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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1315 Worksheet S Peri od: From 10/01/2022 Parts I-III AND SETTLEMENT SUMMARY 09/30/2023 Date/Time Prepared: 2/14/2024 10:45 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 2/14/2024 Time: 10:45 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 10. NPR Date: 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter 13. Settled with Audit 9. [N] Final Report for this Provider CCN 14. [N] Initial Report for this Provider CCN 15. [N] Final Report for this Provider CCN 16. NPR Date: 11. Contractor's Vendor Code: 4. In Contractor's V Contractor use only number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

MISREPRESENTATION OF 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 10/01/2022 and ending 09/30/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Ang	jie Logan	Y	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 Printed Name	Angi e Logan			2
3	Signatory Title	CEO			3
4	Date	02/16/2024 11: 27: 12 AM (PT)			4

Encryption Information Date: 2/14/2024 Time: 10:45 am QAVN8TYZeGTZMPwmcOqrBFDczDkIcO twMdj ONwkDqxhKaxc6n3: H3pUv3pqT Odmw1B29bU0MU02b

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	492, 040	-759, 459	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	268, 864	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		8, 648		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		-18, 331		0	10. 01
10. 02	RURAL HEALTH CLINIC III	0		2, 944		0	10. 02
10. 03	RURAL HEALTH CLINIC IV	0		10, 320		0	10. 03
10. 04	RURAL HEALTH CLINIC V	0		3, 065		0	10. 04
200.00	TOTAL	0	760, 904	-752, 813	0	0	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	e element of t	he above comple	ex 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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1315 Peri od: Worksheet S-2 From 10/01/2022 To 09/30/2023 Part I Date/Time Prepared: 2/14/2024 10:45 am 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 CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 CAMERON MEMORIAL 151315 99915 02/01/2003 Ν 0 3.00 COMMUNITY HOSPITAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF CAMERON MEMORIAL 157315 99915 N l02/01/2003| N 0 7 00 7.00 COMMUNITY 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 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 158545 99915 11/26/2019 N 0 15.01 15.01 0 Hospital-Based Health Clinic - RHC CAMERON OB/GYN 158546 99915 0 0 15.02 15.02 11/25/2019 Ν 1111 15. 03 Hospital-Based Health Clinic - RHC CAMERON NORTH 158570 99915 12/14/2022 0 15.03 N 0 ١V Hospital-Based Health Clinic - RHC V CAMERON FREMONT 158571 99915 07/18/2023 0 0 15.04 Ν 16.00 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: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2022 09/30/2023 20.00 21.00 Type of Control (see instructions) 2 21.00 2. 00 1. 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 UCPs, including supplemental UCPs, for Ν 22.01 this 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 a final UCP to be Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 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 Ν Ν 22.03 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 yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 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.

and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter

'Y" for yes; otherwise, enter "N" for no in column 2.

the IME FTE unweighted count. Enter in column 4,

the direct GME FTE unweighted count.

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMP		RIAL COMMUNITY HOSPIT TA Provider C		Peri od:	wof Form CMS-2 Worksheet S-2	
IOSTITAL AND HOSTITAL HEALTH CARL COMP	LEX IDENTIFICATION DA	TA FLOVIDEL C		From 10/01/2022 To 09/30/2023	Part I	pared:
					1. 00	
ACA Provisions Affecting the Hea 52.00 Enter the number of FTE resident				riod for which	0.00	62. 0
your hospital received HRSA PCRE 52.01 Enter the number of FTE resident	funding (see instructs that rotated from a	ctions) a Teaching Health Cen	ter (THC) int		0.00	62.0
during in this cost reporting per Teaching Hospitals that Claim Re			ns)			
3.00 Has your facility trained reside "Y" for yes or "N" for no in col					N	63. (
	<u> </u>		Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after a			This base yea	r is your cost m	reporti ng	
4.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted nor stations occurring in number of unweighted our hospital. Enter in	-primary care all nonprovider I non-primary care column 3 the ratio	0. (0. 00	0. 000000	64. (
or (cordinit r drivided by (cordinit	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
5.00 Enter in column 1, if line 63	1.00	2. 00	3. 00	4.00	5. 00 0. 000000	
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)			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in	(col. 1 + col. 2))	
Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting	1.00 sEffective	2.00 for cost reporti	3.00 ng periods	
beginning on or after July 1, 20 6.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	ono unweighted non-primar occurring in all nonpr unweighted non-primar	ry care resident rovider settings. ry care resident	0. (66. 0
(column 1 divided by (column 1 +	column 2)). (see ins	tructions)				
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3. 00	4.00	5. 00	1

2.00

5.00

4.00

1.00

HOSPI T	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		TA	Provi der CCN: 15-1315 Peri od:			Workshee	et S-2			
					T	rom 10/01/ o 09/30/		Part I Date/Tir			
		Program Name	Progr	am Code	Unwei ghted	Unwei gh	ted	2/14/202 Ratio (co			
		r r ogram rvame	11091	diii oode	FTEs	FTEs in		(col. 3 + col.			
					Nonprovi der	Hospi ta	al	4))			
		1. 00	,	2. 00	Si te 3. 00	4.00		5. 00			
67. 00	Enter in column 1, the program	1.00	4	2.00	0.00		0. 00			67. 00	
	name associated with each of										
	your primary care programs in which you trained residents.										
	Enter in column 2, the program										
	code. Enter in column 3, the										
	number of unweighted primary care FTE residents attributable										
	to rotations occurring in all										
	non-provider settings. Enter in										
	column 4, the number of unweighted primary care										
	resident FTEs that trained in										
	your hospital. Enter in column										
	5, the ratio of (column 3 divided by (column 3 + column										
	4)). (see instructions)										
								1.00	0		
	Direct GME in Accordance with th	ne FY 2023 IPPS Final	Rul e, 87	FR 49065-490	072 (August 10	, 2022)		1.00	U		
68. 00	For a cost reporting period begi	nning prior to Octobe	er 1, 2022	, did you ob	otain permissio	on from you				68. 00	
	MAC to apply the new DGME formul (August 10, 2022)?	a in accordance with	the FY 20	123 IPPS Fina	al Rule, 87 FR	49065-490	72				
	1. 00 2. 00 3. 00										
70. 00	Inpatient Psychiatric Facility F Is this facility an Inpatient Ps		PF), or c	loes it conta	ain an IPF subp	provi der?	N			70. 00	
	Enter "Y" for yes or "N" for no								_		
/1.00	If line 70 is yes: Column 1: Did recent cost report filed on or b								0	71. 00	
	42 CFR 412. 424(d)(1)(iii)(c)) Co	lumn 2: Did this faci	lity trai	n residents	in a new teach	ni ng					
	program in accordance with 42 CF Column 3: If column 2 is Y, indi										
	(see instructions)	cate will cir program ye	ai began	durring till 3	cost reporting	y period.					
75 00	Inpatient Rehabilitation Facilit		(1.05)							75 00	
75.00	Is this facility an Inpatient Re subprovider? Enter "Y" for yes		/ (TRF), C	or does it co	ontain an ike		N			75. 00	
76. 00	If line 75 is yes: Column 1: Did	I the facility have an							0	76. 00	
	recent cost reporting period end no. Column 2: Did this facility										
	CFR 412.424 (d)(1)(iii)(D)? Ente										
	indicate which program year bega	n during this cost re	eporting p	eriod. (see	instructions)						
								1.00	0		
00.00	Long Term Care Hospital PPS	I (I TOID) 2 . 5 . 1 . "\"	6								
80. 00 81. 00	Is this a long term care hospita Is this a LTCH co-located within					period? Fr	nter	N N		80. 00 81. 00	
	"Y" for yes and "N" for no.										
85 AA	TEFRA Providers Is this a new hospital under 42	CED Section 8/13 /0/f	F) (1) (i) T	FEDA2 Enter	"V" for yes o	or "N" for	no	N		85. 00	
86. 00	Did this facility establish a ne				•		110.	1		86. 00	
07.00	§413.40(f)(1)(ii)? Enter "Y" fo			alassi fi ad i	undon coati an			N.		07.00	
87. 00	Is this hospital an extended neo 1886(d)(1)(B)(vi)? Enter "Y" for		поѕрі таї	Crassified t	inder Section			N		87. 00	
		_				Approved		Number			
						Permane Adjustm		Approv Perman			
						(Y/N)		Adjustm			
00		1.0				1. 00		2.00		00	
88. 00	Column 1: Is this hospital appro amount per discharge? Enter "Y"					N			0	88. 00	
	89. (see instructions)	-	•								
	Column 2: Enter the number of ap	proved permanent adju	ustments.			I			l		

CAMERON MEMORIAL COMM	UNITY HOSPITAL	In Lieu	of Form	CMS-25

SSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period: From 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Pre 2/14/2024 10:	epared
		Wkst. A Lind No.	e Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1. 00	2.00	3. 00	
Col umn 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA talper discharge. Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	based. period rget amount	0. (0 89.0
			1. 00	XI X 2. 00	-
Title V and XIX Services			1.00	2.00	
Does this facility have title V and/or XIX inpatient hospital	I services? Er	nter "Y" for	N	Υ	90.0
yes or "N" for no in the applicable column. .00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applicable of the column.	•		N	Y	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applical	on)? (see		N	92. (
3.00 Does this facility operate an ICF/IID facility for purposes	of title V and	XIX? Enter	N	N	93. (
"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	N	N	94.		
5.00 If line 94 is "Y", enter the reduction percentage in the app 5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes	O. 00 N	0. 00 N	95. 96.		
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the apple. 8.00 Does title V or XIX follow Medicare (title XVIII) for the instepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	0. 00 Y	0. 00 Y	97. 98.		
column 1 for title V, and in column 2 for title XIX. B.01 Does title V or XIX follow Medicare (title XVIII) for the reconstruction of the column 1 for time of the column 2 for title XIX.		Y	98.		
title XIX. B. 02 Does title V or XIX follow Medicare (title XVIII) for the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on the call bed costs on the cal			Y	Y	98.
for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a critice reimbursed 101% of inpatient services cost? Enter "Y" for years.			N 1	N	98.
for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98.
in column 2 for title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co	ck the RCE dis	sallowance on	Y	Y	98.
column 2 for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.
Rural Providers					4
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-	inclusiva ma+b	and of navmon	t Y		105. 106.
for outpatient services? (see instructions)		. ,			
17.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IPEnter "Y" for yes or "N" for no in column 2. (see instructions)	1. (see inst you train I&Rs F and/or IRF ι ons)	tructions) s in an unit(s)?	N		107.
18.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				Docni satas:	108.
	Physi cal 1.00	0ccupati ona 2.00	Speech 3.00	Respiratory 4.00	+
9.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	N N	N N	N N	N N	109. (

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	CAMERON MEMORIAL X IDENTIFICATION DATA	COMMUNITY HOSPITA Provider CC		Peri od:		u of Form CMS- Worksheet S-2	
					0/01/2022 9/30/2023	Part I Date/Time Pre 2/14/2024 10:	
					1. 00	2.00	45 alli
131.00 If this is a Medicare-certified in	ntestinal transplant prog	gram, enter the c	certi fi cat		1.00	2.00	131. 00
date in column 1 and termination of 132.00 If this is a Medicare-certified is in column 1 and termination date,	slet transplant program,	enter the certif	ication d	ate			132. 00
133.00 Removed and reserved	ii appircabre, in corumi	1 2.					133. 00
134.00 If this is a hospital-based organ in column 1 and termination date,			ne OPO num	ber			134. 00
All Providers 140.00 Are there any related organization	or home office costs as	s defined in CMS	Pub 15_1		Υ		140. 00
chapter 10? Enter "Y" for yes or '	N" for no in column 1. I	f yes, and home	office co				110.00
are claimed, enter in column 2 the		er. (see instruct .00	(ions)		3. 00		
If this facility is part of a chai	n organization, enter or	n lines 141 throu		e name and		of the	
home office and enter the home offi 141.00 Name:	Contractor name and	contractor number		actor's Nu	mher:		141. 00
142.00 Street:	PO Box:		John	30101 3 1101	ilber .		142. 00
143. 00 Ci ty:	State:		Zi p Co	ode:			143. 00
						1.00	+
144.00 Are provider based physicians' cos	sts included in Worksheet	t A?				Y	144. 00
					1. 00	2.00	+
145.00 If costs for renal services are cl					1. 00	2.00	145. 00
inpatient services only? Enter "Y' no, does the dialysis facility in	clude Medicare utilizatio						
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	Υ	06/26/2023	146. 00				
yes, enter the approval date (mm/d		, , , ,					
						1.00	-
147.00 Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for	no.			Y	147. 00
148.00 Was there a change in the order of	allocation? Enter "Y" f	for yes or "N" fo	or no.	6		N	148. 00
149.00 Was there a change to the simplifi	ea cost finding method?	Part A	es or "N" Part		itle V	N Title XIX	149. 00
		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '		onent for Part A	and Part		CFR §413	3. 13)	
155.00 Hospi tal 156.00 Subprovi der - TPF		N N	l N N		N N	N N	155. 00 156. 00
157.00 Subprovi der - IRF		N	N N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 00 160. 00
161. 00 CMHC		IN	N N		N	N N	161. 00
				·		1.00	
Multicampus 165.00 s this hospital part of a Multica	ampus hospital that has c	one or more campu	ıses in di	fferent CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	1
166.00 If line 165 is yes, for each						0. 00	166. 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)							
cordiiir 3 (see Tristraetrons)						1.00	
Health Information Technology (HI	Γ) incentive in the Ameri	ican Recovery and	d Reinvest	ment Act		1.00	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under §1886(n)? Enter	"Y" for yes or "	'N" for no		the	Y	167. 00 168. 00
reasonable cost incurred for the H	not a meaningful user, do	oes this provider			shi p	N	168. 01
exception under §413.70(a)(6)(ii) 169.00 f this provider is a meaningful u					nter the	0.0	0169. 00
transition factor. (see instruction				,, 0		3.0	

Health Financial Systems	MMUNITY HOSPITAL	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provider CCN: 15-1315 Period: Workshee			
			To 09/30/2023	Date/Time Pre	
				2/14/2024 10:	45 am_
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2.00	1
171.00 If line 167 is "Y", does this pro	vider have any days for indi	ividuals enrolled in	N	(171. 00
section 1876 Medicare cost plans					
"Y" for yes and "N" for no in col	umn 1. If column 1 is yes, e	enter the number of section	n		
1876 Medicare days in column 2. (see instructions)				

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1315	Peri od: From 10/01/2022 To 09/30/2023	Date/Time Pro 2/14/2024 10:	epared:
				Y/N 1. 00	2. 00	+
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT QUESTIONN	IAI RE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	sponses. Ent	er all dates in t	he	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	corumn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.0
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.0
	Total Colonia por (see Their delitions)		Y/N	Туре	Date	
	Cinconial Data and Dan 1		1.00	2. 00	3. 00	
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 available.	or Compiled,	Y	A		4.0
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differentiates on the filed financial statements? If yes, submit recommendations are considered to the content of the conte		N			5. 0
				Y/N	Legal Oper.	-
	Approved Educational Activities			1. 00	2. 00	
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provide	r N		6.0
	the Legal operator of the program?					
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ed during th	e N		7. 0 8. 0
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	is.		N N		9. 0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. C
	Treaching Trogram on worksheet A: 11 yes, see That detroils.				Y/N	
	I				1. 00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 0 13. 0
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsural instructions.	ance amounts wa	nived? If yes	, see	N	14. 0
5. 00	Bed Complement Did total beds available change from the prior cost reporti	ng period2 lf	VAS SAR INC	tructions	N	15. C
J. 00	pro total beds avairable change from the prior cost reporti		t A		t B	13.0
		Y/N	Date	Y/N	Date	
	DC+D Do+o	1.00	2. 00	3. 00	4. 00	
5. 00	PS&R Data 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		16.0
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/14/2023	Y	11/14/2023	17. 0
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. (

HOSPITAL AND HOSPITAL HEALTH CARE RELIBBURSEWIT OUESTIONMAIRE	Heal th	Financial Systems CAMERON MEMORIAL CO	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CM:	S-2552-10
20.00 If I line 16 or 17 is yes, were adjustments made to PSSR N N N 20.00	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1315	From 10/01/2022	Part II Date/Time P	repared:
N N 20.00				-			
Report data for Other? Describe the other adjustments:	20, 00	If line 16 or 17 is was were adjustments made to PS&P)			20, 00
21.00 Was the cost report prepared only using the provider's N N	20.00				IN IN	14	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00 records? If yes, see instructions. 1.00							
records? If yes, see Instructions. 1.00	21 00	Was the cost report prepared only using the provider's		2. 00		4. 00	21.00
COMPLETED BY COST REIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 2.0 OI Have assets been relifed for Medicare purposes? If yes, see instructions 2.1 OI Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see In 1 yes, see instructions N 24.00 Note the provision of the cost capital ized leases entered into during the cost reporting period? If yes, see N 25.00 Note the provision of the cost capital ized leases entered into during the cost reporting period? If yes, see N 26.00 Note the provision of the cost capital ized leases entered into during the cost reporting period? If yes, see N 27.00 Note the provision of the cost capital ized leases entered into during the cost reporting period? If yes, see N 27.00 Note the provision of the	21.00		IN		IV		21.00
Capital Related Cost 22.00 Have savests been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Ware new Leases and/or amendments to existing Leases entered into during this cost reporting period? N 24.00 If yes, see instructions N 25.00 Have there been new capitalized leases entered into during this cost reporting period? If yes, see N 25.00 Instructions. N 26.00 Ware seess subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Ware sees subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Ware sees subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit to copy. Interest Expense N 28.00 Ware new Loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 Ware new Loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 Ware new Loans, mortgage agreements or letters of credit entered into during the cost reporting N 29.00 Interest Expense N 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Has existing debt been replaced prior to its scheduled maturity with hew debt? If yes, see N 31.00 Ware seed as a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 33.00 If I in a 3 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 34.00 Ware services furnished at the provider feys, see instructions. V						1. 00	
22.00 Have assets been relifed for Medicare purposes? If yes, see instructions N 22.00 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 25.00 Were men leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see N 25.00 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 28.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 29.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 27.00 29.00 Were men loans, nortgage agreements or letters of credit entered into during the cost reporting N 29.00 29.00 Were new loans, nortgage agreements or letters of credit entered into during the cost reporting N 29.00 29.00 Were new loans, nortgage agreements or letters of credit entered into during the cost reporting N 29.00 29.00 Were the provider have a funded depreciation account? If yes, see instructions N 29.00 29.00 Were the provider depreciation account? If yes, see instructions N 29.00 29.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 32.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 32.00 33.00 If in a 21 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If N 33.00 33.00 If in a 21 is yes, were the requirements of Sec. 2135. 2 applied pertaining to compe			PT CHILDRENS F	OSPI TALS)			
23.00 Have changes occurred in the Nedicare depreciation expense due to appraisals made during the cost N 23.00	22 00		instructions			N	22.00
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 Have there been new capital ized leases entered into during the cost reporting period? If yes, see N 25.00 Have there been new capital ized leases entered into during the cost reporting period? If yes, see N 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 29.00 Did the provider have a funded depreciation account? If yes, see instructions at such as a funded depreciation account? If yes, see instructions at such as a funded depreciation account? If yes, see instructions at such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions are such as a funded depreciation account? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual and arrangements with suppliers of services? If yes, see instructions. 32.00 If If ine 32 is yes, were there new agreements or				als made dur	ing the cost		
If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 No.	20.00		ado to apprare	are made ad.	g :		20.00
instructions. 2.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00	24. 00		ed into during	this cost re	porting period?	N	
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 29.00 treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been reportees 32.00 Has exhalted been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Has debt been replaced prior of the scheduled maturity with new debt? If yes, see Instructions. 34.00 Has exhalted been replaced prior of its scheduled maturity with new debt? If yes, see Instructions. 35.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 Has debt been replaced prior scheduled has account	25. 00		the cost repor	ting period?	'If yes, see	N	25. 00
27. 00 Was the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27. 00 copy. Interest Expense	26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00
Interest Expense 28.00 Nere new Ioans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Y 29.00 Ide he provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 29.00 Ide he provider have a funded depreciation account? If yes, see instructions Y 29.00 Ide have a funded depreciation account? If yes, see instructions Y 29.00 Ide have a funded depreciation account? If yes, see instructions X 30.00 Instructions	27. 00	Has the provider's capitalization policy changed during the	e cost reportir	g period? If	yes, submit	N	27. 00
period? If yes, see instructions. 20.00 Did the provider have a funded depreciation account? If yes, see instructions 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see	28 00	Interest Expense	ntered into dur	ing the cost	reporti na	N	28 00
treated as a funded depreciation account? If yes, see instructions 10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see		period? If yes, see instructions.					
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see	30. 00	treated as a funded depreciation account? If yes, see instr	ŕ	N	30. 00		
Purchased Services Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 33.00 1f line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 35.00 36.00 37.00 38.00 38.00 39.00 39.00 39.00 30	31. 00	Has debt been recalled before scheduled maturity without is	, see	N	31. 00		
Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N 33.00 N							
arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If No. 33.00 no. see instructions. Provider-Based Physicians 34.00 Were services there new agreements or amended existing agreements with the provider-based physicians? You like yes, see instructions. No. Home Office Costs Y/N Date	32 00		rvi ces furni she	d through co	ntractual	N	32 00
no, see instructions. Provider-Based Physicians 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Y 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs Y/N Date		arrangements with suppliers of services? If yes, see instru	uctions.	· ·			
34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 If Jine 34 is yes, were there new agreements or amended existing agreements with the provider-based Y 35.00 Physicians during the cost reporting period? If yes, see instructions. Home Office Costs		no, see instructions.	·				
physicians during the cost reporting period? If yes, see instructions. Y/N Date	34. 00	Were services furnished at the provider facility under an a	arrangement wit	h provider-b	ased physicians?	Y	34. 00
Home Office Costs 86.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost 608. 270. 2962 DGOODMAN@WIPFLI.COM 43.00	35. 00			its with the	provi der-based	Υ	35. 00
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 41.00 Enter the employer/company name of the cost report WI PFLI LLP The preparer. 42.00 Enter the telephone number and email address of the cost 608.270.2962 DGOODMAN@WI PFLI.COM 43.00							
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 41.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost 608. 270. 2962 DGOODMAN@WIPFLI.COM 43.00		Homa Office Costs			1.00	2. 00	
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost 608.270.2962 DGOODMAN@WIPFLI.COM 43.00	36. 00				N		36.00
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report WI PFLI LLP 42.00 Enter the telephone number and email address of the cost 608.270.2962 DGOODMAN@WI PFLI.COM 43.00		If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 Instructions. Cost Report Preparer Contact Information	38. 00	If line 36 is yes , was the fiscal year end of the home off			,		38. 00
Cost Report Preparer Contact Information	39. 00	If line 36 is yes, did the provider render services to other					39. 00
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, respectively. 42.00 Enter the employer/company name of the cost report WI PFLI LLP 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 608.270.2962 DG00DMAN@WI PFLI.COM 43.00	40. 00	·	home office?	If yes, see			40. 00
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 608.270.2962 DG00DMAN@WI PFLI.COM 43.00			1.	00	2.	00	
held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 608. 270. 2962 DG00DMAN@WI PFLI.COM 43.00			la				
42.00 Enter the employer/company name of the cost report WI PFLI LLP 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 608.270.2962 DG00DMAN@WI PFLI.COM 43.00	41. 00	held by the cost report preparer in columns 1, 2, and 3,	DAVI D		GOODMAN		41.00
43.00 Enter the telephone number and email address of the cost 608.270.2962 DG00DMAN@WIPFLI.COM 43.00	42. 00	Enter the employer/company name of the cost report	WIPFLI LLP				42. 00
	43. 00	Enter the telephone number and email address of the cost	608. 270. 2962		DGOODMAN@WI PFL	I.COM	43. 00

Heal th	Financial Systems CAMERON MEMORIAL	COMMU	JNI TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-	F	Period: rom 10/01/2022		
				I	o 09/30/2023	Date/Time Pre 2/14/2024 10:	pared: 45 am
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	CPA					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 Financial
 Systems
 CAMERON MEMO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-1315

				'	0 09/30/2023	2/14/2024 10: 4	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	The state of the s	Li ne No.		Avai I abl e			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	23	8, 395	65, 528. 96	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	65, 528. 96	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	2	730	1, 838. 02	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)						12.00
13. 00	NURSERY	43. 00				0	13.00
14. 00	Total (see instructions)		25	9, 125	67, 366. 98		14.00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	116. 00	0	C)		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						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. 03	RURAL HEALTH CLINIC IV	88. 03				0	26. 03
26. 04	RURAL HEALTH CLINIC V	88. 04				0	26. 04
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 Tri ps						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
05 -	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges	20	=	_		_	33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0	1	0	34. 00

Health Financial Systems CAMERON MEMORITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1315

					1	2/14/2024 10:	45 am
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	888	78	3, 069			1.00
2.00	HMO and other (see instructions)	1, 098	o				2.00
3.00	HMO I PF Subprovi der	0	o				3.00
4.00	HMO IRF Subprovider	o	o				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	375	o	1, 062			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		o	85			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 263	78	4, 216			7. 00
8. 00	INTENSIVE CARE UNIT	30	3	100			8. 00
9. 00 10. 00 11. 00 12. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	30	5				9. 00 10. 00 11. 00 12. 00
13.00	NURSERY	1 202	35	416		420.71	13.00
14.00	Total (see instructions)	1, 293	116	4, 732 0		420. 71	
15. 00 15. 10	CAH visits REH hours and visits	U U	U	U			15. 00 15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	
23. 00		U	۷	C	0.00	0.00	23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0		C	0.00	0.00	
24. 00	HOSPICE (non-distinct part)	U	٩	0		0.00	24. 00
25. 00	CMHC - CMHC			C			25. 00
26. 00	RURAL HEALTH CLINIC	1, 107	o	8, 955	0.00	9. 84	
26. 01	RURAL HEALTH CLINIC II	1, 113	0	19, 513		•	
26. 02	RURAL HEALTH CLINIC III	124	Ö	6, 399		l	
26. 03	RURAL HEALTH CLINIC IV	381	ő	6, 824		l .	
26. 04	RURAL HEALTH CLINIC V	4	Ö	1, 301			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	1, 301		1	1
27. 00	Total (sum of lines 14-26)	١	ď	C	0.00	l	
28. 00	Observation Bed Days		0	1, 857		404.72	28. 00
29. 00	Ambul ance Trips	0	ď	1, 037			29.00
30. 00	Employee discount days (see instruction)	١		C			30.00
31. 00	Employee discount days (see Fristraction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	0	104			32. 00
32. 00	Total ancillary labor & delivery room	١	ď	104			32. 00
JZ. UI	outpatient days (see instructions)			C			32.01
33. 00	1 '	0					33.00
33. 01		0					33. 01
	Temporary Expansion COVID-19 PHE Acute Care	o	0	C			34. 00
		1	-1		1	'	

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 Systems
 CAMERON MEMO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-1315

				10	09/30/2023	2/14/2024 10:	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	DADT I CTATICTICAL DATA	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and		0	276	28	1, 100	1. 00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2		O	270	20	1, 100	1.00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			285	o		2. 00
3.00	HMO IPF Subprovider				o		3. 00
4.00	HMO IRF Subprovider				o		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	I NTENSI VE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	276	28	1, 100	14. 00
15. 00	CAH visits	0.00	, and a second		20	.,	15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0.00					21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	0. 00					22. 00 23. 00
24. 00	HOSPICE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					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. 03	RURAL HEALTH CLINIC IV	0. 00					26. 03
26. 04	RURAL HEALTH CLINIC V	0. 00					26. 04
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 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 00	Total ancillary labor & delivery room						32. 00
	outpatient days (see instructions)						
33.00	LTCH non-covered days]		0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care				l		34. 00

	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CN: 15-1315	Peri od:	Worksheet S-	-8
			Component	CCN: 15-8530	From 10/01/2022 To 09/30/2023	3 Date/Time Pr	
					RHC I	2/14/2024 10 Cost	
			'				
					1	. 00	
00	Clinic Address and Identification Street				1500 W MAUMEE	STDEET	1.
00	Street		C	i ty	State	ZIP Code	<u> </u>
				. 00	2. 00	3. 00	
00	City, State, ZIP Code, County		ANGOLOA		1	N 46703	2.
						1.00	
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	ıl or "U" for ı	urban			0 3.
	3				nt Award	Date	
					1. 00	2. 00	
00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		T		I	4.
00	Mi grant Health Center (Section 329(d), PHS Ac						5.
00	Health Services for the Homeless (Section 340						6.
00	Appal achi an Regional Commission						7.
00	Look-Alikes OTHER (SPECIFY)						8. 9.
,0	OTHER (SPECIAL)						7
					1. 00	2. 00	
00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	ther operation	ns in column	N		0 10.
	nour 3.)	Sun	day	N.	Monday	Tuesday	
		from	to	from	to	from	
	5 111 (1)	1. 00	2. 00	3.00	4. 00	5. 00	
00	Facility hours of operations (1)			08: 00	16: 30	08: 00	11.
00	CETWIO			00.00	10. 30	00.00	111
					1. 00	2. 00	
00	1 3 11				N		12.
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.	umn 1. If yes,	enter in colu	nn 2 the	N		0 13
	numbers below.		<u> </u>				
				Prov	i der name	CCN	
					1. 00	2.00	14.
00	RHC/FOHC name CCN				VIV	Total Visits	_
00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	TOTAL VISITE	5
		Y/N 1.00	V 2. 00	XVIII 3. 00	4. 00	5. 00	
	Have you provided all or substantially all		-	_			
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in		-	_			
	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		-	_			
	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		-	_			
	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		-	_			
	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		-	_			15.
	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.		2. 00 Con	3.00 unty			
00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Con 4	3.00			15.
00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	1.00	2.00 Col 4 STEUBEN	3.00 unty 00	4.00	5. 00	
. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Col 4 STEUBEN	3.00 unty	4.00		15.
. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00 Con 4 STEUBEN Wedn	3.00 unty 00	4. 00	5. 00	15.

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY 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	
				From 10/01/2022		
		Component	CCN: 15-8530	To 09/30/2023		
		·			2/14/2024 10:	45 am
			_	RHC I	Cost	
	Fric	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

י ועטי		RUN WEWURTAL C	COMMUNITY HOSPI			eu of Form CM		552
SELL	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1315	Peri od: From 10/01/2022	Worksheet S	5-8	
			Component	CCN: 15-8545	To 09/30/2023			
					RHC II	Cos		
					1	. 00	_	
	Clinic Address and Identification				1201 N WAYNE	CTDEET		1
00	Street			i ty	1381 N. WAYNE State	ZIP Code	-	1
				. 00	2. 00	3.00		
00	City, State, ZIP Code, County		ANGOLA	. 00		N 46703		2
			'		-			
	,					1.00		
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for run	al or "U" for				0	3
				Gra	nt Award	Date	-	
	Source of Federal Funds				1. 00	2. 00	-	
0	Community Health Center (Section 330(d), PHS	Act)				1		4
0	Mi grant Health Center (Section 329(d), PHS Ad							5
0	Health Services for the Homeless (Section 340	O(d), PHS Act)						6
00	Appalachian Regional Commission							7
0	Look-Al i kes							8
0	OTHER (SPECIFY)							9
					1. 00	2.00	-	_
00	Does this facility operate as other than a ho	nsni tal _hased	RHC or FOHC2 F	nter "V" for	1.00 N	2.00	0	10
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of	other operatio	ns in column	, and the second			10
		Sur	nday		Monday	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	Facility hours of operations (1)	I	1	T		1		
00	CLINIC	09: 00	17: 30	08: 00	19: 30	08: 00		11
					1. 00	2.00		
	Have you received an approval for an exception					2.00		
00		on to the prod	uctivity stand	ard?	l N			12
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N N			
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and		CCN		
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	N	CCN 2. 00		
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and	N ider name	2. 00	0	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	ider name 1.00	2.00 Total Visit	0	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. numbers below. RHC/FOHC name, CCN	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and	N ider name	2. 00	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	ider name 1.00	2.00 Total Visit	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	ider name 1.00	2.00 Total Visit	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN 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	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	ider name 1.00	2.00 Total Visit	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN 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	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	ider name 1.00	2.00 Total Visit	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FOHC name, CCN 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	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	ider name 1.00	2.00 Total Visit	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FOHC name, CCN 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.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Prov	ider name 1.00	2.00 Total Visit	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FOHC name, CCN 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	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colus of all provi	Prov XVIII 3.00	ider name 1.00	2.00 Total Visit	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FOHC name, CCN 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.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Prov XVIII 3.00	ider name 1.00	2.00 Total Visit	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN 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)	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colus of all provi	Prov XVIII 3.00	ider name 1.00	2.00 Total Visit	0 S	14 15
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FOHC name, CCN 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.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Prov XVIII 3.00	ider name 1.00 XIX 4.00	2.00 Total Visit	0 S	14 15
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN 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)	d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Prov XVIII 3.00 unty .00	ider name 1.00 XIX 4.00	2.00 Total Visit 5.00	0 S	13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN 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)	d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	V 2.00	r 9, section mn 2 the ders and Prov XVIII 3.00 unty .00	N ider name 1.00 XIX 4.00	2.00 Total Visit 5.00	0 S	14 15

Health Financial Systems CAM	ERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od: From 10/01/2022	Worksheet S-8	
		Component		To 09/30/2023	Date/Time Pre 2/14/2024 10:	pared: 45 am
				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

	Financial Systems CAME AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1315	Peri od:	Worksheet S-	-8
			Component	CCN: 15-8546	From 10/01/2022 To 09/30/2023	Date/Time Pr 2/14/2024 10	
					RHC III	Cost	
					1.	00	
	Clinic Address and Identification						
. 00	Street				306 E. MAUMEE 3 101		1.
				ty	State	ZIP Code	
	0.1 0.1 710 0 1			00	2. 00	3.00	
. 00	City, State, ZIP Code, County		ANGOLA	_	IN	46703	2.
						1. 00	
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for i	ırban			0 3.
					nt Award	Date	-
					1. 00	2. 00	
	Source of Federal Funds						
. 00	Community Health Center (Section 330(d), PHS	Act)					4.
. 00	Migrant Health Center (Section 329(d), PHS Ad						5.
. 00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6.
. 00	Appalachian Regional Commission						7.
. 00	Look-Alikes						8.
. 00	OTHER (SPECIFY)						9.
					1. 00	2. 00	
0. 00	Does this facility operate as other than a ho	ospital-based R	RHC or FOHC? Fi	nter "Y" for	N N		0 10.
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of	ate number of c	other operation	ns in column			
	hours.)	other operati	on (o) and the	opo. attg			
	Tiour s.)						
	illoui s.)		iday		londay	Tuesday	
	liloui S.)	from	to	from	to	from	
1 00	Facility hours of operations (1)	from	to	from 3.00	to 4.00	from 5.00	11
1. 00		from	to	from	to 4.00	from	11.
1. 00	Facility hours of operations (1)	from	to	from 3.00	to 4.00	from 5.00	11.
	Facility hours of operations (1)	from 1.00	to 2.00	from 3.00	to 4. 00	from 5.00	11.
2. 00	Facility hours of operations (1)	from 1.00 on to the produ	to 2.00	from 3.00	to 4.00	from 5.00 08:00	
2. 00	Facility hours of operations (1) CLINIC Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column.	from 1.00 on to the product in CMS Pub. 1 umn 1. If yes,	to 2.00 uctivity standa 100-04, chapter	from 3.00 08:00 ard? - 9, section nn 2 the	to 4.00	from 5.00 08:00	12.
2. 00	Facility hours of operations (1) CLINIC Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	from 1.00 on to the product in CMS Pub. 1 umn 1. If yes,	to 2.00 uctivity standa 100-04, chapter	from 3.00 08:00 ard? - 9, section nn 2 the	to 4.00	from 5.00 08:00	12.
2. 00	Facility hours of operations (1) CLINIC Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in column.	from 1.00 on to the product in CMS Pub. 1 umn 1. If yes,	to 2.00 uctivity standa 100-04, chapter	from 3.00 08:00 ard? - 9, section nn 2 the ders and	to 4.00	from 5.00 08:00	12.
2. 00	Facility hours of operations (1) CLINIC Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	from 1.00 on to the product in CMS Pub. 1 umn 1. If yes,	to 2.00 uctivity standa 100-04, chapter	from 3.00 08:00 ard? 9, section on 2 the ders and Prov	to 4.00	from 5.00 08:00 2.00	12.
2. 00	Facility hours of operations (1) CLINIC Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columbumer of providers included in this report. numbers below.	from 1.00 on to the product in CMS Pub. 1 umn 1. If yes,	to 2.00 uctivity standa 100-04, chapter	from 3.00 08:00 ard? 9, section on 2 the ders and Prov	to 4.00	from 5.00 08:00	0 13.
2. 00	Facility hours of operations (1) CLINIC Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	from 1.00 on to the product in CMS Pub. 1 umn 1. If yes,	to 2.00 uctivity standa 100-04, chapter	from 3.00 08:00 ard? 9, section on 2 the ders and Prov	to 4.00	from 5.00 08:00 2.00	0 13.
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2. 00 3. 00 4. 00	Facility hours of operations (1) CLINIC Have you received an approval for an exception of the second of the secon	from 1.00 on to the product in CMS Pub. 1 Jumn 1. If yes, List the names	to 2.00 uctivity standa 100-04, chapte enter in columns of all provid	from 3.00 08:00 ard? 9, section mn 2 the ders and Prov	to 4.00	from 5.00 08:00 2.00 CCN 2.00 Total Visits	12. 0
2. 00 3. 00 4. 00	Facility hours of operations (1) CLINIC Have you received an approval for an exception of the second of the secon	from 1.00 on to the product in CMS Pub. 1 Jumn 1. If yes, List the names	to 2.00 uctivity standa 100-04, chapte enter in columns of all provid	from 3.00 08:00 ard? 9, section mn 2 the ders and Prov	to 4.00	from 5.00 08:00 2.00 CCN 2.00 Total Visits	12. 0
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Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY 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	
				From 10/01/2022		
		Component	CCN: 15-8546	To 09/30/2023		
		·			2/14/2024 10:	45 am_
				RHC III	Cost	
	Fric	lay	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

I IGS(RON MEMORIAL CO				ieu of Form CMS	
,0111	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1315	Peri od: From 10/01/202	Worksheet S-	8
			Component	CCN: 15-8570	To 09/30/202		
					RHC IV	Cost	7. 43 6
	To a constant of the constant				•	1. 00	
00	Clinic Address and Identification Street				2250 INTERTEC	CH DRIVE, STE A	1
<i>.</i>	Street		Ci	ty	State	ZIP Code	-
				00	2. 00	3. 00	
00	City, State, ZIP Code, County		ANGOLA		ı	N 46703	2
						1.00	
0	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	l or "U" for ι	urban			0 3
	•				nt Award	Date	
	0 05 1 15 1				1. 00	2. 00	
00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		T		1	- 4
0	Migrant Health Center (Section 329(d), PHS Ac						5
0	Health Services for the Homeless (Section 340						6
0	Appal achi an Regi onal Commissi on						7
0	Look-Alikes						8
0	OTHER (SPECIFY)						9
					1. 00	2. 00	
00	Does this facility operate as other than a ho				N		0 10
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)						
	illoui s.)	Sun	day	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
00	Facility hours of operations (1) CLINIC			08: 00	16: 30	08: 00	11
00	CETNIC			06.00	10. 30	08.00	- 1 1
					1. 00	2. 00	
	Have you received an approval for an exception				N		
	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	lin CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colur	9, section nn 2 the			
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	lin CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colur	9, section nn 2 the ders and	N N		
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	lin CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colur	9, section nn 2 the ders and	N N ider name	CCN	
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	lin CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colur	9, section nn 2 the ders and	N N		0 13
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00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all	lin CMS Pub. 1 mm 1. If yes, List the names	00-04, chapter enter in colur of all provid	9, section nn 2 the ders and Prov	N N ider name 1.00	CCN 2.00 Total Visits	0 13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN	lin CMS Pub. 1 mm 1. If yes, List the names	00-04, chapter enter in colur of all provid	9, section nn 2 the ders and Prov	N N ider name 1.00	CCN 2.00 Total Visits	0 13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN 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	lin CMS Pub. 1 mm 1. If yes, List the names	00-04, chapter enter in colur of all provid	9, section nn 2 the ders and Prov	N N ider name 1.00	CCN 2.00 Total Visits	0 13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN 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	lin CMS Pub. 1 mm 1. If yes, List the names	00-04, chapter enter in colur of all provid	9, section nn 2 the ders and Prov	N N ider name 1.00	CCN 2.00 Total Visits	14
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN 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	lin CMS Pub. 1 mm 1. If yes, List the names	00-04, chapter enter in colur of all provid	9, section nn 2 the ders and Prov	N N ider name 1.00	CCN 2.00 Total Visits	0 13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN 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.	lin CMS Pub. 1 mm 1. If yes, List the names	00-04, chapter enter in colur of all provid	9, section nn 2 the ders and Prov	N N ider name 1.00	CCN 2.00 Total Visits	0 13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN 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	lin CMS Pub. 1 mm 1. If yes, List the names	00-04, chapter enter in colur of all provid	9, section nn 2 the ders and Prov	N N ider name 1.00	CCN 2.00 Total Visits	0 13
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN 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)	Hin CMS Pub. 1 Imn 1. If yes, List the names Y/N 1.00	00-04, chapter enter in colur of all provided by the column of all	Prov XVIII 3.00	N N ider name 1.00	CCN 2.00 Total Visits	14
00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report. numbers below. RHC/FQHC name, CCN 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.	Hin CMS Pub. 1 Imn 1. If yes, List the names Y/N 1.00	O0-04, chapter enter in colur of all provided by the column of all	Prov XVIII 3.00	N N N ider name 1.00	CCN 2.00 Total Visits 5.00	0 13
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Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY 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	
				From 10/01/2022		
		Component	CCN: 15-8570	To 09/30/2023		
		·			2/14/2024 10:	45 am
			_	RHC IV	Cost	
	Fric	lay	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	6: 30				11. 00

SPITAL-BASED RHC/FQHC STATISTICAL DATA	MERON MEMORIAL CO		CCN: 15-1315	Peri od:	eu of Form CM Worksheet S	
			CCN: 15-8571	From 10/01/2022 To 09/30/2023	2 B Date/Time P	repar
				RHC V	2/14/2024 1 Cos-	
				I KIIO V	003	
				1	. 00	
Clinic Address and Identification				404 COUTH BBO	AD CEDEET	
00 Street		C	ity	401 SOUTH BROA	ZIP Code	
	ŀ		. 00	2. 00	3. 00	
OO City, State, ZIP Code, County	F	FREMONT			V 46737	
					1.00	
00 HOSPITAL-BASED FQHCs ONLY: Designation - Er	nter "D" for rural	l or "II" for i	urhan		1.00	0
Those The brock Talles ONET. Designation - El	itei k Toi Turai	1 01 0 101 1	1	nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds			_			
Community Health Center (Section 330(d), Ph Migrant Health Center (Section 329(d), PHS						
Health Services for the Homeless (Section 3						
Appal achi an Regional Commission	(a) / . 110 /10t)		1			
00 Look-Alikes						
OO OTHER (SPECIFY)						
				1. 00	2.00	
00 Does this facility operate as other than a	hospi tal -based Ri	HC or FQHC? E	nter "Y" for	N N	2.00	0 1
yes or "N" for no in column 1. If yes, indi 2. (Enter in subscripts of line 11 the type hours.)	cate number of o	ther operation	ns in column			
Thouse of y	Sund	day	M	onday	Tuesday	
	from	to	from	to	from	
F: : +	1.00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) OO CLINIC			08: 00	20: 00	08: 00	1
50 521 M 5			00.00	20.00	00.00	
				1. 00	2. 00	
00 Have you received an approval for an except 00 Is this a consolidated cost report as defined the co				N N		0 1
00 Is this a consolidated cost report as defir 30.8? Enter "Y" for yes or "N" for no in co				IN .		0 1
LOUGE FILE TO LOUVES OF NOTION TO INC.						
number of providers included in this report	t. List the names				1	
	t. List the names		1 .			
number of providers included in this report	t. List the names			der name	CCN	
number of providers included in this report numbers below.	t. List the names			der name 1.00	2. 00	1.
number of providers included in this report numbers below.	Y/N	V	XVIII	1. 00 XI X	2.00 Total Visit	1- S
number of providers included in this report numbers below. OO RHC/FQHC name, CCN		·		1. 00	2. 00	S
number of providers included in this report numbers below. OO RHC/FOHC name, CCN OO Have you provided all or substantially all	Y/N 1.00	V	XVIII	1. 00 XI X	2.00 Total Visit	
number of providers included in this report numbers below. OO RHC/FOHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i	Y/N 1.00	V	XVIII	1. 00 XI X	2.00 Total Visit	S
number of providers included in this report numbers below. OO RHC/FQHC name, CCN OO Have you provided all or substantially all	Y/N 1.00	V	XVIII	1. 00 XI X	2.00 Total Visit	S
number of providers included in this report numbers below. OO RHC/FQHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i 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	Y/N 1.00	V	XVIII	1. 00 XI X	2.00 Total Visit	S
number of providers included in this report numbers below. OO RHC/FQHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i 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	Y/N 1.00	V	XVIII	1. 00 XI X	2.00 Total Visit	S
number of providers included in this report numbers below. OO RHC/FQHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i 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	Y/N 1.00	V	XVIII	1. 00 XI X	2.00 Total Visit	S
number of providers included in this report numbers below. OO RHC/FQHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i 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.	Y/N 1.00	V 2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visit	S
number of providers included in this report numbers below. OO RHC/FQHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no icolumn 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)	Y/N 1.00	V 2.00	XVI I I 3. 00	1. 00 XI X	2.00 Total Visit	1
number of providers included in this report numbers below. OO RHC/FQHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no icolumn 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)	Y/N 1.00	V 2.00 Col 4 STEUBEN	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visit 5.00	S
number of providers included in this report numbers below. OO RHC/FOHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i 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)	Y/N 1.00 n d d d Tuesday	V 2.00 Con 4 STEUBEN Wedn	XVIII 3.00 unty .00	1. 00 XI X 4. 00	2.00 Total Visit 5.00	1
number of providers included in this report numbers below. OO RHC/FOHC name, CCN OO Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no i 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)	Y/N 1.00	V 2.00 Col 4 STEUBEN	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visit 5.00	1

Health Financial Systems CAME	ERON MEMORIAL C	OMMUNITY HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1315	Peri od:	Worksheet S-8	
			00N 4E 0E74	From 10/01/2022		
		Component	CCN: 15-8571	To 09/30/2023	Date/Time Prep 2/14/2024 10:4	
				RHC V	Cost	
	Fri	day	Sa	turday		
	Fri from	day to	Sa from	turday to		
		i				
Facility hours of operations (1)	from	to	from	to		
Facility hours of operations (1) 11.00 CLINIC	from 11.00	to	from	to		11. 00

	Financial Systems CAMERON MEMORIAL COM				eu of Form CMS-2					
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN: 15	F	Period: From 10/01/2022 To 09/30/2023		pared:				
					1. 00					
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					1				
1.00										
	Medicaid (see instructions for each line)					1				
2.00 Net revenue from Medicaid 11,508,553										
3.00 Did you receive DSH or supplemental payments from Medicaid?										
4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?										
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicaid			0	0.00				
6. 00	Medi cai d charges				38, 375, 707 13, 285, 708	6. 00 7. 00				
7. 00										
	Children's Health Insurance Program (CHIP) (see instructions for each line) Net revenue from stand-alone CHIP 0									
	0									
10.00 Stand-allone CHIP charges										
	11.00 Stand-alone CHIP cost (line 1 times line 10)									
	12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions) Other state or local government indigent care program (see instructions for each line)									
	Net revenue from state or local indigent care program (Not i				0	13. 00				
	Charges for patients covered under state or local indigent of				0					
	10)									
15. 00	State or local indigent care program cost (line 1 times line	: 14)			0	15. 00				
	Difference between net revenue and costs for state or local				0	16. 00				
	Grants, donations and total unreimbursed cost for Medicaid,	CHIP and state/loca	al indige	ent care program	ns (see					
	instructions for each line)	6 11 1 1 1 1				47.00				
	Private grants, donations, or endowment income restricted to				0					
	Government grants, appropriations or transfers for support of			(E !	0					
19.00	Total unreimbursed cost for Medicaid, CHIP and state and Ic 8, 12 and 16)	cai indigent care p	programs	(Sum of Tines	1, 777, 155	19. 00				
	o, 12 and 10)	Ilni	nsured	Insured	Total (col. 1					
			tients	patients	+ col . 2)					
			1.00	2. 00	3. 00					
	Uncompensated care cost (see instructions for each line)									
	Charity care charges and uninsured discounts (see instruction		303, 569		000,007					
21. 00	Cost of patients approved for charity care and uninsured disinstructions)	scounts (see	105, 096	0	105, 096	21. 00				
22. 00	Payments received from patients for amounts previously writt	en off as	(0	0	22. 00				
	charity care									
23 00	Cost of charity care (see instructions)		105, 096	6 0	105, 096	1 23 00				

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 | Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

1.00

5, 349, 232

4, 830, 956

1, 853, 879

1, 958, 975

3, 736, 130 31.00

336, 879

518, 276

24.00

25.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

25.00

25. 01

27.00

27.01

28. 00

stay limit

LULAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eriod: rom 10/01/2022	Worksheet A	
				Т	o 09/30/2023	Date/Time Pre 2/14/2024 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)		
		1.00	2. 00	3.00	4. 00	5. 00	
00	GENERAL SERVICE COST CENTERS		4.5// 200	4 5// 200	214 772	4 000 070	1
00	00100 CAP REL COSTS-BLDG & FIXT		4, 566, 200 1, 936, 333		•	4, 880, 972 2, 992, 887	
00	00400 EMPLOYEE BENEFITS DEPARTMENT	478, 261	13, 643, 999			13, 017, 197	
00	00500 ADMINISTRATIVE & GENERAL	7, 347, 277	9, 557, 147			16, 947, 099	
00	00700 OPERATION OF PLANT	1, 273, 045	3, 735, 570			5, 008, 615	1
00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING	962, 583	29, 751 783, 119			182, 830 1, 592, 623	
0. 00	01000 DI ETARY	556, 733	565, 898			1, 066, 499	
. 00	01100 CAFETERI A	0	0			0	1
3. 00	01300 NURSI NG ADMI NI STRATI ON	481, 975	50, 322			532, 297	
i. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	326, 585 490, 029	169, 109 6, 229, 275			495, 694 972, 797	
. 00	01600 MEDICAL RECORDS & LIBRARY	846, 914	405, 789			1, 252, 703	
	INPATIENT ROUTINE SERVICE COST CENTERS	3.37	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	., ===,	_	.,	
0. 00	03000 ADULTS & PEDI ATRI CS	4, 141, 375	1, 932, 632				1
1.00	03100 INTENSIVE CARE UNIT 04300 NURSERY	0	0			86, 036	
3. 00	ANCI LLARY SERVI CE COST CENTERS	l U	0	0	15, 011	15, 011	43
0. 00	05000 OPERATI NG ROOM	1, 864, 143	1, 686, 816	3, 550, 959	-887, 513	2, 663, 446	50
. 00	05100 RECOVERY ROOM	0	0			887, 513	
. 00	05200 DELIVERY ROOM & LABOR ROOM	70, 371	5, 853			103, 029	
. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	2, 374, 489 1, 086, 490	1, 280, 532 2, 805, 406			3, 655, 021 3, 891, 896	
. 00	06500 RESPIRATORY THERAPY	1, 046, 708	464, 887			1, 301, 943	
. 01	06501 SLEEP LAB	0	0	1		84, 416	
. 00	06600 PHYSI CAL THERAPY	1, 468, 200	34, 345			1, 502, 545	
. 00	06900 ELECTROCARDI OLOGY	0	7, 552			132, 788	
. 01	O6901 CARDIAC REHABILITATION O7100 MEDICAL SUPPLIES CHARGED TO PATIENT	81, 631	12, 734 2, 956, 309			94, 365 1, 047, 955	
. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		2, 930, 309			1, 908, 354	
. 00	07300 DRUGS CHARGED TO PATIENTS	l o	0			3, 194, 584	
. 00	03020 CHEMI CAL DEPENDENCY	o	0	0	0	0	
0. 01	03480 ONCOLOGY	0	2, 243, 615			2, 243, 615	
. 02	03030 DIABETIC EDUCATION OUTPATIENT SERVICE COST CENTERS	0	83, 246	83, 246	0	83, 246	76
. 00	08800 RURAL HEALTH CLINIC	1, 076, 324	145, 048	1, 221, 372	137, 416	1, 358, 788	88
. 01	08801 RURAL HEALTH CLINIC II	1, 545, 929	304, 720	1, 850, 649		2, 095, 931	
. 02	08802 RURAL HEALTH CLINIC III	1, 169, 277	407, 077			1, 753, 173	
. 03 . 04	08803 RURAL HEALTH CLINIC IV	930, 797	113, 570			930, 669	
	08804 RURAL HEALTH CLINIC V 09000 CLINIC	985, 168 108, 067	95, 340 17, 641			249, 490 125, 708	
	09001 CLINI C- ORTHO	877, 617	1, 273, 961				
. 02	09002 CLINIC - PEDS ENT FP	1, 049, 517	59, 463	1, 108, 980	226, 737	1, 335, 717	
. 03	09003 NTRAVENOUS THERAPY	92, 384	15, 226			2, 605, 437	
. 04	09004 PSYCHI ATRY 09005 CARDI OLOGY	412, 498 1, 203, 400	283, 747 99, 184			785, 396 1, 389, 039	
. 00	09100 EMERGENCY	2, 315, 266	500, 263			2, 815, 529	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,010,200	000, 200	2,0.0,02,		2,0.0,02,	92
	OTHER REIMBURSABLE COST CENTERS				1		
11. OC	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101
3 00	11300 INTEREST EXPENSE		1, 293, 978	1, 293, 978	-1, 293, 978	0	113
	11400 UTI LI ZATI ON REVI EW-SNF	o	0	_			114
	11600 HOSPI CE	o	0				116
8.00	, ,	36, 663, 053	59, 795, 657	96, 458, 710	-996, 052	95, 462, 658	118
n nr	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	O	0	0	0	0	190
	19200 PHYSICIANS PRIVATE OFFICES		0	1			192
	07950 DAYCARE-I NFANT/TODDLER	o	0	0	0		194
	07951 MOB	0	0	0	0		194
	07952 COMMUNITY HEALTH	66, 537	55, 413	121, 950	-57, 662		
	07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION	0	0		0		194
	07955 MARKETI NG	222, 746	923, 944	1, 146, 690	_		
	07956 GUEST MEALS	, 0	0	0	56, 132		
	07957 OUTSI DE LAUNDRY	0	0	0	0	0	194
	07958 CANCER CENTER	0	0	0	0		194
	07959 URGENT CARE 07960 RHC	0	0	0	0		194 194
	07961 0BGYN		0	0	0		194
74 ''	1	. 4	U		U		1.74

Health Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	AL	In Lie	eu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		eri od:	Worksheet A	
			rom 10/01/2022 o 09/30/2023	Date/Time Pre 2/14/2024 10:		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
194. 13 07963 OCCUPATI ONAL HEALTH	346, 514	123, 402	469, 916	21, 040	490, 956	194. 13
194.14 07964 IMMUNIZATION CLINIC	0	0	C	0	0	194. 14
194. 15 07965 FOUNDATI ON	132, 585	236, 132	368, 717	1, 882	370, 599	194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	o	0	(245, 377	245, 377	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	97, 381	17, 793	115, 174	922, 346	1, 037, 520	194. 17
200.00 TOTAL (SUM OF LINES 118 through 199)	37, 666, 117	61, 161, 068	98, 827, 185	0	98, 827, 185	200. 00

Health Financial Systems	CAMERON MEMORIAL CO	OMMUNITY HOSPITAL	L	In Lie	u of Form CMS-2552
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALA		Provi der CCN		Peri od:	Worksheet A
				From 10/01/2022 To 09/30/2023	Date/Time Prepare
				10 077 007 2020	2/14/2024 10: 45 a
Cost Center Description	Adjustments	Net Expenses			
	(See A-8) 6.00	For Allocation 7.00			
GENERAL SERVICE COST CENTERS	0.00	7.00			
1. 00 00100 CAP REL COSTS-BLDG & FIXT	-1, 289, 800	3, 591, 172			1.
2.00 00200 CAP REL COSTS-MVBLE EQUIP	-118, 198				2.
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-280, 171	12, 737, 026			4.
5.00 00500 ADMINISTRATIVE & GENERAL	-4, 374, 818				5.
7.00 00700 OPERATION OF PLANT	0				7.
8.00 00800 LAUNDRY & LINEN SERVICE	0				8.
9. 00 00900 HOUSEKEEPI NG	0	1, -, -,			9.
10. 00 01000 DI ETARY	-310, 158				10.
11. 00 O1100 CAFETERI A	0	0			11.
13. 00 O1300 NURSING ADMINISTRATION	0	532, 297			13.
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	-3, 300 -14, 253	1			14. 15.
16. 00 01600 MEDICAL RECORDS & LIBRARY	-14, 233	1			16.
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-020	1, 232, 003			10.
30. 00 03000 ADULTS & PEDIATRICS	-878, 797	5, 067, 358			30.
31. 00 03100 INTENSIVE CARE UNIT	0				31.
43. 00 04300 NURSERY	0	15, 011			43.
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	-661, 261	2, 002, 185			50.
51. 00 05100 RECOVERY ROOM	0				51.
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				52.
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-7, 750				54.
60. 00 06000 LABORATORY	-6, 126				60.
65. 00 06500 RESPIRATORY THERAPY	0				65.
65. 01 06501 SLEEP LAB	1 250				65. 66.
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	-1, 250	1, 501, 295 132, 788			69.
69. 01 06901 CARDI AC REHABI LI TATI ON	-1, 367	92, 998			69.
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	1	1			71.
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				72.
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				73.
76. 00 03020 CHEMI CAL DEPENDENCY	0				76.
76. 01 03480 ONCOLOGY	-32, 168	2, 211, 447			76.
76.02 03030 DIABETIC EDUCATION	0	83, 246			76.
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC	0				88.
88. 01 08801 RURAL HEALTH CLINIC II	0	_, -,			88.
88. 02 08802 RURAL HEALTH CLINIC III	-72, 744				88.
88. 03 08803 RURAL HEALTH CLINIC IV	-38, 845	1			88.
88. 04 08804 RURAL HEALTH CLINIC V	0				88.
90. 00 09000 CLI NI C 90. 01 09001 CLI NI C - ORTHO	-1, 722, 427	125, 708 511, 223			90. 90.
90. 02 09002 CLINI C - PEDS ENT FP	-646, 301				90.
90. 03 09003 NTRAVENOUS THERAPY	-040, 301	2, 605, 437			90.
90. 04 09004 PSYCHI ATRY	-531, 232				90.
90. 05 09005 CARDI OLOGY	-724, 279				90.
91. 00 09100 EMERGENCY	0	1			91.
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	RT				92.
OTHER REIMBURSABLE COST CENTERS					
101. 00 10100 HOME HEALTH AGENCY	0	0			101.
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 INTEREST EXPENSE	0	1			113.
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0			114.
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through	117)	0 744 700			116.
100000	117) -11, 715, 865	83, 746, 793			118.
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTE	EN O	0			190.
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTE	EN 0				190.
192. 00 19200 PHYSICIANS PRIVATE OFFICES 194. 00 07950 DAYCARE-I NFANT/TODDLER					192.
194. 01 07951 MOB					194.
194. 02 07952 COMMUNI TY HEALTH	0	64, 288			194.
194. 03 07953 ASSISTED LIVING/CAMERON WOODS	0	0 7, 200			194.
194. 04 07954 EDUCATI ON	0	ارم			194.
194. 05 07955 MARKETI NG	0	953, 627			194.
194. 06 07956 GUEST MEALS	0	56, 132			194.
194. 07 07957 OUTSI DE LAUNDRY	0	. 0			194.
194. 08 07958 CANCER CENTER	0	o			194.
194. 09 07959 URGENT CARE	0	0			194.
194. 10 07960 RHC	1	ı o			194.
	0	l d			
194. 11 07961 OBGYN	0	0			194.
194.11 07961 0BGYN 194.12 07962 TRINE STUDENT HEALTH	0				194.
194. 11 07961 OBGYN	0 0 0 0 0 0	490, 956			

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-1315 Period: From 10/01/2022 Worksheet A	2552-10	u of Form CMS-2	In Lieu		=	HOSPI TAL	COMMU	N MEMORIAL	CAMERO		Systems	Health Financial
To 09/30/2023 Date/Time Prepar	anared:		10/01/2022	From	15-1315	der CCN:		EXPENSES	BALANCE OF	TRI AL	N AND ADJUSTMENTS OF	RECLASSI FI CATION

				2/14/2024 10.4	45 alli
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	7. 00			
194. 15 07965 FOUNDATI ON	0	370, 599			194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	0	245, 377			194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	1, 037, 520)		194. 17
200.00 TOTAL (SUM OF LINES 118 through 199)	-11, 715, 865	87, 111, 320			200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1315

					10 09/3	0/2023 Date/lime Prepared: 2/14/2024 10:45 am
		Increases			<u> </u>	27 1 17 202 1 101 10 4
	Cost Center	Li ne #	Sal ary	0ther		
	2.00 A - LABOR AND DELIVERY	3. 00	4. 00	5. 00		
1. 00	NURSERY	43.00	12, 622	2, 389		1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	22, 539	4, 266		2. 00
	TOTALS		35, 161	6, 655		
	B - PROPERTY INSURANCE	,				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66, 678		1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP		•	<u>25, 878</u>		2. 00
	TOTALS C - CAFETERIA		0	92, 556		
1.00	GUEST MEALS	194. 06	27, 837	28, 295		1.00
1.00	TOTALS			28, 295		1.00
	D - INTEREST EXPENSE		27,007	20, 270		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 289, 800		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		0_	<u>4, 1</u> 78		2. 00
	TOTALS		0	1, 293, 978		
4 00	E - DEPRECIATION EXPENSE	2 22	ما	1 00/ 100		1.00
1. 00	CAP REL COSTS-MVBLE EQUIP		0	<u>1, 026, 498</u> 1, 026, 498		1.00
	F - ICU		U _I	1,020,490		
1.00	INTENSIVE CARE UNIT	31.00	65, 712	20, 324		1.00
	TOTALS		65, 712	20, 324		
	H - SLEEP LAB - EKG	<u> </u>				
1.00	SLEEP LAB	65. 01	38, 599	45, 817		1.00
2.00	ELECTROCARDI OLOGY	<u>69.</u> 00	1 <u>9, 6</u> 10	1 <u>5, 6</u> 56		2. 00
	TOTALS		58, 209	61, 473		
1. 00	I - PUBLIC RELATIONS MARKETING	194. 05	O	12 242		1.00
1.00	TOTALS			1 <u>3, 3</u> 63 13, 363		1.00
	J - RECOVERY ROOM		<u> </u>	13, 303		
1.00	RECOVERY ROOM	51.00	887, 513	0		1. 00
	TOTALS		887, 513			
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	1, 908, 354		1.00
	TOTALS	+		1, 908, 354		
	L - FOUNDATION RECLASS		<u> </u>	1, 700, 334		
1.00	FOUNDATION	194. 15	1, 882	0		1.00
	TOTALS		1, 882	— — <u> </u>		
	M - IMMUNIZATION CLINIC RECLAS	S				
1.00	CLINIC - PEDS ENT FP	<u> </u>	•	5 <u>4, 0</u> 96		1. 00
	TOTALS		0	54, 096		
1. 00	N - DRUGS RECLASS DRUGS CHARGED TO PATIENTS	73. 00	0	5, 692, 411		1.00
1.00	TOTALS			5, 692, 411		1.00
	O - IV THERAPY		<u> </u>	0,072,111		
1.00	I NTRAVENOUS THERAPY	90. 03	0	2, 497, 827		1. 00
	TOTALS		0	2, 497, 827		
	P - EKG HST RECLASS					
1. 00	ELECTROCARDI OLOGY	6900	8 <u>9, 9</u> 70	0		1.00
	TOTALS Q - OFFSITE DEPRECIATION		89, 970	U		
1.00	CAMERON FAMILY MEDICINE -	194. 16	0	1, 092		1.00
	NORTH		Ĭ	., 5,2		1. 65
2.00	CAMERON FAMILY MEDICINE -	194. 17	0	8, 663		2. 00
	FREMONT					
3.00	RURAL HEALTH CLINIC IV	88. 03	0	4, 144		3.00
4. 00	RURAL HEALTH CLINIC V	8804		<u>1, 309</u> 15, 208		4. 00
	R - PROVIDER BENEFITS		<u> </u>	15, 200		
1.00	RURAL HEALTH CLINIC	88.00	0	137, 416		1.00
2.00	RURAL HEALTH CLINIC II	88. 01	О	245, 282		2. 00
3.00	RURAL HEALTH CLINIC III	88. 02	0	176, 819		3. 00
4.00	CLINIC- ORTHO	90. 01	0	82, 072		4. 00
5.00	CLINIC - PEDS ENT FP	90. 02	0	156, 691		5. 00
6.00	PSYCHI ATRY CARDI OLOGY	90. 04 90. 05	0	49, 151 86, 455		6. 00 7. 00
7. 00 8. 00	OCCUPATI ONAL HEALTH	194. 13	0	21, 040		7. 00 8. 00
9. 00	CAMERON FAMILY MEDICINE -	194. 16	0	26, 382		9. 00
	NORTH		1			
10. 00	CAMERON FAMILY MEDICINE -	194. 17	0	63, 978		10.00
44 00	FREMONT	00.00	ا	400.011		
11. 00 12. 00	RURAL HEALTH CLINIC IV RURAL HEALTH CLINIC V	88. 03 88. 04	0	100, 061 17, 378		11. 00 12. 00
12.00	TOTALS	00.04	0	1 <u>7, 378</u> 1, 162, 725		12.00
	1.5.7125	I	기	1, 102, 725		I

RECLASS	TELEVITORS			Provider	CCN. 15-1315	From 10/01/2022 To 09/30/2023	Date/Time Pre 2/14/2024 10:	epared:
		Increases		<u>.</u>				
	Cost Center	Li ne #	Sal ary	Other				
	0 00	0 00	4 00	F 00	Ti and the second secon			4

		Increases		·	
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	
	T - LAUNDRY RECLASS				
1.00	LAUNDRY & LINEN SERVICE		0	153, 079	
	TOTALS		0	153, 079	
	U - NON RHC RECLASS				
1.00	CAMERON FAMILY MEDICINE -	194. 16	194, 207	23, 696	
	NORTH				
2.00	CAMERON FAMILY MEDICINE -	194. 17	774, 730	74, 975	
	FREMONT				
	TOTALS		968, 937	98, 671	_
	V - ALLOWABLE MARKETING COST				
1.00	ADMINISTRATIVE & GENERAL	5. 00	26, 884	123, 592	
2.00	CLINIC - PEDS ENT FP	90. 02	0	15, 950	
3.00	PSYCHI ATRY	90.04	0	4 <u>0, 0</u> 00	
	TOTALS		26, 884	179, 542	
	W - EMPLOYEE WELLNESS COST RE				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2 <u>9, 9</u> 56		
	TOTALS		29, 956		
500.00	Grand Total: Increases		2, 192, 061	14, 332, 761	50

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-1315

						2/14/2024 10: 4	
		Decreases					
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - LABOR AND DELIVERY	7.00	8.00	9.00	10.00		
1. 00	ADULTS & PEDIATRICS	30.00	35, 161	6, 655	0		1. 00
2.00	ABOLTO & FEBTATION	0.00	00, 101	0, 666	o		2. 00
	TOTALS		35, 161	6, 655			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	92, 556	12		1.00
2.00		0.00	0_	0	12		2. 00
	TOTALS		0	92, 556			
1 00	C - CAFETERIA	10.00	27 027	20, 205	٥		1 00
1. 00	TOTALS		<u>27, 837</u> 27, 837	2 <u>8, 2</u> 95 28, 295	0		1. 00
	D - INTEREST EXPENSE		21,831	28, 295			
1. 00	INTEREST EXPENSE	113.00	O	1, 293, 978	11		1. 00
2. 00	TWIEREST EXILENSE	0.00	o	0	11		2. 00
2.00	TOTALS			1, 293, 978	— — — ' †		2.00
	E - DEPRECIATION EXPENSE				'		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 026, 498	9		1.00
	TOTALS		0	1, 026, 498			
	F - ICU						
1. 00	ADULTS & PEDIATRICS	3000	6 <u>5, 7</u> 12	20, 324	0		1. 00
	TOTALS		65, 712	20, 324			
1 00	H - SLEEP LAB - EKG	/F 00	E0 000	(4.470	2		1 00
1.00	RESPI RATORY THERAPY	65.00	58, 209	61, 473	0		1.00
2. 00	TOTALS — — — — —		58, 209	61, 473	0		2. 00
	I - PUBLIC RELATIONS		30, 209	01,473			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	13, 363	0		1. 00
	TOTALS			13, 363	— — - 1		00
	J - RECOVERY ROOM	·	-1	.,	'		
1.00	OPERATING ROOM	50.00	887, 513	0	0		1.00
	TOTALS		887, 513	0			
	K - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 908, 354	0		1.00
	PATI ENT	- $ +$					
	TOTALS L - FOUNDATION RECLASS		0	1, 908, 354			
1. 00	ADMINISTRATIVE & GENERAL	5.00	1, 882	0	0		1. 00
1.00	TOTALS		1, 882	0	— — ^Ч		1.00
	M - IMMUNIZATION CLINIC RECLA	SS	1,002	<u> </u>			
1.00	PHARMACY	15. 00	0	54, 096	0		1. 00
	TOTALS			54, 096			
	N - DRUGS RECLASS						
1.00	PHARMACY	1500	0	<u>5, 692, 4</u> 11	0		1.00
	TOTALS		0	5, 692, 411			
	0 - IV THERAPY						
1. 00	DRUGS CHARGED TO PATIENTS		0	2, 497, 827	0		1. 00
	TOTALS		0	2, 497, 827			
1. 00	P - EKG HST RECLASS	65.00	89, 970	0	٥		1. 00
1.00	RESPIRATORY THERAPY		89, 970	0	0		1.00
	Q - OFFSITE DEPRECIATION		07, 770	<u> </u>			
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	15, 208	9		1. 00
2. 00		0.00	Ö	0	9		2. 00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	15, 208			
	R - PROVIDER BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 162, 725	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0	0		7. 00 8. 00
9. 00		0.00	0	0	0		9. 00
10.00		0.00	0	0	0		10. 00
11. 00		0.00	o	0	o	4	11. 00
12. 00		0.00	ő	0	o		12. 00
	TOTALS			1, 162, 725			
					1		
	T - LAUNDRY RECLASS						
1. 00	HOUSEKEEPI NG	9.00	0	153, 079	0		1. 00
1.00		9.00	0	15 <u>3, 0</u> 79 153, 079	0		1. (

Health Financial Systems RECLASSIFICATIONS

CAMERON MEMORIAL COMMUNITY HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1315

						2/14/2024 10	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
	U - NON RHC RECLASS						
1.00	RURAL HEALTH CLINIC IV	88. 03	194, 207	23, 696	0		1. 00
2.00	RURAL HEALTH CLINIC V	8804	774, 730	7 <u>4, 9</u> 75	0		2. 00
	TOTALS		968, 937	98, 671			
	V - ALLOWABLE MARKETING COST	RECLASS					
1.00	MARKETI NG	194. 05	26, 884	123, 592	0		1. 00
2.00	MARKETI NG	194. 05	0	15, 950	0		2. 00
3.00	MARKETING	194. 05	0	40,000	0		3. 00
	TOTALS		26, 884	179, 542			
	W - EMPLOYEE WELLNESS COST RE	ECLASS					
1.00	COMMUNITY HEALTH	194. 02	29, 956	27, 706	0		1. 00
	TOTALS		29, 956	27, 706			
500.00	Grand Total: Decreases		2, 192, 061	14, 332, 761			500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1315 Peri od: Worksheet A-7 From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/14/2024 10:45 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 019, 703 0 1.00 0 2.00 Land Improvements 0 2.00 0 3.00 284, 903 284, 903 55, 578 3.00 Buildings and Fixtures 61, 152, 127 Building Improvements 0 4.00 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 19, 762, 922 1, 465, 317 1, 465, 317 21, 891 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 82, 934, 752 1, 750, 220 1, 750, 220 77, 469 8.00 9.00 Reconciling Items 0 9.00 82, 934, 752 Total (line 8 minus line 9) 1, 750, 220 1, 750, 220 77, 469 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated 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 2.00 3.00 Buildings and Fixtures 61, 381, 452 0 3.00 0) 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 21, 206, 348 6.00 7.00 HIT designated Assets 0 7.00

84, 607, 503

84, 607, 503

0

Heal th	Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-25						2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1315	Peri od:	Worksheet A-7	
					From 10/01/2022		
					To 09/30/2023	Date/Time Pre 2/14/2024 10:	pared: 45 am
			SI	UMMARY OF CAP	I TAI	2/14/2024 10.	45 4111
			<u> </u>				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	·				instructions)	instructions)	
		9. 00	10.00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	4, 566, 200)	0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 936, 333	3	0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 566, 200		3	0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum	n			
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	· · · · · · · · · · · · · · · · · · ·				
1.00	CAP REL COSTS-BLDG & FLXT	0	4, 566, 200	1			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 936, 333				2. 00
3.00	Total (sum of lines 1-2)	0	6, 502, 533	3			3.00

Heal th	Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	F	reriod: from 10/01/2022 fo 09/30/2023		
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FIXT	61, 381, 452	0	61, 381, 452	0. 743227	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	21, 206, 348	l e			0	2. 00
3. 00	Total (sum of lines 1-2)	82, 587, 800	l .	82, 587, 800		ol	3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other Capi tal -Relate	Total (sum of cols. 5	Depreciation	Lease	
			d Costs	through 7)			
		6. 00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	0	3, 524, 494		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	912, 478		2. 00
3.00	Total (sum of lines 1-2)	0	0	0	4, 436, 972	1, 936, 333	3. 00
			Sl	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see instructions)	through 14)	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		•			
1.00	CAP REL COSTS-BLDG & FIXT	0	66, 678	0	0	3, 591, 172	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	25, 878	0	0	2, 874, 689	2. 00

0 0

66, 678 25, 878 92, 556

0 0 0

0 0 0

3, 591, 172 1. 00 2, 874, 689 2. 00 6, 465, 861 3. 00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Health Financial Systems
ADJUSTMENTS TO EXPENSES CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Period: Worksheet A-8 From 10/01/2022 To 09/30/2023 Date/Time Prepared: 2/14/2024 10: 45 am Provider CCN: 15-1315

						2/14/2024 10:	45 am
				Expense Classification on To/From Which the Amount is t			
				To the miner the time and he	o be haj astea		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00 A		CAP REL COSTS-BLDG & FLXT	1.00		1. 00
	COSTS-BLDG & FLXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-4, 178	CAP REL COSTS-MVBLE EQUIP	2. 00	11	2. 00
3.00	Investment income - other	А	0		0.00	o	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
	di scounts (chapter 8)		_				
5. 00	Refunds and rebates of expenses (chapter 8)		U		0.00	0	5. 00
6. 00	Rental of provider space by	В	-10, 634	ADMINISTRATIVE & GENERAL	5. 00	o	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Tel evi si on and radi o servi ce		0		0.00	0	8. 00
	(chapter 21)		_				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-5, 122, 223		0. 00	0	9. 00 10. 00
	adj ustment						
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	-427, 791			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-289, 995	DI ETARY	10.00	1	14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	О	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than	В	-14, 253	PHARMACY	15.00	o	17. 00
18. 00	patients Sale of medical records and	В	620	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
18.00	abstracts	В	-620	MEDICAL RECORDS & LIBRARY	16.00		18.00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines	В	-4, 683	DI ETARY	10.00		20.00
21. 00	Income from imposition of interest, finance or penalty		U		0.00	0	21. 00
00.00	charges (chapter 21)				0.00		00.00
22. 00	Interest expense on Medicare overpayments and borrowings to		O		0.00	0	22. 00
	repay Medicare overpayments			55051517051/ 71/55151/	45.00		
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	O	RESPI RATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)			511/61 611			
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
05.05	limitation (chapter 14)		_	LITELL ZATLON DELVISIV OVE			05.00
25. 00	Utilization review - physicians' compensation		O	UTILIZATION REVIEW-SNF	114. 00		25. 00
	(chapter 21)			0.5 551 00050 5155 1 5115			a,
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33 00	Depreciation and Interest LOBBYING EXPENSES	A	_6_001	ADMINISTRATIVE & GENERAL	5. 00		33. 00
	LODDII NO ENFLINALA	1 A I	-0, 091	INDMINISTRATIVE α GENERAL	ე. 00	ı V	

| From 10/01/2022 | To 09/30/2023 | Date/Time Prepared:

					0 09/30/2023	2/14/2024 10:	
	·			Expense Classification on	Worksheet A	27 1 17 202 1 10.	TO GIII
				To/From Which the Amount is			
					•		
	Cost Center Description	Basi s/Code (2)		Cost Center		Wkst. A-7 Ref.	
	Transaction of the contraction o	1.00	2.00	3. 00	4. 00	5. 00	
33. 01	MEALS ON WHEELS	В		DI ETARY	10.00		
33. 02		В	-32, 168	ONCOLOGY	76. 01	0	33. 02
00.00	CENTER		477	ADMINISTRATIVE & SENEDAL	F 00		00.00
33. 03		В		ADMI NI STRATI VE & GENERAL	5. 00		
33. 04	RHC OB PHYSICIAN & MIDLEVELS	A	- 12, 144	RURAL HEALTH CLINIC III	88. 02	0	33. 04
22 05	OFFSET		4 277 0/2	ADMINISTRATIVE & CENEDAL	F 00	_	22.05
33. 05	MEDICALD HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00		33. 05
33. 06		A		ADMINISTRATIVE & GENERAL	5. 00		33. 06
33. 07	MI SC REVENUE	В		ADMI NI STRATI VE & GENERAL	5. 00		33. 07
33. 08	OTHER PHYSICIAL THERAPY	В	-1, 250	PHYSI CAL THERAPY	66.00	0	33. 08
22.00	REVENUE		1 2/7	CARRIAG REHARILLEATION	(0.01	_	22.00
33. 09		B		CARDI AC REHABI LI TATI ON	69. 01		33. 09
33. 10		A		ADMINISTRATI VE & GENERAL	5. 00		33. 10
33. 11	NORTH RHC RENTAL REVENUE	В	· ·	RURAL HEALTH CLINIC IV	88. 03		33. 11
33. 12		A .	·	CLINIC - PEDS ENT FP	90. 02		33. 12
33. 13		A	-40, 000	PSYCHI ATRY	90. 04	0	33. 13
F0 00	FEES		44 745 0/5				F0 00
50. 00	TOTAL (sum of lines 1 thru 49)		-11, 715, 865				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-1315 | Period: From 10/01/2022 | Provider CCN: 15-1315 | Period: From 10/01/2022 | From 10/01/

					2/14/2024 10:	45 am
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	2. 00	CAP REL COSTS-MVBLE EQUIP	CMO AND MOB RENTAL	891, 635	1, 005, 655	1.00
2.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	CMO EXPENSE - CAMERON WOODS	0	232, 796	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	47, 375	4. 01
5.00	TOTALS (sum of lines 1-4).			891, 635	1, 319, 426	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:				

- $(1) \ \ \text{Use the following symbols to indicate interrelationship to related organizations:}$
- 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 CO	MMUNITY HOSPITAL	In Lie	u of Form CMS-2552-1
	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1315	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 10/01/2022 To 09/30/2023	Date/Time Prepared:
			10 077 307 2023	2/14/2024 10:45 am
Net Wkst. A-7	Ref.			
Adjustments				
(col. 4 minus				
col . 5) *				
6. 00 7. 00				
A. COSTS INCURRED AND AD.	JUSTMENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED	ORGANIZATIONS OR (CLAIMED
HOME OFFICE COSTS:				

5.00 | -427,791 | | 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.

1.00

2.00

3.00

3.01

4.00

4 01

1103 1101	been posted to norkaneet A,	cordinate and or 2, the amount arrowable should be that cated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	•		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

1.00

2.00

3.00

3.01

4.00

4 01

-114, 020

-232, 796

-26, 850

-3, 300

-3, 450

-47, 375

0

0

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1315

Wkst. A Line # Cost Center/Physician Total Professional Provider RCE Amo	2/14/2024 10:45 am
with the meaning that the man and the man	unt Physician/Prov
I dentifier 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 & PEDI ATRI CS 878, 797 0	0 1.00
2. 00 50. 00 OPERATI NG ROOM 661, 261 661, 261 0	0 2.00
3. 00 60. 00 LABORATORY 18, 563 6, 126 12, 437	0 3.00
4. 00 90. 01 CLI NI C- ORTHO 1, 722, 427 1, 722, 427 0	0 4.00
5. 00 90. 02 CLINIC - PEDS ENT FP 630, 351 630, 351 0	0 5.00
6. 00 90. 04 PSYCHI ATRY 491, 232 491, 232 0	0 6.00
7. 00 90. 05 CARDI OLOGY 724, 279 724, 279 0	0 7.00
8. 00 54. 00 RADI OLOGY-DI AGNOSTI C 7, 750 7, 750 0	0 8.00
9.00 0.00 0 0	0 9.00
10.00 0.00 0 0 0	0 10.00
200. 00 5, 134, 660 5, 122, 223 12, 437	0 200.00
Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provide	
I dentifier Limit Unadjusted RCE Memberships & Compone	
Li mi t Conti nui ng Share of	col. Insurance
1.00 2.00 8.00 9.00 12.00 13.00	14.00
1. 00	0 0 1.00
2. 00 50. 00 O O O O O O O O O	0 0 2.00
3. 00 60. OO LABORATORY 0 0 0	0 0 3.00
4. 00 90. 01 CLI NI C- ORTHO 0 0	0 0 4.00
5. 00 90. 02(CLINIC - PEDS ENT FP 0 0 0	0 5.00
6. 00 90. 04 PSYCHI ATRY 0 0 0	0 6.00
7. 00 90. 05(CARDI 0LOGY 0 0	0 7.00
8. OO 54. OOIRADI OLOGY-DI AGNOSTI C O O	0 8.00
9.00 0.00	0 9.00
10.00 0.00 0	0 10.00
200.00	0 200.00
Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE Adjustm	
Identifier Component Limit Disallowance	
Share of col.	
14	
1.00 2.00 15.00 16.00 17.00 18.00	
1.00 30.00 ADULTS & PEDIATRICS 0 0 87	3, 797 1. 00
	1, 261 2. 00
	5, 126 3. 00
	2, 427 4. 00
	0, 351 5. 00
	1, 232 6. 00
	4, 279 7. 00
	7, 750 8. 00
9.00 0.00 0 0	0 9.00
10.00 0.00 0 0 0	0 10.00
200. 00 0 0 5, 12	2, 223 200. 00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1315 Peri od: Worksheet B From 10/01/2022 Part I Date/Time Prepared: 09/30/2023 2/14/2024 10:45 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 3, 591, 172 3 591 172 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2, 874, 689 2, 874, 689 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 737, 026 29, 415 19, 707 12, 786, 148 4.00 00500 ADMINISTRATIVE & GENERAL 3, 037, 070 16, 165, 563 5 00 12, 572, 281 298, 516 257 696 5 00 7.00 00700 OPERATION OF PLANT 5,008,615 352, 630 184, 874 524, 444 6,070,563 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 182, 830 37, 101 19, 451 239, 382 8.00 00900 HOUSEKEEPI NG 1, 592, 623 6, 288 3, 297 396, 546 1, 998, 754 9.00 9.00 01000 DI ETARY 10.00 1, 290, 476 207, 477 108, 774 10 00 756, 341 217, 884 11.00 01100 CAFETERI A Ω 11.00 01300 NURSING ADMINISTRATION 532, 297 23, 057 32, 015 785, 923 13.00 198.554 13.00 01400 CENTRAL SERVICES & SUPPLY 492, 394 57,070 134, 540 14.00 108, 856 792, 860 14.00 958, 544 40, 349 201, 872 15.00 15.00 01500 PHARMACY 21, 154 1, 221, 919 01600 MEDICAL RECORDS & LIBRARY 1, 252, 083 20, 275 348, 895 1, 621, 253 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 5, 067, 358 652, 298 1, 664, 525 30.00 03000 ADULTS & PEDIATRICS 341. 983 30.00 7, 726, 164 31.00 03100 INTENSIVE CARE UNIT 86.036 41, 223 21, 612 27.071 175, 942 31 00

| Peri od: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: |

					2/14/2024 10:	
		CAPI TAL REI	_ATED_COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col . 7)					
	0	1. 00	2.00	4. 00	4A	
194. 10 07960 RHC	0	0	0	0	0	194. 10
194. 11 07961 OBGYN	0	0	0	0	0	194. 11
194. 12 07962 TRI NE STUDENT HEALTH	146, 028	0	0	56, 563	202, 591	194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	490, 956	0	15, 513	101, 812	608, 281	194. 13
194.14 07964 IMMUNIZATION CLINIC	0	0	0	0	0	194. 14
194. 15 07965 FOUNDATI ON	370, 599	4, 611	4, 249	55, 395	434, 854	194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	245, 377	0	0	23, 107	268, 484	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	1, 037, 520	0	0	221, 131	1, 258, 651	194. 17
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	87, 111, 320	3, 591, 172	2, 874, 689	12, 786, 148	87, 111, 320	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1315

				1	0 09/30/2023	Date/lime Pre 2/14/2024 10:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 4,5 5,0					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 165, 563	7 452 700				5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 383, 226	7, 453, 789 95, 011	1			7. 00 8. 00
9. 00	00900 HOUSEKEEPING	54, 545 455, 432	16, 104	1			9.00
10. 00	01000 DI ETARY	294, 045	531, 327	1		2, 156, 934	10.00
11. 00	01100 CAFETERI A	0	C	o o		0	11. 00
13.00	01300 NURSING ADMINISTRATION	179, 079	59, 046	6 0	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	180, 659	278, 770	0	14, 222	0	14. 00
15. 00	01500 PHARMACY	278, 424	103, 331	0	0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	369, 415	C) 0	0	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 7/0 472	1 (70 475	353,000	400.004	2 121 002	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 760, 473 40, 090	1, 670, 475 105, 568	1	·	2, 121, 993 34, 941	30. 00 31. 00
43. 00	04300 NURSERY	9, 701	37, 575	1		0	43.00
10.00	ANCILLARY SERVICE COST CENTERS	7,701	07,070	21, 17 1	107,001		10.00
50.00	05000 OPERATING ROOM	681, 138	982, 494	1 0	280, 490	0	50.00
51.00	05100 RECOVERY ROOM	371, 769	635, 821	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	53, 491	157, 009			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 155, 979	752, 303	1	,	0	54.00
60.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	1, 021, 049	248, 173	1		0	60.00
65. 00 65. 01	06500 RESPIRATORY THERAPY	389, 859 33, 709	65, 309	i	,	0	65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY	556, 486	564, 697	1 °	93, 628	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	45, 117	33, 728	1	0	0	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	36, 497	56, 362	1	0	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	238, 785	C	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	434, 834	C	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	727, 912	C	0	37, 925	0	73. 00
76. 00 76. 01	03020 CHEMI CAL DEPENDENCY 03480 ONCOLOGY	0	C	0		0	76. 00 76. 01
76. 01	03030 DI ABETI C EDUCATI ON	550, 219 18, 968	C	1	,	0	76. 01
70.02	OUTPATIENT SERVICE COST CENTERS	10, 700		7		U	70.02
88. 00	08800 RURAL HEALTH CLINIC	372, 152	C	0	64, 789	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	553, 358	C	0	128, 393	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	410, 749	C	0	28, 839	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	223, 165	C	0	,	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	68, 052	25 70/	0	,	0	88. 04
90. 00 90. 01	09000 CLI NI C 09001 CLI NI C - ORTHO	45, 440 176, 706	35, 786	1		0	90. 00 90. 01
90. 01	09002 CLINIC - PEDS ENT FP	220, 365			60, 444	0	90.02
90. 03	09003 I NTRAVENOUS THERAPY	616, 902	107, 357	7	0	0	90. 03
90. 04	09004 PSYCHI ATRY	76, 156	·	1	0	0	90. 04
90. 05	09005 CARDI OLOGY	194, 261	C	0		0	90. 05
	09100 EMERGENCY	974, 672	853, 845	0	294, 317	0	,
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
101 0	OTHER REIMBURSABLE COST CENTERS 0 10100 HOME HEALTH AGENCY	O	C	0	0	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	0	0	1101.00
113. 00	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11600 HOSPI CE	0	C	0	0		116. 00
118.00		15, 252, 879	7, 390, 091	388, 938	2, 407, 081	2, 156, 934	118. 00
400.0	NONREI MBURSABLE COST CENTERS	7 007	F4 000			^	1400 00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	7, 037	51, 889	1			190. 00 192. 00
	07950 DAYCARE-I NFANT/TODDLER	422		0	0		194. 00
194.00	107951 MOB				0		194. 00
	2 07952 COMMUNITY HEALTH	18, 082	C		0		194. 02
	3 07953 ASSISTED LIVING/CAMERON WOODS	0	C		0		194. 03
194.04	4 07954 EDUCATI ON	o	C	0	0	0	194. 04
	07955 MARKETI NG	239, 921	C	0	0		194. 05
	07956 GUEST MEALS	15, 403	C	0	0		194. 06
	7 07957 OUTSIDE LAUNDRY	0	C	0	0		194. 07
	3 07958 CANCER CENTER 9 07959 URGENT CARE	0	C		0		194. 08 194. 09
	0/959 DRGENT CARE		(0		194. 09
	107961 RHC		(n		194. 10
	207962 TRINE STUDENT HEALTH	46, 162	C		o o		194. 12
194. 13	07963 OCCUPATI ONAL HEALTH	138, 602	C) 0	0	0	194. 13
194. 1	4 07964 IMMUNIZATION CLINIC	0	C	0	0	0	194. 14

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu	ı of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-1315	From 10/01/2022 To 09/30/2023	Worksheet B Part I Date/Time Prepared: 2/14/2024 10: 45 am

						2/14/2024 10.	45 am
Cost Center	Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8. 00	9. 00	10.00	
194. 15 07965 FOUNDATI ON		99, 085	11, 809	0	0	(194. 15
194.16 07967 CAMERON FAI	MILY MEDICINE - NORTH	61, 176	0	0	9, 876	(194. 16
194.17 07966 CAMERON FAI	MILY MEDICINE - FREMONT	286, 794	0	0	53, 333	(194. 17
200.00 Cross Foot	Adjustments						200. 00
201.00 Negative Co	ost Centers	0	0	0	0	(201.00
202.00 TOTAL (sum	lines 118 through 201)	16, 165, 563	7, 453, 789	388. 938	2, 470, 290	2, 156, 934	1 202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-1315

Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	2/14/2024 10: MEDI CAL	
		ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	11. 00	13.00	14. 00	15. 00	16. 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 ADMINISTRATIVE & 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		0				11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY		1, 024, 048	1 244 E11			13. 00 14. 00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY			1, 266, 511 8, 131	1, 611, 805		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	1	0 0	2, 122	0	1, 992, 790	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	T		T	_1		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	1	0 340, 795 0 6, 690	92, 611 0	0 0	125, 490 2, 696	30. 00 31. 00
43. 00 04300 NURSERY			0	ol Ol	2, 090 3, 762	43.00
ANCI LLARY SERVI CE COST CENTERS		91 91	S ₁	<u> </u>	57.752	10.00
50.00 05000 OPERATING ROOM	1	0 85, 564	181, 438	0	137, 316	50. 00
51. 00 05100 RECOVERY ROOM		0 66, 896	0	0	62, 714	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	1	0 6, 204	39, 027	0	11, 889 471, 996	52. 00 54. 00
60. 00 06000 LABORATORY	1	ol ol	1, 182	o	274, 731	60.00
65. 00 06500 RESPIRATORY THERAPY		89, 334	12, 853	o	26, 784	65. 00
65. 01 06501 SLEEP LAB		0	0	0	11, 599	65. 01
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY		0 141, 175 0 4, 460	5, 183 1, 576	0	63, 359 30, 225	66. 00 69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON		10, 599	468	Ö	6, 044	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		o o	674	О	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	694, 165	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 CHEMI CAL DEPENDENCY		0 0 0 0	0	904, 545	21, 859 0	73. 00 76. 00
76. 00 03020 CHEMICAL DEPENDENCY 76. 01 03480 ONCOLOGY	1		0	ol Ol	217, 594	76. 00
76. 02 03030 DI ABETI C EDUCATI ON	1		44	Ö	556	76. 02
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	1	0 0 0	14, 054 78, 223	0	20, 671 40, 765	•
88. 02 08802 RURAL HEALTH CLINIC III	1		5, 967	ol Ol	21, 345	1
88. 03 08803 RURAL HEALTH CLINIC IV			9, 869	Ö	17, 297	88. 03
88. 04 08804 RURAL HEALTH CLINIC V		0 0	2, 006	0	2, 932	88. 04
90. 00 09000 CLI NI C		8, 991	6, 345	0	5, 374	90.00
90. 01 09001 CLI NI C - ORTHO 90. 02 09002 CLI NI C - PEDS ENT FP			7, 132 7, 405	0	3, 616 7, 713	90. 01 90. 02
90. 03 09003 I NTRAVENOUS THERAPY		8, 019	4, 696	707, 260	80, 777	90. 03
90. 04 09004 PSYCHI ATRY		o	254	O	2, 406	1
90. 05 09005 CARDI OLOGY	1	0 42, 800	776	0	24, 343	1
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	'	0 212, 521	75, 376	٥	280, 232	91. 00 92. 00
OTHER REI MBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY		0 0	0	0	0	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		ol	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		1, 024, 048	1, 251, 577	1, 611, 805	1, 976, 085	118. 00
NONREI MBURSABLE COST CENTERS				ما	-	100.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS PRIVATE OFFICES	1	0 0	0	0		190. 00 192. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER			Ö	o		194. 00
194. 01 07951 MOB		o o	0	o		194. 01
194. 02 07952 COMMUNITY HEALTH		0	2	0		194. 02
194.03 07953 ASSISTED_LIVING/CAMERON_WOODS 194.04 07954 EDUCATION	!	U 0	0	0		194. 03 194. 04
194. 05 07955 MARKETI NG			20	0		194. 05
194. 06 07956 GUEST MEALS		ol o	0	Ö	0	194. 06
194. 07 07957 OUTSI DE LAUNDRY		이	0	o		194. 07
194. 08 07958 CANCER CENTER	!		0	0		194. 08 194. 09
194. 09 07959 URGENT CARE 194. 10 07960 RHC			0	0		194. 09
194. 11 07961 OBGYN		ol ol	o	o		194. 11
194. 12 07962 TRI NE STUDENT HEALTH	1	o o	2, 802	o		194. 12
194. 13 07963 OCCUPATI ONAL HEALTH		0 0	1, 605	이	0	194. 13

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS CAMERON MEMORIAL COMMUNITY HOSPITAL Provider CCN: 15-1315

| Peri od: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: | 2/14/2024 10: 45 am

					2/14/2024 10:	45 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13. 00	14.00	15. 00	16.00	
194. 14 07964 I MMUNI ZATION CLINIC	0	0	0	0	0	194. 14
194. 15 07965 FOUNDATI ON	0	0	517	0	0	194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	0	0	2, 601	0	4, 564	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	0	7, 387	0	12, 141	194. 17
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	1, 024, 048	1, 266, 511	1, 611, 805	1, 992, 790	202. 00

Provider CCN: 15-1315

| Peri od: | Worksheet B | From 10/01/2022 | Part | To 09/30/2023 | Date/Time Prepared: |

			To	09/30/2023 Date/Time Pro 2/14/2024 10:	
Cost Center Description	Subtotal	Intern &	Total	127 : 17 202 : 10	
		Residents Cost			
		& Post Stepdown			
		Adjustments			
CENEDAL CEDILICE COCT CENTEDO	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00 O0500 ADMINISTRATIVE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY					14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	14, 791, 794	1	14, 791, 794		30. 00
31. 00 03100 NTENSI VE CARE UNI T	372, 923	1	372, 923		31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	285, 292	0	285, 292		43. 00
50. 00 05000 OPERATI NG ROOM	5, 337, 747	O	5, 337, 747		50.00
51.00 05100 RECOVERY ROOM	2, 768, 780	0	2, 768, 780		51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	471, 764	0	471, 764		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	7, 654, 521 6, 102, 852	0	7, 654, 521 6, 102, 852		54. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY	2, 314, 470		2, 314, 470		65.00
65. 01 06501 SLEEP LAB	214, 973	l o	214, 973		65. 01
66. 00 06600 PHYSI CAL THERAPY	3, 866, 776	0	3, 866, 776		66. 00
69. 00 06900 ELECTROCARDI OLOGY	313, 111	0	313, 111		69.00
69. 01 06901 CARDI AC REHABILITATION 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	270, 145 1, 287, 414		270, 145 1, 287, 414		69. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 037, 353	1	3, 037, 353		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 886, 825	1	4, 886, 825		73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0	0		76.00
76. 01 03480 ONCOLOGY 76. 02 03030 DI ABETI C EDUCATI ON	3, 266, 311 102, 814	0	3, 266, 311 102, 814		76. 01 76. 02
OUTPATIENT SERVICE COST CENTERS	102,014	<u> </u>	102, 014		70.02
88.00 08800 RURAL HEALTH CLINIC	2, 104, 931	0	2, 104, 931		88. 00
88. 01 08801 RURAL HEALTH CLINIC II	3, 229, 259	1	3, 229, 259		88. 01
88. 02 08802 RURAL HEALTH CLINIC III 88. 03 08803 RURAL HEALTH CLINIC IV	2, 269, 554 1, 298, 869	0	2, 269, 554 1, 298, 869		88. 02 88. 03
88. 04 08804 RURAL HEALTH CLINIC V	389, 427		389, 427		88. 04
90. 00 09000 CLI NI C	323, 085	O	323, 085		90.00
90. 01 09001 CLI NI C- ORTHO	1, 038, 418	1	1, 038, 418		90. 01
90. 02 09002 CLINIC - PEDS ENT FP 90. 03 09003 INTRAVENOUS THERAPY	1, 263, 042 4, 232, 407	0	1, 263, 042 4, 232, 407		90. 02 90. 03
90. 03 09003 NTRAVENOUS THERAPT 90. 04 09004 PSYCHI ATRY	4, 232, 407		4, 232, 407		90.03
90. 05 09005 CARDI OLOGY	1, 158, 191	o	1, 158, 191		90. 05
91. 00 09100 EMERGENCY	6, 968, 506	0	6, 968, 506		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0			92. 00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	0	0	0		101. 00
SPECIAL PURPOSE COST CENTERS	_	-1			
113. 00 11300 INTEREST EXPENSE					113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 116. 00 11600 HOSPI CE	0		0		114. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	82, 034, 595		82, 034, 595		118.00
NONREI MBURSABLE COST CENTERS	02/001/070	9	02/001/070		1.10.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	89, 811	0	89, 811		190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	2, 272	0	2, 272		192. 00 194. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER 194. 01 07951 MOB	0	0	0		194. 00
194. 02 07952 COMMUNI TY HEALTH	97, 442		97, 442		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	1, 292, 882	l I	1, 292, 882		194. 05
194. 06 07956 GUEST MEALS 194. 07 07957 OUTSI DE LAUNDRY	83, 003		83, 003 0		194. 06 194. 07
194. 08 07958 CANCER CENTER			0		194. 07
194. 09 07959 URGENT CARE	0	0	0		194. 09
194. 10 07960 RHC	0	0	0		194. 10
194. 11 07961 0BGYN	0	<u> </u>	0		194. 11

194. 12 07962 TRI NE STUDENT HEALTH

194. 13 07963 OCCUPATI ONAL HEALTH

194. 14 07964 I MMUNI ZATI ON CLINIC

194. 16 07967 CAMERON FAMILY MEDICINE - NORTH

194. 17 07966 CAMERON FAMILY MEDICINE - FREMONT

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

194. 15 07965 FOUNDATI ON

200.00

201.00

202.00

194. 12

194. 13

194. 14

194. 15

194. 16

194. 17

200. 00

201. 00

202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1315 Worksheet B Peri od: From 10/01/2022 To 09/30/2023 Part I Date/Time Prepared: 2/14/2024 10: 45 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00

251, 555

748, 488

546, 265

346, 701

0

0

1, 618, 306

87, 111, 320

0

0

0

0

251, 555

748, 488

546, 265

346, 701

0

0

1, 618, 306

87, 111, 320

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Date/Time Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315

				10	09/30/2023	Date/lime Pre 2/14/2024 10:	
			CAPI TAL REI	LATED COSTS		27 1 17 202 1 10.	To dill
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	2/(1. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 0 0 0	29, 415 298, 516 352, 630 37, 101 6, 288	257, 696 184, 874 19, 451	49, 122 556, 212 537, 504 56, 552 9, 585	49, 122 11, 660 2, 015 0 1, 524	7. 00 8. 00
10. 00 11. 00 13. 00 14. 00 15. 00 16. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0 0 0 0 0	207, 477 0 23, 057 108, 856 40, 349	108, 774 0 32, 015 57, 070 21, 154	316, 251 0 55, 072 165, 926 61, 503 20, 275	837 0 763 517 776 1, 341	10. 00 11. 00 13. 00 14. 00 15. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J U	0	20, 275	20, 275	1, 341	16.00
30. 00 31. 00 43. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0 0 0	652, 298 41, 223 14, 673	21, 612	994, 281 62, 835 22, 365	6, 396 104 20	31.00
50. 00 51. 00 52. 00 54. 00 65. 00 65. 01 66. 00 69. 00 69. 01 71. 00 72. 00 76. 00 76. 01 76. 02	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06500 RESPIRATORY THERAPY 06501 SLEEP LAB 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHABILITATION 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 CHEMICAL DEPENDENCY 03480 ONCOLOGY	0 0 0 0 0 0 0 0 0 0 0	383, 652 248, 280 61, 310 293, 765 96, 909 25, 502 0 220, 507 13, 170 22, 009 0 0	130, 167 32, 143 154, 013 50, 807 13, 370 47, 620 115, 606 6, 905 11, 539 0 0 0	584, 790 378, 447 93, 453 447, 778 147, 716 38, 872 47, 620 336, 113 20, 075 33, 548 0 0 0 0 203, 299	1, 546 1, 405 147 3, 759 1, 720 1, 422 61 2, 324 173 129 0 0 0	51. 00 52. 00 54. 00 60. 00 65. 00 66. 00 69. 00 69. 01 71. 00 72. 00 73. 00 76. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 08803 RURAL HEALTH CLINIC IV 08804 RURAL HEALTH CLINIC V 09000 CLINIC 09001 CLINIC ORTHO 09002 CLINIC - PEDS ENT FP 09003 INTRAVENOUS THERAPY 09004 PSYCHIATRY 09005 CARDI OLOGY 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 0 0 0 0 0 0	0 0 0 0 13, 974 0 0 41, 922 0 0 333, 416	119, 580 64, 030 0 15, 220 72, 821 109, 525 21, 978 32, 363 26, 960 174, 801	124, 342 119, 580 64, 030 0 29, 194 72, 821 109, 525 63, 900 32, 363 26, 960 508, 217 0	577 819 224 337 189 171 736 646 146 183 618 3, 665	88. 02 88. 03 88. 04 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 91. 00 92. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
114.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0 0	0 3, 566, 299	0 2, 823, 827	0 6, 390, 126		113. 00 114. 00 116. 00 118. 00
192. 00 194. 00 194. 01 194. 02 194. 03 194. 05 194. 06 194. 08 194. 08	19200 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICI ANS PRIVATE OFFICES 07950 DAYCARE-INFANT/TODDLER 07951 MOB 07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS 07954 EDUCATION 07956 GUEST MEALS 07957 OUTSI DE LAUNDRY 07959 URGENT CARE 07959 RHC	0 0 0 0 0 0 0 0 0 0	20, 262 0 0 0 0 0 0 0 0 0 0	1, 850 0 0 0 0 0 18, 627 0 0	30, 885 1, 850 0 0 0 0 0 18, 627 0 0 0	0 0 58 0 0 310 44 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10

					2/14/2024 10:	45 am_
		CAPI TAL REL	_ATED_COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 11 07961 OBGYN	0	0	0	0	0	194. 11
194. 12 07962 TRI NE STUDENT HEALTH	0	0	0	0	217	194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	0	0	15, 513	15, 513	391	194. 13
194.14 07964 IMMUNIZATION CLINIC	0	0	0	0	0	194. 14
194. 15 07965 FOUNDATI ON	0	4, 611	4, 249	8, 860	213	194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	0	0	0	0	89	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	0	0	0	850	194. 17
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	3, 591, 172	2, 874, 689	6, 465, 861	49, 122	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1315

					0 07/30/2023	2/14/2024 10:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	8. 00	9. 00	10. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			T			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	567, 872					5. 00
7.00	00700 OPERATION OF PLANT	48, 589	588, 108				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 916	7, 490				8. 00
9.00	00900 HOUSEKEEPI NG	15, 998	1, 27	1	,		9. 00
10.00	01000 DI ETARY	10, 329	41, 922	2 0	472	369, 811	1
11.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	(201	4 / 5		0	0	
13. 00 14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 291	4, 659	•	143	0	1
15. 00	01500 PHARMACY	6, 346 9, 780	21, 99! 8, 15:	1	163	0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	12, 977	0, 13.	1	0	0	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	12,777	`	<u> </u>	<u> </u>		10.00
30.00	03000 ADULTS & PEDIATRICS	61, 862	131, 800	59, 853	6, 904	363, 820	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 408	8, 329		14	5, 991	
43.00	04300 NURSERY	341	2, 96	4, 100	1, 924	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	23, 926	77, 519	1	3, 222	0	
51. 00	05100 RECOVERY ROOM	13, 059	50, 16	1	0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 879	12, 388			0	1
54. 00	05400 RADI OLOGY - DI AGNOSTI C	40, 606	59, 35	1	1, 861	0	1
60.00	06000 LABORATORY	35, 867	19, 58	1	880	0	
65. 00	06500 RESPIRATORY THERAPY	13, 695	5, 153	1		0	1
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	1, 184 19, 548	44, 55!	1	250 1, 076	0	
69. 00	06900 ELECTROCARDI OLOGY	1, 585	2, 66	1	1,070	0	
69. 01	06901 CARDI AC REHABI LI TATI ON	1, 282	4, 44	1	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 388	7, 77	1	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	15, 274	ì		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	25, 569	(ol o	436	0	
76. 00	03020 CHEMI CAL DEPENDENCY	0	(ol o	0	0	
76. 01	03480 ONCOLOGY	19, 328	(o	962	0	76. 01
76. 02	03030 DI ABETI C EDUCATI ON	666	(0	0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	13, 073	(0	
88. 01	08801 RURAL HEALTH CLINIC II	19, 438		0	,	0	
88. 02	08802 RURAL HEALTH CLINIC III	14, 428	(0	331	0	1
88. 03	08803 RURAL HEALTH CLINIC IV	7, 839	(0	794	0	
88. 04	08804 RURAL HEALTH CLINIC V	2, 390	2.02	0		0	
90. 00 90. 01	09000 CLI NI C 09001 CLI NI C- ORTHO	1, 596	2, 82	1 O		0	
90. 01	09001 CLINIC - OKTHO	6, 207 7, 741			867 694	0	
90. 02	09003 I NTRAVENOUS THERAPY	21, 670	8, 47		094	0	
90. 04	09004 PSYCHIATRY	2, 675	0,47		0	0	1
90. 05	09005 CARDI OLOGY	6, 824	Ò		499	0	
91. 00	09100 EMERGENCY	34, 237	67, 369	e o		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART				.,		92.00
	OTHER REIMBURSABLE COST CENTERS	'		•			1
101.00	10100 HOME HEALTH AGENCY	0	(0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
116.00	11600 HOSPI CE	F2F 011	583, 082	0 45 044	27 (52		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	535, 811	583, 082	65, 964	27, 652	369, 811	1118.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	247	4, 094	1 0	0	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	15	4,07				192. 00
	07950 DAYCARE-I NFANT/TODDLER	0	Ò		0		194. 00
	07951 MOB	O		ol o	o		194. 01
	07952 COMMUNITY HEALTH	635	(0		194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	(ol o	0		194. 03
	07954 EDUCATI ON	0	(ol o	0	0	194. 04
194. 0	07955 MARKETI NG	8, 428	(o o	0	0	194. 05
194.00	07956 GUEST MEALS	541	(0	o		194. 06
	07957 OUTSI DE LAUNDRY	0	(0	0		194. 07
	07958 CANCER CENTER	0	(0	0		194. 08
	07959 URGENT CARE	0	(0	0		194. 09
	07960 RHC	0	(0	0		194. 10
	07961 OBGYN	0	() 0	0		194. 11
	207962 TRINE STUDENT HEALTH	1, 622	(و -	0		194. 12
	3 07963 OCCUPATIONAL HEALTH 1 07964 IMMUNIZATION CLINIC	4, 869 0	(0	-		194. 13 194. 14
194. 14	+ U/7U4 IWWUNIZATIUN CLINIC	ı O	(0 ار	ı O	0	1174. 14

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1315	From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Prepared: 2/14/2024 10: 45 am

						2/14/2024 10.	40 alli
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8. 00	9. 00	10.00	
194. 15 07965	FOUNDATI ON	3, 481	932	0	0	0	194. 15
194. 16 07967	CAMERON FAMILY MEDICINE - NORTH	2, 149	0	0	113	0	194. 16
194. 17 07966	CAMERON FAMILY MEDICINE - FREMONT	10, 074	0	0	613	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)	567, 872	588. 108	65. 964	28. 378	369, 811	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1315

Peri od: Worksheet B From 10/01/2022 Part II To 09/30/2023 Date/Time Prepared:

2/14/2024 10:45 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL RECORDS & SERVICES & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15. 00 14.00 16,00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 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 66, 785 01400 CENTRAL SERVICES & SUPPLY 14.00 194, 947 14 00 15.00 01500 PHARMACY 0 1, 251 81, 463 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 327 34, 920 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 2, 194 30.00 03000 ADULTS & PEDIATRICS 22, 226 14, 255 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 436 47 43.00 04300 NURSERY 0 0 43.00 66 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 5, 580 27, 928 0 2, 401 50.00 05100 RECOVERY ROOM 0 51.00 000000000000000 4, 363 C 1,096 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 405 208 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 C 6,007 8, 333 54.00 0 60.00 06000 LABORATORY 182 4,803 60.00 65.00 06500 RESPIRATORY THERAPY 5,826 1, 978 0 468 65.00 65 01 06501 SLEEP LAB 203 C 65 01 06600 PHYSI CAL THERAPY 66.00 9, 207 798 1, 108 66.00 06900 ELECTROCARDI OLOGY 291 243 0 528 69.00 69.00 0 69.01 06901 CARDIAC REHABILITATION 691 72 106 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 104 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 106, 850 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 45, 717 382 73.00 03020 CHEMI CAL DEPENDENCY 76 00 Ω 0 76 00 0 0 03480 ONCOLOGY 76.01 0 0 0 3,804 76.01 03030 DIABETIC EDUCATION 0 76.02 76.02 10 OUTPATIENT SERVICE COST CENTERS 88 00 88 00 08800 RURAL HEALTH CLINIC 0 2 163 0 361 88.01 08801 RURAL HEALTH CLINIC II 0 12,040 0 713 88.01 00000000 08802 RURAL HEALTH CLINIC III 918 0 88.02 373 88.02 0 88.03 08803 RURAL HEALTH CLINIC IV 0 1,519 302 88.03 08804 RURAL HEALTH CLINIC V 88 04 C 309 51 88 04 90.00 09000 CLI NI C 586 977 0 94 90.00 90.01 09001 CLINIC- ORTHO C 1,098 0 63 90.01 09002 CLINIC - PEDS ENT FP 90.02 1.140 135 90.02 0 09003 INTRAVENOUS THERAPY 90.03 523 723 35, 746 1, 412 90.03 0 90.04 09004 PSYCHI ATRY 39 0 42 90.04 90.05 09005 CARDI OLOGY 0 2, 791 119 0 426 90.05 09100 EMERGENCY 0 4, 899 13, 860 0 91.00 91.00 11,602 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 0 66, <u>78</u>5 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 192, 649 81, 463 34, 628 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 192, 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 194. 00 07950 DAYCARE-I NFANT/TODDLER 0000000000000 C 0 0 194.00 194. 01 07951 MOB 0 0 194. 01 0 0 0 0 0 0 0 0 0 0 0 194. 02 07952 COMMUNI TY HEALTH 0 0 194. 02 194.03 07953 ASSISTED LIVING/CAMERON WOODS 0 0 194 03 C 0 194. 04 07954 EDUCATI ON 0 0 194.04 194. 05 07955 MARKETI NG 3 0 194. 05 0 0 194.06 07956 GUEST MEALS 0 0 194, 06 194. 07 07957 OUTSI DE LAUNDRY 0 0 194. 07 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 Ω 0 0 194, 10 194. 11 07961 OBGYN C 0 0 194. 11 194. 12 07962 TRINE STUDENT HEALTH 0 194. 12 431 194. 13 07963 OCCUPATIONAL HEALTH 247 0 194. 13

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS CAMERON MEMORIAL COMMUNITY HOSPITAL

| Peri od: | Worksheet B | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | 2/14/2024 10: 45 am Provider CCN: 15-1315

					2/14/2024 10: 4	45 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16.00	
194.14 07964 IMMUNIZATION CLINIC	0	0	0	0	0	194. 14
194. 15 07965 FOUNDATI ON	0	0	80	0	0	194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORTH	0	o	400	0	80	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	o	1, 137	0	212	194. 17
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	66, 785	194, 947	81, 463	34, 920	202. 00

| Peri od: | Worksheet B | From 10/01/2022 | Part | I | To 09/30/2023 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315

			To	o 09/30/2023 Date/Time Pr 2/14/2024 10	epared:
Cost Center Description	Subtotal	Intern &	Total	27 147 2024 10	. 45 aiii
·		Residents Cost			
		& Post			
		Stepdown Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT	1, 663, 591	0	1, 663, 591		30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	80, 150 31, 781	0	80, 150 31, 781		31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	31, 701	<u> </u>	31, 701		43.00
50. 00 05000 OPERATI NG ROOM	726, 912	0	726, 912		50.00
51.00 05100 RECOVERY ROOM	448, 537	0	448, 537		51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	109, 532	0	109, 532		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	567, 701 210, 749	0 0	567, 701 210, 749		54. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY	67, 636	0	67, 636		65. 00
65. 01 06501 SLEEP LAB	49, 318	o	49, 318		65. 01
66. 00 06600 PHYSI CAL THERAPY	414, 729	0	414, 729		66. 00
69. 00 06900 ELECTROCARDI OLOGY	25, 556	0	25, 556		69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	40, 275	0	40, 275		69. 01
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	8, 492 122, 124	0	8, 492 122, 124		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	72, 104	0	72, 104		73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0	0	0		76. 00
76. 01 03480 ONCOLOGY	227, 393	0	227, 393		76. 01
76. 02 03030 DI ABETI C EDUCATION	683	0	683		76. 02
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	141, 260	o	141, 260		88. 00
88. 01 08801 RURAL HEALTH CLINIC II	154, 065	0	154, 065		88. 01
88.02 08802 RURAL HEALTH CLINIC III	80, 304	0	80, 304		88. 02
88.03 08803 RURAL HEALTH CLINIC IV	10, 791	0	10, 791		88. 03
88. 04 08804 RURAL HEALTH CLINIC V	3, 143	0	3, 143		88. 04
90. 00 09000 CLI NI C 90. 01 09001 CLI NI C - ORTHO	35, 692 81, 792	0 0	35, 692 81, 792		90. 00
90. 02 09002 CLINI C - PEDS ENT FP	119, 881	0	119, 881		90.01
90. 03 09003 I NTRAVENOUS THERAPY	132, 591	o	132, 591		90. 03
90. 04 09004 PSYCHI ATRY	35, 302	0	35, 302		90. 04
90. 05 09005 CARDI OLOGY	38, 237	0	38, 237		90. 05
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	647, 230	0 0	647, 230		91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS		o _l			92.00
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 UTI LI ZATI ON REVI EW-SNF 116. 00 11600 HOSPI CE	0		0		114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 347, 551	0 0	6, 347, 551		116. 00 118. 00
NONREI MBURSABLE COST CENTERS	0, 547, 551	<u> </u>	0, 547, 551		110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	35, 226	0	35, 226		190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	1, 865	0	1, 865		192. 00
194. 00 07950 DAYCARE-I NFANT/TODDLER	0	0	0		194. 00
194. 01 07951 MOB 194. 02 07952 COMMUNI TY HEALTH	693	0	693		194. 01 194. 02
194.03 07953 ASSISTED LIVING/CAMERON WOODS	093		043		194. 02
194. 04 07954 EDUCATI ON	O	Ö	o		194. 04
194. 05 07955 MARKETI NG	27, 368	O	27, 368		194. 05
194. 06 07956 GUEST MEALS	585	0	585		194. 06
194. 07 07957 OUTSI DE LAUNDRY	0	o o	0		194. 07
194. 08 07958 CANCER CENTER 194. 09 07959 URGENT CARE	0		0		194. 08 194. 09
194. 10 07960 RHC	0		0		194. 09
194. 11 07961 OBGYN	o	o	o		194. 11

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201.00

202.00

201. 00

202. 00

Worksheet B
Part II
Date/Time Prepared:
2/14/2024 10: 45 am ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1315 Peri od: From 10/01/2022 To 09/30/2023 Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 194. 12 07962 TRI NE STUDENT HEALTH 2, 270 2, 270 194. 12 194. 13 07963 OCCUPATI ONAL HEALTH 21, 020 21, 020 194. 13 194. 14 07964 I MMUNI ZATI ON CLINIC 0 194. 14 0 194. 15 07965 FOUNDATI ON 194. 15 13, 566 13, 566 194. 16 07967 CAMERON FAMILY MEDICINE - NORTH 2,831 2, 831 194. 16 0 194. 17 07966 CAMERON FAMILY MEDICINE - FREMONT 12,886 12, 886 194. 17 200.00 Cross Foot Adjustments 200. 00 0 0

0

6, 465, 861

0

0

6, 465, 861

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1315 Peri od: From 10/01/2022 To 09/30/2023 Worksheet B-1 Date/Time Prepared: 2/14/2024 10: 45 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP (SQUARE FEET) Cost Center Description **EMPLOYEE** Reconciliation ADMINISTRATIVE & GENERAL **BENEFITS**

		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
	GENERAL SERVI CE COST CENTERS	1. 00	2.00	4. 00	5A	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	102, 797					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		156, 956	1			2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	842 8, 545		1	-16, 165, 563	70, 945, 757	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	10, 094		1	-10, 100, 503	6, 070, 563	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 062	1	1	0	239, 382	8. 00
9.00	00900 HOUSEKEEPI NG	180			0	1, 998, 754	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	5, 939		528, 896	0	1, 290, 476 0	10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	660	_	481, 975	0	785, 923	
14. 00	1	3, 116	l .	1	0	792, 860	
15. 00 16. 00	01500 PHARMACY	1, 155 0	l ·	1	0	., == .,	
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS		1, 107	846, 914	0	1, 621, 253	16. 00
30. 00		18, 672	18, 672	4, 040, 502	0	7, 726, 164	30. 00
31. 00	· · · · · · · · · · · · · · · · · · ·	1, 180	1	1	0		
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	420	420	12, 622	0	42, 576	43. 00
50. 00	05000 OPERATI NG ROOM	10, 982	10, 982	976, 630	0	2, 989, 307	50.00
51. 00		7, 107			0	1, 631, 580	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 755		I	0	234, 757	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	8, 409 2, 774			0	5, 073, 243 4, 481, 076	
65. 00	06500 RESPI RATORY THERAPY	730			0	1, 710, 973	
65. 01	06501 SLEEP LAB	0			0	147, 937	
66. 00 69. 00	06600 PHYSI CAL THERAPY	6, 312 377			0	2, 442, 248	1
69. 00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON	630		1	0	198, 005 160, 175	1
71. 00	1 1	0		0	0	1, 047, 955	1
72. 00		0	0	0	0	1, 908, 354	
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 CHEMI CAL DEPENDENCY	0	_	0	0	3, 194, 584 0	73. 00 76. 00
76. 01	03480 ONCOLOGY			Ö	0	2, 414, 746	1
76. 02		0	0	0	0	83, 246	76. 02
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	6, 789	364, 441	0	1, 633, 265	88. 00
88. 01	08801 RURAL HEALTH CLINIC II			1	0		
88. 02	1	0	-,	1	0	1, 802, 654	
88. 03	08803 RURAL HEALTH CLINIC IV	0		,	0	979, 403	
88. 04 90. 00	08804 RURAL HEALTH CLINIC V 09000 CLINIC	400		119, 355 108, 067	0	298, 659 199, 421	
90. 01	09001 CLI NI C- ORTHO	0	l .	464, 764	Ō	775, 508	
90. 02	I I	0	5, 980		0	967, 115	
90. 03 90. 04	09003 I NTRAVENOUS THERAPY 09004 PSYCHI ATRY	1, 200		1	0	2, 707, 396 334, 225	
90. 05		0	1, 472	1	0	852, 555	
	09100 EMERGENCY	9, 544	9, 544	2, 315, 266	0	4, 277, 543	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
101. 0	10100 HOME HEALTH AGENCY	0	0	O	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	0 11300 INTEREST EXPENSE						113.00
	D 11400 UTILIZATION REVIEW-SNF D 11600 HOSPICE	0	0		0	0	114. 00 116. 00
118. 0		102, 085	154, 179	29, 665, 334	-16, 165, 563	l e	
	NONREI MBURSABLE COST CENTERS	1	1				
	0 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS PRIVATE OFFICES	580			0		190. 00 192. 00
	007950 DAYCARE-I NFANT/TODDLER				0		194. 00
194.0	1 07951 MOB	0	0	0	0	0	194. 01
	2 07952 COMMUNITY HEALTH 3 07953 ASSISTED LIVING/CAMERON WOODS	0	0	36, 581	0		194. 02
	4 07954 EDUCATION	0	0		0		194. 03 194. 04
	5 07955 MARKETI NG	0	1, 017	195, 862	0	1, 052, 941	194. 05
	6 07956 GUEST MEALS	0	0	27, 837	0		194. 06
	7 07957 0UTSIDE LAUNDRY B 07958 CANCER CENTER	0	0	0	0		194. 07 194. 08
	907959 URGENT CARE			0	0		194. 08
	• •	•	•			•	·

| Period: | Worksheet B-1 | From 10/01/2022 | To 09/30/2023 | Date/Time Prepared:

			T	o 09/30/2023	Date/Time Pre 2/14/2024 10:	pared: 45 am
	CAPITAL REL	ATED COSTS			27 1 17 2021 10.	TO GIII
Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation	ADMI NI STRATI VE	
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS SALARI ES)			
	1.00	2.00	4, 00	5A	5. 00	
194. 10 07960 RHC	0	0	0	0		194. 10
194. 11 07961 OBGYN	0	0	0	0	0	194. 11
194.12 07962 TRINE STUDENT HEALTH	0	0	137, 301	0	202, 591	194. 12
194. 13 07963 OCCUPATI ONAL HEALTH	0	847	247, 140	0	608, 281	
194.14 07964 IMMUNIZATION CLINIC	0	0	0	0	-	194. 14
194. 15 07965 FOUNDATI ON	132	232			434, 854	
194. 16 07967 CAMERON FAMILY MEDICINE - NORTH	0	0	56, 090		268, 484	
194. 17 07966 CAMERON FAMILY MEDICINE - FREMONT	0	0	536, 778	0	1, 258, 651	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	2 501 172	2 074 400	10 70/ 140			201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	3, 591, 172	2, 874, 689	12, 786, 148		16, 165, 563	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	34. 934599	18. 315254	0. 411960		0. 227858	203. 00
204.00 Cost to be allocated (per Wkst. B,			49, 122		567, 872	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 001583		0. 008004	205. 00
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

Provider CCN: 15-1315

Peri od: Worksheet B-1 From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/14/2024 10:45 am

				''	0 09/30/2023	2/14/2024 10:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LI NEN SERVI CE	(HOURS OF S	(PATIENT DAYS)	(FTES)	
		(SQUARE FEET)	(PATIENT DAYS)	ERVIC)	10.00	11 00	
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1.00	00100 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	83, 316					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 062	6, 693				8. 00
9.00	00900 HOUSEKEEPI NG	180	0	6, 253			9. 00
10.00	01000 DI ETARY	5, 939	0	104	6, 173		10.00
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	660		0	0	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 116		36	0	0	
15.00	01500 PHARMACY	1, 155	l .	0	0	0	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
30. 00	O3000 ADULTS & PEDIATRICS	18, 672	6, 073	1, 521	6, 073	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 180			100	0	
43. 00	04300 NURSERY	420			0	0	
43.00	ANCI LLARY SERVI CE COST CENTERS	420	1	1 727	U U	U	43.00
50.00	05000 OPERATI NG ROOM	10, 982	0	710	0	0	50.00
51.00	05100 RECOVERY ROOM	7, 107	0		0	0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 755	104	6	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 409	0	410	0	0	54. 00
60.00	06000 LABORATORY	2,774	0	194	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	730		49	0	0	
65. 01	06501 SLEEP LAB	0	0		0	0	
66. 00	06600 PHYSI CAL THERAPY	6, 312		237	0	0	
69.00	06900 ELECTROCARDI OLOGY	377	0	0	0	0	
69. 01	06901 CARDI AC REHABI LI TATI ON	630	0	0	0	0	69. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
72.00	07300 DRUGS CHARGED TO PATIENTS			96	0	0	1
76. 00	03020 CHEMI CAL DEPENDENCY		0	0	0	0	1
76. 01	03480 ONCOLOGY		_	212	0	0	1
76. 02	03030 DI ABETI C EDUCATI ON		_		0	0	
	OUTPATIENT SERVICE COST CENTERS	·			- 1		
88.00	08800 RURAL HEALTH CLINIC	0	0	164	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	325	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	73	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	175	0	0	
88. 04	08804 RURAL HEALTH CLINIC V	0	0	45	0	0	
90.00	09000 CLI NI C	400	0	55	0	0	
90. 01 90. 02	09001 CLI NI C - ORTHO	0	0	191 153	0	0	
90. 02	09003 I NTRAVENOUS THERAPY	1, 200	0	100	0	0	90.02
90. 04	09004 PSYCHI ATRY	1, 200		0	0	0	1
90. 05	09005 CARDI OLOGY			1	0	0	1
	09100 EMERGENCY	9, 544	0			0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
110.00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
	11600 HOSPI CE			0	0	0	116.00
118.00		82, 604	6, 693	6, 093			118.00
110.00	NONREI MBURSABLE COST CENTERS	02,004	0, 073	0, 073	0, 173	0	1110.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	580	0	0	0	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	l .		0		192.00
	07950 DAYCARE-I NFANT/TODDLER	0	0	0	0		194. 00
194. 01	07951 MOB	0	0	0	0	0	194. 01
	07952 COMMUNI TY HEALTH	0	0	0	0		194. 02
	07953 ASSISTED LIVING/CAMERON WOODS	0	0	0	0		194. 03
	07954 EDUCATI ON	0	0	0	0		194. 04
	07955 MARKETI NG	0	0	0	0		194. 05
	07956 GUEST MEALS	0	0	0	0		194. 06
	07957 OUTSI DE LAUNDRY		0	0	0		194. 07
	07958 CANCER CENTER 07959 URGENT CARE			0	0		194. 08 194. 09
	07959 DRGENT CARE		0	0	0		194. 09
	07961 0BGYN	0	0		0		194. 10
194. 12	07962 TRINE STUDENT HEALTH		Ö	0	ő		194. 12
	07963 OCCUPATI ONAL HEALTH	0	0	0	0		194. 13
			-				·

Peri od: Worksheet B-1 From 10/01/2022 To 09/30/2023 Date/Time Prepared:

						2/14/2024 10:	45 am
Cost Center Description	OPERATI	ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLA	NT LI	INEN SERVICE	(HOURS OF S	(PATIENT DAYS)	(FTES)	
	(SQUARE	FEET) (P	PATIENT DAYS)	ERVI C)			
	7. C	0	8. 00	9. 00	10.00	11. 00	
194. 14 07964 I MMUNI ZATI ON CLINIC		0	0	0	0	0	194. 14
194. 15 07965 FOUNDATI ON		132	0	0	0	0	194. 15
194.16 07967 CAMERON FAMILY MEDICINE - NORT	TH	0	0	25	0	0	194. 16
194.17 07966 CAMERON FAMILY MEDICINE - FREM	IONT	O	0	135	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	r. B, 7,4	53, 789	388, 938	2, 470, 290	2, 156, 934	0	202. 00
Part I)							
203.00 Unit cost multiplier (Wkst. B,	Part I) 89.	464077	58. 111161	395. 056773	349. 414223	0.000000	203. 00
204.00 Cost to be allocated (per Wkst	. B, 5	88, 108	65, 964	28, 378	369, 811	0	204. 00
Part II)							
205.00 Unit cost multiplier (Wkst. B,	Part 7.	058764	9. 855670	4. 538302	59. 907824	0.000000	205. 00
206.00 NAHE adjustment amount to be a	llocated						206. 00
(per Wkst. B-2)							
207.00 NAHE unit cost multiplier (Wks	t. D,						207. 00
Parts III and IV)							

	<u> </u>	ERON MEMORIAL CO				u of Form CMS-255	52-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der CC	CN: 15-1315 F	Period: From 10/01/2022	Worksheet B-1	
				j	Го 09/30/2023	Date/Time Prepar	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	2/14/2024 10: 45	am
	·	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		(DI RECT NRS	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS		
		I NG HR)	REQUIS.)		REVENUE)		
		13. 00	14. 00	15. 00	16.00		
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT				1		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 8. 00	OO7OO OPERATION OF PLANT OO8OO 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	204 544					11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	286, 566	3, 481, 814				13. 00 14. 00
15. 00	01500 PHARMACY	0	22, 352	10, 000			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	5, 835	(215, 065, 040	1	16. 00
30. 00	O3000 ADULTS & PEDIATRICS	95, 367	254, 601		13, 543, 038	2	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 872	254, 001		291, 000		30.00
43.00	04300 NURSERY	0	O	(406, 000	I	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	00.044	400 700		14.040.040		FO 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	23, 944 18, 720	498, 798 0		14, 819, 368 6, 768, 212		50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 736	o	(52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	107, 292	(50, 938, 802		54. 00
60.00	06000 LABORATORY	0	3, 250	(•	60.00
65. 00 65. 01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	24, 999	35, 336 0	(2, 890, 614 1, 251, 746	•	65. 00 65. 01
66. 00	06600 PHYSI CAL THERAPY	39, 506	14, 248	(6, 837, 814		66. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 248	4, 333	(69. 00
69. 01 71. 00	O6901 CARDI AC REHABILITATION O7100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 966	1, 286 1, 852	(652, 243		69. 01 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 908, 354	(1		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	5, 612	2, 359, 052	•	73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	0	0	(1		76. 00
76. 01 76. 02	03480 ONCOLOGY 03030 DI ABETI C EDUCATI ON	0	0 121	(23, 483, 042		76. 01 76. 02
70.02	OUTPATIENT SERVICE COST CENTERS	<u> </u>	,		5, 007,000,		. 0. 02
88. 00	08800 RURAL HEALTH CLINIC	0	38, 637		2, 230, 808	I	88. 00
88. 01 88. 02	O8801 RURAL HEALTH CLINIC II O8802 RURAL HEALTH CLINIC III	0	215, 047 16, 404		4, 399, 449 2, 303, 627		88. 01 88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	27, 130		1, 866, 681	l l	88. 02
88. 04	08804 RURAL HEALTH CLINIC V	0	5, 516	(316, 421	8	88. 04
90.00	09000 CLI NI C	2, 516	17, 444	(580, 000		90. 00
90. 01 90. 02	09001 CLINIC - ORTHO	0	19, 607 20, 358	(390, 248 832, 358	I	90. 01 90. 02
90. 02	09003 I NTRAVENOUS THERAPY	2, 244	12, 910	4, 388			90. 02
90. 04	09004 PSYCHI ATRY	0	697	(259, 628		90. 04
90. 05 91. 00	09005 CARDI OLOGY	11, 977	2, 134	(2, 627, 110	•	90. 05 91. 00
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	59, 471	207, 218	(30, 243, 053		91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	(0	10	01. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		ı			11	13. 00
	11400 UTI LI ZATI ON REVI EW-SNF						14. 00
	11600 HOSPI CE	0	o	(o o		16. 00
118.00		286, 566	3, 440, 760	10, 000	213, 262, 250	11	18. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	ol	(ol o	19	90. 00
	19200 PHYSICIANS PRIVATE OFFICES	O	Ö	(92. 00
	07950 DAYCARE-I NFANT/TODDLER	0	0	(o o		94. 00
	07951 M0B	0	0	(94. 01
	07952 COMMUNITY HEALTH 07953 ASSISTED LIVING/CAMERON WOODS		0	(94. 02 94. 03
	07954 EDUCATION		ő	(ol ol	19	94. 04
		ıl	54	(o o	19	94. 05
194.05	07955 MARKETI NG	0	اً ق		.		
194. 05 194. 06	07956 GUEST MEALS	0	0	(
194. 05 194. 06 194. 07	1 1	0 0	0 0	((19	94. 07
194. 05 194. 06 194. 08 194. 08	07956 GUEST MEALS 07957 OUTSI DE LAUNDRY 07958 CANCER CENTER 07959 URGENT CARE	0 0 0	0 0	(((0 0 0 0 0	19 19 19	94. 06 94. 07 94. 08 94. 09
194. 05 194. 07 194. 08 194. 09 194. 10	07956 GUEST MEALS 07957 OUTSI DE LAUNDRY 07958 CANCER CENTER	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	(0 0 0 0 0 0 0	19 19 19 19	94. 07 94. 08

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1315	Peri od:	Worksheet B-1

COST ALLOCA	TION STATISTICAL BASIS		Trovider of	F	From 10/01/2022 To 09/30/2023	Date/Time Pro	
						2/14/2024 10:	:45 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUI S.)	LI BRARY		
		(DI RECT NRS	(COSTED		(GROSS		
		ING HR)	REQUIS.)		REVENUE)		
		13. 00	14. 00	15. 00	16. 00		
	TRINE STUDENT HEALTH	0	7, 703		0		194. 12
1	OCCUPATI ONAL HEALTH	0	4, 411	(0		194. 13
	IMMUNIZATION CLINIC	0	0	(0		194. 14
194. 15 07965	•	0	1, 420		0		194. 15
	CAMERON FAMILY MEDICINE - NORTH	0	7, 151	(492, 546		194. 16
	CAMERON FAMILY MEDICINE - FREMONT	0	20, 309	(1, 310, 244		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, 024, 048	1, 266, 511	1, 611, 805	1, 992, 790		202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	3. 573515	0. 363750	161. 180500	0. 009266		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	66, 785	194, 947	81, 463	34, 920		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 233053	0. 055990	8. 146300	0. 000162		205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2)						207.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	1		I			T

Health Financial Systems CAN	MERON MEMORIAL CO	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: Worksheet From 10/01/2022 Part I To 09/30/2023 Date/Time		pared:
		T: +1 -		11! +-1	2/14/2024 10:	45 am
		litte	XVIII	Hospi tal Costs	Cost	
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	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS	14, 791, 794		14, 791, 79	4 0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	372, 923		372, 92		0	31. 00
43. 00 04300 NURSERY	285, 292		285, 29		0	43. 00
ANCI LLARY SERVI CE COST CENTERS	200/2/2		200,27	-1		10.00
50. 00 05000 OPERATING ROOM	5, 337, 747		5, 337, 74	7 0	0	50.00
51. 00 05100 RECOVERY ROOM	2, 768, 780		2, 768, 78		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	471, 764		471, 76		0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 654, 521		7, 654, 52		0	54. 00
60. 00 06000 LABORATORY	6, 102, 852		6, 102, 85		0	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 314, 470	0	1 ' '		0	65. 00
65. 01 06501 SLEEP LAB	214, 973	0	214, 97		0	65. 01
66. 00 06600 PHYSI CAL THERAPY	3, 866, 776	0	3, 866, 77		0	66.00
69. 00 06900 ELECTROCARDI OLOGY	313, 111		313, 11		0	69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	270, 145		270, 14		0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 287, 414		1, 287, 41		0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 037, 353		3, 037, 35		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 886, 825		4, 886, 82		0	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	4,000,023		1	0 0	0	76.00
76. 01 03480 0NC0L0GY	3, 266, 311		3, 266, 31	-	0	76. 01
76. 02 03030 DI ABETI C EDUCATION	102, 814		102, 81		0	76. 02
OUTPATIENT SERVICE COST CENTERS	102,014		102, 01	4] 0		70.02
88. 00 08800 RURAL HEALTH CLINIC	2, 104, 931		2, 104, 93	1 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	3, 229, 259		3, 229, 25		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	2, 269, 554		2, 269, 55		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	1, 298, 869		1, 298, 86		0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	389, 427		389, 42		0	88. 04
90. 00 09000 CLINIC	323, 085		323, 08		0	90.00
90. 01 09001 CLI NI C- ORTHO	1, 038, 418		1, 038, 41		0	90. 01
90. 02 09002 CLINIC - PEDS ENT FP	1, 263, 042		1, 263, 04		0	90. 02
90. 03 09003 NTRAVENOUS THERAPY	4, 232, 407		4, 232, 40		0	90. 03
90. 04 09004 PSYCHI ATRY	413, 041		413, 04		0	90. 04
90. 05 09005 CARDI OLOGY	1, 158, 191		1, 158, 19		0	90.05
91. 00 09100 EMERGENCY	6, 968, 506		6, 968, 50		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 581, 516		4, 581, 51		0	
OTHER REIMBURSABLE COST CENTERS	4, 301, 310		4, 301, 31	o _l		72.00
101. 00 10100 HOME HEALTH AGENCY	0		1	o I	0	101. 00
SPECIAL PURPOSE COST CENTERS			1	<u>-</u>		1.51.50
113. 00 11300 NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
116. 00 11600 HOSPI CE	0			ا	Λ	116. 00
200.00 Subtotal (see instructions)	86, 616, 111	0	86, 616, 11	ر 1 ما		200. 00
201.00 Less Observation Beds	4, 581, 516		4, 581, 51			201. 00
202.00 Total (see instructions)	82, 034, 595	0				202. 00
(ı	1, 1, 0,	-1 "	ū	,

Health Financial Systems In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1315 Peri od: Worksheet C From 10/01/2022 Part I 09/30/2023 Date/Time Prepared: 2/14/2024 10:45 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 10, 564, 123 10, 564, 123 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 291,000 291,000 31.00 04300 NURSERY 406,000 43.00 43.00 406,000 ANCILLARY SERVICE COST CENTERS 12, 779, 340 50.00 2,040,028 14, 819, 368 0.360187 0.000000 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 1,061,398 5, 706, 814 6, 768, 212 0.409086 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 280, 600 2, 479 1, 283, 079 0.367681 0.000000 52 00 05400 RADI OLOGY-DI AGNOSTI C 49, 207, 530 1.731.272 50, 938, 802 0.150269 0.000000 54.00 54.00 0 205834 0.000000 60.00 06000 LABORATORY 2, 827, 769 26, 821, 624 29, 649, 393 60 00 65.00 06500 RESPIRATORY THERAPY 1, 485, 197 1, 405, 417 2, 890, 614 0.800685 0.000000 65.00 65.01 06501 SLEEP LAB 1, 251, 746 1, 251, 746 0.171739 0.000000 65.01 1, 369, 935 06600 PHYSI CAL THERAPY 0.000000 66.00 5, 467, 879 6, 837, 814 0.565499 66, 00 69.00 06900 ELECTROCARDI OLOGY 130,887 3, 130, 987 3, 261, 874 0.095991 0.000000 69.00 06901 CARDIAC REHABILITATION 648, 643 0.414178 0.000000 69.01 3,600 652, 243 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 765, 980 11, 943, 595 12, 709, 575 0.101295 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.998060 237, 825 2, 805, 432 72 00 3, 043, 257 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 359, 052 7, 941, 222 10, 300, 274 0.474436 0.000000 73.00 03020 CHEMI CAL DEPENDENCY 0.000000 0.000000 76.00 0 76.00 03480 ONCOLOGY 23, 483, 042 23, 483, 042 0.139092 76.01 0.000000 76.01 0 03030 DIABETIC EDUCATION 76.02 4,720 55, 280 60,000 1.713567 0.000000 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 9, 574 2, 221, 234 2, 230, 808 88.00 88 01 08801 RURAL HEALTH CLINIC II 4 399 449 4, 399, 449 88 01 88.02 08802 RURAL HEALTH CLINIC III 831, 626 1, 472, 001 2, 303, 627 88.02 88. 03 08803 RURAL HEALTH CLINIC IV 5, 209 1, 861, 472 1, 866, 681 88.03 88.04 08804 RURAL HEALTH CLINIC V 2,384 314, 037 316, 421 88.04 09000 CLI NI C 580,000 580, 000 0.557043 0.000000 90.00 0 90.00 90.01 09001 CLINIC- ORTHO 0 390, 248 390, 248 2.660918 0.000000 90.01 09002 CLINIC - PEDS ENT FP 1.517426 90.02 0 832, 358 832, 358 0.000000 90.02 09003 I NTRAVENOUS THERAPY 90 03 0 8, 717, 590 8 717 590 0.485502 0.000000 90 03 1.590895 0.000000 90.04 09004 PSYCHI ATRY 0 259, 628 259, 628 90.04 90.05 09005 CARDI OLOGY 110,888 2, 516, 222 2, 627, 110 0.440861 0.000000 90.05 91.00 09100 EMERGENCY 660, 894 29, 582, 159 30, 243, 053 0.230417 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 75, 597 2, 903, 318 2, 978, 915 1.537981 0.000000 92.00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00

208, 700, 746

208, 700, 746

28, 255, 558

28, 255, 558

236, 956, 304

236, 956, 304

116.00

200. 00

201. 00

202.00

116. 00 11600 HOSPI CE

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

			To 09/30/2023	Date/Time Prep 2/14/2024 10:4	
		Title XVIII	Hospi tal	Cost	, o a
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS	0.000000				F0 00
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65. 00
65. 01 06501 SLEEP LAB	0. 000000				65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000				76. 00
76. 01 03480 ONCOLOGY	0. 000000				76. 01
76. 02 03030 DI ABETI C EDUCATI ON	0. 000000				76. 02
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88. 00
88.01 08801 RURAL HEALTH CLINIC II					88. 01
88. 02 08802 RURAL HEALTH CLINIC III					88. 02
88. 03 08803 RURAL HEALTH CLINIC IV					88. 03
88. 04 08804 RURAL HEALTH CLINIC V					88. 04
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 CLI NI C- ORTHO	0. 000000				90. 01
90. 02 09002 CLINIC - PEDS ENT FP	0. 000000				90. 02
90. 03 09003 I NTRAVENOUS THERAPY	0. 000000				90. 03
90. 04 09004 PSYCHI ATRY	0. 000000				90. 04
90. 05 09005 CARDI OLOGY	0. 000000				90. 05
91. 00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF				[-	114. 00
116. 00 11600 HOSPI CE				[-	116. 00
200.00 Subtotal (see instructions)				:	200. 00
201.00 Less Observation Beds				l	201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITA	AL In	Lieu of Form CMS-2552-10

	ERUN WEWORTAL CO	JIVIIVIUNI IT HUSPI I	IAL	III LI E	u or Form CMS	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 10/01/2022 To 09/30/2023	Worksheet C Part I Date/Time Pre	pared:
					Date/Time Pre 2/14/2024 10:	45 am_
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)	0.00	2.00	4.00	F 00	
INDATIENT DOUTINE CEDVICE COCT CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	14, 791, 794		14, 791, 79	4 0	14, 791, 794	30.00
31. 00 03100 NTENSIVE CARE UNIT	372, 923		372, 92		372, 923	31.00
43. 00 04300 NURSERY	285, 292		285, 29			43.00
ANCI LLARY SERVI CE COST CENTERS	200, 292		200, 29	2 0	200, 292	43.00
50. 00 05000 OPERATING ROOM	5, 337, 747		5, 337, 74	7 0	5, 337, 747	50.00
51. 00 05100 RECOVERY ROOM	2, 768, 780		2, 768, 78		2, 768, 780	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	471, 764		471, 76		471, 764	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 654, 521		7, 654, 52		7, 654, 521	54.00
60. 00 06000 LABORATORY	6, 102, 852		6, 102, 85		6, 102, 852	60.00
65. 00 06500 RESPIRATORY THERAPY	2, 314, 470	0			2, 314, 470	
65. 01 06501 SLEEP LAB	214, 973				214, 973	65. 01
66. 00 06600 PHYSI CAL THERAPY	3, 866, 776		3, 866, 77		3, 866, 776	66.00
69. 00 06900 ELECTROCARDI OLOGY	313, 111	0	313, 11		313, 111	
69. 01 06901 CARDI AC REHABI LI TATI ON	270, 145		270, 14		270, 145	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 287, 414		1, 287, 41		1, 287, 414	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 037, 353		3, 037, 35		3, 037, 353	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 886, 825		4, 886, 82		4, 886, 825	73.00
76. 00 03020 CHEMI CAL DEPENDENCY	1,000,029			0 0	4, 000, 023	76.00
76. 01 03480 ONCOLOGY	3, 266, 311		3, 266, 31	-	3, 266, 311	76. 01
76. 02 03030 DI ABETI C EDUCATION	102, 814		102, 81		102, 814	76. 02
OUTPATIENT SERVICE COST CENTERS	102,011		102,01	<u> </u>	102,011	70.02
88. 00 08800 RURAL HEALTH CLINIC	2, 104, 931		2, 104, 93	1 0	2, 104, 931	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	3, 229, 259		3, 229, 25	1	3, 229, 259	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	2, 269, 554		2, 269, 55		2, 269, 554	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	1, 298, 869		1, 298, 86		1, 298, 869	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	389, 427		389, 42		389, 427	88. 04
90. 00 09000 CLI NI C	323, 085		323, 08		323, 085	
90. 01 09001 CLI NI C- ORTHO	1, 038, 418		1, 038, 41		1, 038, 418	90. 01
90. 02 09002 CLINIC - PEDS ENT FP	1, 263, 042		1, 263, 04	2 0	1, 263, 042	90. 02
90. 03 09003 I NTRAVENOUS THERAPY	4, 232, 407		4, 232, 40	7 o	4, 232, 407	90. 03
90. 04 09004 PSYCHI ATRY	413, 041		413, 04	1 0	413, 041	90. 04
90. 05 09005 CARDI OLOGY	1, 158, 191		1, 158, 19	1 0	1, 158, 191	90. 05
91. 00 09100 EMERGENCY	6, 968, 506		6, 968, 50	6 0	6, 968, 506	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 581, 516		4, 581, 51	6	4, 581, 516	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			0		116. 00
200.00 Subtotal (see instructions)	86, 616, 111	0			86, 616, 111	
201.00 Less Observation Beds	4, 581, 516		4, 581, 51		4, 581, 516	
202.00 Total (see instructions)	82, 034, 595	0	82, 034, 59	5 0	82, 034, 595	202. 00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-10									
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der Co		Peri od: Worksheet C				
					From 10/01/2022	Part I			
					Γο 09/30/2023		pared:		
			T: +1	a VIV	Hooni tal	2/14/2024 10: PPS	45 alli		
		Charges		Hospi tal	PPS				
		1	Charges	T-+-1 (1 (0+ 0+	TEEDA			
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6		TEFRA			
				+ col. 7)	Ratio	Inpatient			
		4 00	7.00	0.00	0.00	Ratio			
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00			
30. 00	03000 ADULTS & PEDIATRICS	10, 564, 123		10, 564, 12	2		30.00		
31. 00	03100 I NTENSI VE CARE UNI T	291, 000		291, 00			31.00		
43. 00	04300 NURSERY	406, 000		406, 00			43. 00		
43.00	ANCILLARY SERVICE COST CENTERS	400,000		400,00	J		43.00		
50. 00	05000 OPERATING ROOM	2, 040, 028	12, 779, 340	14, 819, 36	0. 360187	0.000000	50.00		
						l e			
51.00	05100 RECOVERY ROOM	1, 061, 398	5, 706, 814			0.000000			
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 280, 600	2, 479			0.000000			
54.00	05400 RADI OLOGY - DI AGNOSTI C	1, 731, 272	49, 207, 530			0.000000			
60.00	06000 LABORATORY	2, 827, 769	26, 821, 624	29, 649, 39		0.000000			
65. 00	06500 RESPIRATORY THERAPY	1, 485, 197	1, 405, 417	2, 890, 61		0.000000			
65. 01	06501 SLEEP LAB	0	1, 251, 746			0.000000			
66. 00	06600 PHYSI CAL THERAPY	1, 369, 935	5, 467, 879			0. 000000			
69. 00	06900 ELECTROCARDI OLOGY	130, 887	3, 130, 987	3, 261, 87		0. 000000			
69. 01	06901 CARDI AC REHABI LI TATI ON	3, 600	648, 643			0.000000	1		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	765, 980	11, 943, 595			0.000000			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	237, 825	2, 805, 432	3, 043, 25		0.000000			
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 359, 052	7, 941, 222	10, 300, 27		0.000000			
76. 00	03020 CHEMI CAL DEPENDENCY	0	0		0.000000	0.000000	76. 00		
76. 01	03480 ONCOLOGY	0	23, 483, 042	23, 483, 04	0. 139092	0.000000	76. 01		
76. 02	03030 DIABETIC EDUCATION	4, 720	55, 280	60, 00	1. 713567	0.000000	76. 02		
	OUTPATIENT SERVICE COST CENTERS								
88. 00	08800 RURAL HEALTH CLINIC	9, 574	2, 221, 234	2, 230, 80	0. 943573	0.000000	88. 00		
88. 01	08801 RURAL HEALTH CLINIC II	0	4, 399, 449	4, 399, 44	0. 734014	0.000000	88. 01		
88. 02	08802 RURAL HEALTH CLINIC III	831, 626	1, 472, 001	2, 303, 62	0. 985209	0.000000	88. 02		
88. 03	08803 RURAL HEALTH CLINIC IV	5, 209	1, 861, 472	1, 866, 68	0. 695817	0.000000	88. 03		
88. 04	08804 RURAL HEALTH CLINIC V	2, 384	314, 037	316, 42	1 1. 230724	0.000000	88. 04		
90.00	09000 CLI NI C	o	580, 000	580, 00	0. 557043	0. 000000	90.00		
90. 01	09001 CLI NI C- ORTHO	ol	390, 248	390, 24	2. 660918	0. 000000	90. 01		
90. 02	09002 CLINIC - PEDS ENT FP	0	832, 358			0.000000			
90. 03	09003 I NTRAVENOUS THERAPY	o	8, 717, 590			0. 000000	1		
90. 04	09004 PSYCHI ATRY	0	259, 628			0. 000000			
90. 05	09005 CARDI OLOGY	110, 888	2, 516, 222	2, 627, 11		0. 000000			
91. 00	09100 EMERGENCY	660, 894	29, 582, 159			0. 000000			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	75, 597	2, 903, 318			0. 000000			
72.00	OTHER REIMBURSABLE COST CENTERS	13,371	2, 703, 310	2, 770, 71	1. 337 701	0.00000	72.00		
101 00	10100 HOME HEALTH AGENCY	O	0				101. 00		
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		'	J		101.00		
113. 00 11300 NTEREST EXPENSE 113. 00									
	11600 HOSPI CE		0			l	114. 00 116. 00		
200.00		28, 255, 558	208, 700, 746	236, 956, 30	1		200. 00		
201.00		20, 200, 000	200, 700, 740	230, 730, 30	'		201. 00		
201.00		28, 255, 558	208, 700, 746	236, 956, 30	4	l	202. 00		
202.00	Total (See Histiactions)	20, 233, 330	200, 700, 740	230, 730, 30	T	J	1202.00		

			10 09/30/2023	2/14/2024 10:45 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient	THE MIX	1105pi tui	113
555 551151 55551 Pt 511	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 360187			50.00
51.00 05100 RECOVERY ROOM	0. 409086			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 367681			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 150269			54.00
60. 00 06000 LABORATORY	0. 205834			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 800685			65. 00
65. 01 06501 SLEEP LAB	0. 171739			65. 01
66. 00 06600 PHYSI CAL THERAPY	0. 565499			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 095991			69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 414178			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 101295			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 998060			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 474436			73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000			76. 00
76. 01 03480 ONCOLOGY	0. 139092			76. 01
76. 02 03030 DIABETIC EDUCATION	1. 713567			76. 02
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 943573			88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 734014			88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 985209			88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0. 695817			88. 03
88.04 08804 RURAL HEALTH CLINIC V	1. 230724			88. 04
90. 00 09000 CLI NI C	0. 557043			90. 00
90. 01 09001 CLI NI C- ORTHO	2. 660918			90. 01
90. 02 09002 CLINIC - PEDS ENT FP	1. 517426			90. 02
90. 03 09003 I NTRAVENOUS THERAPY	0. 485502			90. 03
90. 04 09004 PSYCHI ATRY	1. 590895			90. 04
90. 05 09005 CARDI OLOGY	0. 440861			90. 05
91. 00 09100 EMERGENCY	0. 230417			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 537981			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 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 10/01/2022 | Part II | To 09/30/2023 | Date/Time Prepared: | Provider CCN: 15-1315

					0 77 307 2023	2/14/2024 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cos		Operating Cost	
			(Wkst. B, Part			Reduction	
		1, col. 26)	`II col. 26)	Cost (col. 1		Amount	
			,	col . 2)			
		1.00	2.00	3.00	4. 00	5. 00	
/	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 337, 747	726, 912	4, 610, 83	5 0	0	50.00
51.00	05100 RECOVERY ROOM	2, 768, 780	448, 537	2, 320, 243	3	0	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	471, 764	109, 532	362, 232	2 0	0	52. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	7, 654, 521	567, 701	7, 086, 820	0	0	54.00
60.00	06000 LABORATORY	6, 102, 852	210, 749	5, 892, 103	3	0	60.00
65.00	06500 RESPIRATORY THERAPY	2, 314, 470	67, 636	2, 246, 83	1 0	0	65. 00
65. 01	06501 SLEEP LAB	214, 973	49, 318	165, 65!	5 0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	3, 866, 776	414, 729	3, 452, 04	7 0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	313, 111	25, 556	287, 55!	5 0	0	69. 00
69. 01	06901 CARDIAC REHABILITATION	270, 145	40, 275	229, 870	o o	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 287, 414	8, 492	1, 278, 922	2 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 037, 353				0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 886, 825				0	73. 00
	03020 CHEMI CAL DEPENDENCY	0	1			0	76. 00
	03480 ONCOLOGY	3, 266, 311	227, 393	3, 038, 918	3 0	0	76. 01
	03030 DIABETIC EDUCATION	102, 814				0	76. 02
	OUTPATIENT SERVICE COST CENTERS			,			
	08800 RURAL HEALTH CLINIC	2, 104, 931	141, 260	1, 963, 67	0	0	88. 00
	08801 RURAL HEALTH CLINIC II	3, 229, 259				0	88. 01
	08802 RURAL HEALTH CLINIC III	2, 269, 554				0	88. 02
	08803 RURAL HEALTH CLINIC IV	1, 298, 869				0	88. 03
	08804 RURAL HEALTH CLINIC V	389, 427					88. 04
	09000 CLI NI C	323, 085	1				90.00
	09001 CLI NI C- ORTHO	1, 038, 418			-		90. 01
	09002 CLINIC - PEDS ENT FP	1, 263, 042					90. 02
90. 03	09003 I NTRAVENOUS THERAPY	4, 232, 407	132, 591			0	90. 03
	09004 PSYCHI ATRY	413, 041	35, 302			0	90. 04
4	09005 CARDI OLOGY	1, 158, 191	38, 237				90. 05
	09100 EMERGENCY	6, 968, 506	1			1	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 581, 516	1			1	92.00
	OTHER REIMBURSABLE COST CENTERS	4, 301, 310	313, 207	7,000,21	0		72.00
	10100 HOME HEALTH AGENCY	0	0	1 (0	0	101.00
	SPECIAL PURPOSE COST CENTERS			1	<u> </u>		101.00
	11300 I NTEREST EXPENSE			1			113. 00
	11400 UTILIZATION REVIEW-SNF					l e	114. 00
	11600 HOSPI CE	0	0	,	o		116. 00
200.00	Subtotal (sum of lines 50 thru 199)	71, 166, 102	l ~				200.00
200.00	Less Observation Beds	4, 581, 516					200.00
201.00	Total (line 200 minus line 201)	66, 584, 586					201.00
202.00	Total (Title 200 millius Title 201)	00, 304, 300	4, 372, 029	1 02,012,00	1	ı	1202.00

Heal th Financial Systems CAMERON MEMORIAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-1315

						2/14/2024 10: 45	
			Ti tI	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to Charg	e		
		Operating Cost	Part I, column	Ratio (col.	5		
		Reduction	8)	/ col. 7)			
		6. 00	7.00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	5, 337, 747	14, 819, 368	0. 36018	7		50.00
51.00	05100 RECOVERY ROOM	2, 768, 780		1	6		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	471, 764		1			52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 654, 521	50, 938, 802	1			54.00
60. 00	06000 LABORATORY	6, 102, 852		1			60.00
65. 00	06500 RESPI RATORY THERAPY	2, 314, 470		1			65. 00
65. 01	06501 SLEEP LAB	214, 973		1			65. 01
66. 00	06600 PHYSI CAL THERAPY	3, 866, 776		1			66. 00
69. 00	06900 ELECTROCARDI OLOGY	3,800,770					69.00
	l i			1			
69. 01	06901 CARDI AC REHABI LI TATI ON	270, 145					69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 287, 414					71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 037, 353		1			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 886, 825					73. 00
76. 00	03020 CHEMI CAL DEPENDENCY	0	1				76. 00
76. 01	03480 ONCOLOGY	3, 266, 311	23, 483, 042				76. 01
76. 02	03030 DI ABETI C EDUCATI ON	102, 814	60, 000	1. 71356	7		76. 02
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	2, 104, 931			3		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	3, 229, 259	4, 399, 449	0. 73401	4		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	2, 269, 554	2, 303, 627	0. 98520	19		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	1, 298, 869	1, 866, 681	0. 69581	7		88. 03
88. 04	08804 RURAL HEALTH CLINIC V	389, 427	316, 421	1. 23072	4		88. 04
90.00	09000 CLI NI C	323, 085			.3		90.00
90. 01	09001 CLI NI C- ORTHO	1, 038, 418	390, 248	2. 66091	8		90. 01
90. 02	09002 CLINIC - PEDS ENT FP	1, 263, 042			6		90. 02
90. 03	09003 I NTRAVENOUS THERAPY	4, 232, 407					90. 03
90. 04	09004 PSYCHI ATRY	413, 041	259, 628				90. 04
90. 05	09005 CARDI OLOGY	1, 158, 191		1			90. 05
91. 00	09100 EMERGENCY	6, 968, 506					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 581, 516					92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	4, 301, 310	2, 770, 713	1. 33770	' 1		72.00
101 00	10100 HOME HEALTH AGENCY	0		0.00000			101. 00
101.00	SPECIAL PURPOSE COST CENTERS			0.00000	0		1101.00
112 00	11300 INTEREST EXPENSE		Ι	I			112 00
	11300 INTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF						113.00
		_		0 00000	10		114.00
	11600 H0SPI CE	0			IU .		116.00
200.00	1 1	71, 166, 102					200.00
201.00		4, 581, 516		1			201. 00
202.00	Total (line 200 minus line 201)	66, 584, 586	225, 695, 181	[202. 00

Health Financial Systems CAME	EDON MEMORIAL CO	OMMUNITY HOSDIT	ΓΛΙ	In Lio	u of Form CMS	DEE2 10
Health Financial Systems CAME APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	ERON MEMORIAL CO AL COSTS	Provider C	CN: 15-1315	Period: From 10/01/2022 To 09/30/2023	u of Form CMS-2 Worksheet D Part II Date/Time Pre 2/14/2024 10:	pared:
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.			column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	<u>'</u>		•			
50. 00 05000 OPERATING ROOM	726, 912	14, 819, 368	0. 04905	1 436, 243	21, 398	50.00
51.00 05100 RECOVERY ROOM	448, 537	6, 768, 212	0. 06627	1 174, 060	11, 535	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	109, 532	1, 283, 079	0. 08536	7 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	567, 701	50, 938, 802	0. 01114	5 376, 596	4, 197	54.00
60. 00 06000 LABORATORY	210, 749	29, 649, 393	0.00710	8 657, 568	4, 674	60.00
65. 00 06500 RESPIRATORY THERAPY	67, 636	2, 890, 614	0. 02339	8 308, 627	7, 221	65. 00
65. 01 06501 SLEEP LAB	49, 318	1, 251, 746	0. 03939	9 0	0	65. 01
66. 00 06600 PHYSI CAL THERAPY	414, 729				12, 061	66.00
69. 00 06900 ELECTROCARDI OLOGY	25, 556			5 31, 378	246	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	40, 275	652, 243	0.06174	8 1, 684	104	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 492				172	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	122, 124				3, 092	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	72, 104				3, 658	73. 00
76. 00 03020 CHEMI CAL DEPENDENCY	0				0	76. 00
76. 01 03480 0NC0L0GY	227, 393	23, 483, 042			0	76. 01
76. 02 03030 DIABETIC EDUCATION	683				54	76. 02
OUTPATIENT SERVICE COST CENTERS		00,000	0.01100	1,720	<u> </u>	70.02
88. 00 08800 RURAL HEALTH CLINIC	141, 260	2, 230, 808	0.06332	2 0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	154, 065	4, 399, 449	0. 03501	9 0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	80, 304			0	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	10, 791		•		0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	3, 143			3 0	0	88. 04
90. 00 09000 CLI NI C	35, 692				0	90.00
90. 01 09001 CLI NI C- ORTHO	81, 792				0	90. 01
90. 02 09002 CLINIC - PEDS ENT FP	119, 881	832, 358			0	90. 02
90. 03 09003 I NTRAVENOUS THERAPY	132, 591				0	90. 03
90. 04 09004 PSYCHI ATRY	35, 302		•		0	90. 04
90. 05 09005 CARDI OLOGY	38, 237				1, 614	90.05
91. 00 09100 EMERGENCY	647, 230				865	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	515, 269				0	92.00
200.00 Total (lines 50 through 199)	5, 087, 298			3, 198, 308		

| Peri od: | Worksheet D | From 10/01/2022 | Part IV | To 09/30/2023 | Date/Time Prepared: Health Financial Systems CAMERON MEMORIAL COMM
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1315 THROUGH COSTS

					10 09/30/2023	2/14/2024 10:	
			Title	xVIII	Hospi tal	Cost	10 diii
	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 OPERATI NG ROOM	0	0	1	0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	1	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	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
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 DIABETIC EDUCATION	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
88. 03	08803 RURAL HEALTH CLINIC IV	0	0)	0 0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0)	0 0	0	88. 04
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	o	0)	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92. 00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Sy	ystems	CAMERON MEMORIAL COMMUNITY HOSPITAL			In Lieu of Form CM		orm CMS-2552-10	
ADDODEL ONMENT OF L	NDATI ENT /OUTDATI ENT	ANCILLARY CERVICE	OTHER DACC	Dravidar CCN, 1F	101E	Donied.	Words	obset D

Peri od: From 10/01/2022 To 09/30/2023 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV THROUGH COSTS Date/Time Prepared: 2/14/2024 10:45 am Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 819, 368 0.00000050.00 51.00 05100 RECOVERY ROOM 0 0 6, 768, 212 0.000000 51.00 000000000000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 283, 079 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0.000000 54 00 50, 938, 802 54 00 0 60.00 06000 LABORATORY 0 29, 649, 393 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 2, 890, 614 0.000000 65. 01 06501 SLEEP LAB 0 0 1, 251, 746 0.000000 65 01 06600 PHYSI CAL THERAPY 0 0 66.00 6, 837, 814 0.000000 66.00 69.00 06900 ELECTROCARDI OLOGY 3, 261, 874 0.000000 69.00 69.01 06901 CARDIAC REHABILITATION 652, 243 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 12, 709, 575 0.000000 71 00 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 3, 043, 257 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 10, 300, 274 0.000000 73.00 03020 CHEMI CAL DEPENDENCY 76.00 0 0.000000 76.00 0 23, 483, 042 76.01 03480 ONCOLOGY 0 0.000000 76.01 76.02 03030 DIABETIC EDUCATION 0 0 60, 000 0.000000 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 2, 230, 808 0.000000 88. 00 0000000000000000 0 0.000000 08801 RURAL HEALTH CLINIC II 4, 399, 449 88.01 0 88 01 88.02 08802 RURAL HEALTH CLINIC III 2, 303, 627 0.000000 88.02 08803 RURAL HEALTH CLINIC IV 0 0 0.000000 88.03 1,866,681 88.03 08804 RURAL HEALTH CLINIC V 88.04 0 0 316, 421 0.000000 88.04 09000 CLI NI C 0 0.000000 90.00 580,000 90 00 90.01 09001 CLINIC- ORTHO 0 390, 248 0.000000 90.01 09002 CLINIC - PEDS ENT FP 90. 02 832, 358 0.000000 90.02 09003 INTRAVENOUS THERAPY 0 0 0.000000 90.03 8, 717, 590 90.03 0 90.04 09004 PSYCHI ATRY 0 259, 628 0.000000 90.04 90. 05 09005 CARDI OLOGY 2, 627, 110 0.000000 90.05 91.00 09100 EMERGENCY 0 30, 243, 053 0.000000 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 978, 915 92.00 0.000000 200.00 Total (lines 50 through 199) 225, 695, 181 200.00

Health Financial Systems	CAMERON MEMORIAL COMM	UNITY HOSPITAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIE	NT ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1315	Peri od:	Worksheet D

near th	Financiai systems came	RUN WEWORTAL CO	WINDING LA HOSPI	IAL	III LIE	u of Form CWS-	2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provi der CCN: 15-1315		Worksheet D Part IV Date/Time Pre 2/14/2024 10:	
			Title	XVIII	Hospi tal	Cost	
	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	n Charges	Pass-Through	
		(col. 6 ÷ col.	_	Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	436, 243		0 0	0	50. 00
51.00	05100 RECOVERY ROOM	0. 000000	174, 060		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	376, 596		0 0	0	54.00
60.00	06000 LABORATORY	0. 000000	657, 568		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	308, 627		0 0	0	65. 00
65. 01	06501 SLEEP LAB	0. 000000	0		0 0	0	65. 01
66.00	06600 PHYSI CAL THERAPY	0. 000000	198, 858		0 0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	31, 378		0 0	0	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0. 000000	1, 684		0 0	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	257, 631		0 0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	77, 055		0 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	522, 559		0 0	0	1
76. 00	03020 CHEMI CAL DEPENDENCY	0. 000000	0		0	0	1
	03480 ONCOLOGY	0. 000000	0		0 0	0	
	03030 DI ABETI C EDUCATI ON	0. 000000	4, 720		0 0	0	76. 02
	OUTPATIENT SERVICE COST CENTERS		.,			_	1
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	l o	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0. 000000	0		0 0	0	88. 04
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	0	90. 01
90. 02	09002 CLINIC - PEDS ENT FP	0. 000000	0		0 0	o o	
90. 03	09003 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	90. 03
90. 04	09004 PSYCHI ATRY	0. 000000	0		0 0	0	90. 04
90. 05	09005 CARDI OLOGY	0. 000000	110, 888		0 0	0	90. 05
91. 00	09100 EMERGENCY	0. 000000	40, 441		0 0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0, 111		0 0	0	1
200.00	,	3. 222000	3, 198, 308		0 0		200. 00
				•	•		

Health Financial Systems CAME	ERON MEMORIAL C	OMMUNITY HOSPI	ΓAL	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	Provi der CCN: 15-1315		Worksheet D Part V Date/Time Pre 2/14/2024 10:		
		Title	XVIII	Hospi tal	Cost		
			Charges		Costs		
Cost Center Description		PPS Reimbursed		Cost	PPS Services		
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)		
	Worksheet C,	inst.)	Servi ces	Servi ces Not			
	Part I, col. 9	1	Subject To	Subj ect To			
			Ded. & Coins				
	1.00	0.00	(see inst.)	(see inst.)	F 00		
ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00		
50. 00 05000 OPERATING ROOM	0. 360187	1 0	2, 689, 04	3 0	0	50.00	
51. 00 05100 RECOVERY ROOM	0. 409086						
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 367681	1		0 0			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 150269	1		0		54.00	
60. 00 06000 LABORATORY	0. 205834	1	4, 722, 87	-			
65. 00 06500 RESPI RATORY THERAPY	0. 800685		207, 08		0	65.00	
65. 00 06500 RESPIRATORY THERAPY	0. 171739	1					
66. 00 06600 PHYSI CAL THERAPY	0. 171739	1	1, 030, 08			66.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 095991		596, 98			1	
69. 00 06900 ELECTROCARDI OLOGT 69. 01 06901 CARDI AC REHABI LI TATI ON	0. 093991	1	189, 51			1	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 101295		407, 64		0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 101243	1	601, 29		0	1	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 474436	1					
76. 00 03020 CHEMI CAL DEPENDENCY	0. 000000			0 0	0		
76. 01 03480 ONCOLOGY	0. 139092			٦			
76. 02 03030 DI ABETI C EDUCATI ON	1. 713567			0 0			
OUTPATIENT SERVICE COST CENTERS	1. 713307			0 0	·	70.02	
88. 00 08800 RURAL HEALTH CLINIC						88. 00	
88. 01 08801 RURAL HEALTH CLINIC II						88. 01	
88. 02 08802 RURAL HEALTH CLINIC III						88. 02	
88. 03 08803 RURAL HEALTH CLINIC IV						88. 03	
88. 04 08804 RURAL HEALTH CLINIC V						88. 04	
90. 00 09000 CLI NI C	0. 557043	0	94, 34	4 0	0	90.00	
90. 01 09001 CLI NI C- ORTHO	2. 660918	0	199, 70	0 8	0	90. 01	
90. 02 09002 CLINIC - PEDS ENT FP	1. 517426	0	70, 96	0	0	90. 02	
90. 03 09003 I NTRAVENOUS THERAPY	0. 485502	. 0	3, 493, 22	26, 738	0	90. 03	
90. 04 09004 PSYCHI ATRY	1. 590895	0	27, 30	04	0	90. 04	
90. 05 09005 CARDI OLOGY	0. 440861	0	504, 81	0 0	0	90. 05	
91. 00 09100 EMERGENCY	0. 230417	0	4, 374, 48	3, 753	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 537981	0	926, 62	.0	0	92.00	
200.00 Subtotal (see instructions)		0	42, 358, 01	8 30, 584	0	200. 00	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201. 00	
Only Charges							
202.00 Net Charges (line 200 - line 201)		0	42, 358, 01	8 30, 584	0	202. 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 10/01/2022 To 09/30/2023 Part V Date/Time Prepared: 2/14/2024 10:45 am 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.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 968, 558 0 50.00 51.00 05100 RECOVERY ROOM 334, 447 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 632, 890 0 54.00 60. 00 | 06000 | LABORATORY 972, 128 19 60.00 65.00 06500 RESPIRATORY THERAPY 165.812 0 65.00 06501 SLEEP LAB 0 65.01 24, 927 65.01 66.00 06600 PHYSI CAL THERAPY 582, 509 0 66.00 06900 ELECTROCARDI OLOGY 0 69.00 57, 305 69.00 06901 CARDIAC REHABILITATION 78, 493 69 01 69 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 41, 292 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 600, 128 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1,041,436 0 73.00 03020 CHEMI CAL DEPENDENCY 76.00 0 76.00 76.01 03480 ONCOLOGY 1, 140, 248 0 76.01 03030 DIABETIC EDUCATION 76.02 76. 02 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 08803 RURAL HEALTH CLINIC IV 88.03 88.03 08804 RURAL HEALTH CLINIC V 88.04 88 04 90.00 09000 CLI NI C 52, 554 90.00 09001 CLINIC- ORTHO 90. 01 531, 407 90.01 90.02 09002 CLINIC - PEDS ENT FP 107, 686 90.02 0 09003 INTRAVENOUS THERAPY 90.03 1, 695, 966 12, 981 90.03 90.04 09004 PSYCHI ATRY 43, 438 90.04 09005 CARDI OLOGY 90.05 222, 551 90.05 91 00 09100 EMERGENCY 1,007,957 91.00 865 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 425, 124 92.00

12, 726, 856

12, 726, 856

13, 865

13, 865

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

200.00

201.00

202.00

Health Financial Systems CAME	ERON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 10/01/2022 To 09/30/2023		narod:
				10 09/30/2023	2/14/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 663, 591	296, 751	1, 366, 84	0 4, 926	277. 47	30.00
31.00 INTENSIVE CARE UNIT	80, 150		80, 15	100	801.50	31. 00
43. 00 NURSERY	31, 781		31, 78	1 416	76. 40	43.00
200.00 Total (lines 30 through 199)	1, 775, 522		1, 478, 77	1 5, 442		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	78					30.00
31.00 INTENSIVE CARE UNIT	3	2, 405				31. 00
43. 00 NURSERY	35					43.00
200.00 Total (lines 30 through 199)	116	26, 722	1			200. 00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of Form CMS-2552-1								
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D		
					From 10/01/2022 To 09/30/2023	Part II Date/Time Pre	nared·	
					10 077 007 2020	2/14/2024 10:	45 am	
				e XIX	Hospi tal	PPS		
	Cost Center Description	Capi tal	Total Charges			Capital Costs		
			(from Wkst. C,	to Charges	Program	(column 3 x		
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)		
		Part II, col.	8)	2)				
		26)	2.00	2.00	4.00	Г 00		
	ANCILLARY CERVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00		
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	726, 912	14, 819, 368	0.04905	19, 721	967	50.00	
51. 00	05100 RECOVERY ROOM	448, 537						
52. 00	05200 DELIVERY ROOM & LABOR ROOM	109, 532					1	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	567, 701						
60. 00	06000 LABORATORY	210, 749					1	
65. 00	06500 RESPIRATORY THERAPY	67, 636		1		•	65.00	
65. 01	06501 SLEEP LAB	49, 318				l	1	
66. 00	06600 PHYSI CAL THERAPY	414, 729		1		1	66.00	
69. 00	06900 ELECTROCARDI OLOGY	25, 556					69.00	
69. 01	06901 CARDI AC REHABI LI TATI ON	40, 275				l	1	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 492				o o	1	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	122, 124				l o	72. 00	
73. 00	07300 DRUGS CHARGED TO PATIENTS	72, 104				456	1	
76. 00	03020 CHEMI CAL DEPENDENCY	0		1		0	1	
76. 01	03480 ONCOLOGY	227, 393	23, 483, 042			l o	76. 01	
76. 02	03030 DI ABETI C EDUCATION	683					1	
	OUTPATIENT SERVICE COST CENTERS					<u> </u>	1	
88. 00	08800 RURAL HEALTH CLINIC	141, 260	2, 230, 808	0.06332	22 0	0	88. 00	
88. 01	08801 RURAL HEALTH CLINIC II	154, 065	4, 399, 449	0. 03501	9 0	0	88. 01	
88. 02	08802 RURAL HEALTH CLINIC III	80, 304	2, 303, 627	0. 03486	0 0	0	88. 02	
88. 03	08803 RURAL HEALTH CLINIC IV	10, 791	1, 866, 681	0. 00578	31 0	0	88. 03	
88. 04	08804 RURAL HEALTH CLINIC V	3, 143	316, 421	0.00993	0	0	88. 04	
90.00	09000 CLI NI C	35, 692	580, 000	0. 06153	88 0	0	90. 00	
90. 01	09001 CLI NI C- ORTHO	81, 792			0 0	0	1 ,0.0.	
90. 02	09002 CLINIC - PEDS ENT FP	119, 881	832, 358			0	90. 02	
90. 03	09003 I NTRAVENOUS THERAPY	132, 591				0	90. 03	
90. 04	09004 PSYCHI ATRY	35, 302				0	1 ,0.0.	
90. 05	09005 CARDI OLOGY	38, 237				0	90. 05	
91. 00	09100 EMERGENCY	647, 230				917		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	515, 269		1			1 /2.00	
200.00	Total (lines 50 through 199)	5, 087, 298	225, 695, 181	[310, 054	6, 206	200. 00	

	RON MEMORIAL CO				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	S Provider CO		Peri od:	Worksheet D	
				rom 10/01/2022 o 09/30/2023		narod.
			1	0 09/30/2023	Date/Time Pre 2/14/2024 10:	pareu:
-		Ti tl	e XIX	Hospi tal	PPS	45 411
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	ol	0	C	0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	ام	0	0	0	0	31. 00
43. 00 04300 NURSERY	اً ا	0		0	o o	
200.00 Total (lines 30 through 199)		n	ď	il o	ı	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
cost center beserver on	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Days	3 . 601. 0)	l 110graiii bays	
		minus col. 4)				
	4.00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	O	0	4, 926	0.00	78	30.00
31. 00 03100 I NTENSI VE CARE UNI T]	0	100			
43. 00 04300 NURSERY		n	416			
200.00 Total (lines 30 through 199)		0	5, 442		•	200. 00
Cost Center Description	Inpati ent	Ü	0, 112	-	110	200.00
oost conten beschiptron	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
LANDATI ENT. DOUTLAND OFFINA OF COOT OFFITEDO	7.00					

30. 00 31. 00 43. 00

200. 00

30.00 | 03000 | ADULTS & PEDIATRICS | 03100 | O4300 |

| Peri od: | Worksheet D | From 10/01/2022 | Part IV | To 09/30/2023 | Date/Time Prepared: Health Financial Systems CAMERON MEMORIAL COMM
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1315 THROUGH COSTS

Non Physician Non Physician Non Physician Non Physician Anesthetist Cost Non Physician Anesthetist Cost Non Physician Program Program Program Post-Stepdown Adjustments Non Physician Anesthetist Non Physician Program Program Post-Stepdown Adjustments Non Physician Program Prog						10 09/30/2023	2/14/2024 10:	
Anesthetist Cost Program Program Program Adjustments Program Program Adjustments Another Program Program Program Program Adjustments Program Program Program Adjustments Program Program Program Adjustments Program Program Program Program Adjustments Program				Titl	e XIX	Hospi tal		
ANCILLARY SERVICE COST CENTERS 1.00 2A 2.00 3A 3.00		Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
ANCILLARY SERVICE COST CENTERS		·	Anesthetist	Program	Program	Post-Stepdown		
ANCILLARY SERVICE COST CENTERS			Cost	Post-Stepdown		Adjustments		
ANCILLARY SERVICE COST CENTERS								
50.00 05000 0FERATING ROOM 0 0 0 0 0 0 0 0 0			1.00	2A	2. 00	3A	3. 00	
51. 00 05100 RECOVERY ROOM 0 0 0 0 0 0 51. 00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 54. 00 054. 00 054. 00 054. 00 0 0 0 0 0 0 0 0 0								
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 54. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 65. 00 65. 01 06501 SLEEP LAB 0 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67. 00 06900 CLECTROCARDI OLOGY 0 0 0 0 0 0 69. 01 06901 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 69. 01 06901 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 76. 00 03020 CHEMI CAL DEPENDENCY 0 0 0 0 0 0 76. 01 03480 ONCOLOGY 0 0 0 0 0 0 76. 02 03030 DABETI C EDUCATI ON 0 0 0 0 0 88. 01 08801 RURAL HEALTH CLINI C 11 0 0 0 0 0 88. 01 08803 RURAL HEALTH CLINI C 11 0 0 0 0 88. 02 08803 RURAL HEALTH CLINI C 11 0 0 0 0 90. 01 09001 CLINI C 0 0 0 0 90. 01 09001 CLINI C 0 0 0 90. 01 09001 CLINI C 0 0 0 90. 01 09002 CLINI C PEDS ENT FP 0 0 0 90. 01 09002 CLINI C PEDS ENT FP 0 0 90. 01 09002 CLINI C PEDS ENT FP 0 0 0 90. 01 09003 0 0 0 0 90. 01 09002 CLINI C PEDS ENT FP 0 0 0 90. 01 09003 0 0 0 0 0 90. 01 09000 CLINI C PEDS ENT FP 0 0 0 0 90. 01 09003 CLINI C PEDS ENT FP 0 0 0 0 90. 01 09004 CLINI C PEDS ENT FP 0 0 0 0 90. 01 09004			0	0		0	0	
54. 00		05100 RECOVERY ROOM	0	0		0	0	51.00
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65. 00 65. 01 06501 SLEEP LAB 0 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 01 06901 CARDI AC REHABI LI TATI ON 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 76. 00 03020 CHEMI CAL DEPENDENCY 0 0 0 0 0 76. 01 03480 ONCOLOGY 0 0 0 0 0 76. 02 007300 DIABETI C EDUCATI ON 0 0 0 0 76. 02 007400 THERAPY 0 0 0 0 88. 01 08800 RURAL HEALTH CLINI C 1 0 0 0 88. 01 08801 RURAL HEALTH CLINI C 1 0 0 0 0 88. 02 RURAL HEALTH CLINI C 1 0 0 0 0 88. 03 08803 RURAL HEALTH CLINI C 1 0 0 0 0 88. 04 08804 RURAL HEALTH CLINI C V 0 0 0 0 90. 02 09000 CLINI C - PEDS ENT FP 0 0 0 0 0 90. 02 09000 CLINI C - PEDS ENT FP 0 0 0 0 90. 02 09000 CLINI C - PEDS ENT FP 0 0 0 0 90. 02 09000 CLINI C - PEDS ENT FP 0 0 0 0 90. 00 09000 CLINI C - PEDS ENT FP 0 0 0 0 90. 01 09000 CLINI C - PEDS ENT FP 0 0 0 0 90. 01 09000 CLINI C - PEDS ENT FP 0 0 0 0 90. 02 09000 CLINI C - PEDS ENT FP 0 0 0 0 90. 01 00 00 0 0 0 0 90. 02 00 00 0 0 0 90. 02 00 00 0 0 0 0 90. 02 00 00 00 0 0 0 90. 02 00 00 00 00 00 00 90. 02 00 00 00 00 00 90. 02 00 00 00 00 00 90. 02 00 00 00 00 00 90. 02 00 00 00 00 00 90. 02 09000 CLINI C - PEDS ENT FP 0 0 0 0 90. 02 00 00 00 00 00 00 90. 02 00 00 00 00 00 00 90. 02 00 00 00 00 00 00 90. 02 00 00 00 00 00 00 90. 02 00 00 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
65. 01 06501 SLEEP LAB 0 0 0 0 0 0 0 0 0 65. 01 66. 00 6600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 65. 01 66. 00 6600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 66. 00 69. 00 69. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	0	0		0 0	0	60. 00
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 66. 00 69. 00 69. 00 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 69. 00 69. 00 69. 01 06901 CARDIAC REHABILITATION 0 0 0 0 0 0 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65. 00
69. 00	65. 01	06501 SLEEP LAB	0	0		0	0	65. 01
69. 01	66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
72. 00	69. 01	06901 CARDI AC REHABI LI TATI ON	0	0		0 0	0	69. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 76. 00 03020 CHEMI CAL DEPENDENCY 0 0 0 0 0 0 76. 00 76. 01 03480 ONCOLOGY 0 0 0 0 0 0 0 76. 01 76. 02 03030 DI ABETI C EDUCATION 0 0 0 0 0 0 0 76. 01 76. 02 00TPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINIC III 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 88. 03 88. 04 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 0 88. 03 88. 04 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 88. 03 89. 04 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71. 00
76. 00	72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
76. 01	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
76. 02 03030 DI ABETI C EDUCATION 0 0 0 0 0 0 76. 02 OUTPATIENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINI C II 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINI C II I 0 0 0 0 0 0 88. 02 88. 03 08803 RURAL HEALTH CLINI C IV 0 0 0 0 0 0 88. 02 88. 04 08804 RURAL HEALTH CLINI C IV 0 0 0 0 0 0 88. 03 90. 00 09000 CLINI C 0 0 0 0 0 0 0 90. 00 90. 01 09001 CLINI C 0 0 0 0 0 0 0 0 90. 01 90. 02 09002 CLINI C - PEDS ENT FP 0 0 0 0 0 0 0 0 90. 02	76.00	03020 CHEMI CAL DEPENDENCY	0	0		0 0	0	76. 00
S8. 00 OBSOO RURAL HEALTH CLINIC O O O O O O O O O O O O S8. 00	76. 01	03480 ONCOLOGY	0	0		0 0	0	76. 01
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 0 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 88. 03 88. 04 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 88. 03 88. 04 08904 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 0 88. 04 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 02	03030 DIABETIC EDUCATION	0	0		0 0	0	76. 02
88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC II II 0 0 0 0 0 0 0 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 0 0 0 0 0 88. 03 88. 04 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 0 0 88. 04 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 90. 00 90. 01 90. 01 09001 CLINIC - ORTHO 0 0 0 0 0 0 90. 02 90. 02 09002 CLINIC - PEDS ENT FP 0 0 0 0 0 0 0 90. 02		OUTPATIENT SERVICE COST CENTERS						
88. 02 08802 RURAL HEALTH CLINIC III	88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
88. 03	88. 01	08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88. 01
88. 04 08804 RURAL HEALTH CLINIC V	88. 02	08802 RURAL HEALTH CLINIC III	0	0		0 0	0	88. 02
90. 00	88. 03	08803 RURAL HEALTH CLINIC IV	0	0		0	0	88. 03
90. 01 09001 CLI NI C - ORTHO	88. 04	08804 RURAL HEALTH CLINIC V	0	0		0 0	0	88. 04
90. 02 09002 CLINIC - PEDS ENT FP 0 0 0 0 90. 02	90.00	09000 CLI NI C	O	0		0 0	0	90. 00
	90. 01	09001 CLI NI C- ORTHO	O	0		0 0	0	90. 01
	90. 02	09002 CLINIC - PEDS ENT FP	O	0		0 0	0	90. 02
90. 03 09003 I N I RAVENOUS THERAPY 0 0 0 0 0 0 0 90. 03	90. 03	09003 I NTRAVENOUS THERAPY	O	0		0 0	0	90. 03
90. 04 09004 PSYCHI ATRY 0 0 0 0 90. 04	90.04	09004 PSYCHI ATRY	O	0		0 0	0	90. 04
90. 05 09005 CARDI OLOGY 0 0 0 90. 05	90. 05	09005 CARDI OLOGY	o	0		0	0	90. 05
91. 00 09100 EMERGENCY 0 0 0 91. 00	91.00	09100 EMERGENCY	o	0		0 0	0	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 92. 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	200.00	Total (lines 50 through 199)	0	0		0	0	200. 00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-1	
ADDODTI ONMENT OF INDATIENT/OUTDATIENT	ANCILLADY SEDVICE OTHER DASS	Drovi don CCN: 15 1215	Pari ad:	Workshoot D

Peri od: From 10/01/2022 To 09/30/2023 Part IV THROUGH COSTS Date/Time Prepared: 2/14/2024 10:45 am Title XIX Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 819, 368 0.00000050.00 51.00 05100 RECOVERY ROOM 0 0 6, 768, 212 0.000000 51.00 000000000000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 283, 079 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 50, 938, 802 0.000000 54 00 0 60.00 06000 LABORATORY 0 29, 649, 393 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 2, 890, 614 0.000000 65. 01 06501 SLEEP LAB 0 0 1, 251, 746 0.000000 65 01 06600 PHYSI CAL THERAPY 0 66.00 0 6, 837, 814 0.000000 66.00 69.00 06900 ELECTROCARDI OLOGY 3, 261, 874 0.000000 69.00 69.01 06901 CARDIAC REHABILITATION 652, 243 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 12, 709, 575 0.000000 71 00 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 3, 043, 257 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 10, 300, 274 0.000000 73.00 03020 CHEMI CAL DEPENDENCY 76.00 0 0.000000 76.00 0 23, 483, 042 76. 01 03480 ONCOLOGY 0 0.000000 76.01 76.02 03030 DIABETIC EDUCATION 0 0 60, 000 0.000000 76.02 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 2, 230, 808 0.000000 88. 00 0000000000000000 0 0.000000 08801 RURAL HEALTH CLINIC II 4, 399, 449 88.01 0 88 01 88.02 08802 RURAL HEALTH CLINIC III 2, 303, 627 0.000000 88.02 08803 RURAL HEALTH CLINIC IV 0 0.000000 88.03 1,866,681 88.03 08804 RURAL HEALTH CLINIC V 88.04 0 316, 421 0.000000 88.04 09000 CLI NI C 0 580, 000 0.000000 90.00 90 00 09001 CLINIC- ORTHO 09002 CLINIC - PEDS ENT FP 90.01 0 390, 248 0.000000 90.01 90. 02 832, 358 0.000000 90.02 09003 I NTRAVENOUS THERAPY 0 0 8, 717, 590 0.000000 90.03 90.03 0 90.04 09004 PSYCHI ATRY 0 259, 628 0.000000 90.04 90. 05 09005 CARDI OLOGY 2, 627, 110 0.000000 90.05 91.00 09100 EMERGENCY 0 30, 243, 053 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 2, 978, 915 92.00 0.000000 200.00 Total (lines 50 through 199) 225, 695, 181 200.00

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPIT		UNI TY HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1315	Peri od:	Worksheet D

From 10/01/2022 To 09/30/2023 Part IV
Date/Time Prepared: THROUGH COSTS 2/14/2024 10:45 am Title XIX Hospi tal PPS Outpati ent I npati ent Outpati ent Cost Center Description Inpatient Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col. 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 19, 721 0 0 50.00 0 05100 RECOVERY ROOM 51.00 0.000000 10, 648 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 13, 950 0 52.00 52.00 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 52, 158 0 54.00 0 06000 LABORATORY 0 60.00 0.000000 71, 179 60.00 0 65.00 06500 RESPIRATORY THERAPY 0.000000 26, 818 0 65.00 65.01 06501 SLEEP LAB 0.000000 0 0 65.01 0 66.00 06600 PHYSI CAL THERAPY 0.000000 3, 698 66.00 0 0 06900 ELECTROCARDI OLOGY 0.000000 69.00 3, 960 0 69.00 69.01 06901 CARDIAC REHABILITATION 0.000000 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 0 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 65,081 0 73.00 03020 CHEMI CAL DEPENDENCY 0.000000 0 76.00 76.00 0 03480 ONCOLOGY 0 76.01 76 01 0.000000 0 0 03030 DIABETIC EDUCATION 76.02 0.000000 0 0 76.02 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 88.00 08801 RURAL HEALTH CLINIC II 0.000000 Ω 0 0 0 Ω 88 01 88.01 08802 RURAL HEALTH CLINIC III 88.02 0.000000 0 0 88.02 88. 03 08803 RURAL HEALTH CLINIC IV 0.000000 0 88.03 08804 RURAL HEALTH CLINIC V 0 0 88.04 0.000000 0 88.04 0 90 00 09000 CLI NI C 0.000000 0 90.00 0 09001 CLINIC- ORTHO 90.01 0.000000 0 90.01 0 90.02 09002 CLINIC - PEDS ENT FP 0.000000 0 90.02 09003 INTRAVENOUS THERAPY 0.000000 0 0 90.03 90.03 0 90. 04 90.04 09004 PSYCHI ATRY 0.000000 Ω 0 0 90.05 09005 CARDI OLOGY 0.000000 0 90.05 91. 00 09100 EMERGENCY 0.000000 0 91.00 42, 841 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 92.00 310, 054 200.00 Total (lines 50 through 199) 0 200.00

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1315	Peri od: From 10/01/2022	Worksheet D-1	1002 10
			Date/Time Pre 2/14/2024 10:	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

		Title XVIII	Hospi tal	Cost	10 4111
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		6, 073	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			4, 926	
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be		21 of the cost	3, 069	4. 00
5.00	Total swing-bed SNF type inpatient days (including private rooreporting period	olii days) tili odgir becelliber	31 Of the Cost	259	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3°	1 of the cost	803	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		21 -6 -1	21	7.00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	ii days) through beceiiber .	31 Of the Cost	21	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after December 31	of the cost	64	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding s	swing-bed and	888	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	om davs)	91	10. 00
	through December 31 of the cost reporting period (see instruct	ti ons)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		om days) after	284	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00
	through December 31 of the cost reporting period	3 .			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	an (exercarring swring bear as	1937	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		., .		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of th	he cost		18. 00
40.00	reporting period			04/ 05	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of a	the cost	216. 95	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the	e cost	216. 95	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		14, 791, 794	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	14, 791, 794	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting	g period (line	4, 556	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December (x, y)	31 of the cost reporting p	period (line 8	13, 885	25. 00
26. 00	Total swing-bed cost (see instructions)			2, 638, 565	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		12, 153, 229	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed chai	rges)	0	28. 00 29. 00
30. 00	Semi -private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instructi	ions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line	ne 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	12, 153, 229	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see		J	2, 467. 16	38. 00
39. 00	Program general inpatient routine service cost per drem (see			2, 190, 838	
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 190, 838	

	Financial Systems CAME ATION OF INPATIENT OPERATING COST	RON MEMORIAL CO	OMMUNITY HOSPIT	CN: 15-1315 F	Peri od:	eu of Form CMS-2 Worksheet D-1	
					From 10/01/2022 Fo 09/30/2023		
		T		XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 -	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	<u>)</u>	0	42.00
43. 00	INTENSIVE CARE UNIT	372, 923	100	3, 729. 23	30	111, 877	43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3. col. 3	J. Line 200)			1. 00 1, 200, 768	48. 00
48. 01	Program inpatient cellular therapy acquisition			III, line 10,	column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.C	01)(see instruc	tions)		3, 503, 483	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	Wkst D sum	of Parts I and	1 0	50.00
00.00		atront routino	301 11 003 (11 011	mot. b, sum	or rares r and		00.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (fr	om Wkst. D, su	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines!	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost excluding the state of the stat		lated, non-phy	sician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55. 00	Target amount per discharge						55.00
55. 01	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor o	use only)				0.00	55. 01 55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55.					0.00	1
57. 00	, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	irget amount (I	ine 56 minus I	ine 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	or line EE from	the cost rone	rting poriod o	anding 1004	0 00	58. 00 59. 00
37.00	updated and compounded by the market basket)	or title 55 from	i the cost repo	iting period e	ending 1990,	0.00	39.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year c	ost report, up	odated by the	0.00	60. 00
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	hich operating	g costs (line	0	61. 00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payme	ent (see instru	ıcti ons)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	ng period (See	224, 512	64. 00
65.00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Necemb	ner 31 of the c	ost reporting	neriod (See	700, 673	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (Tine	64 prus rine 6	5)(title XVIII	only); for	925, 185	
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
71. 00	Adjusted general inpatient routine service of						71.00
72. 00	Program routine service cost (line 9 x line	•	. /1:= 44 ::	25\			72.00
73. 00 74. 00	Medically necessary private room cost application of the cost application of t		•	ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•		orksheet B, Pa	art II, column		75. 00
7, 00	26, line 45)	0)					7, 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78.00
79. 00	Aggregate charges to beneficiaries for excess			*.	- 1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		cost limitation	(line /8 minu	is line /9)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem rimi)				82. 00
83. 00	Reasonable inpatient routine service costs (ıs)				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in		uns)				84. 00 85. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		· line 2)			1, 857 2, 467. 16	1
89. 00		•	,			4, 581, 516	1
		· ·					

Health Financial Systems CAME	RON MEMORIAL CO	OMMUNITY HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023	Date/Time Pre 2/14/2024 10:	pared: 45 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 663, 591	14, 791, 794	0. 11246	7 4, 581, 516	515, 269	90. 00
91.00 Nursing Program cost	0	14, 791, 794	0.00000	4, 581, 516	0	91.00
92.00 Allied health cost	0	14, 791, 794	0.00000	4, 581, 516	0	92. 00
93.00 All other Medical Education	0	14, 791, 794	0. 000000	4, 581, 516	0	93. 00

	Financial Systems CAMERON MEMORIAL CO		_	u of Form CMS-2	2552-10
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1315	Peri od: From 10/01/2022	Worksheet D-1	
			To 09/30/2023		
		T		2/14/2024 10: 4	<u>45 am</u>
		Title XIX	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				ı
. 00	Inpatient days (including private room days and swing-bed days	avs excluding newborn)		6, 073	1. 00
. 00	Inpatient days (including private room days, excluding swine			4, 926	
. 00	Private room days (excluding swing-bed and observation bed		rivate room days.	0	3. 00
	do not complete this line.			_	
. 00	Semi-private room days (excluding swing-bed and observation	bed days)		3, 069	4. 00
. 00	Total swing-bed SNF type inpatient days (including private	room days) through Decembe	er 31 of the cost	259	5. 00
	reporting period				1
. 00	Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	803	6. 00
	reporting period (if calendar year, enter 0 on this line)				n.
. 00	Total swing-bed NF type inpatient days (including private re	oom days) through Decembe	r 31 of the cost	21	7. 00
	reporting period				
00	Total swing-bed NF type inpatient days (including private re	oom days) after December 3	31 of the cost	64	8. 00
. 00	reporting period (if calendar year, enter 0 on this line)	to the Drogram (evaluding	a out na bod and	78	9. 00
. 00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excluding	g swing-bed and	/8	9.00
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private)	room days)	0	10. 00
, 00	through December 31 of the cost reporting period (see instru		days)	O	10.00
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year,		, , , , , , , , , , , , , , , , , , ,		
2. 00	Swing-bed NF type inpatient days applicable to titles V or 3		te room days)	0	12.00
	through December 31 of the cost reporting period				1
3. 00	Swing-bed NF type inpatient days applicable to titles V or 2			0	13.00
	after December 31 of the cost reporting period (if calendar				n.
	Medically necessary private room days applicable to the Pro	gram (excluding swing-bed	days)		14. 00
	Total nursery days (title V or XIX only)				15.00
6. 00	Nursery days (title V or XIX only)			35	16. 00
7 00	SWING BED ADJUSTMENT	i thursuah Desemb	- E + L		17.00
. 00	Medicare rate for swing-bed SNF services applicable to servi	ices inrough becember 31 (or the cost		17. 00
2 00	reporting period Medicare rate for swing-bed SNF services applicable to servi	icas after December 21 of	the cost		18. 00

		1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1 00	I NPATI ENT DAYS	(072	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	6, 073 4, 926	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	4, 926	3. 00
3.00	do not complete this line.	U	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	3. 069	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	259	5. 00
0.00	report in g period	207	0.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	803	6. 00
	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	21	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	64	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	78	9. 00
10.00	newborn days) (see instructions)	0	10 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period	_	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	416	
16. 00	Nursery days (title V or XIX only)	35	16. 00
47.00	SWING BED ADJUSTMENT		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
10.00	reporting period		10 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	216. 95	19. 00
17.00	report in g peri od	210.75	17.00
20. 00	Medical drate for swing-bed NF services applicable to services after December 31 of the cost	216. 95	20. 00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	14, 791, 794	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 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 31 of the cost reporting period (line 6	0	23. 00
04.00	x line 18)	4 55/	04.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4, 556	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	13, 885	25. 00
23.00	In line 20)	13, 003	25.00
26. 00	Total swing-bed cost (see instructions)	2, 638, 565	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12, 153, 229	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	12 152 220	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	12, 153, 229	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 467. 16	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	192, 438	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	1		

		RON MEMORIAL CO				eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	F	eriod: rom 10/01/2022 o 09/30/2023	Worksheet D-1 Date/Time Pre 2/14/2024 10:	
	Cost Center Description	Total Inpatient Costl	Total	e XIX Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS Program Cost (col. 3 x col.	
		1.00	2.00	3. 00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	285, 292	416	685. 80	35	24, 003	42. 00
43. 00 44. 00 45. 00 46. 00 47. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	372, 923	100	3, 729. 23	3	11, 188	43. 00 44. 00 45. 00 46. 00 47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					103, 769	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				column 1)	331, 398	
50. 00	Pass through costs applicable to Program inpull!	atient routine s	services (from	Wkst. D, sum	of Parts I and	26, 722	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	y services (fro	om Wkst. D, su	m of Parts II	6, 206	51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu	ding capital rel	ated, non-phys	sician anesthe	tist, and	32, 928 298, 470	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
55. 01	Permanent adjustment amount per discharge					l e	55. 01
55. 02	Adjustment amount per discharge (contractor					l	55. 02
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operations)		rget amount (Li	ine 56 minus L	ine 53)	0 0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ng cost and tar	get amount (1)	1110 00 1111 1103 1	1110 00)	ő	58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repor	rting period e	ndi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	m prior year co	ost report, up	dated by the	0.00	60. 00
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of th	ne amount by wh	hich operating	costs (line	0	61. 00
(2.00	enter zero. (see instructions)		J. J	,			(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instrud	ctions)			0	62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Decer	mber 31 of the	cost reportin	g period (See	0	64. 00
65. 00		ts after Decembe	er 31 of the co	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line 6	5)(title XVIII	only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 of	f the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) 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	ty/ICF/IID rout	tine service c	ost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service of		ne 70 ÷ line :	2)			71. 00 72. 00
73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 x lii	ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	ce costs (line	72 + line 73)	•	rt II, column		74. 00 75. 00
76. 00	26, line 45) 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 excess		rovi der records	s)			78. 00 79. 00
80. 00	Total Program routine service costs for compa			*	s line 79)		80.00
81.00	Inpatient routine service cost per diem limi				•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		<i>3)</i>				84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions					1, 857	87. 00
88. 00	Adjusted general inpatient routine cost per		line 2)			2, 467. 16	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				4, 581, 516	89.00

Health Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2022 To 09/30/2023		pared: 45 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	1, 663, 591	14, 791, 794	0. 11246	7 4, 581, 516	515, 269	90.00
91.00 Nursing Program cost	0	14, 791, 794	0.000000	4, 581, 516	0	91.00
92.00 Allied health cost	0	14, 791, 794	0. 000000	4, 581, 516	0	92. 00
93.00 All other Medical Education	0	14, 791, 794	0. 000000	4, 581, 516	0	93. 00

Heal th	Financial Systems CAMERON MEMORIAL COMM	MUNITY HOSPI	ΓAL	In Lie	eu of Form CMS-2	2552-10
	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 10/01/2022 To 09/30/2023	Worksheet D-3	pared:
		Title	: XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1	1 (00 017	1	
	D3000 ADULTS & PEDIATRICS			1, 628, 817		30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY			90, 000		31.00
	NCILLARY SERVICE COST CENTERS					43. 00
	D5000 OPERATING ROOM		0. 36018	37 436, 243	157, 129	50.00
	D5100 RECOVERY ROOM		0. 40908			
	D5200 DELIVERY ROOM & LABOR ROOM		0. 36768		0	52.00
	D5400 RADI OLOGY-DI AGNOSTI C		0. 15026			
	06000 LABORATORY		0. 20583			
	06500 RESPI RATORY THERAPY		0. 80068		247, 113	
	06501 SLEEP LAB		0. 17173		0	65. 01
66.00	06600 PHYSI CAL THERAPY		0. 56549	198, 858	112, 454	66. 00
69.00	D6900 ELECTROCARDI OLOGY		0. 09599	31, 378	3, 012	69. 00
69. 01	D6901 CARDIAC REHABILITATION		0. 41417	1, 684	697	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 10129	257, 631	26, 097	71. 00
72.00	D7200 IMPL. DEV. CHARGED TO PATIENTS		0. 99806	77, 055	76, 906	72. 00
73.00	D7300 DRUGS CHARGED TO PATIENTS		0. 47443	522, 559	247, 921	73. 00
	D3020 CHEMI CAL DEPENDENCY		0.00000	00	0	76. 00
	D3480 ONCOLOGY		0. 13909		0	76. 01
-	D3030 DIABETIC EDUCATION		1. 71356	7 4, 720	8, 088	76. 02
	DUTPAȚIENT SERVICE COST CENTERS					
	D8800 RURAL HEALTH CLINIC		0. 00000		0	88. 00
	D8801 RURAL HEALTH CLINIC II		0. 00000		0	88. 01
	D8802 RURAL HEALTH CLINIC III		0. 00000		0	88. 02
	D8803 RURAL HEALTH CLINIC IV		0.00000		0	88. 03
	D8804 RURAL HEALTH CLINIC V		0.00000		0	88. 04
	D9000 CLINIC		0. 55704		0	90.00
	D9001 CLINIC- ORTHO		2. 66091		0	90. 01
	09002 CLINIC - PEDS ENT FP		1. 51742		0	90. 02
	D9003 I NTRAVENOUS THERAPY		0. 48550 1. 59089			

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48, 886

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92.00 0 1, 200, 768 200. 00

201. 00

202. 00

0. 485502 1. 590895

0.440861

0. 230417

1. 537981

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40, 441

3, 198, 308

3, 198, 308

90. 04 | 09004 | PSYCHI ATRY

91. 00 09100 EMERGENCY

90.05

201.00

202.00

09005 CARDI OLOGY

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

Heal th Financial		ERON MEMORIAL COMMUNITY HOSPIT			eu of Form CMS-2	
INPAILENT ANCILL	ARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od: From 10/01/2022	Worksheet D-3	
		Component (CCN: 15-Z315	To 09/30/2023	Date/Time Pre	
		Ti +Lo	XVIII	Swing Beds - SNF	2/14/2024 10: Cost	45 am
Cost	Center Description	IIIIe	Ratio of Cos		Inpatient	
COST	Center bescription		To Charges	Program	Program Costs	
			10 onal ges	Charges	(col. 1 x col.	
				onal goo	2)	
			1, 00	2. 00	3. 00	
I NPATI ENT	ROUTINE SERVICE COST CENTERS				0.00	
30. 00 03000 ADUL	.TS & PEDIATRICS					30.00
31. 00 03100 I NTE	NSIVE CARE UNIT					31.00
43. 00 04300 NURS	SERY					43.00
ANCI LLARY	SERVI CE COST CENTERS					1
50.00 05000 OPER	ATING ROOM		0. 36018	37 0	0	50.00
51.00 05100 RECC	VERY ROOM		0. 40908	36 0	0	51.00
52. 00 05200 DELI	VERY ROOM & LABOR ROOM		0. 36768	31 0	0	52.00
54. 00 05400 RADI	OLOGY-DI AGNOSTI C		0. 15026	59 26, 118	3, 925	54.00
60. 00 06000 LABO	RATORY		0. 20583	63, 047	12, 977	60.00
65. 00 06500 RESP	PIRATORY THERAPY		0. 80068	8, 419	6, 741	65.00
65. 01 06501 SLEE			0. 17173			
66. 00 06600 PHYS	SI CAL THERAPY		0. 56549	301, 053	170, 245	66.00
	TROCARDI OLOGY		0. 09599	8, 606	826	
	DIAC REHABILITATION		0. 41417		0	
	CAL SUPPLIES CHARGED TO PATIENT		0. 10129	· ·	1, 479	
	DEV. CHARGED TO PATIENTS		0. 99806		0	72. 00
	S CHARGED TO PATIENTS		0. 47443		75, 698	
	II CAL DEPENDENCY		0. 00000		0	
76. 01 03480 ONCC			0. 13909		0	
	BETIC EDUCATION		1. 71356	57 0	0	76. 02
	SERVICE COST CENTERS					1
	L HEALTH CLINIC		0. 00000		0	
	L HEALTH CLINIC II		0. 00000		0	
	L HEALTH CLINIC III		0. 00000		0	
	L HEALTH CLINIC IV		0. 00000		0	
	L HEALTH CLINIC V		0. 00000		0	
90. 00 09000 CLI N			0. 55704		0	
90. 01 09001 CLI N			2. 66091		0	
	IIC - PEDS ENT FP		1. 51742		0	
	AVENOUS THERAPY		0. 48550		0	
90 04 09004 PSYC	HIAIRY		1 59089	05 n	1 0	90 0

0. 485502 1. 590895

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581, 666

90. 03 90. 04 0

90.05

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201. 00 202. 00

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0 92.00

271, 953 200. 00

90. 04 09004 PSYCHI ATRY

91. 00 09100 EMERGENCY

90.05

202.00

09005 CARDI OLOGY

91.00 OPTION EMERGENCY
92.00 OP200 OBSERVATION BEDS (NON-DISTINCT PART
200.00 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)

Hoal th	n Financial Systems CAMERON MEMORIAL COMM	MINITY HOSDI:	TAI	In Lie	eu of Form CMS-	2552 10
	IENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1315	Peri od:	Worksheet D-3	
TIME ATT	TENT ANOTEEART SERVICE COST ALTORITONIMENT	Trovider c	ON. 15 1515	From 10/01/2022		
				To 09/30/2023	Date/Time Pre 2/14/2024 10:	
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00				148, 333		30.00
				9, 000		31.00
43.00				10, 000		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00			0. 3601	-		
			0. 4090			
			0. 3676			
54.00			0. 1502			
60.00			0. 2058			
65.00	06500 RESPI RATORY THERAPY		0. 8006		21, 473	65.00
65. 01	06501 SLEEP LAB		0. 1717	39 0	0	65. 01
66. 00			0. 5654		2, 091	
69. 00	06900 ELECTROCARDI OLOGY		0. 0959	91 3, 960	380	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON		0. 4141	78 0	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1012	95 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 9980	60 0		1 , 2. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 4744	36 65, 081	30, 877	73.00
76.00	03020 CHEMI CAL DEPENDENCY		0.0000	00	0	76. 00
76. 01	03480 ONCOLOGY		0. 1390	92 0	0	76. 01
76. 02	03030 DI ABETI C EDUCATI ON		1. 7135	67 O	0	76. 02

0.943573

0.734014

0. 985209

0.695817

1. 230724

0.557043

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1.590895

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1. 537981

42, 841

310, 054

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0 88.04

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90. 02 90. 03

90.04

90.05

91. 00 92. 00

201. 00

202. 00

0 88.02

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0

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0 92.00 103,769 200.00

9, 871

OUTPATIENT SERVICE COST CENTERS
08800 RURAL HEALTH CLINIC

08801 RURAL HEALTH CLINIC II

08802 RURAL HEALTH CLINIC III

08803 RURAL HEALTH CLINIC IV

08804 RURAL HEALTH CLINIC V

09001 CLINIC- ORTHO 09002 CLINIC - PEDS ENT FP

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)

09003 INTRAVENOUS THERAPY

09000 CLI NI C

09004 PSYCHI ATRY

09005 CARDI OLOGY

91. 00 09100 EMERGENCY

88.00

88. 01

88. 02

88. 03

88. 04

90.00

90.01

90.02

90.03

90.04

90.05

200.00

201.00

202.00

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1315	From 10/01/2022	Worksheet E Part B Date/Time Prepared: 2/14/2024 10:45 am
		T: +1 - \(\lambda \tau \tau \tau \tau \tau \tau \tau \ta	11! +-1	0+

Martical and other services (sent interfractions)		Title XVIII Ho	spi tal	Cost	45 alli
APAT F. METICAL MAD OTHER HEATH IS FERNICES 1.00				1 00	
Bedical and other services (see instructions) 12,740,721 1.00 2.00 Notice and other services reinbursed under OPPS (see instructions) 2.00 2.0		PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
3.00 3.00	1.00			12, 740, 721	1.00
0.001 capaginent (see Instructions)		· · · · · · · · · · · · · · · · · · ·		1	•
				1	•
Infer the hospital specific payment to cost ratio (see instructions)				1	•
		· · · · · · · · · · · · · · · · · · ·		1	•
1.700 Transitional corridor payment (see instructions) 0 8.00 0.00	6.00	Line 2 times line 5			1
Ancil lary service other pass through costs from West. D. Pt. IV, col. 13, line 200 0 9,00				l l	1
10.00 Organ acquisitions 12,740,721 11.00 Total coext (sum of lines 1 and 10) (sae instructions) 12,740,721 11.00 Total coext (sum of lines 1 and 10) (sae instructions) 12,740,721 11.00 Total coext (sum of lines 1 and 10) (sae instructions) 12,00,740,721 11.00 12.00 12.00 12.00 13.00 13.00 13.00 14.00 13.00				1	1
1.00				1	1
Reasonable Charges				1	1
12.00 Ancillary service charges 0 12.00 13.00 17.01 17.0					
13.00 Organ acquisition charges (crom Wist. D-4, Pt. III, col. 4, line 69)	12 00			1 0	12.00
14.00				1	•
Customary charges Cust				1	•
16.00 ABOUNTS that would have been realized from patients Iable for payment for services on a chargebasis 0 16.00 had such payment been made in accordance with 42 CFR \$413.13(0) 0.000000 17.00 17.00 18.		Customary charges			
had such payment been made in accordance with 42 CFR \$413.13(e)					•
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	16.00		argebasis	0	16.00
18.00 Total customary charges (see instructions) 0 18.00 19.00 18.	17. 00			0.000000	17. 00
instructions	18. 00			0	18. 00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 12.868, 128 21.00	19. 00		(see	0	19. 00
Instructions	20.00		(500	0	20.00
22.00 Interna and residents (see instructions) 0.20.00 0.20.00 10tal prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 0.24.00	20.00		(366		20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.23.00	21. 00			12, 868, 128	21. 00
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 24. 00 COMPUTATION OF REINBURSHEMENT STITLEMENT		· · · · · · · · · · · · · · · · · · ·		1	1
COMPUTATION OF RELIMBURSEMENT SETTLEMENT 9,856 25,00					•
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 99, 856 25.00	24.00				24.00
27. 00 Subtotal [(I) Ines 21 and 24 minus the sum of i) Ines 25 and 26) plus the sum of i Ines 22 and 23] (see 5,372,197 27. 00 Instructions) 0 28. 00 28	25. 00			99, 856	25. 00
Instructions					
28. 00 Direct graduate medical education payments (From Wkst. E-4, Line 50) 28. 00 28	27. 00		B] (see	5, 372, 197	27. 00
28.50 REH facIlity payment amount 28.50 29.90 ESRD direct medical education costs (from Wkst. E-4, line 36) 0.99.00 0.90	28 00			0	28 00
Subtotal (sum of lines 27, 28, 28.50 and 29)					1
31 .00 Subtotal (line 30 minus line 31)				1	1
Subtotal (line 30 minus line 31)					ı
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 505,302 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 505,302 34.00 36.00 Allowable bad debts (see instructions) 505,302 36.00 37.00 Subtotal (see instructions) 505,302 36.00 37.00 Subtotal (see instructions) 5,698,992 37.00 38.00 MSP-LCC reconciliation amount from PS&R 5,698,992 37.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 5,997 0 0 0 0 0 0 0 0 0					1
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	32.00			3, 370, 340	32.00
35. 00 Adjusted reimbursable bad debts (see instructions) 328, 446 35, 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 505, 302 36. 00 37. 00 Subtotal (see instructions) 5,698,992 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 MSP-LCC reconciliation amount (see instructions) 0 39. 00 39.		Composite rate ESRD (from Wkst. I-5, line 11)			
36. 00 Al Jowable bad debts for dual eligible beneficiaries (see instructions) 505, 302 36, 00 37. 00 Subtotal (see instructions) 5,698,992 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECLEY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 50 39. 75 N95 respirator payment adjustment amount (see instructions) 0 39. 75 39. 97 Demonstration payment adjustment amount before sequestration 0 39. 97 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 40. 03 Sequestration in adjustment (see instructions) 0 39. 99 40. 01 Sequestration adjustment (see instructions) 113, 980 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment (see instructions) 40. 02 40. 02 40. 02 The rinter im payments 6, 344, 471 41. 00 41. 00 Interim payments 6, 344, 471 <					
37.00 Subtotal (see instructions) 5,698,992 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.97 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.90 39.00				1	•
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50					
39.50 Pi oneer ACO demonstrati on payment adjustment (see instructions) 39.50 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.75 39.97 Demonstration payment adjustment amount before sequestration 0 39.75 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 5.698,992 40.00 40.01 Sequestration adjustment (see instructions) 5.698,992 40.00 40.01 Sequestration adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 6,344,471 41.00 42.00 Tentative settlement (for contractors use only) 41.01 42.00 Tentative settlement-PARHM (for contractor use only) 42.00 43.00 Bal ance due provider/program (see instructions) 43.01 43.01 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 45.01 45					
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39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 5, 698, 992 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 6, 344, 471 41. 00 41. 01 Interim payments-PARHM 41. 01 41. 01 42. 01 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Bal ance due provider/program (see instructions) -759, 459 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 415. 2 TO BE COMPLETED BY CONTRACTOR 0 90. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 93. 00					1
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40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 94. 00 93. 00 95. 00 Time Value of Money (see instructions) 96. 00 97. 00 97. 00 97. 00 Time Value of Money (see instructions) 98. 00 Time Value of Money (see instructions) 99. 00 99. 00 90. 00					•
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42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions)	41. 01	Interim payments-PARHM			
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)				0	1
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44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00		, , , ,		-139, 439	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00		, , , , , , , , , , , , , , , , , , , ,	· 1,	0	1
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00		§115. 2			
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	00.00			_	00.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00					
93.00 Time Value of Money (see instructions) 0 93.00				1	•
94.00 Total (sum of lines 91 and 93) 0 94.00	93. 00	Time Value of Money (see instructions)		0	93. 00
	94. 00	Total (sum of lines 91 and 93)		0	94.00

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lie	of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1315	Peri od:	Worksheet E	
			From 10/01/2022	Part B	
			To 09/30/2023	Date/Time Pre	
				2/14/2024 10:	45 am_
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200 00 Part B Combined Billed Days				0	200 00

mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.633,791 6,344,471 1.00 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate
1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 2,633,791 6,344,471 1.00 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate
submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate
services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate 3.00
write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate
3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate
amount based on subsequent revision of the interim rate
for the cost reporting period. Also show date of each
payment. If none, write "NONE" or enter a zero. (1)
Program to Provider
3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01
3.02 0 0 3.02
3.03 0 0 3.03
3.04
3.05
Provider to Program
3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50
3.51 0 0 3.51
3.52
3.53
3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99
3.50-3.98)
4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,633,791 6,344,471 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 Provider
5.01 TENTATI VE TO PROVI DER O 5.01
5.02
5.03
Provi der to Program
5.50 TENTATI VE TO PROGRAM OI 0 5.50
5.51
5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99
5. 50-5. 98)
6.00 Determined net settlement amount (balance due) based on 6.00
the cost report. (1)
6.01 SETTLEMENT TO PROVIDER 492,040 0 6.01
6.02 SETTLEMENT TO PROGRAM 0 759, 459 6.02
7.00 Total Medicare program Liability (see instructions) 3,125,831 5,585,012 7.00
Contractor NPR Date
Number (Mo/Day/Yr)
0 1.00 2.00
8.00 Name of Contractor WISCONSIN PHYSICIAN SERVICES 08001 8.00

ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Component (1	Period: From 10/01/2022 Fo 09/30/2023		pared:
		Ti tl e	XVIII	Swing Beds - SNF		45 alli
			t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		912, 14		0	1
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		(0	0	2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3. 00
	payment. If none, write "NONE" or enter a zero. (1)			1		-
2 01	Program to Provider ADJUSTMENTS TO PROVIDER				0	3. 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER					1
3. 02					0	
3. 04					0	
3. 05					0	1 0.0.
0.00	Provider to Program			21		0.00
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3.51				o	0	3. 51
3.52				o	0	3. 52
3.53				D	0	3. 53
3.54			(D	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(D	0	3. 99
	3. 50-3. 98)				_	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		912, 14	4	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
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVIDER			D	0	
5. 02				D	0	
5. 03			(0	0	5. 03
F F0	Provi der to Program				0	0
5. 50 5. 51	TENTATI VE TO PROGRAM				0	
5. 51					0	1
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	0.02
3. 77	5. 50-5. 98)		'		0	3. 77
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		268, 86	1	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		200,00	,	0	
7. 00	Total Medicare program liability (see instructions)		1, 181, 00	3	0	
,, 55			., ., ., .,	Contractor	NPR Date	7. 30

Number 1.00

08001

WISCONSIN PHYSICIAN SERVICES

(Mo/Day/Yr) 2.00

8. 00

8.00 Name of Contractor

Health Financial Systems CAMERON MEMORIAL COMMUNITY HOSPITAL In Lieu of					2552-10
CALCUL	From 10/01/2022 To 09/30/2023				epared:
				2/14/2024 10:	45 am_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00 Medicare days (see instructions)				2. 00	
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	4.00 Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c		Wkst. S-2. Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00					9. 00
10.00					10.00
10.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	(See Thisti deti ons)			1 10.00
20.00	Initial/interim HIT payment adjustment (see instructions)				30.00
					31. 00
	31.00 Other Adjustment (specify)				31.00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1315		Worksheet E-2
			From 10/01/2022	
		Component CCN: 15-7315	To 00/30/2023	Data/Tima Dranarad

		Component CCN: 15-Z315	To 09/30/2023	Date/Time Pre 2/14/2024 10:	
		Title XVIII	Swing Beds - SNF		45 alli
		THE ATTE	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)		934, 437	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D,	274, 673	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir	ng-bed pass-through, see			
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4. 00
5. 00	instructions) Program days		375	0	5. 00
6. 00	Interns and residents not in approved teaching program (see in	etructione)	3/3	0	6.00
7. 00	Utilization review - physician compensation - SNF optional met		0	U	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	ined only	1, 209, 110	0	8. 00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		1, 209, 110	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11. 00
	professional services)	, ,			
12.00	Subtotal (line 10 minus line 11)		1, 209, 110	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	4, 000	0	13. 00
	for physician professional services)				
14. 00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (see instructions)		1, 205, 110	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	O		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	17. 00
17. 00	Adjusted reimbursable bad debts (see instructions)		0	0	17. 00
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	Ö	18. 00
19. 00	Total (see instructions)	uo:. 03)	1, 205, 110	0	19. 00
19. 01	Sequestration adjustment (see instructions)		24, 102	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	19. 25
20.00	Interim payments		912, 144	0	20. 00
20. 01	Interim payments-PARHM				20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	21. 00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	268, 864	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod under the 21st			200.00
	Cost Reimbursement				
201 00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line			201. 00
201.00	66 (title XVIII hospital))				2011.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3. col. 3. line	,		202. 00
	200 (title XVIII swing-bed SNF))				
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the currer	it 5-year demonst	ration	
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see instr				207. 00
208. OC	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	z, col. I, sum of lines			208. 00
200 00	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instruc	rtions)			209. 00
	Reserved for future use	, ci olis <i>j</i>			210. 00
210.00	Comparision of PPS versus Cost Reimbursement				2 10.00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
5 . 5 .	instructions)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
			·		•

Health Financial Systems	CAMERON MEMORIAL COMM	JNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1315	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part V Date/Time Prepared: 2/14/2024 10:45 am
		Ti +Lo YVIII	Hospi tal	Cost

	Title XVIII Hospital	2/14/2024 10:4 Cost	45 am_
		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT	1.00	
1. 00	Inpatient services	3, 503, 483	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2. 00
3.00	Organ acqui si ti on	0	3. 00
3.01	Cellular therapy acquisition cost (see instructions)	0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)	3, 503, 483	4. 00
5.00	Primary payer payments	4, 194	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3, 534, 324	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges	1	
7.00	Routine service charges	0	7. 00
8. 00 9. 00	Ancillary service charges	0	8. 00 9. 00
10.00	Organ acquisition charges, net of revenue Total reasonable charges		9. 00 10. 00
10.00	Customary charges	0	10.00
11. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	12. 00
	had such payment been made in accordance with 42 CFR 413.13(e)		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	15.00
4, 00	instructions)		4, 00
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16. 00
17. 00	instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	3, 534, 324	
20. 00	Deductibles (exclude professional component)	352, 334	20. 00
21.00	Excess reasonable cost (from line 16)	0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)	3, 181, 990	22. 00
23. 00	Coi nsurance	800	23. 00
24.00	Subtotal (line 22 minus line 23)	3, 181, 190	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12, 974	
26. 00	Adjusted reimbursable bad debts (see instructions)	8, 433	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12, 974	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	3, 189, 623	
29. 00 29. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	29. 00 29. 50
29. 30	Recovery of accelerated depreciation.		29. 30
29. 99	Demonstration payment adjustment amount before sequestration		29. 99
30. 00	Subtotal (see instructions)	3, 189, 623	30.00
30. 01	Sequestration adjustment (see instructions)	63, 792	
30. 02	Demonstration payment adjustment amount after sequestration	0	30. 02
30. 03	Sequestration adjustment-PARHM		30. 03
31.00	Interim payments	2, 633, 791	31.00
31. 01	Interim payments-PARHM		31. 01
32.00	Tentative settlement (for contractor use only)	0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)		32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	492, 040	33. 00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34. 00
	[3110.2	1	

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1315	Peri od: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/14/2024 10:45 am

			10 09/30/2023	2/14/2024 10:	
		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX	K SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)				4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges		0, 550		
8.00	Routi ne servi ce charges		36, 553		8. 00
9.00	Ancillary service charges		310, 054	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		346, 607	0	12. 00
13. 00	Amount actually collected from patients liable for payment for	s sorvi cos on a chargo	0	0	13. 00
13.00	basis	ser vices on a charge		U	13.00
14. 00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
00	a charge basis had such payment been made in accordance with			· ·	
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	3 (.,	0. 000000	0. 000000	15. 00
16.00	Total customary charges (see instructions)		346, 607	0	
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	346, 607	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide		0	22 00
23. 00	Other than outlier payments Outlier payments		126, 306	0	
24. 00	Program capital payments		0	U	24.00
25. 00	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	1
27. 00	Subtotal (sum of lines 22 through 26)		126, 306	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		120, 300	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		126, 306	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1=27 222		
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		0	0	32. 00
33.00	Coinsurance			0	33. 00
34.00	Allowable bad debts (see instructions)			0	34. 00
35.00	Utilization review				35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
38. 00	Subtotal (line 36 ± line 37)			0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0 126, 045		39. 00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)			0	
41. 00	Interim payments	126, 045	0		
42. 00	Balance due provider/program (line 40 minus line 41)	0	0		
43. 00	Protested amounts (nonallowable cost report items) in accordar	ice with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

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

Provider CCN: 15-1315

Peri od: From 10/01/2022 To 09/30/2023 Date/Ti me Prepared: 2/14/2024 10:45 am

In Lieu of Form CMS-2552-10

——————————————————————————————————————					2/14/2024 10:	45 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	10 700 120	1 0		1 0	1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	19, 799, 139	0	_	1	
3.00	Notes recei vabl e			_	0	3.00
4. 00	Accounts recei vabl e	11, 347, 875	o o	o o	l o	
5.00	Other recei vable	1, 471, 166		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	1, 476, 431		0	0	
8.00	Prepai d expenses	1, 474, 958		0	0	
9. 00 10. 00	Other current assets Due from other funds	0	0	_	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	35, 569, 569	1	_	1	11.00
11.00	FIXED ASSETS	33, 307, 307				11.00
12.00	Land	2, 019, 703	0	0	0	12. 00
13.00	Land improvements	0	0	0		13. 00
14. 00	Accumulated depreciation	0	0	0	1	14. 00
15.00	Bui I di ngs	61, 381, 451	1	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-35, 061, 466	0	0	0	16. 00 17. 00
18. 00	Accumulated depreciation			_	0	18.00
19. 00	Fi xed equipment			_	0	19.00
20. 00	Accumulated depreciation	0	Ö	Ō	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	21, 206, 348	1	0	0	23. 00
24. 00	Accumulated depreciation	-17, 026, 027	0	0	0	24. 00
25. 00	Mi nor equipment depreciable	0		0	0	25. 00 26. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets			0	0	27.00
28. 00	Accumulated depreciation			0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	838, 453	1	_	l o	29. 00
30.00	Total fixed assets (sum of lines 12-29)	33, 358, 462	2 0	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	36, 624, 445		_	-	1
32.00	Deposits on leases	0	0	_	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	10, 085, 715	0	_	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	46, 710, 160			0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	115, 638, 191	1	_	Ö	36.00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	3, 846, 830	0	0	_	37. 00
38. 00	Salaries, wages, and fees payable	5, 258, 402	1	0		38. 00
39. 00	Payroll taxes payable	66, 342	1	0	0	
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	2, 196, 835	0	0	0	40. 00 41. 00
41.00	Accelerated payments			0	0	42.00
43. 00	Due to other funds		Ó	0	0	43. 00
44. 00	Other current liabilities	455, 527	Ö	Ō	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	11, 823, 936	0	0	0	45. 00
	LONG TERM LIABILITIES	1				
46. 00	Mortgage payable	0	0	_	-	
47. 00	Notes payable	0	0	_	-	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	43, 626, 027) '	_		48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	43, 626, 027		_		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	55, 449, 963				51.00
	CAPI TAL ACCOUNTS		•			1
52.00	General fund balance	60, 188, 228	3			52. 00
53. 00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant		1		0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
_0.00	replacement, and expansion					-3.55
59. 00	Total fund balances (sum of lines 52 thru 58)	60, 188, 228	0	0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	115, 638, 191	0	0	0	60. 00
	[59]	I	1	l	I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1315

			T	o 09/30/202	3 Date/Time Prep 2/14/2024 10:4	
	General	Fund	Special Pu	rpose Fund	Endowment Fund	45 4111
	1.00	2. 00	3. 00	4. 00	5. 00	
1.00 Fund balances at beginning of period		53, 849, 695			0	1.00
2.00 Net income (loss) (from Wkst. G-3, li	ne 29)	6, 338, 538				2.00
3.00 Total (sum of line 1 and line 2)		60, 188, 233			0	3.00
4. 00 ROUNDI NG	0		0		0	4. 00
5. 00	0		0		0	5. 00
6.00	0		0		0	6.00
7.00	0		J		0	7.00
8.00	0		0		0	8.00
9.00 10.00 Total additions (sum of line 4-9)	٩	0	U			9. 00 10. 00
` '		40 100 222				11.00
11.00 Subtotal (line 3 plus line 10) 12.00 ROUNDING		60, 188, 233	0		0	12.00
13. 00 ROUNDING	5		0			12.00
14. 00	0		0			14.00
15. 00	١		0			15. 00
16. 00	١		0		0	16.00
17. 00	١		0			17. 00
18.00 Total deductions (sum of lines 12-17)	i i	5	0			18.00
19.00 Fund balance at end of period per bal		60, 188, 228			0	19.00
sheet (line 11 minus line 18)		00, 100, 220				17.00
10.1000 (1.100 1.10	Endowment Fund	PI ant	Fund			
	6. 00	7. 00	8. 00			
1.00 Fund balances at beginning of period	0		0			1. 00
2.00 Net income (loss) (from Wkst. G-3, li	ne 29)					2. 00
3.00 Total (sum of line 1 and line 2)	0		0			3. 00
4. 00 ROUNDI NG		0				4. 00
5. 00		0				5. 00
6. 00		0				6. 00
7. 00		0				7. 00
8. 00		0				8. 00
9. 00		0				9. 00
10.00 Total additions (sum of line 4-9)	0		0			10.00
11.00 Subtotal (line 3 plus line 10)	0	_	0			11.00
12. 00 ROUNDI NG		0				12.00
13. 00		0				13. 00
14. 00		0				14. 00
15. 00						
		U				15. 00
16. 00		0				16. 00
16. 00 17. 00		0	_			16. 00 17. 00
16.00 17.00 18.00 Total deductions (sum of lines 12-17)		0	0			16. 00 17. 00 18. 00
16. 00 17. 00		0	0			16. 00 17. 00

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 CAMERO

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

			o 09/30/2023	Date/lime Pre 2/14/2024 10:	
	Cost Center Description	Inpati ent	Outpati ent	Total	TO GIII
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	10, 970, 123		10, 970, 123	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	C		0	5. 00
6.00	Swing bed - NF	C		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)	10, 970, 123		10, 970, 123	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	291, 000		291, 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 UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	291, 000		291, 000	16. 00
47.00	11-15)	44 0/4 40		44 0/4 400	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	11, 261, 123	l l	11, 261, 123	17. 00
18. 00	Ancillary services	16, 034, 754		201, 171, 261	18. 00
19. 00	Outpati ent servi ces	110, 888	1 1	12, 465, 341	19. 00
20. 00	RURAL HEALTH CLINIC	9, 574	1 1	2, 230, 808	
20. 01	RURAL HEALTH CLINIC II	0	4, 275, 352	4, 275, 352	•
20. 02	RURAL HEALTH CLINIC III	831, 626		2, 303, 627	20. 02
20. 03	RURAL HEALTH CLINIC IV	5, 209		1, 866, 681	20. 03
20. 04	RURAL HEALTH CLINIC V	2, 384	I I	316, 421	20. 04
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	C	0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)			0	25. 00
26. 00	HOSPI CE			1 000 700	26. 00
27. 00	NON REI MBURSABLE PROFESSI ONAL FEES		1,002,770	1, 802, 790	
27. 01 28. 00		549, 603		5, 998, 950	27. 01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	28, 805, 161	214, 887, 193	243, 692, 354	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		98, 827, 185		29. 00
30. 00	ADD (SPECIFY)		1 1		30.00
31. 00	ADD (SECTED)		1		31. 00
32. 00			1		32. 00
33. 00			I I		33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		O		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00			1		39. 00
40. 00					40.00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)				42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	98, 827, 185		43. 00
	to Wkst. G-3, line 4)		75,527,100		
		•			•

	Financial Systems CAMERON MEMORIAL ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet G-3	
STATE	ENT OF REVENUES AND ENTENUES	110V1 del 20M. 10 1010	From 10/01/2022		
			To 09/30/2023	Date/Time Pre 2/14/2024 10:	
				27 147 2024 10.	45 4111
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		243, 692, 354	1. 00
2.00	Less contractual allowances and discounts on patients' ac	counts		146, 263, 080	2. 00
3.00	Net patient revenues (line 1 minus line 2)			97, 429, 274	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		98, 827, 185	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	l .		-1, 397, 911	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			361, 086	6. 00
7.00	Income from investments			984, 773	
8.00	Revenues from telephone and other miscellaneous communica	ation services		0	8. 00
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
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			310, 158	
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to oth	ner than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	
18.00	Revenue from sale of medical records and abstracts			0	
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			838, 018	•
24. 01	340B CONTRACT REVENUE			572, 649	
24. 02 24. 03	PHYLSICAN INCENTIVE PAYMENTS			188, 485	
24. 03	UNREALIZED GAIN ON INVESTMENTS COVID-19 PHE Funding			3, 630, 134 859, 143	
	Total other income (sum of lines 6-24)			7, 744, 446	
	Total (line 5 plus line 25)			6, 346, 535	
	LOSS ON DISPOSAL OF PROPERTY				27 00

7, 997

7, 997 28. 00 6, 338, 538 29. 00

27.00

0 27.01

27. 00 LOSS ON DISPOSAL OF PROPERTY

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

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
		From 10/01/2022	
	Component CCN: 15-8530	To 09/30/2023	Date/Time Prepared:
	·		2/14/2024 10:45 am
			4 .

			Component	JCN: 15-8530 I	0 09/30/2023	2/14/2024 10:	
					RHC I	Cost	
		Compensation	Other Costs	Total (col. 1	Reclassi fi cati	Reclassi fied	
		·		+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS	400 500	20.000	4/0.7/4	75 400	500.040	4 00
1.00	Physi ci an	432, 532	30, 229		75, 488	538, 249	1.00
2.00	Physician Assistant	250 050	0	·	61, 928	0	2.00
3. 00 4. 00	Nurse Practitioner	250, 858	0	250, 858	01, 928	312, 786	3. 00 4. 00
4. 00 5. 00	Visiting Nurse Other Nurse	218, 687	0	218, 687	0	218, 687	5.00
6.00	Clinical Psychologist	210,007	0	210,007	0	210,007	6.00
7. 00	Clinical Social Worker	21, 420	0	21, 420	0	21, 420	7. 00
8. 00	Laboratory Techni ci an	21,420	0	21, 420	0	21,420	8. 00
9. 00	Other Facility Health Care Staff Costs	75, 416	0	75, 416	0	75, 416	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	998, 913	30, 229				
11. 00	Physician Services Under Agreement	770, 713	30, 227 N	1,027,142	137, 410	1, 100, 330	11. 00
12. 00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13. 00	Other Costs Under Agreement	Ö	0	0	0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14. 00
15. 00	Medical Supplies	0	42, 152	42, 152	0	42, 152	15. 00
16. 00	Transportation (Health Care Staff)	0	3, 825			3, 825	16. 00
17. 00	Depreciation-Medical Equipment	o	0	0	0	0	17. 00
18. 00	Professional Liability Insurance	0	0	0	0	0	18. 00
19. 00	Other Health Care Costs	0	0	0	0	0	19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	45, 977	45, 977	0	45, 977	21. 00
22. 00	Total Cost of Health Care Services (sum of	998, 913	76, 206	1, 075, 119	137, 416	1, 212, 535	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES				T		
23. 00	Pharmacy	0	0	0	0	0	23. 00
24. 00	Dental	0	0	0	0	0	24. 00
25. 00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	0	0	0	26. 00
27. 00	Nonallowable GME costs	_	_	_	_	_	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27) FACILITY OVERHEAD						
20 00	Facility Overhead Facility Costs	O	10, 396	10, 396	0	10, 396	29. 00
30. 00	Administrative Costs	77, 411	58, 446			135, 857	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	77, 411	68, 842			146, 253	31.00
31.00	30)	77,411	00, 042	140, 200		140, 200	31.00
32. 00	Total facility costs (sum of lines 22, 28	1, 076, 324	145, 048	1, 221, 372	137, 416	1, 358, 788	32. 00
	and 31)						

Health Financial Systems	CAMERON MEMORIAL COMMU	JNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1315	Peri od: From 10/01/2022	Worksheet M-1
		Component CCN: 15-8530	To 09/30/2023	Date/Time Prepared:

			Componen	t con	1. 13-0330	10	077 307 2023	2/14/2024 10	
							RHC I	Cost	
		Adjustments	Net Expense	s					
			for Allocati	on					
			(col. 5 + col.	1.					
			6)						
		6.00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	0	538, 2	49					1. 00
2.00	Physician Assistant	o		o					2. 00
3.00	Nurse Practitioner	o	312, 7	86					3.00
4.00	Visiting Nurse	o		o					4. 00
5.00	Other Nurse	o	218, 6	87					5. 00
6.00	Clinical Psychologist	o		o					6. 00
7.00	Clinical Social Worker	o	21, 4	20					7. 00
8.00	Laboratory Techni ci an	o		o					8. 00
9.00	Other Facility Health Care Staff Costs	o	75, 4	16					9. 00
10.00	Subtotal (sum of lines 1 through 9)	o	1, 166, 5	58					10.00
11.00	Physician Services Under Agreement	ol		o					11.00
12.00	Physician Supervision Under Agreement	ol		o					12.00
13.00	Other Costs Under Agreement	ol		ol					13.00
14.00	Subtotal (sum of lines 11 through 13)	o		ol					14.00
15.00	Medical Supplies	o	42, 1	52					15. 00
16.00	Transportation (Health Care Staff)	o	3, 8	25					16. 00
17.00	Depreciation-Medical Equipment	o		ol					17. 00
18.00	Professional Liability Insurance	o		ol					18. 00
19.00	Other Health Care Costs	o		o					19. 00
20.00	Allowable GME Costs								20. 00
21.00	Subtotal (sum of lines 15 through 20)	o	45, 9	77					21. 00
22. 00	Total Cost of Health Care Services (sum of	o	1, 212, 5						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	0		0					28. 00
	through 27)								
	FACILITY OVERHEAD								
29. 00	Facility Costs	0	10, 3						29. 00
30.00	Administrative Costs	o	135, 8	57					30.00
31.00	Total Facility Overhead (sum of lines 29 and	o	146, 2	53					31. 00
	30)								
32. 00	Total facility costs (sum of lines 22, 28	0	1, 358, 7	88					32. 00
	and 31)								

Health Financial Systems	CAMERON MEMORIAL COMMU	UNI TY HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL PASED DUC/FOUC COSTS		Drovi don CCN, 1E 121E	Dori od:	Workshoot M 1		

Heal th	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	ΓAL	In Lie	eu of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1315 F	Peri od:	Worksheet M-1	
					From 10/01/2022 To 09/30/2023	D-+- /T: D	
			Component	CCN: 15-8545 T	o 09/30/2023	Date/Time Pre 2/14/2024 10:	
					RHC II	Cost	
		Compensation	Other Costs	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
	FACULLEY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	E/E 000	0	E/E 003	120 (40	704 722	1 00
1. 00 2. 00	Physician Physician Assistant	565, 082 140, 744	0		1		1. 00 2. 00
3. 00	Nurse Practitioner	333, 714	0	1	1		3.00
4. 00	Visiting Nurse	333, 714	0	333,714	00, 754	1 414,000	4. 00
5.00	Other Nurse	183, 496	0	183, 496		183, 496	5. 00
6. 00	Clinical Psychologist	103, 470	0	103, 470		103, 470	6.00
7. 00	Clinical Social Worker	0	0			Ö	7. 00
8.00	Laboratory Techni ci an	0	0			o o	8. 00
9. 00	Other Facility Health Care Staff Costs	194, 700	0	194, 700	0	194, 700	
10.00	Subtotal (sum of lines 1 through 9)	1, 417, 736	0	1		1, 663, 018	
11. 00	Physician Services Under Agreement	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	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0	(0	0	14. 00
15.00	Medical Supplies	0	223, 808	223, 808	0	223, 808	15. 00
16.00	Transportation (Health Care Staff)	0	106	106	0	106	16. 00
17.00	Depreciation-Medical Equipment	0	0	C	0	0	17. 00
18.00	Professional Liability Insurance	0	0	C	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	223, 914			223, 914	
22. 00	Total Cost of Health Care Services (sum of	1, 417, 736	223, 914	1, 641, 650	245, 282	1, 886, 932	22. 00
	lines 10, 14, and 21)						
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	٥	0) 0	0	22.00
23. 00 24. 00	Pharmacy Dental	0	0	1		0	23. 00 24. 00
25. 00	Optometry	0	0				25. 00
25. 00	Tel eheal th	0	0			0	25. 00
25. 01	Chronic Care Management	0	0			0	25. 01
26. 00	All other nonreimbursable costs	0	0			0	26. 00
27. 00	Nonallowable GME costs	Ö)	Ĭ	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	0	0	28. 00
	through 27)		_				
	FACILITY OVERHEAD				1		
29.00	Facility Costs	0	21, 990	21, 990	0	21, 990	29. 00
30.00	Administrative Costs	128, 193	58, 816	187, 009	0	187, 009	30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	128, 193	80, 806	208, 999	0	208, 999	31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	1, 545, 929	304, 720	1, 850, 649	245, 282	2, 095, 931	32. 00
	and 31)			l			

Health Financial Systems	CAMERON MEMORIAL COMMUN	NITY HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	F	Provider CCN: 15-1315	Peri od: From 10/01/2022	Worksheet M-1		
		Component CCN: 15-8545				

Adjustments				Component	CCN. 13-034	, 10	0 97 307 2023	2/14/2024 10:	
FACILITY HEALTH CARE STAFF COSTS							RHC II		
Coll 5 + col 6		·	Adjustments	Net Expenses		<u>'</u>			
FACILITY HEALTH CARE STAFF COSTS			•	for Allocation	n				
FACILITY HEALTH CARE STAFF COSTS				(col. 5 + col.					
FACILITY HEALTH CARE STAFF COSTS				6)					
1.00			6. 00	7. 00					
2.00 Physician Assistant									
3.00 Nurse Practitioner	1.00		0						1.00
4.00 0	2.00	Physician Assistant	0	165, 432	2				2. 00
5.00	3.00	Nurse Practitioner	0	414, 668	3				3. 00
6.00	4.00	Visiting Nurse	0	C					4. 00
7.00	5.00	Other Nurse	0	183, 496					5. 00
8.00	6.00	Clinical Psychologist	0	C					6. 00
9.00 Other Facility Health Care Staff Costs 0 194,700 10.00 Subtotal (sum of lines 1 through 9) 0 1,663.018 10.00 11.00 Physician Services Under Agreement 0 0 0 11.00 12.00 13.00 14.00 14.00 15.00 14.00 15.00 16.00 16.00 16.00 17.00 17.00 17.00 18.00 1	7.00	Clinical Social Worker	0	C					7. 00
10. 00 Subtotal (sum of lines 1 through 9) 0 1,663,018 10. 00	8.00	Laboratory Techni ci an	0	C					8. 00
11.00 Physician Services Under Agreement 0 0 0 0 12.00 Physician Suprvision Under Agreement 0 0 0 0 12.00 13.00 14.00	9.00	Other Facility Health Care Staff Costs	0	194, 700					9. 00
12.00 Physici an Supervision Under Agreement 0	10.00	Subtotal (sum of lines 1 through 9)	0	1, 663, 018	3				10.00
13.00 Other Costs Under Agreement 0 0 0 0 14.00 14.00 14.00 14.00 14.00 15.00 14.00 15.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 18.00 17.00 18.00	11.00	Physician Services Under Agreement	0						11. 00
14.00 Subtotal (sum of lines 11 through 13)	12.00	Physician Supervision Under Agreement	0	(12.00
15.00	13.00	Other Costs Under Agreement	0	(13.00
16. 00 Transportation (Health Care Staff) 0 106 17. 00 Depreciation-Medical Equipment 0 0 0 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 19. 00 0 18. 00 19. 00 0 19. 00 0 19. 00 0 19. 00 0 19. 0	14.00	Subtotal (sum of lines 11 through 13)	0	(14. 00
17. 00 Depreciation-Medical Equipment 0 0 0 0 18. 00 19. 00 19. 00 19. 00 19. 00	15.00	Medical Supplies	0	223, 808	3				15. 00
18. 00 Professional Liability Insurance 0 0 0 0 0 18. 00 19. 00 0 0 0 0 0 0 0 0 0	16.00	Transportation (Health Care Staff)	0	106					16. 00
19. 00 Other Health Care Costs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17.00	Depreciation-Medical Equipment	0	(17. 00
20. 00 Allowable GME Costs 20. 00 21. 00 223, 914 21. 00 22. 00	18.00	Professional Liability Insurance	0	(18. 00
21.00 Subtotal (sum of lines 15 through 20) 0 223,914 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22.00 Costs Other Than RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 24.00 Dental 0 0 0 25.00 Optometry 0 0 0 25.01 Tel eheal th 0 0 25.02 Chronic Care Management 0 0 0 25.02 26.00 All other nonreimbursable costs 0 0 26.00 27.00 Nonallowable GME costs 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 27.00 Total Facility Costs 0 21,990 30.00 30.00 Total facility costs (sum of lines 29 and 30) 30.00 32.00 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00 Costs Other Care Management 0 0 0 23.00 23.00 23.00 23.00 24.00 0 0 0 25.01 25.01 25.01 26.00 0 0 27.00 25.02 28.00 0 0 29.00 0 0 29.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 20.00 0 0 20.00	19.00	Other Health Care Costs	0	(19. 00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 23.00 24.00 Dental 0 0 0 24.00 25.00 Optometry 0 0 0 25.00 25.01 Tel eheal th 0 0 0 25.00 25.02 Chronic Care Management 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 0 27.00 Nonallowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 27.00 Total Facility Costs 0 21,990 30.00 Administrative Costs 0 208,999 32.00 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00 32.00 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00	20.00	Allowable GME Costs							20. 00
Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES	21.00	Subtotal (sum of lines 15 through 20)	0	223, 914	ı				21. 00
23. 00 Pharmacy 0 0 0 23. 00	22.00	Total Cost of Health Care Services (sum of	0	1, 886, 932	2				22. 00
23. 00 Pharmacy		lines 10, 14, and 21)							
24.00 Dental 0 0 0 24.00 25.00 Optometry 0 0 0 0 25.01 Tel eheal th 0 0 0 25.02 Chronic Care Management 25.01 26.00 All other nonreimbursable costs 0 0 27.00 Nonallowable GME costs 26.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 29.00 Facility Overhead 27.00 30.00 Administrative Costs 0 21,990 30.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00		COSTS OTHER THAN RHC/FQHC SERVICES							
25. 00		Pharmacy	0	()				23. 00
Tel eheal th 0 0 0 0 25.01	24.00	Dental	0	(
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	Optometry	0	(25. 00
26. 00	25. 01	Tel eheal th	0	C					25. 01
27. 00 Nonallowable GME costs 27. 00 28. 00	25. 02	Chronic Care Management	0	C					25. 02
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00	All other nonreimbursable costs	0	C					26. 00
through 27) FACILITY OVERHEAD 29. 00 Facility Costs 30. 00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28	27.00	Nonallowable GME costs							27. 00
FACILITY OVERHEAD 29. 00 30. 00 Administrative Costs	28. 00	Total Nonreimbursable Costs (sum of lines 23	0	()				28. 00
29.00 Facility Costs 0 21,990 30.00 Administrative Costs 0 187,009 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00 32.00 32.00 32.00 33.0									
30.00 Administrative Costs 0 187,009 31.00 Total Facility Overhead (sum of lines 29 and 30) 7 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00									
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00		1	0						
30) 32.00 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00			0		1				1
32.00 Total facility costs (sum of lines 22, 28 0 2,095,931 32.00	31. 00		0	208, 999	9				31.00
		1 1							
and 31)	32. 00		0	2, 095, 931					32. 00
		ana 31)		l	I				I

Health Financial Systems	CAMERON MEMORIAL COMMU	JNI TY HOSPI TAL	In Lieu of F		u of Form CMS-2552-10
ANALYSIS OF HOSDITAL BASED DUC/FOUR COSTS		Drovi don CCN, 1E 121E	Dori od		Workshoot M 1

Heal th	Financial Systems CAME	RON MEMORIAL CO	MMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-1315	Peri od:	Worksheet M-1	
					From 10/01/2022	5	
			Component	CCN: 15-8546	To 09/30/2023	Date/Time Pre 2/14/2024 10:	
					RHC III	Cost	45 alli
		Compensation	Other Costs	Total (col	1 Reclassificati	Reclassi fi ed	
		oompensati on	other costs	+ col . 2)	ons	Trial Balance	
				' ' ' ' ' ' ' '		(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	600, 535	281, 635	882, 17	0 123, 026	1, 005, 196	1. 00
2.00	Physician Assistant	0	0)	0	0	2. 00
3.00	Nurse Practitioner	267, 314	0	267, 31	4 53, 793	321, 107	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	94, 668	0	94, 66	8 0	94, 668	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 Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	139, 206	0	139, 20		139, 206	9. 00
10.00	Subtotal (sum of lines 1 through 9)	1, 101, 723	281, 635	1, 383, 35	8 176, 819	1, 560, 177	10.00
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	1	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	21 105	21 10	0	0	14.00
15.00	Medical Supplies Transportation (Health Care Staff)	0	21, 105 6, 030			21, 105	15.00
16. 00 17. 00	Depreciation-Medical Equipment	0	0, 030	0,03	0	6, 030 0	16. 00 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	J	0		0		20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	27, 135	27, 13	5	27, 135	21. 00
22. 00	Total Cost of Health Care Services (sum of	1, 101, 723	308, 770				22. 00
22.00	lines 10, 14, and 21)	1, 101, 723	300, 770	1, 410, 47	170,017	1, 307, 312	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	0	0	,	0 0	0	24. 00
25. 00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0 0	0	25. 01
25. 02	Chronic Care Management	0	0)	0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0)	0	0	26. 00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0)	0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	65, 394			00,07.	29. 00
30.00	Administrative Costs	67, 554	32, 913			100, 467	30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	67, 554	98, 307	165, 86	1 0	165, 861	31. 00
32. 00	30) Total facility costs (sum of lines 22, 28	1, 169, 277	407, 077	1, 576, 35	4 176, 819	1, 753, 173	32. 00
32.00	and 31)	1, 107, 277	407,077	1, 570, 30	170,019	1, 755, 175	32.00
	10.00	ı		I .	1	1	1

Health Financial Systems	CAMERON MEMORIAL COMMU	JNITY HOSPITAL	In Lieu of Form CMS-2552-1			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1315	Peri od: From 10/01/2022	Worksheet M-1		
		Component CCN: 15-8546	To 09/30/2023	Date/Time Prepared:		

			Component	OON. 15 (0540	10	0 97 307 2023	2/14/2024 10	
							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	-47, 713	957, 483						1.00
2.00	Physician Assistant	0	0	1					2. 00
3.00	Nurse Practitioner	-25, 031	296, 076	1					3. 00
4.00	Visiting Nurse	0	0	1					4. 00
5.00	Other Nurse	0	94, 668						5. 00
6.00	Clinical Psychologist	0	0	1					6. 00
7.00	Clinical Social Worker	0	0	1					7. 00
8.00	Laboratory Techni ci an	0	0	1					8. 00
9.00	Other Facility Health Care Staff Costs	0	139, 206						9. 00
10.00	Subtotal (sum of lines 1 through 9)	-72, 744	1, 487, 433						10.00
11. 00	Physician Services Under Agreement	0	0						11. 00
12.00	Physician Supervision Under Agreement	0	0	1					12. 00
13.00	Other Costs Under Agreement	0	0	1					13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0	1					14. 00
15. 00	Medical Supplies	0	21, 105						15. 00
16. 00	Transportation (Health Care Staff)	0	6, 030	1					16. 00
17. 00	Depreciation-Medical Equipment	0	0	1					17. 00
18. 00	Professional Liability Insurance	0	0	1					18. 00
19. 00	Other Health Care Costs	0	0	1					19. 00
20. 00	Allowable GME Costs								20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	27, 135	1					21. 00
22. 00	Total Cost of Health Care Services (sum of	-72, 744	1, 514, 568						22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23. 00	Pharmacy	0	0	1					23. 00
24. 00	Dental	0	0	1					24. 00
25. 00	Optometry	0	0	1					25. 00
25. 01	Tel eheal th	0	0	1					25. 01
25. 02	Chronic Care Management	0	0	1					25. 02
26. 00	All other nonreimbursable costs	0	0	1					26. 00
27. 00	Nonallowable GME costs		_						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1					28. 00
	through 27)								_
20.00	FACILITY OVERHEAD		/F 60.						20.00
29. 00	Facility Costs	0	65, 394						29. 00
30.00	Administrative Costs	0	100, 467						30.00
31. 00	Total Facility Overhead (sum of lines 29 and	O	165, 861						31. 00
22.00	30)	70 744	1 (00 400						22.00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	-72, 744	1, 680, 429						32. 00
	and 31)		I	I					1

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lieu of Form CMS-2552-			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1315	Peri od: Worksheet M-1			
		From 10/01/2022			
	Component CCN: 15 0570	To 00/20/2022 Dato/Time Propared:			

			Component (From 10/01/2022 To 09/30/2023	Date/Time Pre 2/14/2024 10:	
						Cost	10 4111
		Compensation	Other Costs	Total (col. 1	Reclassi fi cati	Reclassi fied	
		'		+ col . 2)	ons	Trial Balance	
				<u> </u>		(col. 3 + col.	
						4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	405, 321	0	405, 321	-17, 745	387, 576	1. 00
2.00	Physician Assistant	0	0	(0	0	2. 00
3.00	Nurse Practitioner	226, 275	0	226, 275	-13, 969	212, 306	3. 00
4.00	Visiting Nurse	0	0	(0	0	4. 00
5.00	Other Nurse	116, 035	0	116, 035	-24, 210	91, 825	5. 00
6.00	Clinical Psychologist	o	0	(0	0	6. 00
7.00	Clinical Social Worker	o	0	(0	0	7. 00
8.00	Laboratory Techni ci an	o	0	(0	0	8. 00
9.00	Other Facility Health Care Staff Costs	117, 579	0	117, 579	-24, 532	93, 047	9. 00
10.00	Subtotal (sum of lines 1 through 9)	865, 210	0	865, 210	-80, 456	784, 754	10.00
11. 00	Physician Services Under Agreement	o	0		0	0	11. 00
12.00	Physician Supervision Under Agreement	o	0	(0	0	12. 00
13.00	Other Costs Under Agreement	o	0	(0	0	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	o	0	(0	0	14. 00
15. 00	Medical Supplies	o	34, 679	34, 679	-7, 236	27, 443	15. 00
16. 00	Transportation (Health Care Staff)	o	4, 263	4, 263	-889	3, 374	16. 00
17.00	Depreciation-Medical Equipment	o	0		0	0	17. 00
18. 00	Professional Liability Insurance	o	0		o	0	18. 00
19. 00	Other Health Care Costs	o	0	(0	0	19. 00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	o	38, 942	38, 942	-8, 125	30, 817	21. 00
22. 00	Total Cost of Health Care Services (sum of	865, 210	38, 942	904, 152	-88, 581	815, 571	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	O	0	(0	0	25. 00
25. 01	Tel eheal th	O	0	(0	0	25. 01
25. 02	Chronic Care Management	o	0	(0	0	25. 02
26.00	All other nonreimbursable costs	o	0	(0	0	26. 00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	o	0	(0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	9, 447	9, 44	2, 172	11, 619	29. 00
30.00	Administrative Costs	65, 587	65, 181	130, 768	-27, 289	103, 479	30.00
31.00	Total Facility Overhead (sum of lines 29 and	65, 587	74, 628	140, 215	-25, 117	115, 098	31.00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	930, 797	113, 570	1, 044, 367	-113, 698	930, 669	32. 00
	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	Period: Worksheet M-1 From 10/01/2022
	Component CCN: 15-8570	To 09/30/2023 Date/Time Prepared: 2/14/2024 10:45 am

			Component	0011. 10 00	370	10	0 97 307 2023	2/14/2024 10	
							RHC IV	Cost	
		Adjustments	Net Expenses						
			for Allocation						
			(col. 5 + col.						
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physi ci an	-38, 845	348, 731						1. 00
2.00	Physician Assistant	0	C						2. 00
3.00	Nurse Practitioner	0	212, 306	o					3. 00
4.00	Visiting Nurse	0	C						4. 00
5.00	Other Nurse	0	91, 825	i					5. 00
6.00	Clinical Psychologist	0	C						6. 00
7.00	Clinical Social Worker	0	C						7. 00
8.00	Laboratory Techni ci an	0	C	1					8. 00
9.00	Other Facility Health Care Staff Costs	0	93, 047						9. 00
10.00	Subtotal (sum of lines 1 through 9)	-38, 845	745, 909						10.00
11. 00	Physician Services Under Agreement	0	C)					11. 00
12.00	Physician Supervision Under Agreement	0	C	1					12. 00
13.00	Other Costs Under Agreement	0	C	1					13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	C						14. 00
15. 00	Medi cal Supplies	0	27, 443	8					15. 00
16. 00	Transportation (Health Care Staff)	0	3, 374	·					16. 00
17. 00		0	C	1					17. 00
18. 00	Professional Liability Insurance	0	C	1					18. 00
19. 00		0	C						19. 00
20. 00	Allowable GME Costs								20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	30, 817	1					21. 00
22. 00	Total Cost of Health Care Services (sum of	-38, 845	776, 726						22. 00
	lines 10, 14, and 21)								_
	COSTS OTHER THAN RHC/FQHC SERVICES	_		ı					
23. 00	9	0	C						23. 00
24. 00	Dental	0	C	1					24. 00
25. 00	Optometry	0	C	1					25. 00
25. 01	Tel eheal th	0	C	1					25. 01
25. 02	9	0	C	1					25. 02
26. 00	All other nonreimbursable costs	0	C						26. 00
27. 00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C)					28. 00
	through 27)								_
	FACILITY OVERHEAD								
29. 00		0	11, 619	1					29. 00
30.00	Administrative Costs	0	103, 479						30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	115, 098	5					31. 00
22.00	30)	20.045	001 001						1 22 00
32. 00	Total facility costs (sum of lines 22, 28	-38, 845	891, 824	-					32. 00
	and 31)		I	1					1

Heal th	Financial Systems	CAMERON MEMORIAL CO	OMMUNITY HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CO		Peri od:	Worksheet M-1	
			Component (From 10/01/2022 To 09/30/2023		
					RHC V	Cost	
		Compensation	Other Costs	Total (col. 1	Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	556, 047	0	556, 04	7 -424, 624	131, 423	1.00
2.00	Physician Assistant	0	0		0	0	2.00
3.00	Nurse Practitioner	109, 984	0	109, 98	4 -81, 761	28, 223	3.00
4 00	Viciting Nurse	1	1			ا ما	4 00

		'		+ col . 2)	ons	Trial Balance (col. 3 + col.	
		1. 00	2. 00	3. 00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1.00	Physi ci an	556, 047	0	556, 047	-424, 624	131, 423	1. 00
2. 00	Physician Assistant	0	0	0	0	0	2. 00
3.00	Nurse Practitioner	109, 984	0	109, 984	-81, 761	28, 223	3.00
4. 00	Visiting Nurse	0	0	0	0., 701	0	4. 00
5. 00	Other Nurse	221, 479	0	221, 479	-174, 170	_	5. 00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7. 00	Clinical Social Worker	0	0	0	0	0	7. 00
8.00	Laboratory Techni ci an	0	0	0	0	0	8.00
9. 00	Other Facility Health Care Staff Costs	19, 475	0	19, 475	-15, 315	4, 160	9. 00
10.00	Subtotal (sum of lines 1 through 9)	906, 985	0	906, 985	-695, 870		10.00
11. 00	Physician Services Under Agreement	0	0	0	0	0	11. 00
12. 00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13. 00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	O	0	0	0	0	14.00
15. 00	Medical Supplies	0	27, 171	27, 171	-21, 367	5, 804	15. 00
16.00	Transportation (Health Care Staff)	0	4, 739	4, 739	-3, 726	1, 013	16. 00
17. 00	Depreciation-Medical Equipment	0	0	0	0	0	17. 00
18.00	Professional Liability Insurance	0	0	0	0	0	18. 00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	31, 910	31, 910	-25, 093	6, 817	21.00
22. 00	Total Cost of Health Care Services (sum of	906, 985	31, 910	938, 895	-720, 963	217, 932	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			I		ı	
23. 00	Pharmacy	0	0	0	0	0	23. 00
24. 00	Dental	0	0	0	0	0	24. 00
25. 00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26. 00	All other nonreimbursable costs	U	U	U	0	0	26. 00 27. 00
27. 00 28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23)	0	0	0	0	0	28.00
26.00	through 27)	U	U	U	U	0	26.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	11, 582	11, 582	-7, 799	3, 783	29. 00
30. 00	Administrative Costs	78. 183	51, 848		-102, 256		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	78, 183 78, 183	63, 430	•	-110, 055		31.00
51.50	30)	75, 105	33, 430	111,013	110,000	01,000	31.00
32. 00	Total facility costs (sum of lines 22, 28	985, 168	95, 340	1, 080, 508	-831, 018	249, 490	32. 00
	and 31)		,	.,,	22.,010		
	•			'		•	

Health Financial Systems	CAMERON MEMORIAL COMMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1315	Peri od: From 10/01/2022	Worksheet M-1
	Component CCN: 15-8571		

Adjustments				Component	CCN: 15-85/1	10	09/30/2023	2/14/2024 10	
Adjustments Not Expenses for All location (col. 5 + col. 6)							RHC V		. 45 alli
FACILITY HEALTH CARE STAFF COSTS			Adiustments	Net Expenses			TKITO V	0031	
FACILITY HEALTH CARE STAFF COSTS			riaj ao emorreo						
Activity Health Care STAFF COSTS									
FACILITY HEALTH CARE STAFF COSTS									
FACILITY HEALTH CARE STAFF COSTS			6. 00						
1.00		FACILITY HEALTH CARE STAFF COSTS			'				
2.00	1.00		0	131, 42	3				1.00
3.00	2.00	1 7	0		1				2.00
4.00	3.00		0	28, 22	3				3.00
5.00	4.00	Visiting Nurse	0		ol				4. 00
6.00	5.00		0	47, 30	9				5. 00
7. 00	6.00	Clinical Psychologist	0		ol				6. 00
9.00 Other Facility Health Care Staff Costs 0 4, 160 10.00 10.00 Subtotal (sum of lines 1 through 9) 0 211, 115 115 10.00 11.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 14.00 13.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 16.00 17.00 17	7.00		0		ol				7. 00
9.00 Other Facility Health Care Staff Costs 0 4, 160 10.00 Subtotal (sum of lines 1 through 9) 0 211, 115 10.00 11.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 14.00	8.00	Laboratory Techni ci an	0		ol				8. 00
10.00 Subtotal (sum of lines 1 through 9) 0 211, 115 10.00 11.00 12.00 12.00 12.00 12.00 12.00 13.00 0 0 0 0 0 12.00 13.00 0 0 0 0 0 14.00 0 0 0 14.00 0 15.00 14.00 0 0 0 0 0 15.00 15.00 16.00 16.00 17.00 15.00 16.00 17.00 16.00 17.00 16.00 17.00 17.00 18.00 18.00 19.	9.00		0	4, 16	ol				9. 00
11.00 Physician Services Under Agreement 0 0 0 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 16.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.	10.00		0	211, 11	5				10.00
13. 00 14. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 20. 00 19. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 25. 01 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 20	11. 00		0		1				11. 00
13. 00 Other Costs Under Agreement 0 0 0 0 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 15. 00 14. 00 15. 00 15. 00 16. 00 17. 00 15. 00	12.00	Physician Supervision Under Agreement	0		ol				12. 00
15. 00 Medical Supplies			0		ol				13. 00
15. 00 Medical Supplies	14.00	Subtotal (sum of lines 11 through 13)	0		ol				14. 00
17. 00 Depreciation-Medical Equipment 0 0 0 0 18. 00 19. 00 18. 00 0 0 0 0 0 0 0 0 0	15. 00	,	0	5, 80	4				15. 00
18. 00	16.00	Transportation (Health Care Staff)	0	1, 01	3				16. 00
19.00 Other Health Care Costs 0 0 0 0 19.00 20.00 20.00 All lowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 6,817 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 22	17.00	Depreciation-Medical Equipment	0		ol				17. 00
20.00 Allowable GME Costs 21.00 Subtotal (sum of lines 15 through 20) 0 6,817 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy Dental 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 25.00 Optometry 0 0 0 0 25.01 Tel eheal th 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 0 0 27.00 Nonallowable GME costs 0 0 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18.00	Professional Liability Insurance	0		ol				18. 00
21.00 Subtotal (sum of lines 15 through 20) 0 6,817 21.00	19.00	Other Health Care Costs	0		ol				19. 00
22. 00	20.00	Allowable GME Costs							20. 00
Lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES	21.00	Subtotal (sum of lines 15 through 20)	0	6, 81	7				21. 00
COSTS OTHER THAN RHC/FQHC SERVICES 23.00 Pharmacy 0 0 0 23.00 24.00 Dental 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 25.00 25.00 25.01 Tel eheal th 0 0 0 0 25.00 25.02 26.00 All other nonrel mbursable costs 0 0 0 25.02 26.00 All other nonrel mbursable costs 0 0 0 26.00 27.00 28.00 Total Nonrel mbursable Costs (sum of lines 23 0 0 0 0 28.00 29.00 29.00 Administrative Costs 0 3,783 29.00 30.00 Total Facility Overhead (sum of lines 29 and 0 31,558 31.00 30.00 31.00 30.00 31.00 31.558 31.00	22. 00	Total Cost of Health Care Services (sum of	0	217, 93	2				22. 00
23. 00 Pharmacy									
24.00 Dental Dent		COSTS OTHER THAN RHC/FQHC SERVICES							
25. 00 Optometry O	23.00	Pharmacy	0		0				23. 00
25. 01 Tell eheal th	24.00	Dental	0		0				24. 00
25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 29. 00 FACILITY OVERHEAD 29. 00 Administrative Costs 0 27, 775 30. 00 Administrative Costs 0 27, 775 31. 00 Total Facility Overhead (sum of lines 29 and 30) 30 Total Facility Overhead (sum of lines 29 and 30) 31. 00 Output	25.00	Optometry	0		0				25. 00
26. 00	25. 01	Tel eheal th	0		0				25. 01
27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28. 00 through 27) FACILITY OVERHEAD 29. 00 30. 00 Administrative Costs 0 27, 775 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 30) 30 Total Facility Overhead (sum of lines 29 and 30) 31. 00	25. 02	Chronic Care Management	0		0				25. 02
28.00	26.00	All other nonreimbursable costs	0		0				26. 00
through 27) FACILITY OVERHEAD 29.00 30.00 Administrative Costs	27. 00	Nonallowable GME costs							27. 00
FACILITY OVERHEAD 29.00 Facility Costs	28. 00	Total Nonreimbursable Costs (sum of lines 23	0	1	0				28. 00
29.00 Facility Costs 0 3,783 29.00 30.00 Administrative Costs 0 27,775 30.00 31.00 30) 31,558 31.00									
30.00 Administrative Costs 0 27,775 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 31,558 31.00									
31.00 Total Facility Overhead (sum of lines 29 and 0 31,558 31.00		1			1				
30)			0						
	31. 00		0	31, 55	8				31.00
		'	_						00.0-
	32. 00	Total facility costs (sum of lines 22, 28	0	249, 49	U				32. 00
and 31)		janu 31)		I	I				1

Heal th	Financial Systems CAME	RON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der C		Peri od:	Worksheet M-2	
					From 10/01/2022 To 09/30/2023	Date/Time Pre	
			Component	CCN: 15-8530	To 09/30/2023	2/14/2024 10:	
					RHC I	Cost	10 4
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1					
1.00	Physi ci an	0. 64			· ·	1	1. 00
2.00	Physician Assistant	0. 00		, , ,			2. 00
3.00	Nurse Practitioner	1. 51					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 15			5, 859		
5.00	Visiting Nurse	0.00				0	5. 00
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0. 08 0. 19				243	6. 00 7. 00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)			•		209	7.00
7. 01	Diabetes Self Management Training (FQHC	0. 00 0. 00					7.01
7.02	only)	0.00				0	7.02
8. 00	Total FTEs and Visits (sum of lines 4	2. 42	8, 955			8, 955	8.00
0.00	through 7)	2. 12	0, 700			0, 700	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
		1			'		
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			1, 212, 535	10. 00
	Total nonreimbursable costs (from Wkst. M-1,					0	11. 00
12.00	Cost of all services (excluding overhead) (s					1, 212, 535	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr	146, 253					
15. 00	Parent provider overhead allocated to facili	746, 143					
16. 00	Total overhead (sum of lines 14 and 15)					892, 396	
	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16	UC (1.1	10 1: 1	0)		892, 396	
	Overhead applicable to hospital based RHC/FQ					892, 396	
∠∪. ∪∪	Total allowable cost of hospital-based RHC/F	unc services (s	sum of fines to	and 19)		2, 104, 931	₁ 20.00

ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Peri od: From 10/01/2022	Worksheet M-2		
			Component (To 09/30/2023	Date/Time Prep 2/14/2024 10:4		
					RHC II	Cost		
	·	Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of		
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.		
					3)	4		
		1. 00	2.00	3. 00	4. 00	5. 00		
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
1.00	Physi ci an	1. 42					1.00	
2. 00	Physician Assistant	0. 77	4, 065	2, 10	0 1, 617		2.00	
3. 00	Nurse Practitioner	1. 90	10, 310	2, 10	0 3, 990		3.00	
4. 00	Subtotal (sum of lines 1 through 3)	4. 09	19, 513		11, 571	19, 513	4.00	
5. 00	Visiting Nurse	0.00	0			0	5.00	
6. 00	Clinical Psychologist	0.00				0		
7. 00	Clinical Social Worker	0.00	0			0	7.00	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.0	
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02	
	onl y)							
8. 00	Total FTEs and Visits (sum of lines 4	4. 09	19, 513			19, 513	8.00	
	through 7)							
9. 00	Physician Services Under Agreements		0			0	9.00	
						1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE			VI CES				
	Total costs of health care services (from W					1, 886, 932		
11. 00	Total nonreimbursable costs (from Wkst. M-1						11.00	
12. 00	Cost of all services (excluding overhead) (,			1, 886, 932		
13. 00	Ratio of hospital-based RHC/FQHC services (1. 000000 208, 999		
	14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)							
15. 00								
16. 00						1, 342, 327		
17. 00	Allowable GME overhead (see instructions)					0		
18. 00						1, 342, 327		
19. 00	The state of the s					1, 342, 327		
20 00	Total allowable cost of hospital-based RHC/	ENUC corvicos (s	rum of Linos 10	and 10)		3, 229, 259	1 20 00	

Heal th	Financial Systems CAME	ERON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
					From 10/01/2022 To 09/30/2023	Date/Time Pre	
			Component	CCN: 15-8546	To 09/30/2023	2/14/2024 10:	
					RHC III	Cost	10 a
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 43			· ·		1.00
2.00	Physician Assistant	0.00					2. 00
3.00	Nurse Practitioner	1. 03					3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 46			3, 969		
5.00	Visiting Nurse	0.00				0	5. 00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7. 00
7. 01 7. 02	Medical Nutrition Therapist (FOHC only)	0.00	ļ			0	7. 01 7. 02
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8. 00	Total FTEs and Visits (sum of lines 4	1. 46	6, 399			6, 399	8.00
0.00	through 7)	1.40	0,377			0,377	0.00
9.00	Physician Services Under Agreements		0			0	9.00
7.00	Trigor or are oor trigor or and rigin or more						71.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	0 HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			1, 514, 568	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	
12.00	Cost of all services (excluding overhead) (s					1, 514, 568	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (fr		165, 861	14. 00			
15.00	Parent provider overhead allocated to facili	589, 125					
16. 00	Total overhead (sum of lines 14 and 15)					754, 986	
17. 00						0	
	Enter the amount from line 16					754, 986	
	Overhead applicable to hospital-based RHC/FQ					754, 986	
20.00	Total allowable cost of hospital-based RHC/F	UHC services (s	sum of lines 10	and 19)		2, 269, 554	20.00

Heal th	Financial Systems CAME	ERON MEMORIAL C	OMMUNITY HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S		Provi der C	CN: 15-1315 F	Peri od: From 10/01/2022	Worksheet M-2	
			Component		To 09/30/2023	Date/Time Pre 2/14/2024 10:	
					RHC IV	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col . 1 x col .		
		1.00	2.00	3.00	3) 4. 00	5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	Posi ti ons						
1.00	Physi ci an	0. 64	3, 255	4, 200	2, 688		1.00
2.00	Physician Assistant	0.00			1		2.00
3.00	Nurse Practitioner	1. 11					3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 75			5, 019	6, 824	4. 00
5. 00	Visiting Nurse	0.00				0	5. 00
6.00	Clinical Psychologist	0.00				0	6. 00
7.00	Clinical Social Worker	0.00	0			0	7. 00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	1. 75	6, 824			6, 824	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOCDITAL DACE	D DUC/FOUR CED	VII CEC		1. 00	
	Total costs of health care services (from Wk			VICES		776, 726	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					776,726	
12. 00	Cost of all services (excluding overhead) (s					776, 726	
13. 00	Ratio of hospital -based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital -based RHC/FQHC overhead - (fr			ne 31)		115, 098	
15. 00	Parent provider overhead allocated to facili	407, 045					
16. 00	Total overhead (sum of lines 14 and 15)		522, 143				
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					522, 143	
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		522, 143	19. 00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		1, 298, 869	20. 00

		RON MEMORIAL CO	OMMUNITY HOSPI			eu of Form CMS-2	2552-10
ALLOCA ²	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component		From 10/01/2022 To 09/30/2023	Date/Time Pre	narod:
			Component	CCN. 15-6571	10 09/30/2023	2/14/2024 10:	
					RHC V	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		1 00/		1 00/		
	Physi ci an	0. 33	l .	1	·	l	1.00
	Physician Assistant	0.00				l .	2. 00
	Nurse Practitioner	0. 15				1	3. 00
	Subtotal (sum of lines 1 through 3)	0. 48			1, 701	1, 701	
	Visiting Nurse	0.00				0	
	Clinical Psychologist Clinical Social Worker	0. 00 0. 00				0	
	Medical Nutrition Therapist (FQHC only)					0	
	Diabetes Self Management Training (FQHC	0. 00 0. 00	_			0	
7.02	only)	0.00				0	7.02
8. 00	Total FTEs and Visits (sum of lines 4	0. 48	1, 301			1, 701	8. 00
0.00	through 7)	0. 10	1,001			1, 701	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
	<u> </u>	'		•	"		
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			VI CES			
	Total costs of health care services (from Wk					217, 932	10. 00
	Total nonreimbursable costs (from Wkst. M-1,					0	
	Cost of all services (excluding overhead) (s					217, 932	
	Ratio of hospital-based RHC/FQHC services (I					1.000000	
	Total hospital-based RHC/FQHC overhead - (fr	31, 558					
	Parent provider overhead allocated to facili	139, 937					
	Total overhead (sum of lines 14 and 15)					171, 495	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16		40 11 -	2)		171, 495	
	Overhead applicable to hospital-based RHC/FQ					171, 495	
20.00	Total allowable cost of hospital-based RHC/F	unc services (s	sum of Tines TO	and 19)		389, 427	J 20.00

	Financial Systems CAMERON MEMORIAL COMM			u of Form CMS-2	
CALCUL SERVI (ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1315	Peri od: From 10/01/2022	Worksheet M-3	
SERVI	LES .	Component CCN: 15-8530	To 09/30/2023	Date/Time Prep 2/14/2024 10:	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		2, 104, 931	1.00
2.00	Cost of injections/infusions and their administration (from W			48, 031	2. 00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		2, 056, 900	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	lino (1)		8, 955 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 9)		8, 955	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			229. 69	7. 00
			Cal cul ati on		
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022)	09/30/2023)	
0.00	Description of the Control of the Co	(1.00	2. 00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	. 6 or your contractor)	275. 29 229. 69	285. 75 229. 69	
9.00	CALCULATION OF SETTLEMENT		227.07	227.07	9.00
10.00	Program covered visits excluding mental health services (from	contractor records)	279	828	10.00
11.00	Program cost excluding costs for mental health services (line	9 x line 10)	64, 084	190, 183	11. 00
12.00	Program covered visits for mental health services (from contr	actor records)	0	0	12. 00
13.00	Program covered cost from mental health services (line 9 x li	*	0	0	
14.00	Limit adjustment for mental health services (see instructions		0	0	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	254, 267	15.00
16. 01	Total program charges (see instructions) (from contractor's re			237, 433	
16. 02	Total program preventive charges (see instructions)(from prov	*		13, 844	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		14, 826	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		171, 304	16. 04
4 (05	(Titles V and XIX see instructions.)			407 400	4/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	186, 130 0	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		25, 311	
. 0. 00	records)	(1. 6 66.11. 46.6.		20,011	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		39, 636	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			186, 130	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		38, 108	
22. 00	,			224, 238	
23. 00	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00		->		0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	S)		0	1
26. 00	Net reimbursable amount (see instructions)			224, 238	
26. 01	Sequestration adjustment (see instructions)				26. 01
26. 02	, ,			0	
27. 00	Interim payments			211, 105	1
28. 00	Tentative settlement (for contractor use only)			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.				29.00
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II,		0	30. 00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	UNITY HOSPITAL Provider CCN: 15-1315	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES	Component CON, 15 OF 45	From 10/01/2022	Doto/Time Dro	
	Component CCN: 15-8545	To 09/30/2023	Date/Time Prep 2/14/2024 10:4	
	Title XVIII	RHC II	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		3, 229, 259	1. (
.00 Cost of injections/infusions and their administration (from W	kst. M-4, line 15)		0	2. (
.00 Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		3, 229, 259	3. (
.00 Total Visits (from Wkst. M-2, column 5, line 8)			19, 513	1
Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		10 513	5.0
.00 Total adjusted visits (line 4 plus line 5) .00 Adjusted cost per visit (line 3 divided by line 6)			19, 513 165. 49	1
Adjusted cost per visit (Time 3 divided by Time 0)		Cal cul ati on		,.,
		Rate Period 1		
		(10/01/2022	(01/01/2023	
		through 12/31/2022)	through 09/30/2023)	
		1. 00	2.00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	228. 60	237. 29	8.
.00 Rate for Program covered visits (see instructions)		165. 49	165. 49	9.
CALCULATION OF SETTLEMENT		004	000	1.0
D.00 Program covered visits excluding mental health services (from 1.00 Program cost excluding costs for mental health services (line	•	281 46, 503	137, 688	10.
2.00 Program covered visits for mental health services (from contra	•	40, 503	137, 088	1
3.00 Program covered cost from mental health services (line 9 x lines)	•	0	0	1
4.00 Limit adjustment for mental health services (see instructions		0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instructions	s)			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	184, 191	1
6.01 Total program charges (see instructions)(from contractor's re	*		231, 065	
6.02 Total program preventive charges (see instructions)(from province 22 Total program preventive charges (see instructions)(from province 22 Total program preventive charges (see instructions)	•		32, 393	1
6.03 Total program preventive costs ((line 16.02/line 16.01) times 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0)			25, 822 108, 765	1
(Titles V and XIX see instructions.)	3 and 10) times .00)		100, 703	10.
6.05 Total program cost (see instructions)		0	134, 587	16.
7.00 Primary payer amounts			0	17.
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		22, 413	18.
records) 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		35, 156	10
records)	is) (ITOIII COITTI actor		35, 150	17.
0.00 Net Medicare cost excluding vaccines (see instructions)			134, 587	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	
2.00 Total reimbursable Program cost (line 20 plus line 21)			134, 587	
3.00 Allowable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions)	musti sps)		0	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
5.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	1
5.99 Demonstration payment adjustment amount before sequestration	-,		- 1	25.
6.00 Net reimbursable amount (see instructions)			134, 587	1
6.01 Sequestration adjustment (see instructions)			2, 692	26.
6.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			150, 226	1
8.00 Tentative settlement (for contractor use only)	02 27 and 20)		10 221	
9.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accorda			-18, 331	
0.00 Protested amounts (nonallowable cost report items) in accordance chapter I, §115.2	TICE WITH CMS PUD. 15-11,		U	30.

	Financial Systems CAMERON MEMORIAL COMM			u of Form CMS-2	
SERVI CE	TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1315	Peri od: From 10/01/2022	Worksheet M-3	
SERVICE	S	Component CCN: 15-8546	To 09/30/2023	Date/Time Pre	pared
				2/14/2024 10:	45 am
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		2, 269, 554	1. (
- 1	Cost of injections/infusions and their administration (from W			7, 434	1
1	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		2, 262, 120	
	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line ()		6, 399 0	4. 5.
- 1	Total adjusted visits (line 4 plus line 5)	Title 9)		6, 399	6.
- 1	Adjusted cost per visit (line 3 divided by line 6)			353. 51	7.
. 00	najastou sost poi viort (iiilo o aiviasa zj iilo o)		Cal cul ati on		, ·
			Rate Period 1		
			(10/01/2022	(01/01/2023	
			through 12/31/2022)	through 09/30/2023)	
			1. 00	2. 00	
3. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	461. 27	478. 80	8.
	Rate for Program covered visits (see instructions)		353. 51	353. 51	9.
	CALCULATION OF SETTLEMENT				
	Program covered visits excluding mental health services (from	•	31	93	•
	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr		10, 959 0	32, 876 0	1
- 1	Program covered cost from mental health services (line 9 x li	*	0	0	•
- 1	Limit adjustment for mental health services (see instructions	*	0	0	
	Graduate Medical Education Pass Through Cost (see instruction			_	15.
6. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	43, 835	16.
	Total program charges (see instructions)(from contractor's re	*		31, 802	
	Total program preventive charges (see instructions) (from provi	•		1, 739	
	Total program preventive costs ((line 16.02/line 16.01) times			2, 397	
	Total Program non-preventive costs ((line 16 minus lines 16.0) (Titles V and XIX see instructions.)	3 and 18) times .80)		32, 060	16.
1	Total program cost (see instructions)		0	34, 457	16.
	Primary payer amounts			0	1
	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		1, 363	18.
	records)				
	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		5, 740	19.
- 1	records) Net Medicare cost excluding vaccines (see instructions)			34, 457	20.
- 1	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)			21.
- 1	Total reimbursable Program cost (line 20 plus line 21)			34, 597	•
3. 00	Allowable bad debts (see instructions)			0	23.
	Adjusted reimbursable bad debts (see instructions)			0	23.
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction: Demonstration payment adjustment amount before sequestration	3)			25. 25.
	Net reimbursable amount (see instructions)			34, 597	•
	Sequestration adjustment (see instructions)				26.
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			30, 961	
	Tentative settlement (for contractor use only)			0	28.
	Balance due component/program (line 26 minus lines 26.01, 26.0			2, 944	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II,		0	30.

*	MUNITY HOSPITAL		u of Form CMS-2	
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC ERVICES	Provider CCN: 15-1315	Peri od: From 10/01/2022	Worksheet M-3	
ERVICES	Component CCN: 15-8570	To 09/30/2023	Date/Time Pre	pared
	·		2/14/2024 10:	
	Title XVIII	RHC I V	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		1, 298, 869	1. (
.00 Cost of injections/infusions and their administration (from W			20, 054	2. (
.00 Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		1, 278, 815	3.
.00 Total Visits (from Wkst. M-2, column 5, line 8)			6, 824	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)			6, 824	1
.00 Adjusted cost per visit (line 3 divided by line 6)			187. 40	7.
		Cal cul ati on	of Limit (1)	
		Rate Period 1	Rate Period 2	
		(10/01/2022	(01/01/2023	
		through	through	
		12/31/2022)	09/30/2023)	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	1 6 or your contractor)	1. 00	2. 00 126. 00	8. (
.00 Rate for Program covered visits (see instructions)	. o or your contractor)	113.00		1
CALCULATION OF SETTLEMENT		113.00	120.00	, , · ·
0.00 Program covered visits excluding mental health services (from	contractor records)	24	357	10.
1.00 Program cost excluding costs for mental health services (line		2, 712	44, 982	11.
2.00 Program covered visits for mental health services (from contr	actor records)	0	0	12.
3.00 Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.
4.00 Limit adjustment for mental health services (see instructions		0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instruction	*			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	47, 694	
6.01 Total program charges (see instructions)(from contractor's re	•		85, 061	•
6.02 Total program preventive charges (see instructions)(from prov 6.03 Total program preventive costs ((line 16.02/line 16.01) times	•		1, 593 893	•
6.03 Total program preventive costs ((line 16.02/line 16.01) times 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0			36, 343	•
(Titles V and XIX see instructions.)	and roj trilles . 00)		30, 343	10.
6.05 Total program cost (see instructions)		0	37, 236	16.
7.00 Primary payer amounts			0	1
B.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		1, 372	18. (
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		16, 420	19. (
0.00 Net Medicare cost excluding vaccines (see instructions)			37, 236	20.
1.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		10, 787	
2.00 Total reimbursable Program cost (line 20 plus line 21)	,		48, 023	22.
3.00 Allowable bad debts (see instructions)			0	23.
3.01 Adjusted reimbursable bad debts (see instructions)			0	23.
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	_		0	
5.50 Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
5.99 Demonstration payment adjustment amount before sequestration			49.023	
6.00 Net reimbursable amount (see instructions) 6.01 Sequestration adjustment (see instructions)			48, 023 960	
6.02 Demonstration payment adjustment amount after sequestration			960	
7.00 Interim payments			36, 743	
8.00 Tentative settlement (for contractor use only)			30, 743 0	28.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		10, 320	•
0.00 Protested amounts (nonallowable cost report items) in accorda	· · · · · · · · · · · · · · · · · · ·		0	1
chapter I, §115.2				I

	Financial Systems CAMERON MEMORIAL COMM ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	UNITY HOSPITAL Provider CCN: 15-1315	In Lie	u of Form CMS-2 Worksheet M-3	
SERVI CE		Provider CCN: 15-1315	From 10/01/2022	worksneet M-3	
OLIVI OL		Component CCN: 15-8571	To 09/30/2023	Date/Time Prep 2/14/2024 10:4	
		Title XVIII	RHC V	Cost	45 aiii
				1 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		389, 427	1.00
1	Cost of injections/infusions and their administration (from W			4, 356	•
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		385, 071	3.00
	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 0)		1, 701 0	4. 00 5. 00
1	Total adjusted visits (line 4 plus line 5)	11 ne 7)		1, 701	6.00
1	Adjusted cost per visit (line 3 divided by line 6)			226. 38	
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2022	(01/01/2023	
			through	through	
			12/31/2022) 1. 00	09/30/2023) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or vour contractor)	113.00	126. 00	8. 00
1	Rate for Program covered visits (see instructions)		113. 00	126. 00	•
	CALCULATION OF SETTLEMENT				
1	Program covered visits excluding mental health services (from	•	0	4	
1	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contra	•	0	504 0	1
1	Program covered cost from mental health services (line 9 x li	•	0	0	
	Limit adjustment for mental health services (see instructions		0	0	1
	Graduate Medical Education Pass Through Cost (see instruction				15. 00
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0		16.00
1	Total program charges (see instructions)(from contractor's real program preventive charges (see instructions)(from province)	*		973 0	ı
1	Total program preventive costs ((line 16.02/line 16.01) times	•		0	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0)			403	1
	(Titles V and XIX see instructions.)				
	Total program cost (see instructions)		0	403	
	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0	17. 00 18. 00
16.00	records)	(11 oiii coitti actoi		U	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		195	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			403	20.00
1	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		3, 128	•
	Total reimbursable Program cost (line 20 plus line 21)	,		3, 531	
23. 00	Allowable bad debts (see instructions)			0	23. 00
	Adjusted reimbursable bad debts (see instructions)			0	
1	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction:	s)		0	
	Demonstration payment adjustment amount before sequestration	~ <i>,</i>		0	
	Net reimbursable amount (see instructions)			-	26. 00
	Sequestration adjustment (see instructions)			71	
	Demonstration payment adjustment amount after sequestration				26. 02
	Interim payments Tentative settlement (for contractor use only)			395	27. 00 28. 00
	Balance due component/program (line 26 minus lines 26.01, 26.0	02. 27. and 28)		-	29.00
	Protested amounts (nonallowable cost report items) in accordan	•		0, 000	1
	chapter I, §115.2				1

Heal th	Financial Systems CAMERON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Lie	eu of Form CMS-2	2552-10
СОМРИТ	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CO	CN: 15-1315 CCN: 15-8530	Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Pre 2/14/2024 10:	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCINES	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, 166, 558	1, 166, 5	1, 166, 558	1, 166, 558	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000159	0. 0017	0. 000257	0.000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	185	2, 0	300	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	7, 309	17, 8	18 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7, 494	19, 8	75 300	0	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	1, 212, 535			1	
	Worksheet M-1, col. 7, line 22)					
7.00	Total overhead (from Wkst. M-2, line 19)	892, 396				
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 006180		0. 000247	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	5, 515			0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	13, 009	34, 50	520	0	10. 00
11.00	Total number of injections/infusions (from your records)	39	4:	33 63	0	11. 00
12.00	Cost per injection/infusion (line 10/line 11)	333. 56	79.	68 8. 25	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	36	3.	23 44	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14.00	Program cost of injections/infusions and their	12, 008	25, 7	363	0	14. 00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)					
					COST OF	
					I NJECTI ONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
15 00	Total cost of injections/infusions and their administration	a acota (our -f	Coolumno 1	1. 00	2. 00	15. 00
15. 00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		corumns I,		48, 031	15.00
16. 00	Total Program cost of injections/infusions and their admini		(sum of		38, 108	16 00
10.00	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount				30, 100	10.00
	COLUMNIS 1, 2, 2.01, and 2.02, LINE 14) (CLAUSIEL THIS AMOUNT TO WKST. M-3, LINE 21)					

Heal th	Financial Systems CAMERON MEMORIAL C	COMMUNITY HOSPIT	ĀL	In Li∈	eu of Form CMS-2	2552-10
COMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1315	Peri od: From 10/01/2022	Worksheet M-4	
		· ·	CCN: 15-8546	To 09/30/2023	Date/Time Prep 2/14/2024 10:	
			XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 487, 433			1, 487, 433	
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000000	0. 0004	0. 000000	0.000000	2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	0	5'	99 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	0	4, 3	62 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	0	4, 9	61 0	0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 514, 568	1, 514, 5	1, 514, 568	1, 514, 568	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	754, 986				
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000000			0.000000	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	0	2, 4		0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	7, 4		0	10. 00
11. 00	Total number of injections/infusions (from your records)	0	· ·	06 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	0.00	70.	0.00		12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	0		2 0	0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14.00	Program cost of injections/infusions and their	0	1.	40 0	0	14. 00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)				2007 05	
					COST OF	
					INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2.00	
15. 00	Total cost of injections/infusions and their administratio		columns 1,		7, 434	15. 00
16. 00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. Total Program cost of injections/infusions and their admin		(sum of		140	16. 00
10.00	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou					. 0. 00
				•		

Heal th	Financial Systems CAMERON MEMORIAL C	OMMUNITY HOSPIT	ΓAL	In Li€	eu of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider Component (CN: 15-1315 CCN: 15-8570	Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-4 Date/Time Pre 2/14/2024 10:	
		Ti +l o	XVIII	RHC IV	Cost	45 alli
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCINES	VACCI NES	VACCINES	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)	745, 909	745, 9	745, 909	745, 909	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000188	0. 0006	0. 000000	0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	140	50	01 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	6, 372	4, 9	79 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	6, 512	5, 4	30	0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	776, 726			776, 726	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	522, 143	522, 1	43 522, 143	522, 143	7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 008384				
9.00	Overhead cost - injection/infusion (line 7 x line 8)	4, 378	3, 6	34 0	0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	10, 890	9, 1	54 0	0	10. 00
11.00	Total number of injections/infusions (from your records)	34	1:	21 0	0	11. 00
12.00	Cost per injection/infusion (line 10/line 11)	320. 29	75.	74 0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	15		79 0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4, 804	5, 9	33 0	0	14. 00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)	•		20, 054	
16. 00	Total Program cost of injections/infusions and their adminicolumns 1, 2, 2.01, and 2.02, line 14) (transfer this amount				10, 787	16. 00
[25.5mm2.7, 2, 2.57, 3.6 2.62, 1716 17]						•

Health Financial Systems CAMERON MEMORIAL C				u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC		Peri od:	Worksheet M-4	
	Component (CCN: 15-8571	From 10/01/2022 To 09/30/2023	Date/Time Pre	nared.
	·			2/14/2024 10:	
		XVIII	RHC V	Cost	
	PNEUMOCOCCAL VACCINES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY	
	VACCINES	VACCINES	VACCINES	PRODUCTS	
	1. 00	2.00	2. 01	2. 02	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10)	211, 115	211, 11	5 211, 115	211, 115	1. 00
2.00 Ratio of injection/infusion staff time to total health	0. 000022	0. 00109	0. 000000	0.000000	2. 00
care staff time	_			_	
3.00 Injection/infusion health care staff cost (line 1 x line 2)	5	23	0	0	3. 00
4.00 Injections/infusions and related medical supplies costs	187	2, 01	6	0	4. 00
(from your records)	107	2,01	0	0	4.00
5.00 Direct cost of injections/infusions (line 3 plus line 4)	192	2, 24	.6	0	5. 00
6.00 Total direct cost of the hospital-based RHC/FQHC (from	217, 932	217, 93	2 217, 932	217, 932	6. 00
Worksheet M-1, col. 7, line 22)					
7.00 Total overhead (from Wkst. M-2, line 19)	171, 495	171, 49		· ·	7. 00
8.00 Ratio of injection/infusion direct cost to total direct	0. 000881	0. 01030	0. 000000	0. 000000	8. 00
cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8)	151	1, 76	.7	0	9. 00
10.00 Total injection/infusion costs and their administration	343	4, 01		0	10.00
costs (sum of lines 5 and 9)	0.10	1, 01		o o	10.00
11.00 Total number of injections/infusions (from your records)	1	4	9 0	0	11. 00
12.00 Cost per injection/infusion (line 10/line 11)	343.00	81. 9	0.00	0.00	12.00
13.00 Number of injection/infusion administered to Program	1	3	4 0	0	13. 00
beneficiaries					40.04
13.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14.00 Program cost of injections/infusions and their	343	2, 78	5 0	0	14. 00
administration costs (line 12 times the sum of lines 13	0.0	2,70		Ü	
and 13.01, as applicable)					
				COST OF	
				I NJECTI ONS /	
				INFUSIONS AND ADMINISTRATION	
			1, 00	2. 00	
15.00 Total cost of injections/infusions and their administration	n costs (sum of	col umns 1,	1.00	4, 356	15. 00
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 admini				3, 128	16. 00
columns 1, 2, 2.01, and 2.02, line 14) (transfer this amour	nt to Wkst. M-3	, line 21)			

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 15-1315 Component CCN: 15-8530	Peri od: From 10/01/2022 To 09/30/2023	

RHC Cost Part B	
mm/dd/yyyy Amount	
1.00 2.00	
1.00 Total interim payments paid to hospital-based RHC/FOHC 211, 105	1.00
2.00 Interim payments payable on individual bills, either submitted or to be submitted to	2. 00
the contractor for services rendered in the cost reporting period. If none, write	
"NONE" or enter a zero	
3.00 List separately each retroactive lump sum adjustment amount based on subsequent	3. 00
revision of the interim rate for the cost reporting period. Also show date of each	
payment. If none, write "NONE" or enter a zero. (1)	
Program to Provider	
3.01	3. 01
3.02	3. 02
3.03	3. 03
3.04	3. 04
3.05	3. 05
Provider to Program	
3.50	3. 50
3.51	3. 51
3. 52	3. 52
3. 53	3. 53
3.54	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 211,105	4.00
27)	
TO BE COMPLETED BY CONTRACTOR	
	5. 00
each payment. If none, write "NONE" or enter a zero. (1)	
Program to Provider	
	5. 01
5.02	5. 02
5.03	5. 03
Provi der to Program	
	5. 50
5.51	5. 51
5. 52	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
6.02 SETTLEMENT TO PROGRAM 0	6. 02
	7. 00
Contractor NPR Date	
Number (Mo/Day/Yr)	
0 1.00 2.00	
8.00 Name of Contractor WI SCONSI N PHYSI CI AN SERVI CES 08001	8. 00

Health Financial Systems	CAMERON MEMORIAL CO	MMUNITY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FG SERVICES RENDERED TO PROGRAM BENEFICIARIES	HC PROVI DER FOR	Provider CCN: 15-1315 Component CCN: 15-8545	From 10/01/2022	Worksheet M-5 Date/Time Prepared: 2/14/2024 10:45 am

		Component CCN: 15-8545	10 09/30/2023	2/14/2024 10: 4	
			RHC II	Cost	10 dill
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			150, 226	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.00
	the contractor for services rendered in the cost reporting	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	Program to Provider			0	3. 01
3. 01					3. 01
3. 02					3. 02
3. 04					3. 04
3. 05					3. 05
3.03	Provider to Program			0	5. 05
3.50	Trovidor to frogram			0	3. 50
3. 51				0	3. 51
3. 52				ol ol	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) (trans	fer to Worksheet M-3, line		150, 226	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR		-		
5. 00	List separately each tentative settlement payment after des	k review. Also show date o	f		5. 00
	each payment. If none, write "NONE" or enter a zero. (1)				
5. 01	Program to Provider			0	5. 01
5. 02				0	5. 01
5. 02					5. 02
5.05	Provider to Program			0	5. 05
5. 50	Trovidor to frogram			0	5. 50
5. 51				o o	5. 51
5. 52				ol	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 PROVIDER	•		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			18, 331	6. 02
7. 00	Total Medicare program liability (see instructions)			131, 895	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
0.00		0	1.00	2. 00	0.00
8. 00	Name of Contractor	WISCONSIN PHYSICIAN SERVIC	ES 08001		8. 00

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH SERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 15-1315 Component CCN: 15-8546	From 10/01/2022	

RHC III Cost
1.00 1.00 1.00 2.00 2.00 1.00 2.00
1.00 2.00
1.00 2.00
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero content and payments and period in the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)
the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero
the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero
"NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider
revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 3.05 Provider to Program 5.50 3.51 3.52 3.52 3.53 3.54 3.99 4.00 Total Interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program
payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.04 0.0 3.03 3.04 0.0 3.04 3.05 Provider to Program 0.0 3.05
Program to Provider
3. 01 3. 02 3. 03 3. 03 3. 04 4. 00 3. 03 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 59 4. 00 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 01 5. 02 5. 03 5. 02 5. 03 5. 03 5. 04 5. 05 5. 06 5. 07 5. 08 5.
3.02 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider to Program 9.3.02 3.03 3.03 3.03 3.04 3.05 9.3.0
3. 03 3. 04 3. 05 Provider to Program
3. 04 3. 05 Provider to Program
3. 05 Provider to Program 3. 50 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Worksheet M-3, line 30, 961 4. 00 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5. 01 5. 02 5. 03 Provider to Program
Provider to Program
3. 50 3. 51 3. 52 3. 53 3. 53 3. 54 3. 99 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Worksheet M-3, line 5. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5. 01 5. 02 5. 03 Provider to Program
3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) T0 BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) T0 BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program
3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 30,961 4.00 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 30,961 4.00 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program
27) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program
TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program TO BE COMPLETED BY CONTRACTOR 5.00 5.00 9 5.00 9 5.01 5.02 9 5.03
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program 5.00 5.00 5.00 5.00 5.00
each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02 5.03 Provider to Program each payment. If none, write "NONE" or enter a zero. (1) 0 5.01 5.02 5.03 Provider to Program
Program to Provi der 5.01 5.02 5.03 Provi der to Program Program to Provi der 5.01 5.02 5.03 Provi der to Program 5.01 5.02 5.03
5.01 5.02 5.03 Provider to Program
5.02 5.03 Provi der to Program 5.02 5.03
5.03 Provider to Program 5.03
Provider to Program
, , ,
5.50
5.51 0 0 5.51
5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 5.99
6.00 Determined net settlement amount (balance due) based on the cost report. (1)
6.01 SETTLEMENT TO PROVIDER 2,944 6.01
6.02 SETTLEMENT TO PROGRAM 0 6.02
7.00 Total Medicare program liability (see instructions) 33,905 7.00
Contractor NPR Date
Number (Mo/Day/Yr)
0 1.00 2.00
8.00 Name of Contractor WI SCONSI N PHYSI CI AN SERVI CES 08001 8.00

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-1315 Component CCN: 15-8570	Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/14/2024 10:45 am

		Component Con. 13-8370	10 09/30/2023	2/14/2024 10: 4	
			RHC IV	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			36, 743	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		ol	2. 00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3. 01
3.02				0	3. 02
3.03				0	3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 5
3.52				0	3. 5
3. 53				0	3. 5
3.54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	ster to worksheet M-3, line		36, 743	4. 00
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	ck review Also show date of	F		5. 00
3.00	each payment. If none, write "NONE" or enter a zero. (1)	or review. Also show date of			3. 00
	Program to Provider				
5. 01	r rogram to rrovius.			0	5. 0°
5. 02				l ol	5. 0
5. 03				l ol	5. 03
	Provider to Program		<u> </u>		
5.50				0	5. 50
5. 51				0	5. 5
5. 52				0	5. 5.
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 9
6. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6. 0
6. 01	SETTLEMENT TO PROVIDER			10, 320	6.0
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			47, 063	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
0.00		0	1. 00	2. 00	0.00
8.00	Name of Contractor				8.00

Health Financial Systems	CAMERON MEMORIAL COMM	UNI TY HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1315 Component CCN: 15-8571	Peri od: From 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/14/2024 10:45 am

		Component Con. 13-8371	10 07/30/2023	2/14/2024 10: 4	
			RHC V	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			395	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		l ol	2. 00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero	•			
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3. 01
3.02				0	3. 02
3.03				0	3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 51
3.52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		395	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5. 00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5. 01
5. 02				0	5. 02
5.03	Describber to Describe			0	5. 03
г го	Provider to Program				F F0
5.50				0	5. 50
5. 51 5. 52					5. 51 5. 52
5. 99	·			l 0	5. 99
6.00	,	e cost report. (1)		2.0/5	6. 00
6.01	SETTLEMENT TO PROVIDER			3, 065	6. 01
6.02	SETTLEMENT TO PROGRAM Total Medicara program Lightlity (see instructions)			_	6. 02
7. 00	Total Medicare program liability (see instructions)		Contine	3, 460	7. 00
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
8.00	Name of Contractor	U	1. 00	2. 00	8. 00
0.00	Intalie of Contractor	I	I	1	0.00