0	0	90.00
90. 01 09001 CLI NI C- 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

| Period: | Worksheet D | From 10/01/2021 | Part IV | To | 09/30/2022 | Date/Time | Prepared:
 Heal th Financial
 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

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

				7	To 09/30/2022	Date/Time Pre 2/22/2023 3:0	pared:
-			Ti tl	e XIX	Hospi tal	PPS	о ріп
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				_		
50.00		0	0	(14, 221, 741	0.000000	
51.00		0	0	(-, ,	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(1, 133, 489		52.00
54.00		0	0	(48, 142, 915	0.000000	54.00
60.00	06000 LABORATORY	0	0	(28, 904, 883	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	(3, 668, 707	0.000000	65.00
65.01	06501 SLEEP LAB	0	0	(1, 118, 233	0.000000	65. 01
66.00	06600 PHYSI CAL THERAPY	0	0	(6, 248, 645	0.000000	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(3, 300, 676	0.000000	69. 00
69. 01	06901 CARDIAC REHABILITATION	0	0	(539, 342	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(7, 729, 224	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(2, 813, 130	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(10, 455, 030	0.000000	73. 00
76.00	03020 CHEMI CAL DEPENDENCY	0	0	(0	0.000000	76. 00
76.01	03480 ONCOLOGY	0	0	(21, 506, 696	0.000000	76. 01
76.02	03030 DIABETIC EDUCATION	0	0	(64, 004	0.000000	76. 02
	OUTPATIENT SERVICE COST CENTERS						
88.00		0	0	(2, 179, 947		
88. 01	08801 RURAL HEALTH CLINIC II	0	0	(3, 729, 278		
	08802 RURAL HEALTH CLINIC III	0	0	(1, 996, 074	0.000000	
	09000 CLI NI C	0	0	(542, 397		
90. 01	09001 CLI NI C- ORTHO	0	0	(31, 487	0.000000	90. 01
90. 02	09002 CLINIC - PEDS ENT FP	0	0	(567, 986	0.000000	90. 02
90. 03	09003 I NTRAVENOUS THERAPY	0	0	(8, 775, 477	0.000000	90. 03
90.04	09004 PSYCHI ATRY	0	0	(251, 879	0.000000	90. 04
90.05	09005 CARDI OLOGY	0	0	(28, 951	0.000000	
91.00	09100 EMERGENCY	0	0	(31, 582, 431	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(2, 875, 249	0. 000000	92.00
200.0	Total (lines 50 through 199)	0	0	(208, 757, 478		200. 00

| Peri od: | Worksheet D | From 10/01/2021 | Part IV | To | 09/30/2022 | Date/Time Prepared:
 Heal th Financial
 Systems
 CAMERON MEMORIAL COMMUNITY HOSPITAL

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

				10 09/30/2022	2/22/2023 3:0	
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	Ŭ	Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	19, 721		0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	10, 648		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	13, 950		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	52, 158		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	71, 179		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	26, 818		0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 698		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 960		0	0	69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	65, 081		0	0	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000	0		0 0	0	76.00
76. 01 03480 0NC0L0GY	0. 000000	0		0 0	0	76. 01
76. 02 03030 DI ABETI C EDUCATI ON	0. 000000	0		0 0	0	76. 02
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0	0	88. 02
90. 00 09000 CLI NI C	0. 000000	0		0	0	90.00
90. 01 09001 CLINI C- ORTHO	0. 000000	0		0	0	90. 01
90. 02 09002 CLI NI C - PEDS ENT FP	0. 000000	0		0	0	90. 02
90. 03 09003 I NTRAVENOUS THERAPY	0. 000000	0		0	0	90. 03
90. 04 09004 PSYCHI ATRY	0. 000000	0		0	0	90. 04
90. 05 09005 CARDI OLOGY	0. 000000	0		0 0	0	90. 05
91. 00 09100 EMERGENCY	0. 000000	42, 841		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92.00
200.00 Total (lines 50 through 199)		310, 054		0 0	0	200. 00
			•	•	•	•

Health Financial Systems	CAMERON MEMORIAL COMMU	UNITY HOSPITAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1315	Peri od: From 10/01/2021	Worksheet D-1	
			To 09/30/2022	Date/Time Pre 2/22/2023 3:0	pared: 6 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1 00	

DATE ALL PROVIDER COMPONENTS 1.00	-		Title XVIII	Hospi tal	2/22/2023 3:0 Cost	ь рш
Inpatient days (including private room days and swing-bed days, excluding neaborn) 1.00		Cost Center Description		110061 101		
IRACHIERT DAYS		DADT I ALL DROWNER COMPONENTO			1. 00	
Inpatient days (including private room days and seing-bed days, excluding newborn) 6.870 1.00						
Injustient days (including private room days, excluding swing-bed and newborn days) 5,513 2,00	1. 00		s. excluding newborn)		6. 870	1.00
do not complete this line. 4.00 Simip-riviter room days (sectualing swing-bed and observation bed days) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 219 5.00 reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.01 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Sing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and new days) after the cost reporting period (if calendar year, enter 0 on this line) 9.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after though December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Sing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13.00 Sing-bed NF type inpatient days applicable to title XVIII only (including private room days) 14.00 Sing-bed NF type inpatient days applicable to title XVIII only (including private room days) 15.00 Sing-bed NF type inpatient days applicable to title XVIII o						•
	3.00		ys). If you have only pr	ivate room days,	0	3.00
Total Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	4 00	·			0 (07	4 00
reporting period ("Foreign and period Not Stype Inpatient days (including private room days) after December 31 of the cost reporting period ("Foreign and period Not				or 31 of the cost	•	1
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 1.00 Swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 1.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after becamber 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Swing-bed WF type inpatient days applicable to titles V or XX only (including private room days) 9.01 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.02 Swing-bed WF type inpatient days applicable to the Program (excluding swing-bed days) 9.03 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.04 Medically necessary private room days applicable to the Program (excluding swing-bed days) 9.05 Interport of the cost reporting period (if calendar year, enter 0 on this line) 9.06 Medical processary private room days applicable to the Program (excluding swing-bed days) 9.07 Interport of the cost reporting period (if calendar year, enter 0 on this line) 9.08 Interport of the cost reporting period (in see 15.00 interport) 9.09 Medical pracessary days (title V or XXX only) 9.00 North of the cost reporting period (in see 15.00 interport) 9.00 Medical pracessary days (title V or XXX only) 9.00 Medical rate for swing-bed SWF services applicable to services through December 31 of the cost r	3.00		om days) trii odgir becembe	i or or the cost	217	3.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,007 9,00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,007 9,00 Total inpatient days applicable to title XVIII only (including private room days) 114 10,00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12,00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 12,00 Swing-bed MF type inpatient days applicable to the Program (excluding swing-bed days) 0 12,00 Total nursery days (title V or XIX only) 0 15,00 Total nursery days (title V or XIX only) 0 15,00 Total nursery days (title V or XIX only) 0 15,00 16,00 Nursery days (title V or XIX only) 0 15,00 16,00	6.00		om days) after December	31 of the cost	1, 043	6. 00
reporting period 70 Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 70 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 71 Including private room days applicable to title XVIII only (including private room days) 72 Including private room days) 73 Including private room days (see Instructions) 74 Including private room days) 75 Including private room days) 76 Including private room days) 77 Including private room days) 78 Including private room days) 79 Including private room days) 79 Including private room days) 79 Including private room days) 70 Including private room days) 71 Including private room days) 72 Including private room days) 73 Including private room days) 74 Including private room days) 75 Including private room days) 76 Including private room days) 77 Including private room days) 78 Including private room days) 79 Including private room days) 79 Including private room days) 79 Including private room days) 70 Including private room days) 71 Including private room days) 71 Including private room days) 72 Including private room days applicable to titles Vor XIX only (Including private room days) 73 Including private room days applicable to titles Vor XIX only (Including private room days) 74 Including private room days applicable to services applicable to services through December 31 of the cost reporting period 75 Including private room days applicable to services after Dece	7.00			04 6 11		7 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) 7. Total inpatient days including private room days applicable to the Program (excluding swing-bed and n. 0.07 on exborn days) (see instructions) 8. Migh-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 8. Migh-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 8. Migh-bed SNF type inpatient days applicable to title XVIII only (including private room days) after period (see instructions) 9. Migh-bed SNF type inpatient days applicable to title XVIII only (including private room days) after period (see instructions) 14. On Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 15. On Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 16. On SNF type-bed NF type inpatient days applicable to title XVIII only (including private room days) 17. On Might declip and the days applicable to title XVIII only (including private room days) 18. On Might declip necessary private room days applicable to title XVIII only (including private room days) 19. On Might declip necessary private room days applicable to title XVIII only (including private room days) 19. On Might declip necessary private room days applicable to title XVIII only (including private room days) 19. On Might declip necessary private room days applicable to XVIII only (including private room days) 19. On Might declip necessary private room days applicable to XVIII only (including private room days) 19. On Might declip necessary private room days applicable to XVIII only (including private room days) 19. On Might declip necessary private room days applicable to Services after December 31	7.00		m days) through December	31 of the cost	23	7.00
reporting period (if calendar year, enter 0 on this line) 10. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SNR type inpatient days applicable to title XVIII only (including private room days) 11. 01. 00 Swing-bed SNR type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12. 00 Swing-bed NR type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Total nursery days (title V or XIX only) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Nursery days (title V or XIX only) 17. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 0 2 2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0 2 2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0 2 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 2.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 2.0	8. 00		m davs) after December 3	1 of the cost	72	8.00
newborn days) (see instructions) 114 10.00 Nome, bed SMF type inpatient days applicable to title XVIII only (including private room days) 115 10.00 Nome, bed SMF type inpatient days applicable to title XVIII only (including private room days) after 116 20 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 117 20 Swing-bed Nome in the cost reporting period (if calendar year, enter 0 on this tine) 118 20 Swing-bed Nome in the cost reporting period (if calendar year, enter 0 on this tine) 119 20 Swing-bed Nome in the cost reporting period (if calendar year, enter 0 on this tine) 119 20 Swing-bed Nome in the cost reporting period (if calendar year, enter 0 on this tine) 119 20 Swing-bed Nome in the cost reporting period (if calendar year, enter 0 on this tine) 119 20 Swing-bed Nome in the cost reporting period (if calendar year, enter 0 on this tine) 119 20 Swing-bed Nome in the cost reporting period (if calendar year, enter 0 on this tine) 119 20 Swing-bed Nome in the cost reporting period (if calendar year, enter 0 on this tine) 119 20 Swing-bed SWI title V or XIX only) 110 20 3 Swing-bed SWI title V or XIX only) 110 20 3 Swing-bed SWI title V or XIX only) 110 20 3 Swing-bed SWI title V or XIX only) 110 20 3 Swing-bed SWI title V or XIX only) 110 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only SWI title V or XIX only) 110 20 20 3 Swing-bed SWI title V or XIX only SWI title			,			
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24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 4, 990 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average period emprivate room period (line 29 + line 3) 31.00 Average semi-private room period (line 29 + line 3) 32.00 Average period emprivate room charge (line 30 + line 4) 33.00 Average period emprivate room charge differential (line 32 minus line 33)(see instructions) 35.00 Average period emprivate room cost differential (line 34 x line 31) 9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 160, 841) 37.00 PRATI II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 90.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 91.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 92.00 Average period period (line 34 x line 38) 93.00 Average period period period (line 34 x line 36) 94.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	·	31 of the cost reportin	g period (line d	0	23.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 160, 841) 37.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 38.00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 12, 160, 841) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 205.85 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,221,291 39.00 40.00	38. 00				2, 205. 85	38.00
		, , ,	•			39. 00
41.00 Total Program general inpatient routine service cost (Tine 39 + Tine 40) 2,221,291 41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41.00	Trotal Program general impatrent routine service cost (IINe 39	+ ITTIE 40)	ا	2, 221, 291	41.00

	Financial Systems CAME TATION OF INPATIENT OPERATING COST	RON MEMORIAL CO		CN: 15-1315	Peri od:	u of Form CMS-2 Worksheet D-1	
01			11.45.		From 10/01/2021 To 09/30/2022	Date/Time Pre	pared:
			T: +1 a	N/// I I	Hooni tal	2/22/2023 3:0	6 pm
	Cost Center Description	Total	Total	XVIII Average Per	Hospital Program Days	Cost Program Cost	
		I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
40.00	MUDCEDY (+: +1 - V 0 VIV1.)	1. 00	2.00	3.00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0. 0	0	0	42.00
43. 00	INTENSIVE CARE UNIT	421, 580	130	3, 242. 9	2 36	116, 745	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	·						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	oust defiter bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			1, 176, 461	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		3, 514, 497	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS	ationt mouting	condoca (fro	m Wka+ D av	m of Donto L and	0	FO 00
50.00	Pass through costs applicable to Program inp	atrent routine	services (110	III WKSt. D, Su	II OI PALLS I AND	U	50.00
51. 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)		•	•			
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-ph	ysician anest	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					1
	Program di scharges					0	54.00
	Target amount per discharge					0. 00	55.00
56.00	,				50)	0	
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	line 53)	0	
59.00		enorting period	endina 1996	undated and c	omnounded by the		
07.00	market basket	ppor tring period	charrig 1770,	apaarea ana e	ompounded by the	0.00	07.00
60.00	, ,					0. 00	
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (IInes 54 x	60), or 1% o	r the target		
62. 00		riisti deti olisj				0	62.00
63. 00		nent (see instru	ctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST			 		054.447	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Dece	mber 31 of th	e cost report	ing period (See	251, 467	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reportin	g period (See	966, 162	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	1, 217, 629	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	no costs through	Docombor 21	of the cost r	oporting poriod	0	67.00
07.00	(line 12 x line 19)	ie costs tillough	becember 31	or the cost i	eportring perrou	0	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.00
	(line 13 x line 20)			(0)			/
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service of	,		•	•		71.00
72. 00	Program routine service cost (line 9 x line	,					72.00
73.00	Medically necessary private room cost applic		•				73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II column		74.00 75.00
, 5. 00	26, line 45)	TOUTTHE SELVICE	costs (IIOIII	WOI KSHEEL D,	rart II, COLUMIII		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovidor ross	de)			78.00 79.00
79. 00 80. 00	Total Program routine service costs for comp	, ,		,	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi			(,		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82.00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS		,]
87. 00	Total observation bed days (see instructions	5)				1, 816	1
	Adjusted general inpatient routine cost per	diam (line 27 ·	line 2)			2, 205. 85	1 88 00
88. 00	Observation bed cost (line 87 x line 88) (se	•	11116 2)			4, 005, 824	

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 087, 901	14, 965, 234	0. 13951	7 4, 005, 824	558, 881	90.00
91.00 Nursing Program cost	0	14, 965, 234	0.00000	0 4, 005, 824	0	91.00
92.00 Allied health cost	0	14, 965, 234	0.00000	0 4, 005, 824	0	92.00
93.00 All other Medical Education	0	14, 965, 234	0. 00000	0 4, 005, 824	0	93. 00

Health Financial Systems	Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-25						
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-1315	Peri od: From 10/01/2021	Worksheet D-1			
			To 09/30/2022	Date/Time Pre 2/22/2023 3:0	pared: 6 pm		
	Title XIX Hospital						
Cost Center Description							
				1. 00			
PART I - ALL PROVIDER COMPONENTS							
I NIDATI FAIT DAVC							

		Title XIX Hospital	PPS	
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			
1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)	6, 870	1.00
2.00	Inpatient days (including private room days, excluding swing-		5, 513	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days	ays). If you have only private room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation by	and days)	3, 697	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro			
	reporting period]	
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December 31 of the cost	1, 043	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)			
7. 00	Total swing-bed NF type inpatient days (including private roof reporting period	om days) through December 31 of the cost	23	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 31 of the cost	72	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding swing-bed and	61	9. 00
10 00	newborn days) (see instructions)	anly (including private room days)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		0	11. 00
	December 31 of the cost reporting period (if calendar year, e			
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private room days)	0	12.00
12 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including private room days)	0	13. 00
13. 00	after December 31 of the cost reporting period (if calendar y		0	13.00
14. 00	Medically necessary private room days applicable to the Progr		0	14. 00
15.00	Total nursery days (title V or XIX only)	, ,	344	15.00
16. 00	Nursery days (title V or XIX only)		13	16. 00
47.00	SWING BED ADJUSTMENT	The state of the s	T	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31 of the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of the cost		18. 00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of the cost	216. 95	19. 00
20.00	reporting period	os after December 21 of the cost	214 05	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after beceiiber 31 of the cost	216. 95	20. 00
21. 00	Total general inpatient routine service cost (see instruction	ns)	14, 965, 234	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost reporting period (line	0	22. 00
	5 x line 17)			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reporting period (line o	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporting period (line	4, 990	24. 00
2 00	7 x line 19)	or or the cost reporting period (into	1,770	21100
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting period (line 8	15, 620	25. 00
04 00	x line 20)		0.004.000	04.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)	2, 804, 393 12, 160, 841	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(TITIE 21 IIII IIII 20)	12, 100, 041	27.00
28.00	General inpatient routine service charges (excluding swing-be	ed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)	0.000000	•
32. 00 33. 00	Average semi-private room per diem charge (line 30 ÷ line 3)		0. 00 0. 00	•
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	0.00	•
35. 00	Average per diem private room cost differential (line 34 x li		0.00	•
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost differential (line	12, 160, 841	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see		2, 205. 85	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line		134, 557	•
40.00	Medically necessary private room cost applicable to the Progr	•	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	7 + IINE 4U)	134, 557	41.00

	Financial Systems CAMER ATION OF INPATIENT OPERATING COST	RON MEMORIAL CO	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 10/01/2021 To 09/30/2022	Date/Time Pre	pared:
			Ti +I	e XIX	Hospi tal	2/22/2023 3: 0 PPS	06 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 259, 194	2.00	3. 00 753. ⁴	4. 00 17 13	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units		344	755	13	7, 173	42.00
	INTENSIVE CARE UNIT	421, 580	130	3, 242. 9	92 4	12, 972	43. 00 44. 00 45. 00 46. 00 47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					86, 449	
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	ons)		243, 773	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	23, 356	50.00
51. 00	Pass through costs applicable to Program inp.	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	7, 770	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				31, 126	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	elated, non-phy	ysician anest	hetist, and	212, 647	
54. 00	Program di scharges					0	54.00
55.00							55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (ine 56 minus	line 53)	0	1
58. 00	Bonus payment (see instructions)	· ·			ŕ	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996, i	updated and c	ompounded by the	0.00	59.00
60.00		cost report, up	dated by the i	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see		0	61.00			
	Relief payment (see instructions)	·				0	
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıcti ons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	oer 31 of the (cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after [December 31 of	the cost rep	orting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facil)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	,	ine /U ÷ line	۷)			71.00
73.00	Medically necessary private room cost applications	abĺe to Program					73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)				Part II, column		74.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00
79. 00	Aggregate charges to beneficiaries for excess			79.00			
80.00	, ,		80.00				
81. 00 82. 00	· · · · · · · · · · · · · · · · · · ·						
83.00	.00 Reasonable inpatient routine service costs (see instructions)						
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ons)				84.00
86. 00		•	,				86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1, 816	87.00
U1. UU	,	•	line 2)			2, 205. 85	
88. 00	Adjusted general inpatient routine cost per	urem (iiie 27 -	11116 2)			2, 200. 00	1 00.00

Health Financial Systems CAME	RON MEMORIAL CO	MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-						
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 10/01/2021	Worksheet D-1			
				To 09/30/2022				
		Ti tl	e XIX	Hospi tal	PPS	ervation d Pass ugh Cost dl. 3 x 4) (see		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation			
		(from line	column 2	Observati on	Bed Pass			
		21)		Bed Cost	Through Cost			
				(from line	(col. 3 x			
				89)	col. 4) (see			
					instructions)			
	1. 00	2. 00	3. 00	4. 00	5. 00			
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST							
90.00 Capital -related cost	2, 087, 901	14, 965, 234	0. 13951	7 4, 005, 824	558, 881	90.00		
91.00 Nursing Program cost	0	14, 965, 234	0.00000	0 4, 005, 824	0	91.00		
92.00 Allied health cost	0	14, 965, 234	0.00000	0 4, 005, 824	0	92.00		
93.00 All other Medical Education	0	14, 965, 234	0. 00000	0 4, 005, 824	0	93.00		

	Financial Systems CAMERON MEMORIAL COMMU ENT ANCILLARY SERVICE COST APPORTIONMENT		TAL CN: 15-1315	In Lie	u of Form CMS-2 Worksheet D-3	
11017411	ENT ANOTEEANT SERVICE GOST ALTONITONIMENT	TTOVIGET C	ON. 15 1515	From 10/01/2021 To 09/30/2022		
				10 07/30/2022	2/22/2023 3: 0	16 pm
		Titl∈	e XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	0.00	col . 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS			1, 766, 908		30.00
31.00	03100 INTENSIVE CARE UNIT			1, 766, 906	l	31.00
43. 00	04300 NURSERY			100,000		43. 00
43.00	ANCILLARY SERVICE COST CENTERS					43.00
50.00	05000 OPERATING ROOM		0. 32664	40 370, 481	121, 014	50.00
51.00	05100 RECOVERY ROOM		0. 40298			
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 41704		0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 14409		85, 364	
60.00	06000 LABORATORY		0. 1901		l	60.00
65. 00	06500 RESPI RATORY THERAPY		0. 60996		221, 291	
65. 01	06501 SLEEP LAB		0. 1496		0	65. 01
66.00	06600 PHYSI CAL THERAPY		0. 53873		131, 010	66.00
69.00	06900 ELECTROCARDI OLOGY		0. 1046			69.00
69. 01	06901 CARDI AC REHABI LI TATI ON		0. 46160	09	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1436	77 294, 469	42, 308	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 89689	95 110, 470	99, 080	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3170	13 719, 664	228, 143	73.00
76.00	03020 CHEMI CAL DEPENDENCY		0.00000	00	0	76. 00
76. 01	O3480 ONCOLOGY		0. 1267		0	76. 01
76. 02	O3O3O DI ABETI C EDUCATI ON		1. 6280	70 6, 400	10, 420	76. 02
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC		0.00000		0	1
88. 01	08801 RURAL HEALTH CLINIC II		0.00000		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III		0.00000		0	
90.00	09000 CLI NI C		0. 61422		0	
90. 01	09001 CLI NI C- ORTHO		17. 39340		0	
90. 02	09002 CLINIC - PEDS ENT FP		2. 11918		0	
90. 03	09003 I NTRAVENOUS THERAPY		0. 50345		0	
90.04	09004 PSYCHI ATRY		2. 01865		0	
90.05	09005 CARDI OLOGY		32. 3330		0	
91. 00 92. 00	09100 EMERGENCY		0. 22059			91.00 92.00
92. 00 200. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART Total (sum of lines 50 through 94 and 96 through 98)		1. 39320	3, 809, 678	0 1, 176, 461	
200.00		(Lino 61)		3, 809, 6/8	1, 1/0, 461	200.00
201.00		(TITIE OI)		3, 809, 678		201.00
202. U	p met charges (Title 200 millions Title 201)		1	3,007,078	I	12U2. UU

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1315	Peri od: From 10/01/2021	Worksheet D-3	
		Component	CCN: 15-Z315	To 09/30/2022	Date/Time Pre 2/22/2023 3:0	pared 6 pm
		Titl∈		Swing Beds - SNF	Cost	
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS					30.0
31. 00	03100 I NTENSI VE CARE UNI T					31.0
43. 00	04300 NURSERY		L			43. C
-0.00	ANCILLARY SERVICE COST CENTERS		0.22//	40 5 005	1 005	
0.00	05000 OPERATING ROOM 05100 RECOVERY ROOM		0. 3266 0. 4029		1, 935	1
1.00	05200 DELIVERY ROOM & LABOR ROOM		0. 4029	·	731 0	
4.00	05400 RADI OLOGY-DI AGNOSTI C		0. 4170		3, 896	
0.00	06000 LABORATORY		0. 1901	·	19, 395	
5. 00	06500 RESPIRATORY THERAPY		0. 6099		11, 010	
5. 01	06501 SLEEP LAB		0. 1496	·	0	
6. 00	06600 PHYSI CAL THERAPY		0. 5387		229, 400	
9. 00	06900 ELECTROCARDI OLOGY		0. 1046	·	1, 765	1
	06901 CARDI AC REHABI LI TATI ON		0. 46160		0	
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1436		4, 166	1
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 89689	·	0	1
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 3170		21, 433	73.
6. 00	03020 CHEMI CAL DEPENDENCY		0.0000		0	76.
6. 01	03480 ONCOLOGY		0. 1267	59 0	0	76.
6. 02	03030 DI ABETI C EDUCATI ON		1. 6280	70 0	0	76. (
	OUTPATIENT SERVICE COST CENTERS					
8.00	08800 RURAL HEALTH CLINIC		0.0000	00	0	88.
8. 01	08801 RURAL HEALTH CLINIC II		0.00000		0	
8. 02	08802 RURAL HEALTH CLINIC III		0.00000		0	88.
0. 00	09000 CLI NI C		0. 6142		0	
0. 01	09001 CLI NI C- ORTHO		17. 3934		0	90.
0. 02	09002 CLINIC - PEDS ENT FP		2. 11918		0	90.
0. 03	09003 I NTRAVENOUS THERAPY		0. 5034!		0	
	09004 PSYCHI ATRY		2. 0186		0	
90.05	09005 CARDI OLOGY		32. 3330		0	90.
	09100 EMERGENCY		0. 22059		20	91.

0 92.00

293, 751 200. 00 201. 00

202.00

1. 393209

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

200.00 201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

	Financial Systems CAMERON MEMORIAL				u of Form CMS-2						
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1315	Peri od: From 10/01/2021	Worksheet D-3						
				To 09/30/2022	Date/Time Pre 2/22/2023 3:0						
		Ti tl	e XIX	Hospi tal	PPS						
	Cost Center Description		Ratio of Cos		I npati ent						
			To Charges	Program	Program Costs						
				Charges	(col . 1 x						
			1.00	0.00	col . 2)						
	INDATIENT DOUTINE CEDVICE COCT CENTEDS		1.00	2. 00	3. 00						
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		1	140 222		30.00					
30. 00 31. 00	03100 INTENSIVE CARE UNIT			148, 333 9, 000		30.00					
	04300 NURSERY			10, 000		43.00					
43.00	ANCILLARY SERVICE COST CENTERS			10,000		43.00					
50.00			0. 3266	40 19, 721	6, 442	50.00					
51.00	05100 RECOVERY ROOM		0. 40298			51.00					
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 4170								
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1440								
60.00	06000 LABORATORY		0. 1901								
65.00	06500 RESPIRATORY THERAPY		0. 6099		16, 358	1					
65. 01	06501 SLEEP LAB		0. 1496	16 0	0	65. 01					
66.00	06600 PHYSI CAL THERAPY		0. 5387	32 3, 698	1, 992	66.00					
69.00	06900 ELECTROCARDI OLOGY		0. 1046!	55 3, 960	414	69.00					
69. 01	06901 CARDI AC REHABI LI TATI ON		0. 46160	0	0	69. 01					
71.00			0. 1436		0						
72.00			0. 89689		0	72.00					
73.00			0. 3170		20, 632						
	03020 CHEMI CAL DEPENDENCY		0.00000		0						
76. 01	03480 ONCOLOGY		0. 1267		0						
76. 02			1. 6280	70 0	0	76. 02					
	OUTPATIENT SERVICE COST CENTERS		1 00/45	~!							
	08800 RURAL HEALTH CLINIC		0. 96458		0						
88. 01	08801 RURAL HEALTH CLINIC II		0. 85340		0						
88. 02			0. 90083		0	88. 02					
90.00			0. 6142		0						
	09001 CLI NI C - ORTHO		17. 3934 2. 11918		0	90. 01 90. 02					
90. 02			0. 5034		0	90.02					
	09004 PSYCHI ATRY		2. 0186		0						
	100005 CARDI OLOCY		2.0100			1					

32. 333011 0. 220598

1. 393209

310, 054

90.05

91.00

92.00

202.00

0

86, 449 200. 00 201. 00

90. 05 09005 CARDI OLOGY

91. 00 09100 EMERGENCY

200.00 201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1315	Peri od: From 10/01/2021 To 09/30/2022	Worksheet E Part B Date/Time Prepared: 2/22/2023 3:06 pm

	THE MILLS	2/22/2023 3:0	6 pm
	Title XVIII Hospital	Cost	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12, 135, 979	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions) OPPS payments	0	2. 00 3. 00
4. 00	Outlier payment (see instructions)	0	
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	1
6. 00 7. 00	Line 2 times line 5	0	6. 00 7. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	1
10.00	Organ acqui si ti ons	0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	12, 135, 979	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12. 00	Reasonable charges Ancillary service charges	1 0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
	Total reasonable charges (sum of lines 12 and 13)	0	•
	Customary charges		
	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17. 00
18. 00	Total customary charges (see instructions)	0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19.00
20.00	instructions)		20.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21. 00	Lesser of cost or charges (see instructions)	12, 257, 339	21.00
	Interns and residents (see instructions)	0	22. 00
	Cost of physicians' services in a teaching hospital (see instructions)	0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	114, 430	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6, 354, 727	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	5, 788, 182	27. 00
	instructions)	_	
	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0 0	28. 00 29. 00
	Subtotal (sum of lines 27 through 29)	5, 788, 182	•
	Primary payer payments	6, 163	1
32. 00	Subtotal (line 30 minus line 31)	5, 782, 019	32.00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		1 00 00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)	0 460, 862	33. 00 34. 00
	Adjusted reimbursable bad debts (see instructions)	299, 560	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	366, 909	•
37. 00	Subtotal (see instructions)	6, 081, 579	37.00
	MSP-LCC reconciliation amount from PS&R	0	ł
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	39. 00 39. 50
39. 97	Demonstration payment adjustment amount before sequestration	0	ı
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	ı
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
	Subtotal (see instructions)	6, 081, 579	•
40. 01	Sequestration adjustment (see instructions)	45, 612	1
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs	0	40. 02 40. 03
	Interim payments	6, 044, 955	
41. 01	Interim payments-PARHM		41.01
	Tentative settlement (for contractors use only)	0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)	0.000	42.01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	-8, 988	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
55	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount (see instructions)	0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)	0.00	•
	Total (sum of lines 91 and 93)	0	•

Health Financial Systems	CAMERON MEMORIAL COMM	In Lieu	of Form CMS	-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1315		Worksheet E Part B Date/Time Pr 2/22/2023 3:	
	Title XVIII Hospital		Cost		
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(200. 00

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C		Period: From 10/01/2021 To 09/30/2022	Worksheet E-1 Part I Date/Time Pre 2/22/2023 3:0	pared:
		Title	XVIII	Hospi tal	Cost	
		I npati en	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 168, 11	6 0	6, 044, 955 0	
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER			O	0	3. 01
3. 02	THE CONTINUE TO THE THE PLANT		1	0	0	3. 02
3. 03				o	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. 51			1	0	0	3. 51
3. 52			1	0	0	3. 52
3. 53				0	0	3.53
3. 54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		'	0	U	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 168, 11	6	6, 044, 955	4. 00
	TO BE COMPLETED BY CONTRACTOR			•		1
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)					
- 04	Program to Provider				_	
5. 01	TENTATI VE TO PROVI DER	1	1	0	0	
5. 02 5. 03			1	0	0	
5. 03	Provider to Program			U	0	5.03
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 50				0		
5. 52			1	Ö	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1	Ö	ĺ	
,	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		52, 69	7	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			o o	8, 988	
7.00	Total Medicare program liability (see instructions)		3, 220, 81	3	6, 035, 967	
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2. 00	
0 00	Name of Contractor	MISCUNSIN DAVE	CLUM SEDVICE	00001	I	0 00

WISCONSIN PHYSICIAN SERVICES

08001

8. 00

8.00 Name of Contractor

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		F	Period: From 10/01/2021 Fo 09/30/2022	Worksheet E-1 Part Date/Time Pre	pared:
		,			2/22/2023 3:0	
			xVIII S	wing Beds - SNF	Cost	
		i npati en	it Part A	Pai	LB	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		1, 405, 725	5	0	1.00
2.00	Interim payments payable on individual bills, either		(0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					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			_		
3. 01	ADJUSTMENTS TO PROVIDER		(0	
3. 02			(0	3. 02
3. 03					0	3.03
3. 04 3. 05					0	3. 04 3. 05
3.03	Provider to Program			<u>/ </u>	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3.50
3. 51					o	3. 51
3.52					0	3. 52
3.53			(0	3. 53
3. 54			(0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98))	0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 405, 725	5	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	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 Provi der	ı	1	.1	_	
5. 01 5. 02	TENTATI VE TO PROVI DER				0	5. 01
5. 02 5. 03						
5.05	Provider to Program			<u> </u>	U	5.03
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51					0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVI DER		89, 758	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 495, 483		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2. 00	
8. 00	Name of Contractor	WISCONSIN PHYS	SICIAN SERVICES	08001		8. 00

Heal th	u of Form CMS-:	2552-10						
	Financial Systems CAMERON MEMORIAL COMM ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1315	Peri od: From 10/01/2021	Worksheet E-1				
	Part II Date/Time Pre							
		T1.11 \0.0011		2/22/2023 3: 0	6 pm			
		Title XVIII	Hospi tal	Cost				
				1. 00				
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION							
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.				1.00			
2. 00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus	for cost		2.00			
	reporting periods beginning on or after 10/01/2013, line 32)							
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00			
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	d plus for cost		4. 00			
	reporting periods beginning on or after 10/01/2013, line 32)							
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00			
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00			
	line 168							
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00			
9.00	Sequestration adjustment amount (see instructions)				9. 00			
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00			
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH							
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00			
31.00	Other Adjustment (specify)				31.00			
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00			

Health Financial Systems		CAMERON MEMORIAL (COMMU	INITY HOSPITA	AL			In Lieu	of Form CMS-2552-	-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	-	SWING BEDS		Provi der CC	CN: 1	15-1315	Perio		Worksheet E-2	
							From	10/01/2021		
				Component C	CCN:	15-Z315	To	09/30/2022	Date/Time Prepare	d:
				•			1		2/22/2023 3 06 pm	

		Component CCN: 15-Z315	To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
		Title XVIII	Swing Beds - SNF		и рііі
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 229, 805	0	
2. 00 3. 00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	296, 689	0	2.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi		· ·	0	3.00
	instructions)	ng-bed pass-thi odgii, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4.00
	instructions)				
5.00	Program days		552	0	
6. 00	Interns and residents not in approved teaching program (see i			0	
7. 00	Utilization review - physician compensation - SNF optional me	thod only	1 52/ 404		7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		1, 526, 494	0	
10.00	Subtotal (line 8 minus line 9)		1, 526, 494	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	1, 320, 474	0	
11.00	professional services)	cable to physician		Ĭ	11.00
12.00	Subtotal (line 10 minus line 11)		1, 526, 494	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	19, 710	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (see instructions)		1, 506, 784	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	->	0	0	
16. 50 16. 55	Pioneer ACO demonstration payment adjustment (see instruction Rural community hospital demonstration project (§410A Demonst				16. 50 16. 55
10. 55	adjustment (see instructions)	ration) payment	U		10. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		0	Ō	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	1
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.00
	Total (see instructions)		1, 506, 784	0	
	Sequestration adjustment (see instructions)		11, 301	0	
	Demonstration payment adjustment amount after sequestration)		0	0	1
	Sequestration adjustment-PARHM pass-throughs				19.03
19. 25	Sequestration for non-claims based amounts (see instructions) Interim payments		1, 405, 725	0	
	Interim payments Interim payments-PARHM		1, 405, 725	U	20.00
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)				21. 01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	89, 758	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	Trod drider the 21st			200.00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, lin	е		202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the surre	nt E voor domone	tration	204. 00
	period)	Tirst year of the curre	nt 5-year demons	stration	
205 00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbur				
207.00	Program reimbursement under the §410A Demonstration (see inst				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines	1		208.00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209.00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line	200 plus lino 210) (600			215. 00
Z 13. UU	instructions)	207 prus rine 210) (See			2 15.00
	· · · · · · · · · · · · · · · · · · ·		į į	ı	1

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-13	From 10/01/2021	Worksheet E-3 Part V Date/Time Prepared: 2/22/2023 3:06 pm
	Title XVIII	Hospi tal	Cost

2.00 Nursing and Allied Health Managed Care payment (see instructions) 0 2.00 3.00 Organ acquisition 0 3.00					2/22/2023 3:0	6 pm
PART V - CALCULATION OF RETIBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETIBURSEMENT			Title XVIII	Hospi tal	Cost	
PART V - CALCULATION OF RETIBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETIBURSEMENT						
Inpatient services 3,514,977 1.00 2.00 Nursing and Allied Health Managed Care payment (see instructions) 0 3.00					1.00	
Nursing and Allied Health Managed Care payment (see instructions)		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REI MBURSEMENT		
1.00 Organ acquisition 3,1514,797 4,00 5,000 Primary payer payments 3,514,9612 5,000 Primary payer payments 3,514,9612 6,000 Control Cost (Line 4 less Line 5). For CAH (see Instructions) 3,514,9612 6,000 ComPUTATION OF LESSER OF COST OR CHARGES 8,000 COMPUTATION OF LESSER OF COST OR CHARGES 0,000 7,000	1.00	Inpati ent servi ces			3, 514, 497	1.00
Organ acquisition 3,104 0,	2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
Subtotal (sum of lines 1 through 3)	3.00		,		0	3.00
5.00	4.00				3, 514, 497	4.00
Total cost (line 4 less line 5). For CAH (see instructions) 3,549,642 6.00						
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Routine service charges 0 7.00 0 0 0 0 0 0 0 0 0						
Reasonable charges 0	0.00				0,017,012	0.00
Routine service charges						
Ancil lary service charges 0 0 0 0 0 0 0 0 0	7 00	9			0	7 00
0						
10. 00 Total reasonable charges 0 10. 00						
Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00						
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00	10.00					10.00
12.00 Amount's that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 cFR 413.13(e) 0.000000 13.00 14.00 10.000000 15.00 10.000000 15.00 10.000000 15.00 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.0000000 10.0000000 10.0000000 10.0000000 10.0000000 10.00000000 10.00000000 10.0000000000	11 00		payment for services on	a charge basis	0	11 00
had such payment been made in accordance with 42 CFR 413.13(e)						
13.00	12.00			on a charge basis		12.00
14.00 Total customary charges (see instructions) 0 14.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see 0 15.00	13 00		,		0.000000	13 00
15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT						
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 16. 00 16. 00 17. 00			Ly if line 14 exceeds li	no 6) (soo		
16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT	13.00		Ty IT TITLE 14 EXCEEDS IT	116 0) (366	U	13.00
Instructions Cost of physicians' services in a teaching hospital (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Cost of covered services (sum of lines 6, 17 and 18) 18.00 Cost of covered services (sum of lines 6, 17 and 18) 3,549,642 19.00 20.00 Deductibles (exclude professional component) 322,512 20.00 20.00 Excess reasonable cost (from line 16) 21.00 22.00 23.00	16 00		lv if line 6 exceeds lin	ne 14) (see	0	16 00
17.00	10.00		Ty IT TITLE O EXCEEDS ITT	16 14) (366	U	10.00
SOMPUTATION OF REIMBURSEMENT SETTLEMENT 18.00 19	17 00		ructions)		0	17 00
18.00	17.00		actions)			17.00
19.00 Cost of covered services (sum of lines 6, 17 and 18) 3,549,642 19.00 20.00 Deductibles (exclude professional component) 322,512 20.00 21.00 Excess reasonable cost (from line 16) 21.00 22.00 Subtotal (line 19 minus line 20 and 21) 3,227,130 22.00 23.00 23.00 24.00 Subtotal (line 22 minus line 23) 27.726 25.00 27.726 25.00 27.726 25.00 27.726 27.00 27.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 18,022 26.00 27.726 25.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 18,022 26.00 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 19,042 27.00 29.00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 29.99 29.99 Demonstration payment adjustment amount before sequestration 29.99 29.90	18 00		4 line 49)		0	18 00
20.00 Deductibles (exclude professional component) 322, 512 20.00			.,			
21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 3.227, 130 22.00 3.227, 130 22.00 3.227, 130 22.00 23.00 20 insurance 0 23.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 27,726 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 27,000 Allowable bad debts for dual eligible beneficiaries (see instructions) 19,042 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 29.98 Recovery of accelerated depreciation. 0 29.98 29.99 Demonstration payment adjustment before sequestration 29.99 29.90 20.00						
22. 00 Subtotal (line 19 minus line 20 and 21) 3, 227, 130 22. 00 23. 00 Coinsurance 0 23. 00 24. 00 Subtotal (line 22 minus line 23) 3, 227, 130 24. 00 25. 00 All owable bad debts (exclude bad debts for professional services) (see instructions) 27, 726 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 18, 022 26. 00 27. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 19, 042 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 3, 245, 152 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 98 Recovery of accelerated depreciation. 0 29. 95 29. 99 Demonstration payment adjustment amount before sequestration 0 29. 96 30. 01 Sequestration adjustment (see instructions) 3, 245, 152 30. 00 30. 02 Demonstration payment adjustment amount after sequestration 24, 33 30. 01 31. 01 Interim payments 3, 168, 116 31. 00 31. 01 Interim payments-PARHM 3. 10, 10 32. 00					·	
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34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00					52, 697	
§115. 2	34. 00	, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
		[9115. 2		l		l

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1315	Peri od: From 10/01/2021 Part VII To 09/30/2022 Date/Ti me Prepared: 2/22/2023 3:06 pm

		1	o 09/30/2022	Date/lime Pre 2/22/2023 3:0	
		Title XIX	Hospi tal	PPS	-
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CVI DES TON TITLES V ON XIX	V OLIVITOLO		1
1. 00	Inpatient hospital/SNF/NF services		O		1.00
2. 00	Medical and other services		l	0	2.00
3. 00	Organ acquisition (certified transplant centers only)		0	O	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)			0	4.00
5. 00	Inpatient primary payer payments		0	U	5.00
6. 00	Outpatient primary payer payments		١	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		l ol	U	7.00
	Reasonable Charges				1
8. 00	Routine service charges		36, 553		8.00
9. 00	Ancillary service charges		310, 054	0	
10.00	Organ acquisition charges, net of revenue		310, 034	U	10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	i i		244 407	0	
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		346, 607	U	12.00
13. 00	Amount actually collected from patients liable for payment for	s sorvi cos on a chargo	O	0	13.00
13.00	basis	services on a charge	٩	U	13.00
14.00	Amounts that would have been realized from patients liable for	r navment for services on	0	0	14.00
14.00	a charge basis had such payment been made in accordance with		Ĭ		14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CIR 3413. 13(e)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		346, 607	0.00000	
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	346, 607	0	
17.00	line 4) (see instructions)	y II IIIle To execeds	340,007	0	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18.00
	16) (see instructions)	, , , , , , , , , , , , , , , , , , , ,		_	
19. 00	Interns and Residents (see instructions)		ol	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	o	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line		o	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22.00	Other than outlier payments		126, 306	0	22. 00
23.00	Outlier payments		o	0	23.00
24.00	Program capital payments		o		24.00
25.00	Capital exception payments (see instructions)		o		25. 00
26.00	Routine and Ancillary service other pass through costs		o	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		126, 306	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		126, 306	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	126, 306	0	31.00
32.00	Deducti bl es		o	0	32.00
33.00	Coinsurance		261	0	33.00
34.00	Allowable bad debts (see instructions)		o	0	34.00
35.00	Utilization review		o		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	126, 045	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		126, 045	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		126, 045	0	40.00
41.00	Interim payments		126, 045	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		O	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	O	0	43.00
	chapter 1, §115.2				

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

only)

Provider CCN: 15-1315

Peri od: Worksheet G From 10/01/2021 09/30/2022 Date/Time Prepared:

In Lieu of Form CMS-2552-10

2/22/2023 3:06 pm General Fund Speci fi c Endowment Plant Fund Purpose Fund Fund 1.00 2.00 4.00 3.00 CURRENT ASSETS 1.00 Cash on hand in banks 21, 564, 054 0 0 0 1.00 0 0 2.00 Temporary investments 0 2.00 0 3 00 Notes receivable 0 0 3 00 0 4.00 Accounts receivable 11, 581, 034 0 4.00 5.00 0 0 0 5.00 Other receivable 1, 363, 610 o 6.00 Allowances for uncollectible notes and accounts receivable 0 0 6.00 o 1 529 058 0 7 00 7 00 0 Inventory 0 0 8.00 Prepaid expenses 2, 613, 081 0 8.00 0 9.00 Other current assets 0 9.00 10.00 Due from other funds 0 ol 0 10.00 Total current assets (sum of lines 1-10) 38, 650, 837 0 11.00 0 0 11.00 FIXED ASSETS 12.00 Land 2,019,703 0 0 0 12.00 Land improvements 0 0 13.00 0 13.00 0 14.00 Accumulated depreciation 0 14.00 Bui I di ngs o 15.00 61, 152, 127 0 0 15.00 Accumulated depreciation 16.00 -31, 765, 450 0 0 0 0 0 16.00 0 Leasehold improvements 17.00 17.00 0 0 18 00 Accumulated depreciation r 0 18 00 Fixed equipment 19.00 19.00 0 0 20.00 Accumulated depreciation 0 0 0 0 20.00 0 21.00 Automobiles and trucks C 0 21.00 22.00 Accumulated depreciation 0 22.00 19, 762, 922 23.00 Major movable equipment 0 0 0 0 23.00 Accumulated depreciation 0 24.00 -15, 945, 945 0 24.00 0 25.00 Minor equipment depreciable 0 25.00 Accumulated depreciation 0 0 26.00 26.00 0 0 27.00 HIT designated Assets 0 0 27.00 C 0 28.00 Accumulated depreciation 0 28.00 0 0 29.00 Mi nor equi pment-nondepreci abl e 212, 917 0 29.00 Total fixed assets (sum of lines 12-29) 30.00 35, 436, 274 0 0 0 30.00 OTHER ASSETS 31 00 27, 994, 311 31.00 Investments 0 0 0 0 32.00 Deposits on Leases 0 0 32.00 0 0 33.00 Due from owners/officers 0 33.00 o 34.00 4, 226, 503 0 34.00 Other assets 0 Total other assets (sum of lines 31-34) 0 0 35.00 32, 220, 814 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 106, 307, 925 0 0 0 36.00 CURRENT LIABILITIES 37 00 3, 141, 788 0 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 5, 644, 116 0 38.00 Payroll taxes payable 747, 002 0 0 0 39.00 39.00 40.00 Notes and Loans payable (short term) 960, 667 0 0 40.00 0 o Deferred income 0 41 00 41 00 C 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities ol 44.00 2.131.754 0 0 44.00 0 Total current liabilities (sum of lines 37 thru 44) 45.00 12, 625, 327 0 0 45.00 ONG TERM LIABILITIES Mortgage payable 0 0 0 46.00 46,00 0 0 Notes payable 0 47.00 47.00 C 48.00 Unsecured Loans 0 0 0 48.00 Other long term liabilities 0 0 49.00 49.00 39, 832, 903 0 Total long term liabilities (sum of lines 46 thru 49) 39, 832, 903 0 ol 0 50.00 50.00 51.00 Total liabilities (sum of lines 45 and 50) 52, 458, 230 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 53, 849, 695 52.00 0 Specific purpose fund 53.00 53.00 54.00 Donor created - endowment fund balance - restricted 0 54 00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 53, 849, 695 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 106, 307, 925 0 0 0 60.00

7.00

8.00

9.00

10.00

11.00

12.00 13.00

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18.00

Total additions (sum of line 4-9)

Deductions (debit adjustments) (specify)

Total deductions (sum of lines 12-17)

Fund balance at end of period per balance

Subtotal (line 3 plus line 10)

sheet (line 11 minus line 18)

In Lieu of Form CMS-2552-10 Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-1315 Peri od: Worksheet G-1 From 10/01/2021 09/30/2022 Date/Time Prepared: 2/22/2023 3:06 pm General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 49, 027, 962 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 4, 821, 721 2.00 2.00 3.00 Total (sum of line 1 and line 2) 53, 849, 683 ol 3.00 4.00 ROUNDI NG 4.00 0 5.00 0 5.00 0 0 0 0 6.00 0 6.00 0 7.00 0 7.00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 12 53, 849, 695 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 0 0 0 0 0 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 53, 849, 695 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 0 0 3.00 Total (sum of line 1 and line 2) 3.00 4.00 ROUNDI NG 4.00 5.00 5.00 6.00 0 6.00

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 Heal th Financial
 Systems
 CAMERON

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

			To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
	Cost Center Description	I npati ent	Outpati ent	Total	D piii
	oust don'to boson per on	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	12, 260, 86	00	12, 260, 860	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12, 260, 86	00	12, 260, 860	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	393, 00	00	393, 000	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	393, 00	00	393, 000	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12, 653, 86	00	12, 653, 860	17. 00
18. 00	Ancillary services	19, 906, 30			
19. 00	Outpati ent servi ces		0 10, 198, 177	10, 198, 177	19.00
20. 00	RURAL HEALTH CLINIC	10, 67		2, 179, 947	20.00
20. 01	RURAL HEALTH CLINIC II	10, 0,	0 3, 729, 278		1
20. 02	RURAL HEALTH CLINIC III	740, 11		1, 996, 074	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	740, 11	1, 233, 701	1, 770, 074	21.00
22. 00	HOME HEALTH AGENCY			0	22.00
23. 00	AMBULANCE SERVICES			0	23.00
24. 00	CMHC				24.00
25. 00					25.00
	AMBULATORY SURGI CAL CENTER (D. P.)				
26.00	HOSPI CE		0 0	0	26.00
27. 00	NON REI MBURSABLE	101 00	0 4, 103, 728		27.00
27. 01	PROFESSIONAL FEES	191, 89			27. 01
28. 00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.	33, 502, 83	196, 788, 989	230, 291, 824	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		00 005 020		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		88, 005, 938		29.00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33. 00			0		33.00
34.00			0		34.00
35. 00			0		35.00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		0		37.00
38. 00			0		38. 00
39.00			0		39. 00
40.00			0		40.00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	88, 005, 938		43.00
	to Wkst. G-3, line 4)				

111-	CAMEDON HENODIAL CO	MANUAL TV. LIOCOL TAI	la lia		NEE 2 4 0
	Financial Systems CAMERON MEMORIAL COI ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1315	Period:	u of Form CMS-2 Worksheet G-3	
SIAILN	LNI OF REVENUES AND EXPENSES	FIOVIDE CCN. 15-1315	From 10/01/2021	WOLKSHEET G-3	
			To 09/30/2022		
				2/22/2023 3:0	6 pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, I	ine 28)		230, 291, 824	1.00
2.00	Less contractual allowances and discounts on patients' acco			135, 237, 706	2.00
3. 00	Net patient revenues (line 1 minus line 2)			95, 054, 118	
4.00	Less total operating expenses (from Wkst. G-2, Part II, lin	e 43)		88, 005, 938	
5.00	Net income from service to patients (line 3 minus line 4)	,		7, 048, 180	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			-28, 333	6.00
7.00	Income from investments			78, 076	7.00
8.00	Revenues from telephone and other miscellaneous communicati	on services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			268, 979	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING INCOME			521, 689	24.00
24. 01	340B CONTRACT REVENUE			299, 973	
	PHYLSICAN INCENTIVE PAYMENTS			104, 400	
04 50	00// D 40 DUE E . I'			0 0/5 054	04 50

2, 065, 351

2, 065, 351 24, 50 3, 310, 135 25, 00 10, 358, 315 26, 00 39, 403 27, 00 5, 497, 191 27, 01 5, 536, 594 28, 00 4, 821, 721 29, 00

24.50

24. 50 COVI D-19 PHE Funding

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 LOSS ON DISPOSAL OF PROPERTY

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

27. 01 UNREALIZED LOSS ON INVESTMENT

	51	DOM MEMORIAL OF	OMMUNITY HOODIS	FA!	1 . 11	. C. F OHC .	2550 40
	Financial Systems CAME SIS OF HOSPITAL-BASED RHC/FQHC COSTS	RON MEMORIAL CO	Provider C		In Lie Period:	u of Form CMS-2 Worksheet M-1	
			Component		From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
					RHC I	Cost	Орш
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
				'		(col. 3 +	
						col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	406, 007	32, 084	438, 09	102, 494	540, 585	1.00
2.00	Physician Assistant	0	0		o	0	2.00
3.00	Nurse Practitioner	227, 663	0	227, 663	51, 247	278, 910	3.00
4.00	Visiting Nurse	0	0		o	0	4. 00
5.00	Other Nurse	307, 188	0	307, 188	0	307, 188	5.00
6.00	Clinical Psychologist	0	0		17, 642	17, 642	6.00
7.00	Clinical Social Worker	17, 544	0	17, 544	1 0	17, 544	7. 00
8.00	Laboratory Techni ci an	0	0		o	0	8.00
9.00	Other Facility Health Care Staff Costs	41, 123	0	41, 123	0	41, 123	9. 00
10.00	Subtotal (sum of lines 1 through 9)	999, 525	32, 084	1, 031, 609	171, 383	1, 202, 992	10.00
11.00	Physician Services Under Agreement	0	0		o	0	11.00
12.00	Physician Supervision Under Agreement	0	0		o	0	12.00
13.00	Other Costs Under Agreement	0	0		o	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	(0	0	14.00
15.00	Medical Supplies	0	32, 148	32, 148	0	32, 148	15.00
16.00	Transportation (Health Care Staff)	0	6, 045	6, 045	0	6, 045	16.00
17.00	Depreciation-Medical Equipment	0	0	(0	0	17. 00
18.00	Professional Liability Insurance	0	0	(0	0	18. 00
19.00	Other Health Care Costs	0	0	(0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38, 193	38, 193	0	38, 193	21.00
22.00	Total Cost of Health Care Services (sum of	999, 525	70, 277	1, 069, 802	171, 383	1, 241, 185	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	25. 01
25. 02	Chronic Care Management	0	0	(0	0	25. 02
26.00	All other nonreimbursable costs	0	0	(0	0	26. 00
	Nonallowable GME costs						27. 00
20 00	Tatal Naprai mburaabla Caata (aum of Linea 22		1 0	l /	N 0		20 00

85, 776

85, 776

1, 085, 301

0

9, 816

117, 540

127, 356

1, 197, 158

9, 816

31, 764

41, 580

111, 857

0 28.00

29.00

30.00

31.00

32.00

9, 816 117, 540 127, 356

1, 368, 541

0

171, 383

28.00

31.00

32.00

through 27)
FACILITY OVERHEAD
29.00 Facility Costs

30.00 Administrative Costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	CAMERON MEMORIAL COMMU	INITY HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1315	Peri od: From 10/01/2021	Worksheet M-1		
		Component CCN: 15-8530		Date/Time Prepared:		

			Component	CCN: 15-8530	То	09/30/2022	Date/Time Pre 2/22/2023 3:0	
						RHC I	Cost	о ріп
		Adjustments	Net Expenses					
		.,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS			'				
1.00	Physi ci an	0	540, 58	5				1.00
2.00	Physician Assistant	o		o				2.00
3.00	Nurse Practitioner	o	278, 91	o				3.00
4.00	Visiting Nurse	o		o				4.00
5. 00	Other Nurse	0	307, 18	8				5.00
6. 00	Clinical Psychologist	o	17, 64	1				6.00
7. 00	Clinical Social Worker	o	17, 54	1				7.00
8. 00	Laboratory Techni ci an	0		0				8.00
9. 00	Other Facility Health Care Staff Costs	0	41, 12	-1				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 202, 99					10.00
11. 00	Physician Services Under Agreement	0		0				11.00
12.00	Physician Supervision Under Agreement	0		o				12.00
13. 00	Other Costs Under Agreement	0		o				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0		o				14.00
15. 00	Medical Supplies	0	32, 14					15. 00
16. 00	Transportation (Health Care Staff)	0	6, 04					16.00
17. 00	Depreciation-Medical Equipment	0		0				17. 00
18. 00	Professional Liability Insurance	0		0				18.00
19.00	Other Health Care Costs	0		0				19.00
20.00	Allowable GME Costs	U		٥				20.00
21. 00	Subtotal (sum of lines 15 through 20)		38, 19	2				21.00
21.00	Total Cost of Health Care Services (sum of	0	1, 241, 18	1				22.00
22.00	lines 10, 14, and 21)	۷	1, 241, 10	٥				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0		o				23. 00
24. 00	Dental	0		0				24.00
25. 00	Optometry	0		0				25. 00
25. 00	Tel eheal th	0		0				25. 00
25. 01	Chronic Care Management	0		0				25. 01
26. 00	All other nonreimbursable costs	0		0				26. 00
27. 00	Nonallowable GME costs	U		٥				27.00
28. 00	4	0		o				28.00
28.00	Total Nonreimbursable Costs (sum of lines 23	U		٩				28.00
	through 27) FACILITY OVERHEAD							1
29. 00		0	9, 81	6				29. 00
30.00	Administrative Costs	0	117, 54	1				30.00
31.00	4	-		1				31.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	۷	127, 35	٥				31.00
32. 00	Total facility costs (sum of lines 22, 28	0	1, 368, 54	1				32.00
JZ. UU	and 31)	١	1, 300, 34	"				32.00
	Jana 017	ı		1				1

Health Financial Systems	CAMERON MEMORIAL CO	MMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 10/01/2021		
		Component	CCN: 15-8545	To 09/30/2022	Date/Time Pre 2/22/2023 3:0	pared: 6 pm
				RHC II	Cost	
	Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
	·		+ col . 2)	i ons	Trial Balance	
					(col. 3 +	
					col. 4)	
	1 00	2 00	3 00	4 00	5.00	

Compensation Other Costs Total (col. 1 Reclassificat ions Trial B (col. 2) 1.00 2.00 3.00 4.00 5.0	al ance 3 + 4)
(col. col. 1.00 2.00 3.00 4.00 5.0	3 + 4) 0 22,309 93,982 2.00
1.00 2.00 3.00 4.00 5.0	4) 0 22, 309 1. 00 93, 982 2. 00
1.00 2.00 3.00 4.00 5.0	4) 0 22, 309 1. 00 93, 982 2. 00
	22, 309 1. 00 93, 982 2. 00
FACILITY HEALTH CARE STAFF COSTS	93, 982 2. 00
	93, 982 2. 00
1. 00 Physi ci an 513, 470 0 513, 470 108, 839 6	•
2. 00 Physi ci an Assi stant 139, 563 0 139, 563 54, 419 1	29, 332 3. 00
3.00 Nurse Practitioner 274, 913 0 274, 913 54, 419 3	
4.00 Visiting Nurse 0 0 0 0	0 4.00
	29, 823 5. 00
6.00 Clinical Psychologist 0 0 0	0 6.00
7.00 Clinical Social Worker 0 0 0	0 7.00
8.00 Laboratory Technician 0 0 0	0 8.00
	79, 784 9.00
	55, 230 10.00
11. 00 Physician Services Under Agreement 0 0 0 0	0 11.00
12. 00 Physician Supervision Under Agreement 0 0 0	0 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 14.00
	78, 466 15. 00
16. 00 Transportation (Health Care Staff) 0 95 95 0	95 16.00
17. 00 Depreciation-Medical Equipment 0 0 0	0 17.00
18.00 Professional Liability Insurance 0 0 0 0 0 19.00 Other Health Care Costs 0 0 0	0 18.00
20. 00 Allowable GME Costs	20.00
	78, 561 21. 00
	33, 791 22. 00
lines 10, 14, and 21)	
COSTS OTHER THAN RHC/FQHC SERVICES 23 00 Pharmacy O	0 23.00
251 55 1 1141 1145	
24. 00 Dental	0 24.00
25. 00 Optometry	0 25.00
25. 01 Tel eheal th	0 25.01
25. 02 Chroni c Care Management	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	
	17, 580 29. 00
	11, 182 30. 00
	28, 762 31. 00
[30]	
	62, 553 32. 00
and 31)	I

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1315	Peri od:	Worksheet M-1
	Component CCN: 15-8545	From 10/01/2021 To 09/30/2022	

	2023 3:06 pm
RHC I I	Cost
Adjustments Net Expenses	
for	
Allocation	
(col. 5 +	
col. 6)	
6.00 7.00	
FACILITY HEALTH CARE STAFF COSTS	
1. 00 Physi ci an 0 622, 309	1.00
2. 00 Physi ci an Assi stant 0 193, 982	2.00
3. 00 Nurse Practitioner 0 329, 332	3.00
4.00 Visiting Nurse 0 0	4. 00
5.00 Other Nurse 0 229,823	5. 00
6.00 Clinical Psychologist 0 0	6. 00
7.00 Clinical Social Worker 0 0	7.00
8. 00 Laboratory Techni ci an 0 0	8. 00
9.00 Other Facility Health Care Staff Costs 0 179,784	9. 00
10.00 Subtotal (sum of lines 1 through 9) 0 1,555,230	10.00
11.00 Physician Services Under Agreement 0 0	11.00
12.00 Physician Supervision Under Agreement 0 0	12.00
13.00 Other Costs Under Agreement 0 0	13.00
14.00 Subtotal (sum of lines 11 through 13) 0 0	14.00
15.00 Medical Supplies 0 178,466	15. 00
16.00 Transportation (Health Care Staff) 0 95	16.00
17.00 Depreciation-Medical Equipment 0 0	17. 00
18.00 Professional Liability Insurance 0 0	18. 00
19.00 Other Health Care Costs 0 0	19. 00
20.00 Allowable GME Costs	20.00
21.00 Subtotal (sum of lines 15 through 20) 0 178,561	21.00
22.00 Total Cost of Health Care Services (sum of 0 1,733,791	22. 00
lines 10, 14, and 21)	
COSTS OTHER THAN RHC/FOHC SERVICES	
23. 00 Pharmacy 0 0	23. 00
24.00 Dental 0 0	24.00
25.00 Optometry 0 0	25. 00
25. 01 Tel eheal th 0 0	25. 01
25. 02 Chroni c Care Management 0 0	25. 02
26.00 All other nonreimbursable costs 0 0	26.00
27.00 Nonallowable GME costs	27. 00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0	28. 00
through 27)	
FACILITY OVERHEAD	
29. 00 Facility Costs	29.00
30. 00 Admi ni strati ve Costs 0 311, 182	30.00
31.00 Total Facility Overhead (sum of lines 29 and 0 328,762	31.00
30)	
32.00 Total facility costs (sum of lines 22, 28 0 2,062,553	32.00
and 31)	1

		MERON MEMORIAL C				eu of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C		Period: From 10/01/2021	Worksheet M-1	
			Component		To 09/30/2022		
					RHC III	Cost	<u>o p</u>
		Compensation	Other Costs	Total (col. 1	Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS	(07.045	200 5/3	007 (4	00.040	005.054	1 00
1.00	Physician	687, 045	200, 567	887, 61	98, 342	1	1.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	1/1 2/5		141 24	U 10 171	0	2. 00 3. 00
4. 00	Visiting Nurse	161, 365		161, 36	5 49, 171	210, 536	1
5. 00	Other Nurse	89, 988		89, 98	0	89, 988	
6. 00	Clinical Psychologist	09, 900		09, 90	0	09, 900	6.00
7. 00	Clinical Social Worker						1
8. 00	Laboratory Technician						8.00
9. 00	Other Facility Health Care Staff Costs	106, 951		106, 95	1 0	106, 951	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 045, 349					
11. 00	Physician Services Under Agreement	0	200,007	1,2.0,7.	0 0	0	1
12. 00	Physician Supervision Under Agreement	0	ا		o o	ō	12.00
13.00	Other Costs Under Agreement	0	d		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	l c		0 0	0	14.00
15.00	Medical Supplies	0	10, 037	10, 03	7 0	10, 037	15.00
16.00	Transportation (Health Care Staff)	0	4, 766	4, 76	6 0	4, 766	16.00
17.00	Depreciation-Medical Equipment	0	l c		0 0	0	17.00
18.00	Professional Liability Insurance	0	C		0	0	18. 00
19.00	Other Health Care Costs	0	C)	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14, 803			,	
22. 00	Total Cost of Health Care Services (sum of	1, 045, 349	215, 370	1, 260, 71	9 147, 513	1, 408, 232	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES		1				
23. 00	Pharmacy	0			0	-	20.00
24. 00	Dental				0	1	24. 00 25. 00
25. 00 25. 01	Optometry Tel eheal th				0	0	25. 00 25. 01
25. 01	Chronic Care Management				0		25.01
26. 00	All other nonreimbursable costs				0 0		26.00
	Name I award a CME anata		1	Ί	U U		26.00

74, 702

74, 702

1, 120, 051

27. 00

29.00

30.00

31.00

32.00

0 28.00

60, 160

104, 942

165, 102

1, 573, 334

0

147, 513

0

60, 160

104, 942

165, 102

1, 425, 821

60, 160

30, 240

90, 400

305, 770

27.00 Nonallowable GME costs

through 27)
FACILITY OVERHEAD
29.00 Facility Costs

30.00 Administrative Costs

28.00

31.00

32.00

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1315	Peri od: Worksheet M-1 From 10/01/2021
	Component CCN: 15-8546	To 09/30/2022 Date/Time Prepared:

			Component	CCN: 15-8546	То	09/30/2022	Date/Time Pro 2/22/2023 3:0	
						RHC III	Cost	
		Adjustments	Net Expenses					
		,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS			•				
1.00	Physi ci an	-195, 363	790, 59	1				1.00
2.00	Physician Assistant	o		ol				2.00
3.00	Nurse Practitioner	-97, 681	112, 85	5				3.00
4. 00	Visiting Nurse	0		o				4.00
5. 00	Other Nurse	o	89, 98	8				5.00
6. 00	Clinical Psychologist	ol	21,12	o l				6.00
7. 00	Clinical Social Worker	ol		0				7.00
8. 00	Laboratory Techni ci an	Ö		o l				8.00
9. 00	Other Facility Health Care Staff Costs	0	106, 95	1				9.00
10.00	Subtotal (sum of lines 1 through 9)	-293, 044	1, 100, 38					10.00
11. 00	Physician Services Under Agreement	-273, 044	1, 100, 30					11.00
12. 00	Physician Supervision Under Agreement	0						12.00
		O O						13.00
13.00	Other Costs Under Agreement	U						1
14.00	Subtotal (sum of lines 11 through 13)	0	40.00					14.00
15.00	Medical Supplies	0	10, 03	•				15.00
16. 00	Transportation (Health Care Staff)	0	4, 76	1				16. 00
17. 00	Depreciation-Medical Equipment	0	1	0				17. 00
18. 00	Professional Liability Insurance	0		0				18. 00
	Other Health Care Costs	0		0				19. 00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14, 80	3				21.00
22.00	Total Cost of Health Care Services (sum of	-293, 044	1, 115, 18	8				22.00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0		0				23. 00
24.00	Dental	0		0				24.00
25.00	Optometry	0		0				25.00
25.01	Tel eheal th	0		0				25. 01
25.02	Chronic Care Management	0		0				25. 02
26.00	All other nonreimbursable costs	0		0				26.00
27.00	Nonallowable GME costs							27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	o		ol				28.00
	through 27)							
	FACILITY OVERHEAD							
29.00	Facility Costs	0	60, 16	0				29. 00
30.00	Administrative Costs	o	104, 94	•				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	ol	165, 10					31.00
	30)	Ĭ						
32. 00	Total facility costs (sum of lines 22, 28	-293, 044	1, 280, 29	ol				32.00
	and 31)	,	, , = .					
		'		'				•

Heal th	Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2021	Doto/Time Dro	narad.
			Component	CCN: 15-8530	To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
					RHC I	Cost	<u>o p</u>
		Number of FTE	Total Visits	Producti vi ty	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						
	Posi ti ons						
1.00	Physi ci an	0. 63					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	1. 45					3.00
4.00	Subtotal (sum of lines 1 through 3)	2.08			5, 691	9, 119	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0. 29				248	
7. 00	Clinical Social Worker	0. 24	l .			191	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)	0.44	0.550			0.550	
8. 00	Total FTEs and Visits (sum of lines 4	2. 61	9, 558			9, 558	8. 00
0 00	through 7)		0			0	0.00
9. 00	Physician Services Under Agreements		0			Ü	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSDITAL BAS	ED BHC/EOHC SEI	DVI CES		1.00	
	Total costs of health care services (from W			KVICLS		1, 241, 185	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					1, 241, 109	
12.00	Cost of all services (excluding overhead) (s					1, 241, 185	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital -based RHC/FQHC overhead - (fr			ine 31)		127, 356	
15. 00	Parent provider overhead allocated to facili			1110 01)		734, 205	
16. 00	Total overhead (sum of lines 14 and 15)	ty (see Thistia	oti olis)			861, 561	
17. 00	Allowable GME overhead (see instructions)					0	•
	Enter the amount from line 16					861, 561	
	Overhead applicable to hospital-based RHC/FC	OHC services (I	ine 13 x line	18)		861, 561	
	Total allowable cost of hospital-based RHC/F					2, 102, 746	20.00
	•	•		•	·		•

Heal th	Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2021 To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00	0.00		1 x col . 3)	col . 4	
	LUCUTO AND DESCRIPTIVETY	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons Physi ci an	1. 33	4, 742	4, 20	0 5, 586		1 00
1. 00 2. 00	Physician Assistant	0. 56					1. 00 2. 00
3. 00	Nurse Practitioner	1. 49					3.00
4. 00	Subtotal (sum of lines 1 through 3)	3. 38			9, 891	18. 746	4.00
5. 00	Visiting Nurse	0.00		1	7,071	0	5.00
6. 00	Clinical Psychologist	0.00	l .	1		0	6.00
7. 00	Clinical Social Worker	0.00	l .			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		,		Ö	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7. 02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	3. 38	18, 746			18, 746	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWARIE COOT ARRIVAGARIE		ED DUG (EQUA OF	D. // 050		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T Total costs of health care services (from Wk			RVICES		1 722 701	10 00
10.00	Total nonreimbursable costs (from Wkst. M-1,					1, 733, 791 0	10. 00 11. 00
12.00	Cost of all services (excluding overhead) (s	·	,			1, 733, 791	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1, 733, 791	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		328, 762	14.00
15. 00	Parent provider overhead allocated to facili			1110 31)		1, 120, 034	
16. 00	Total overhead (sum of lines 14 and 15)	ty (See Thistia	oti olis)			1, 448, 796	
17. 00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					1, 448, 796	
19.00	Overhead applicable to hospital-based RHC/FC	MC services (I	ine 13 x line	18)		1, 448, 796	19. 00
20.00	Total allowable cost of hospital-based RHC/F	FQHC services (sum of lines 1	0 and 19)		3, 182, 587	20.00

Number of FTE Personnel Total Visits Productivity Minimum Creater of 2/72/2023 3:06 pm RHC III Cost	Heal th	Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
Component CCN: 15-8546 To 09/30/2022 Date/Time Prepared: 2/22/2023 3:06 pm RtC III Cost	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C			Worksheet M-2	
Number of FTE Total Visits Productivity Minimum Visits (col. 2 or col. 2 or col. 4 1 x col. 3) col. 4 2 or col. 4 1 x col. 3) col. 4 2 or col. 4 1 x col. 3) col. 4 2 or c				Component				
Number of FTE Personnel Total Visits Productivity Standard (1) Standard (1) Visits (col. 2 or col. 2 or col. 2 or col. 4 1 x col. 3) 1 x col. 3 1 x col. 3						RHC III		о рііі
Note			Number of FTE	Total Visits	Producti vi ty			
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)	Visits (col.	col. 2 or	
VISITS AND PRODUCTIVITY						1 x col. 3)	col. 4	
Positions			1. 00	2.00	3.00	4. 00	5. 00	
1.00		VISITS AND PRODUCTIVITY						
2.00								
3.00 Nurse Practitioner 0.88 3,357 2,100 1,848 3.00								
4.00 Subtotal (sum of lines 1 through 3) 1.28 5,617 3,528 5,617 4.00					•			
5.00 Visiting Nurse			1		•			
6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 0 0			1		•	3, 528	·	
7. 00 Clinical Social Worker 0.00 0 0 0 7. 00 7. 00 7. 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7. 01 0 7. 01 0 0 0 0 0 0 0 0 0							_	
7. 01 Medical Nutrition Therapist (FQHC only)			1	l .			_	
7. 02 Di abetes Sel f Management Training (FOHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	l .			-	
Solid Soli				_			-	
8.00 Total FTEs and Visits (sum of lines 4 through 7) 9.00 Physician Services Under Agreements 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00	7. 02		0.00	0			0	7.02
through 7) Physician Services Under Agreements 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00	0.00		4 00	F (47			F (47	0.00
9.00 Physician Services Under Agreements 0 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 1.00	8.00		1. 28	5,617			5,617	8.00
1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.	0 00						0	0.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,115,188 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,115,188 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 15.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 165,102 14.00 15.00 Total overhead (sum of lines 14 and 15) 517,842 15.00 17.00 Allowable GME overhead (see instructions) 682,944 16.00 17.00 Cost of all services (line 13 x line 18) 682,944 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 682,944 19.00 19.	9.00	Priysi ci aii sei vi ces under Agreements		0			U	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,115,188 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,115,188 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 15.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 165,102 14.00 15.00 Total overhead (sum of lines 14 and 15) 517,842 15.00 17.00 Allowable GME overhead (see instructions) 682,944 16.00 17.00 Cost of all services (line 13 x line 18) 682,944 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 682,944 19.00 19.							1 00	
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,115,188 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,115,188 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 15.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 165,102 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 517,842 15.00 16.00 Total overhead (sum of lines 14 and 15) 682,944 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 682,944 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 682,944 19.00		DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BAS	ED RHC/FOHC SE	RVLCES		1.00	
11. 00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12. 00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1, 115, 188 12.00 13. 00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 14. 00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 165, 102 14.00 15. 00 Parent provider overhead allocated to facility (see instructions) 517, 842 15.00 16. 00 Total overhead (sum of lines 14 and 15) 682, 944 16.00 17. 00 Allowable GME overhead (see instructions) 0 17.00 18. 00 Enter the amount from line 16 682, 944 18.00 19. 00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 682, 944 19.00					020		1, 115, 188	10.00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,115,188 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 165,102 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 517,842 15.00 17.00 Allowable GME overhead (sum of lines 14 and 15) 682,944 16.00 18.00 Enter the amount from line 16 682,944 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 682,944 19.00								
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 15.00 Allowable GME overhead (see instructions) 1682,944 16.00 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1.000000 13.00 165, 102 14.00 517, 842 15.00 682, 944 16.00 682, 944 18.00							1. 115. 188	l
14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 165,102 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 517,842 15.00 16.00 Total overhead (sum of lines 14 and 15) 682,944 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 682,944 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 682,944 19.00								
16.00 Total overhead (sum of lines 14 and 15) 682,944 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 682,944 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 682,944 19.00	14.00				ine 31)			
16.00 Total overhead (sum of lines 14 and 15) 682,944 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 682,944 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 682,944 19.00	15.00				,		517, 842	15.00
18.00Enter the amount from line 16682,94418.0019.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)682,94419.00	16.00		<i>,</i>	,			682, 944	16.00
18.00Enter the amount from line 16682,94418.0019.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)682,94419.00	17.00	Allowable GME overhead (see instructions)					0	17.00
	18.00						682, 944	18.00
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 1,798,132 20.00	19.00	Overhead applicable to hospital-based RHC/FC	NHC services (I	ine 13 x line	18)		682, 944	19.00
	20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		1, 798, 132	20.00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	MUNITY HOSPITAL C Provider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES		From 10/01/2021		
	Component CCN: 15-8530	To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
	Title XVIII	RHC I	Cost	<u> </u>
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
Total Allowable Cost of hospital-based RHC/FQHC Services (fr	om Wkst. M-2. line 20)		2, 102, 746	1. (
Cost of injections/infusions and their administration (from			62, 216	1
.00 Total allowable cost excluding injections/infusions (line 1			2, 040, 530	1
.00 Total Visits (from Wkst. M-2, column 5, line 8)			9, 558	4.
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
.00 Total adjusted visits (line 4 plus line 5)			9, 558	6.
.00 Adjusted cost per visit (line 3 divided by line 6)			213. 49	7.
		Cal cul ati on	of Limit (1)	
		Rate Period 1		
		(10/01/2021	(01/01/2022	
		through	through	
		12/31/2021)	09/30/2022) 2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §2	0.6 or your contractor)	269. 63	275. 29	8. (
.00 Rate for Program covered visits (see instructions)	,	213. 49	213. 49	
CALCULATION OF SETTLEMENT				Ī
0.00 Program covered visits excluding mental health services (fro	m contractor records)	292	868	10.
1.00 Program cost excluding costs for mental health services (lin	•	62, 339	185, 309	1
2.00 Program covered visits for mental health services (from cont	•	0	0	1
3.00 Program covered cost from mental health services (line 9 x l	•	0	0	
4.00 Limit adjustment for mental health services (see instruction 5.00 Graduate Medical Education Pass Through Cost (see instructio	•	0	0	14. 15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1,		0	247, 648	
6.01 Total program charges (see instructions)(from contractor's r			228, 651	1
6.02 Total program preventive charges (see instructions)(from pro	•		6, 764	1
6.03 Total program preventive costs ((line 16.02/line 16.01) time	*		7, 326	16.
6.04 Total Program non-preventive costs ((line 16 minus lines 16.)	03 and 18) times .80)		167, 799	16.
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	175, 125	
7.00 Primary payer amounts	. (6		0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions) (Trom contractor		30, 573	18.
records) 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		38, 262	19.
records)			55, -5-	
0.00 Net Medicare cost excluding vaccines (see instructions)			175, 125	20.
1.00 Program cost of vaccines and their administration (from Wkst	. M-4, line 16)		50, 512	
2.00 Total reimbursable Program cost (line 20 plus line 21)			225, 637	1
3.00 Allowable bad debts (see instructions) 3.01 Adjusted reimbursable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions) 4.00 Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	1
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tractrons)		0	
5.50 Pioneer ACO demonstration payment adjustment (see instructio	ns)		0	
5.99 Demonstration payment adjustment amount before sequestration			0	25.
6.00 Net reimbursable amount (see instructions)			225, 637	26.
6.01 Sequestration adjustment (see instructions)			1, 692	1
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			230, 429	
8.00 Tentative settlement (for contractor use only)	02 27 and 20)		0 4 494	
9.00 Balance due component/program (line 26 minus lines 26.01, 26 0.00 Protested amounts (nonallowable cost report items) in accord			-6, 484 0	1
o. oo procesteu amounts (nonarrowabre cost report rems) III accord	ance with Gws rub. 13-11	'	U	ا ا

Heal th Financial Syste				u of Form CMS-2	
	SEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1315	Peri od: From 10/01/2021	Worksheet M-3	
SERVI CES		Component CCN: 15-8545	To 09/30/2022	Date/Time Pre	pared:
				2/22/2023 3:0	6 pm
		Title XVIII	RHC II	Cost	
				1. 00	
DETERMINATION O	RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00 Total Allowable	Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		3, 182, 587	1.00
1	ons/infusions and their administration (from W			0	
	cost excluding injections/infusions (line 1 m	inus line 2)		3, 182, 587	1
1	rom Wkst. M-2, column 5, line 8)	1: 20 0)		18, 746	•
1 7	ts under agreement (from Wkst. M-2, column 5, visits (line 4 plus line 5)	Tine 9)		0 18, 746	
1	er visit (line 3 divided by line 6)			169. 77	1
naj usteu eest p	y visit (iiiio o di vi ded by iiiio o)		Cal cul ati on	of Limit (1)	7.00
			Rate Period 1		
			(10/01/2021	(01/01/2022	
			through	through	
			12/31/2021)	09/30/2022) 2. 00	
8.00 Per visit payme	nt limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	223. 90	228. 60	8.00
	n covered visits (see instructions)		169. 77	169. 77	1
CALCULATION OF :					1
10.00 Program covered	visits excluding mental health services (from	contractor records)	303	898	10.00
1 0	cluding costs for mental health services (line		51, 440	152, 453	1
9	visits for mental health services (from contr	,	0	0	
9	cost from mental health services (line 9 x li	•	0	0	
1	t for mental health services (see instructions Education Pass Through Cost (see instruction	,	0	0	14. 00 15. 00
	ost (sum of lines 11, 14, and 15, columns 1, 2	•	0	203, 893	
9	harges (see instructions)(from contractor's re	*	Ĭ	223, 079	
	reventive charges (see instructions)(from prov	•		14, 757	
16.03 Total program p	reventive costs ((line 16.02/line 16.01) times	line 16)		13, 488	16. 03
	on-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		130, 282	16.04
	IX see instructions.)			440.770	4, 05
	ost (see instructions)		0	143, 770 0	
, , ,	ary deductible for RHC only (see instructions)	(from contractor		27, 552	1
records)	ny deddetrore for kno omy (see filstraetrons)	(11 om contractor		27,002	10.00
1 1	nsurance for RHC/FQHC services (see instructio	ns) (from contractor		36, 154	19.00
records)					
1	st excluding vaccines (see instructions)			143, 770	1
Ü	vaccines and their administration (from Wkst.	M-4, line 16)		0 143, 770	
	ole Program cost (line 20 plus line 21) ebts (see instructions)			143, 770	
1	rsable bad debts (see instructions)			0	1
,	ebts for dual eligible beneficiaries (see inst	ructions)		0	1
	TS (SEE INSTRUCTIONS) (SPECIFY)	,		0	
25.50 Pioneer ACO dem	Pioneer ACO demonstration payment adjustment (see instructions)				25. 50
25.99 Demonstration p	ayment adjustment amount before sequestration			0	25. 99
1	e amount (see instructions)			143, 770	26. 00 26. 01
27.00 Interim payment 28.00 Tentative settl	ement (for contractor use only)			159, 332 0	
1	ponent/program (line 26 minus lines 26.01, 26.	02. 27. and 28)		-16, 640	1
	ts (nonallowable cost report items) in accorda	•	,	0	1
chapter I, §115				_	1

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES		From 10/01/2021		
	Component CCN: 15-8546	To 09/30/2022	Date/Time Pre 2/22/2023 3:0	
	Title XVIII	RHC III	Cost	
			1 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
Total Allowable Cost of hospital-based RHC/FQHC Services (fr	om Wkst. M-2, line 20)		1, 798, 132	1.0
.00 Cost of injections/infusions and their administration (from			6, 788	2. (
.00 Total allowable cost excluding injections/infusions (line 1	minus line 2)		1, 791, 344	3.0
.00 Total Visits (from Wkst. M-2, column 5, line 8)			5, 617	4.
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
.00 Total adjusted visits (line 4 plus line 5) .00 Adjusted cost per visit (line 3 divided by line 6)			5, 617 318. 91	6. 7.
Adjusted cost per visit (iffie 3 divided by fille 0)		Cal cul ati on		/.
		54. 54. 41. 51.		
		Rate Period 1		
		(10/01/2021	(01/01/2022	
		through 12/31/2021)	through 09/30/2022)	
		1.00	2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §2	0.6 or your contractor)	451. 79	461. 27	8. (
Rate for Program covered visits (see instructions)		318. 91	318. 91	9.
CALCULATION OF SETTLEMENT		0.0	00	1,0
0.00 Program covered visits excluding mental health services (fro 1.00 Program cost excluding costs for mental health services (lin		32 10, 205	29, 659	10.
2.00 Program covered visits for mental health services (from cont		10, 203	29,039	1
3.00 Program covered cost from mental health services (line 9 x l	,	ő	0	1
4.00 Limit adjustment for mental health services (see instruction	•	0	0	
5.00 Graduate Medical Education Pass Through Cost (see instructio	ns)			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1,		0	39, 864	1
6.01 Total program charges (see instructions)(from contractor's r	•		30, 955	
6.02 Total program preventive charges (see instructions)(from pro	•		2, 834	1
6.03 Total program preventive costs ((line 16.02/line 16.01) time 6.04 Total Program non-preventive costs ((line 16 minus lines 16.	•		3, 650 27, 944	1
(Titles V and XIX see instructions.)	os and roj trilles . ooj		27, 744	10.
6.05 Total program cost (see instructions)		0	31, 594	16.
7.00 Primary payer amounts			0	17.
B.00 Less: Beneficiary deductible for RHC only (see instructions	(from contractor		1, 284	18.
records) 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	and) (from contractor		F 247	10
9.00 Beneficiary coinsurance for RHC/FQHC services (see instructine records)	ons) (IT on Contractor		5, 367	19.
0.00 Net Medicare cost excluding vaccines (see instructions)			31, 594	20.
1.00 Program cost of vaccines and their administration (from Wkst	. M-4, line 16)		146	21.
2.00 Total reimbursable Program cost (line 20 plus line 21)			31, 740	
3.00 Allowable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions)	tructions)		0	1
4.00 Allowable bad debts for dual eligible beneficiaries (see ins 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	structions)		0	
5.50 Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
5.99 Demonstration payment adjustment amount before sequestration				25.
6.00 Net reimbursable amount (see instructions)			31, 740	1
6.01 Sequestration adjustment (see instructions)			238	26.
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			31, 143	
8.00 Tentative settlement (for contractor use only)	. 02 27 and 20)		0	
9.00 Balance due component/program (line 26 minus lines 26.01, 26 0.00 Protested amounts (nonallowable cost report items) in accord			359	29. 30.
chapter I, §115. 2	ance with own rub. 13-11	'] 55.

Heal th	Financial Systems CAMERON MEMORIAL C	OMMUNITY HOSPIT	-AL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO		Peri od:	Worksheet M-4	
		Component (rom 10/01/2021 o 09/30/2022	Date/Time Pre 2/22/2023 3:0	
		Title	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 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 202, 992 0. 000306	1, 202, 992 0. 001906		1, 202, 992 0. 000000	1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	368	2, 293	841	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	13, 907	19, 315	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	14, 275	21, 608	841	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 241, 185	1, 241, 185	1, 241, 185	1, 241, 185	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	861, 561	861, 561	861, 561	861, 561	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 011501	0. 017409	0. 000678	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	9, 909	14, 999	584	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	24, 184	36, 607	1, 425	0	10.00
11.00	Total number of injections/infusions (from your records)	77	480	176	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	314. 08	76. 2 <i>6</i>	8. 10	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	72	350	121	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			28	0	13. 01
14. 00	Program cost of injections/infusions and their	22, 614	26, 691	1, 207	0	14. 00

administration costs (line 12 times the sum of lines 13

and 13.01, as applicable)

15.00

Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 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)

62, 216

50, 512

15.00

16.00

llool +b	Financial Systems CAMERON MEMORIAL CO	OMMUNITY HOODIT	TA1	la li o	u of Form CMS-2	DEED 10
	Financial Systems CAMERON MEMORIAL CO TATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider C		Peri od:	Worksheet M-4	
CONIFO	ATTON OF HOSPITAL-BASED KITC/TQTC VACCINE COST	FI OVI dei Co		From 10/01/2021	WOLKSHEET M-4	
		Component (o 09/30/2022	Date/Time Pre 2/22/2023 3:0	
			XVIII	RHC III	Cost	
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	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, 100, 385		· · ·		1
2.00	Ratio of injection/infusion staff time to total health	0. 000000	0. 000425	0. 000000	0. 000000	2.00
	care staff time	_		_	_	
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	O	468	0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	0	3, 742	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	4, 210	0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 115, 188			1, 115, 188	
7.00	Total overhead (from Wkst. M-2, line 19)	682, 944	682, 944	682, 944	682, 944	7.00
8. 00	Ratio of injection/infusion direct cost to total direct	0. 000000			0.000000	8.00
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	2, 578	0	0	9.00
10.00	Total injection/infusion costs and their administration	0	6, 788	0	0	10.00
	costs (sum of lines 5 and 9)					
11.00	Total number of injections/infusions (from your records)	0	93		0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	0.00	72. 99	0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	0	2	0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
	administered to MA enrollees					
14. 00	Program cost of injections/infusions and their	0	146	0	0	14.00

6, 788

146

15.00

16.00

administration costs (line 12 times the sum of lines 13

and 13.01, as applicable)

15.00

Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 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)

Health Financial Systems	CAMERON MEMORIAL COM	MUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASE SERVICES RENDERED TO PROGRAM BENEFICE		Provider CCN: 15-1315 Component CCN: 15-8530	Period: From 10/01/2021 To 09/30/2022	

		component CCN: 15-8530	10 09/30/2022	2/22/2023 3: 06	
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1, 00	2.00	
00 T	Total interim payments paid to hospital-based RHC/FQHC			230, 429	1.
00 I t "	nterim payments payable on individual bills, either submithe contractor for services rendered in the cost reporting 'NONE" or enter a zero	period. If none, write		0	2.
r	List separately each retroactive lump sum adjustment amoun revision of the interim rate for the cost reporting period payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3.
01	rogram to rrovider			0	3.
02				ő	3.
03				0	3.
04				0	3.
05				0	3.
_	rovider to Program			U	3
50	Tovider to Frogram			0	3
51				0	3
2				0	3
4					
3				0	3
54	21	20)		0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3			0	3
	Total interim payments (sum of lines 1, 2, and 3.99) (tran	ster to Worksheet M-3, line	9	230, 429	4
	27)				
	O BE COMPLETED BY CONTRACTOR	-l	.el		_
е	ist separately each tentative settlement payment after de each payment. If none, write "NONE" or enter a zero. (1)	SK review. Also show date c	OT		5
_	rogram to Provider				
)1				0	5
2				0	5
3				0	5
	rovider to Program				
0				0	5
1				0	5
2				0	5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5			0	5
	Determined net settlement amount (balance due) based on th	e cost report. (1)			6
	SETTLEMENT TO PROVIDER			0	6
	SETTLEMENT TO PROGRAM			6, 484	6
00 T	Total Medicare program liability (see instructions)			223, 945	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
00 N	Name of Contractor	WISCONSIN PHYSICIAN SERVICE	ES 08001		8.

Health Financial Systems	CAMERON MEMORIAL COM	MUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASEI SERVICES RENDERED TO PROGRAM BENEFICIA		Provi der CCN: 15-1315 Component CCN: 15-854	From 10/01/2021	

		Component CCN: 15-8545	10 09/30/2022	2/22/2023 3: 06	
			RHC II	Cost	-
			Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2. 00	
00 T	Total interim payments paid to hospital-based RHC/FQHC			159, 332	1.
00 I	Interim payments payable on individual bills, either submithe contractor for services rendered in the cost reporting 'NONE" or enter a zero	period. If none, write		0	2.
r	List separately each retroactive lump sum adjustment amoun revision of the interim rate for the cost reporting period payment. If none, write "NONE" or enter a zero. (1)				3.
01	Togram to Frovider			0	3.
02				0	3.
03				0	3.
04				0	3.
)5	Nest date to Description			0	3
	Provider to Program			0	2
0					3
1				0	3
2				0	3
3				0	3
4		00)		0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3			0	3
2	Total interim payments (sum of lines 1, 2, and 3.99) (tran: 27)	sfer to Worksheet M-3, line		159, 332	4
	O BE COMPLETED BY CONTRACTOR				
е	List separately each tentative settlement payment after de each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5
Pi	Program to Provider				
)1				0	5
)2				0	5
3				0	5
P	Provider to Program				
0				0	5
1				0	5
2				0	5
9 S	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5	. 98)		0	5
o D	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
1 S	SETTLEMENT TO PROVIDER	•		0	6
2 S	SETTLEMENT TO PROGRAM			16, 640	6
о т	Total Medicare program liability (see instructions)			142, 692	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
00 N	Name of Contractor	WISCONSIN PHYSICIAN SERVICE	ES 08001		8.

Health Financial Systems	CAMERON MEMORIAL COM	MUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASEI SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-1315 Component CCN: 15-8546	From 10/01/2021	

		Component CCN: 15-8546		Date/Time Prep 2/22/2023 3:00	
			RHC III	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			31, 143	1.00
2.00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	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				o	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3. 51
3. 52				o	3. 52
3.53				ol	3.53
3.54				ol	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	98)		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transf		9	31, 143	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk	k 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
	Provider to Program			-	
5. 50				0	5.50
5. 51				0	5. 51
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	98)		Ö	5. 99
6. 00	Determined net settlement amount (balance due) based on the			Ĭ	6.00
6. 01	SETTLEMENT TO PROVIDER	5551 . opor c. (1)		359	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			31, 502	7.00
7.00	Total medicale program frability (see fistractions)		Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor	ISCONSIN PHYSICIAN SERVIC		2.00	8.00